



Accurate patient selection, meticulous surgery, and collaborative postoperative care are essential to great outcomes with LASIK, PRK, EVO ICL, RLE/CLR, and cataract surgery. At Pacific Vision Institute, we are committed to collaborative eye care with our optometric colleagues and are grateful to the co-managing doctors in the San Francisco Bay Area optometric community for their trust with their patients, family members, and their own vision correction surgery.

Letting the Data Decide:

An Optometrist's Guide to Evidence-Based Decision Making in Modern Vision Correction Surgery

Patients trust their primary eye care doctor's opinion on surgical vision correction more than any advertisement, online review, or friend's recommendation. That trust carries real responsibility: the right recommendation depends on what the published evidence and a surgeon's own tracked outcomes actually show. This issue is adapted from *Seeing Clearly*, a book by Drs. Faktorovich and Parra on the evidence base for laser vision correction, EVO ICL, refractive lens exchange, and cataract surgery, currently in press. It is organized around the decisions the doctor may face in the chair: is this patient a candidate, which procedure fits their eyes and their goals, what should you tell them to expect before and after surgery, and what does the latest evidence show about the essentials of postoperative care.

THE BOOK'S CENTRAL PRINCIPLE

- Published clinical trial data establish the benchmark - what a technology can achieve, on average, across many surgeons and centers.
- A surgeon's own tracked, continuously refined outcomes determine what an individual patient is actually likely to experience.
- Both numbers matter. Teaching patients to ask for the second one is one of the most useful things a co-managing doctor can do.

SEEING CLEARLY

An Evidence-Based Guide to
Modern Laser, Lens, and
Cataract Surgery

- THE DATA.
THE EVIDENCE.
- THE OPTIONS.
EXPLAINED.
- BETTER DECISIONS.
BETTER OUTCOMES.

How to Use Data to Make Better
Decisions about Vision Correction Surgery

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Clinical News & Views

When to Initiate the Conversation

Patients in multifocal contact lenses have been the most common group of patients we've seen who have researched RLE/CLR, heard commercials on the radio, and are knowledgeable about different intraocular lenses, especially multifocal IOLs. They come in ready to schedule their surgery. Unless there is an ocular contraindication to multifocal IOL, they typically do well with them and the results have been exceptional.

PATIENT PRESENTATION	WHAT IT MAY SIGNAL	YOUR NEXT STEP
 Under 50, motivated to reduce dependence on glasses/contacts	 Candidate for LASIK, PRK, or EVO ICL depending on prescription and corneal findings	 Discuss laser vs. lens-based correction; refer for multimodal testing to confirm candidacy and finalize treatment plan
 50+, in multifocal contact lenses, arriving at their annual exam with some knowledge of treatments, having heard radio ads or from a friend	 Most likely a candidate for RLE/CLR, most likely with multifocal IOL – either trifocal or EDOF	 Discuss RLE including advanced IOL options; refer for RLE candidacy confirmation and to finalize treatment plan, including advanced IOL selection
 50+, prescription changing, subtle lens findings on exam	 Early cataract; the lens is often the likely culprit even with mild nuclear sclerosis	 Look for vacuoles, cortical opacities, oil droplet cataract on retroillumination. Discuss RLE or cataract surgery with advanced IOLs; refer for confirmation and to finalize treatment plan, including advanced IOL selection
 50+, decreased best-corrected vision or subjective dissatisfaction with vision that interferes with activities of daily living	 Could be lens-related, but also dry eye, EBMD, or epiretinal membrane	 Rule out surface and retinal causes first; once ruled out lens change should be considered. Discuss cataract surgery with advanced IOLs; refer for confirmation and to finalize treatment plan, including advanced IOL selection

In the majority of patients, procedure recommendation can be made based on age and refraction alone. Patients under 50 are considered for LASIK, PRK, or EVO ICL. Patients over 50, can be guided toward RLE. And patients over 60, most likely have lens changes that make cataract surgery an excellent path toward vision improvement.

