Lessons from a Surgeon-Patient

A personal recollection of undergoing refractive correction.

BY DEAN CORBETT, BSc, MBChB, FRANZCO

I have always considered myself a sympathetic practitioner, taking my patients’ feelings and desires into consideration throughout the preoperative examination process and making sure they feel at ease during surgery. Occasionally, however, sympathy is not enough, as a patient may feel less than 100% confident of the surgical procedure and its ability to address his or her problem. Now, having undergone an ophthalmic procedure myself, I have another tool for patient education, communication, and relationship-building: empathy.

After having the Kamra corneal inlay (AcuFocus, Inc.) implanted and a LASIK enhancement procedure for my intermediate and distance vision, I can share my experience with patients to reinforce realistic expectations and explain the advantages of refractive correction from a personal viewpoint as well as that of an experienced clinician.

WHY I UNDERWENT SURGERY

At 48 years of age, I started to notice a decrease in visual quality. I had always been moderately hyperopic, but presbyopia set in rather quickly and I began having trouble with the daily near, intermediate, and distance visual tasks required in my busy refractive surgery practice. As you know, presbyopia is harder on hyperopes than myopes, who still retain near vision because of the nature of their refractive error. I look at a lot of pictures and data from imaging software, read the LCD displays on our instruments, and have to decipher tiny print on the packaging of products, and with my decreasing near vision I required spectacle correction for such tasks. I was constantly putting my glasses on at my desk and taking them off before I went into the operating room, where detailed near-vision tasks are not as commonly required but certainly encountered.

I tried monovision contact lenses, which worked well functionally. But I was intolerant to the lenses, and I also did not like the idea of bifocal or progressive spectacles, as I felt this would be cumbersome in my daily work. Following the postoperative course of 18 patients that I had treated with the Kamra corneal inlay and hearing about the rejuvenation of their near vision, even in relatively low light, and their decreased dependence on glasses, I made the decision to undergo the procedure myself. It was a natural progression from seeing my patients’ outcomes to having the inlay put in my own eye. In March 2011, I had the Kamra implanted in my nondominant eye.

The Kamra corneal inlay is intended for use in patients with presbyopia. To maximize reading vision, the ideal refraction for the Kamra inlay is -0.50 D to plano. The refractive error in my left eye was +2.25 -0.50 X 90º. Ideally, a refractive error more than 0.25 D should be treated with LASIK at the time of surgery. Therefore, my surgeon, Minoru Tomita, MD, PhD, and I agreed to combine the inlay procedure with LASIK to address my deteriorating intermediate and distance visual acuity. (To watch a recent interview with Dr. Tomita, visit eyetube.net/?v=neeru.)

LESSONS LEARNED

I had never been on the other side of the laser before. Surgically, I knew what to expect and was comfortable that my desire to address my quality of vision outweighed concerns about possible complications of the procedure. However, that did not stop me from thinking, “What happens if something goes wrong and I can no longer operate?” My confidence in the LASIK procedure coupled with the removable (or perhaps better considered upgradable) nature of the inlay surgery gave me confidence to proceed.

I learned a few things from my experience as a patient, all of which I take into consideration every time I meet and treat a new patient:
Lesson No. 1: Being a patient is more intense than I thought. The preoperative work-up that I underwent at the Shinagawa LASIK Center in Japan was extremely rigorous. As I have moderate dry eye, my eyes were uncomfortable and very red following the 3 hours of testing and examination. This has given me greater understanding of what my patients go through during the preoperative work-up at my own practice.

For me, on approaching surgery, there was no fear at all—not in a conscious sense—but I did have dreams of weird complications the night before, indicating a subconscious concern about having my eye operated on. I suspect that these concerns are even greater in the average patient, as at least I have firsthand experience performing this and other refractive correction procedures.

Lesson No. 2: The measurement of visual acuity is subjective. Of course, I knew this prior to undergoing corneal inlay implantation; however, I was reminded just how much of a gray area measuring visual acuity is. We rely on the patient’s depiction of what he or she can confidently see, and there is a vast difference between patients who pinpoint visual acuity and those who don’t bother to give an accurate response. This could be the difference of a couple of lines of visual acuity in some situations and, in some cases, not definable by the simple measurement of high contrast Snellen visual acuity on a chart that we call vision.

Lesson No. 3: No two patients are alike. As I said before, I have always tried to be sympathetic with my patients. But this specific experience reminded me that each patient has individual wants and expectations, and each will have a unique response to surgery. Only a portion of patients—those who are practical and relatively calm—will have an experience similar to what I had. More anxious patients might not relate to my description of surgery. Therefore, I tell my patients about my experience, but I also remind them that each person’s surgical journey is distinctively his or her own. With that said, being able to share my experience does help build the surgeon-patient relationship.

CONCLUSION

Corneal inlay implantation is not meant to be a panacea for all of near-vision tasks, but it was the most suitable solution for the rapid onset of presbyopia that I was experiencing. It also allowed my surgeon to use LASIK to address the hyperopic correction I needed as well. The good news is that I have only needed reading glasses for very low-light tasks since the procedure, something I explain to all patients as part of the informed consent. (This, in my experience, is a limitation to all current surgical methods of treating presbyopia.) Everything at work is vastly easier, and I have been nothing but delighted with the visual improvement I have experienced for performing daily tasks.

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