Matching the Procedure to the Patient: A Candidacy Overview



For many patients, “LASIK” has become synonymous with vision correction surgery and for many patients, it is the right choice. For others, the right choice may be other laser vision correction treatments or lens based procedures like EVO ICL or RLE/CLR or cataract surgery with advanced lens implants. A thin or irregular cornea may point toward PRK. A moderate myope with minimal higher order aberrations may do well with SMILE — though it isn't the right choice for patients who can't have LASIK, and those hoping for the sharpest possible outcome. These patients are better served by custom LASIK or PRK. Higher prescriptions or corneas that rule out laser entirely may call for EVO ICL, while a presbyopic patient in their fifties who wants both distance and near vision may be better served by refractive lens exchange, which treats the aging lens directly. And any patient whose cataract is interfering with daily life — night driving, reading, recognizing faces, slowing down of activities they used to enjoy — is a cataract surgery candidate regardless of which of these categories they'd otherwise fit. For most patients, treatment recommendation can be made based on patient's age, prescription, and an eye exam.

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 PROCEDURE	 TYPICAL RX RANGE	 BEST CANDIDATES	 RECOMMEND OTHER PROCEDURE WHEN...
 LASIK	Low–moderate myopia, hyperopia, astigmatism	 Normal corneal thickness and topography; age 18+; refractive stability within 0.5D in a year AGE 18+	 Thin/irregular cornea, high myopia, presbyope who wants both distance and near and doesn't like monovision
 PRK	Similar range to LASIK	 Thin or irregular cornea otherwise unsuitable for LASIK; age 18+; refractive stability within 0.5D in a year AGE 18+	 Patient who doesn't want to go through the epithelial healing period; presbyope who wants both distance and near and doesn't like monovision
 SMILE	Myopia and myopic astigmatism only	 Moderate myopes with or without mild astigmatism, patients with minimal higher order aberrations AGE 22+	 Any patient who is not a LASIK candidate; mild myopes, moderate astigmatism; those wanting the best chance at 20/16 or better
 EVO ICL	–3.00 D to –20.00 D myopia (toric 1–4 D cylinder)	 High myopia; thin/irregular cornea; dry eye unresolved after treatment; age 21–60 AGE 21–60	 Anterior chamber depth insufficient; patient not comfortable with an intraocular procedure
 RLE	Moderate–high hyperopia; high myopia; significant astigmatism	 Presbyopic, typically 50+; not a laser or ICL candidate, or wants both distance and near vision AGE 50+	 Patient under ~50 without cataract who is good candidate for LASIK, PRK, or EVO ICL
 Cataract surgery	Any refractive error	 Cataract causing symptoms interfering with activities of daily living	 Not medically indicated — consider RLE if patient is presbyopic without cataract

 Final treatment choice should be based on a comprehensive eye exam, lifestyle needs, and a discussion with your surgeon.

LASIK, by the numbers



LASIK is one of the most studied procedures in medicine. A meta-analysis by Sandoval et al, published in the Journal of Cataract & Refractive Surgery and encompassing 67 peer-reviewed studies comprising 67,893 eyes treated between 2008 and 2015, reported that 90.8% of myopic eyes achieved postoperative UDVA of 20/20 or better. A recent update to the same data set extended the analysis to include contemporary platforms and reported that 96.4% of eyes in the most recent treatment cohort achieved 20/20 or better—a figure that reflects improvements in excimer laser platform technology, customized treatment ablation profiles, and patient selection algorithms. Patient satisfaction data from the PROWL-1 and PROWL-2 studies found that nearly 100% of participants reported satisfaction with their LASIK outcomes, and indicated they would recommend it to a friend or family member. These data were collected using validated PRO instruments and represent, to date, the most rigorous assessment of patient-reported LASIK satisfaction in a prospective, FDA-commissioned framework. The 2024 systematic review and

meta-analysis published in the Journal of Advanced Trends in Medical Research, which analyzed 26 studies comprising 1,879 LASIK patients, confirmed stable long-term outcomes for myopia and astigmatism with minimal complications, while noting that hyperopic outcomes require further long-term study

“Custom LASIK” is an umbrella term spanning five femtosecond platforms and four excimer customization modalities — up to 20 distinct procedure combinations share the name, which is why a surgeon's own tracked outcomes with their specific combination matter the most. Patients evaluating their options should ask what are the surgeon's specific outcomes — their personal rates of 20/20, 20/16, and 20/12.5 — with the technology they use? Published clinical trial data sets expectations for a technology platform and some platforms are better than others. A surgeon's own tracked outcomes reveal what to expect from that surgeon.



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PRK, by the numbers

Studies show that with PRK, patients can achieve excellent visual outcomes across all standard acuity thresholds. Head-to-head comparative studies consistently show equivalent visual outcomes between PRK and LASIK at 3–6 months postoperatively in

WHO IS A GOOD PRK CANDIDATE?

CLINICAL SITUATION	PRK INDICATED?
 Thin corneas below safe LASIK threshold	 YES
 Anterior basement membrane dystrophy	 YES
 Superficial corneal scarring or irregularity	 YES
 High-impact occupation or contact sports	 YES
 Military special operations roles	 YES
 Enhancement after prior LASIK or other refractive surgery	 YES
 Patient preference for flap-free procedure	 YES
 Adequate cornea, healthy ocular surface	 PRK OR LASIK — BASED ON FULL EVALUATION

appropriate candidates. A systematic review and meta-analysis by Shortt et al. (Cochrane Database) identified no statistically significant differences in efficacy or safety between the two procedures for low-to-moderate myopia at one year. In a prospective multicenter FDA trial of 334 eyes, 99.4% achieved 20/20 or better and 92.0% achieved 20/16 or better at 6 months — results that were maintained at 12 months, with patient satisfaction of 98.8%. A large cohort study of 1,250 eyes treated with PRK found that 92.1% of eyes achieved 20/20 or better and 99.2% achieved 20/40 or better at final follow-up. A 10-year retrospective study across 509 PRK eyes confirmed that at 5 and 10 years, PRK efficacy was similar to femtosecond LASIK in higher myopia ranges of –6 to –10 diopters and beyond.

Custom PRK: The Same Technology as LASIK Applied to the Surface

Corneal laser reshaping with PRK is identical to LASIK. The same four treatment modalities — wave-

front-guided, wavefront-optimized, topography-guided, and ray tracing-guided — are applied in PRK, using the same preoperative corneal mapping, the same diagnostic data transfer to the laser, and the same individualized ablation profiles. The difference is in how the stroma is accessed, not in how the correction is planned or executed. A patient who is a candidate for custom LASIK is, in most cases, a candidate for the equivalent custom PRK.

SMILE, by the numbers

The SMILE FDA pivotal trial reported 89% of eyes at 20/20 or better at 12 months, versus 96.4% for contemporary custom LASIK. A randomized contralateral-eye study at Stanford found 94% of custom LASIK eyes at 20/20 or better versus 83% of SMILE eyes in the fellow eye of the same patients. SMILE's early dry-eye comfort advantage over LASIK is real but transient, disappearing by 12 months in randomized data — it should not be the deciding factor. Because SMILE currently has no wavefront-guided, wavefront-optimized, topography-guided, or ray tracing customization option, percentages of patients seeing

20/20 and better than 20/20 are not as high as custom LASIK. SMILE is also a lamellar procedure like LASIK and most corneal findings that disqualify a patient from LASIK disqualify them from SMILE for the same underlying reason.

VISUAL OUTCOMES: SMILE vs CUSTOM LASIK

FDA trial and peer-reviewed data comparison across acuity thresholds

ACUITY THRESHOLD	SMILE (FDA TRIAL)	WAVEFRONT-GUIDED LASIK	WAVEFRONT-OPTIMIZED LASIK	TOPOGRAPHY-GUIDED LASIK	RAY TRACING LASIK
 20/20 or better	84–89%	93%	93%	93%	94.4%
 20/16 or better	59.3%	64%	76%	65%	70.2%
 20/12.5 or better	Not reported in FDA trial	36%	41%	34%	26.4%

KEY POINT

- A patient who isn't a good LASIK candidate isn't a good SMILE candidate either. And because SMILE can't incorporate wavefront-optimized, topography-guided, or ray tracing-guided customization the way LASIK can, its rates of better than 20/20 vision are not as good as LASIK

Clinical News & Views

EVO ICL: A Closer Look for Co-Managing Doctors

EVO ICL occupies a distinct niche: patients whose prescription or corneal anatomy makes them not ideal candidates for laser vision correction. In February 2026, the FDA expanded the age indication for EVO/EVO+ ICL from 21 to 60 years old, following three-year trial safety data in 629 eyes. The FDA pivotal trial reported 87.6% of eyes achieving 20/20 or better. A 10-year longitudinal study (Alfonso et al.) of 127 eyes documented a large share of patients remained at or near 20/20 a decade out. For the toric platform specifically, published cohorts document mean rotational stability under 5 degrees in the large majority of eyes. At comparable mean preoperative prescriptions for patients with high myopia— approximately -7.60 D across all three study cohorts — the three procedures achieve broadly similar 20/20 rates.

At low to moderate myopia, where both the EVO ICL and custom LASIK can be viable options, treatment with custom LASIK achieves meaningfully higher rates of vision better than 20/20 — a difference that reflects the ICL's lack of customization capability. Patients with astigmatism below 1.00 D may also better served by LASIK or PRK, as the EVO Toric ICL's minimum cylinder correction is 1.00 D while astigmatism as low as 0.25 D can be corrected with laser vision correction. Where the ICL holds its advantage is in corneal anatomy — it is appropriate for thin, flat, and irregular corneas — and in its correction range, which spans from -3.00 to -20.00 D.

EVO ICL vs Custom LASIK: Visual Acuity

	EVO ICL	Custom LASIK
Modalities included	Sphere + cylinder correction No HOA customization	Wavefront-optimized, topography-guided, ray tracing Pooled across FDA trials
Mean preoperative Rx	-4.61 D (range -3.00 to -6.00 D) ¹	-3.38 to -4.25 D (range -0.25 to -9.00 D) ² Varies across platform trials
20/20 or better	94.5% ¹	93–96% ² WFO 93% · Topo-guided 93% · Contemporary platforms 96.4%
20/16 or better	57.5% ¹	65–76% ² Topo-guided 65% · Ray tracing 70.2% · WFO 76%
20/12.5 or better	Not reported in FDA moderate myopia subgroup	34–41% ² Topo-guided 34% · WFO 41%

Figures are pooled from separate FDA trial datasets — not a single head-to-head study. The EVO ICL 20/20 and 20/16 figures are from the moderate myopia subgroup (-3.00 to -6.00 D) of the FDA trial. The EVO ICL 20/12.5 gap reflects the absence of this endpoint in the primary FDA subgroup trial.

¹ Packer M et al. EVO ICL for moderate myopia: FDA trial subgroup (-3.00 to -6.00 D). Clin Ophthalmol. 2022;16:3981–3991. PMID: 36510599.

² Custom LASIK pooled — WFO (mean -4.15 D, range -0.50 to -7.00 D); Moshirfar M et al. J Refract Surg. 2008;24(4):S424–430. Topo-guided (range up to -9.00 D); FDA PMA P030008/S012 (Contoura Vision, 2016). Ray tracing (mean -3.38 D, range -0.25 to -8.50 D); Krueger RR et al. Ophthalmol Ther. 2025. Contemporary platforms 96.4%; Sandoval HP et al. J Cataract Refract Surg. 2016;42(8):1224–1234. 20/12.5: Manche EE, Roe J. Am J Ophthalmol. 2014;157(6):1170–80.

WHAT TO TELL PATIENTS ABOUT VAULT AND SIZING

- “Vault” is the space between the ICL and your natural lens - the key safety parameter your surgeon monitors after surgery.
- Sizing uses corneal diameter and anterior chamber depth measurements, but what matters most is whether the surgeon tracks their own vault outcomes over time and refines their sizing approach accordingly - not just which published formula they start from.

Refractive Lens Exchange (RLE): A Closer Look for Co-Managing Doctors

RLE questions tend to come from a different patient than EVO ICL questions — typically a presbyopic patient in their fifties who wants to see better distance and near. RLE is an identical surgical technique to cataract surgery, but is performed before a clinically significant cataract has developed. It is generally considered when laser vision correction is inadvisable or when a phakic IOL is unsuitable due to patients wanting to address presbyopia. RLE is particularly well suited to patients with presbyopia and hyperopia, where laser correction is associated with higher regression. A 5-year follow-up study of hyperopic LASIK found a hyperopic shift — driven primarily by changes in the aging natural lens. RLE addresses this problem at its source: once the natural lens is replaced, that driver of refractive drift is eliminated, and vision becomes the stable, permanent correction. Among patients 45 and older presenting for laser vision correction screening, presbyopia — particularly emmetropic and hyperopic presbyopia — was the leading reason for LASIK non-candidacy. Many of these patients are well suited for RLE instead.



WHAT TO TELL PATIENTS ABOUT RLE

- “RLE uses the same surgery technique as cataract surgery, done a bit earlier - before your lens clouds - to improve your reading vision and reduce your dependence on glasses permanently.

Clinical News & Views

Cataract Surgery: A Closer Look for Co-Managing Doctors



Cataracts remain the leading cause of visual impairment, with roughly 28 million procedures performed annually worldwide. The most important shift in modern cataract care is the move away from a visual acuity threshold for surgical timing. **The American Academy of Ophthalmology's Preferred Practice Pattern** makes clear that surgery is indicated when the cataract causes symptoms interfering with daily activities — not when acuity drops to 20/40. This gives you latitude to refer based on functional complaints (night driving difficulty, glare, halos, washed-out colors, needing more light to read) even when Snellen acuity is good. The benefits of timely surgery extend well beyond the eye chart. First-eye cataract surgery is associated with roughly a 33% reduction in falls in prospective study. A 2024 meta-analysis of more than 558,000 older adults found that cataract surgery patients were 25–30% less likely to develop cognitive decline or dementia over 7–10 years compared with those who had untreated cataracts — a protective association not seen with other eye procedures. Up to 90% of patients

report improvement not just in vision but in overall quality of life after surgery. The IRIS Registry analysis of 440,781 cataract procedures found 20/40 or better vision in 94.3% of eyes, with 95% patient satisfaction.

Multiple randomized controlled trials — including the FEMCAT study — and a Cochrane systematic review found no clinically meaningful advantage of femtosecond laser-assisted cataract surgery (FLACS) over manual phacoemulsification in an experienced surgeon's hands. Any capsulotomy-consistency advantage from FLACS appears to be measurable only at a microscopic level and does not translate into a better outcome for the average patient — useful context when patients ask whether they should pay extra for a “laser cataract surgery” upgrade.

Some patients describe a temporary improvement in near vision as a nuclear cataract develops — so-called “second sight,” caused by the densifying lens shifting the eye toward myopia. It is not a true improvement and will not persist after surgery if basic IOL is chosen; it's a useful opening to discuss which lens technology will best replace



Cataract Surgery vs. RLE

	Cataract Surgery	Refractive Lens Exchange
Indication	Lens has clouded enough to impair function — medically indicated	Lens is clear or minimally cloudy but has lost accommodative flexibility
Surgical technique	Identical	Identical
Typical patient	Any age with visually significant cataract	Presbyopic, typically 50+, motivated to reduce glasses dependence
Lens conversation	Advanced IOL discussion is a secondary benefit of a necessary surgery	Advanced IOL selection is the primary purpose of an elective surgery

Subtle Lens Changes Can Be Symptomatic

Exam Finding	Why It Matters
Lens vacuoles, even a few	Early sign of lenticular change worth discussing with the patient
Anterior or posterior cortical opacity	May be visually significant even when mild on exam
Oil droplet cataract on retroillumination	Best seen on retroillumination; associated with prescription change and glare complaints
Mild “age-appropriate” nuclear sclerosis with new Rx change	In the absence of another explanation, the lens is the likely cause of the change
Decreased BCVA without a clear surface or retinal cause	Rule out dry eye, EBMD, and epiretinal membrane first — if new, consider the lens

Clinical News & Views

Talking to Patients About Advanced IOLs

For lens replacement surgery — either RLE or cataract surgery — the conversation should always include advanced IOL options. Think of it as the Rule of Three: an advanced lens implant can correct the cataract, distance vision, and near vision, but a basic lens addresses only the first of the three and cannot correct astigmatism — which is why patients who elect basic lens will need glasses for distance, intermediate, and near after surgery. They may be especially surprised if their cataract induced a myopic shift and they were able to read without glasses prior to their surgery. It is essential to test both distance and near uncorrected vision in patients preoperatively and discuss the loss of uncorrected near vision after cataract surgery unless advanced IOL is chosen.

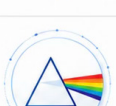
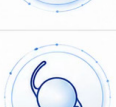
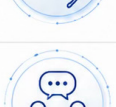
Can I Get A Basic Lens and Upgrade Later If I Don't Like it?

Lens exchange is technically possible but not straightforward. In the first days to weeks after surgery, while the capsular bag is still accessible, exchanging a lens is a relatively manageable procedure. Once posterior capsular opacification develops, or once the capsule has fully contracted around the lens — typically within weeks to months — a lens exchange becomes a substantially more complex operation with higher risk. The practical answer for most patients is that the choice made at the time of surgery is the one they will live with permanently, and that choice deserves the full weight of the preoperative consultation



A SIX-STEP IOL SELECTION PROTOCOL

Synthesized from ASCRS Clinical Survey data, ESCRS premium IOL guidelines, and patient-reported outcomes literature. A framework for organizing the variables that bear on IOL selection — not a rigid algorithm.

1		Assess ocular health Perform corneal topography, tomography, macular OCT, tear film evaluation. Any abnormality must be either treated (if treatable) or incorporated into the IOL recommendation and discussion with the patient.
2		Establish refractive target for distance For most patients, bilateral emmetropia is the default refractive goal. Monovision (one eye targeted for near) and micro-monovision (small interocular difference) can be recommended to some patients.
3		Quantify astigmatism and decide toric vs. non-toric Determine whether toric IOL is indicated. For a patient with corneal astigmatism of 0.75 D or greater, the toric variant of the chosen IOL platform is recommended or postoperative adjustment is made if a Light Adjustable Lens is recommended.
4		Align visual priorities with the IOL category Basic (glasses for all distances), toric (glasses for intermediate and near, unless monovision), EDOF (good distance and intermediate, limited near), trifocal/multifocal (broadest spectacle independence). Assess patient's dysphotopsia sensitivity to help navigate lens selection.
5		Select specific lens within the chosen category Within each category, multiple platforms are commercially available. Lens selection within category should be based on the surgeon's own documented outcomes with each specific lens platform, the patient's refractive profile and ocular dimensions, and any patient-specific factors.
6		Discuss expectations Confirm the patient can articulate: (a) a realistic probability range for spectacle independence at each distance; (b) primary functional tradeoff associated with the selected lens; (c) expected neuroadaptation timeline.

Lens Type	Best Suited For	What to Tell the Patient
Basic	Patients who understand the tradeoffs of needing bifocals, trifocals, or progressive glasses at all times, especially if they have astigmatism	"You will likely need glasses for all distances, including driving, watching TV, computer, and reading."
Toric	Patients with corneal astigmatism, especially if macular or optic nerve findings exclude multifocal/EDOF	"This corrects your astigmatism at the same time as your cataract/lens surgery — you will see distance without glasses, but reading glasses are still needed."
Trifocal / multifocal	Normal macula, optic nerve, and cornea; wants the least dependence on glasses at all distances	"This gives you the widest range of vision — far, middle, and near — but works best if your eyes are otherwise healthy."
EDOF	Wants good distance/intermediate vision with optimal nighttime vision	"Great for driving and computer work; you may still want reading glasses for fine print."
Light Adjustable Lens (LAL)	Corneal, retinal, or optic nerve considerations, high precision expectations, or wants to 'test drive' their vision before it's locked in	"We can fine-tune your prescription in the weeks after surgery, based on how you actually see, before locking it in."

Refractive Surgery Advisor

Surgeon-Specific Outcomes: The Most Important Number

Published benchmarks show what a technology can achieve; a surgeon's own tracked outcomes show what a specific patient is actually likely to get. A surgeon who rigorously tracks their results, identifies their own systematic biases, and refines their approach accordingly will consistently outperform published population benchmarks. Center-specific, surgeon-specific outcomes data is one of the most meaningful quality signals a patient — or a referring doctor — can ask for. The metrics worth asking about differ slightly by procedure, but the principle is the same across all of them:

Procedure	Key Personal Metrics to Ask About
LASIK	% BETTER than 20/20, % within ± 0.25 D of target, enhancement rate
PRK	% BETTER than 20/20, % within ± 0.25 D of target, enhancement rate
EVO ICL	% 20/20 or better, vault distribution, % within target vault range, enhancement rate
RLE	% 20/20+ at intended distance(s), % within ± 0.50 D, toric alignment accuracy, enhancement rate, spectacle independence
Cataract surgery	Same as RLE, plus posterior capsule rupture rate (the primary intraoperative quality metric)

Refractive Surgery Advisor:

Q: A patient asks me directly — ‘what would you recommend?’ How should I frame my answer?

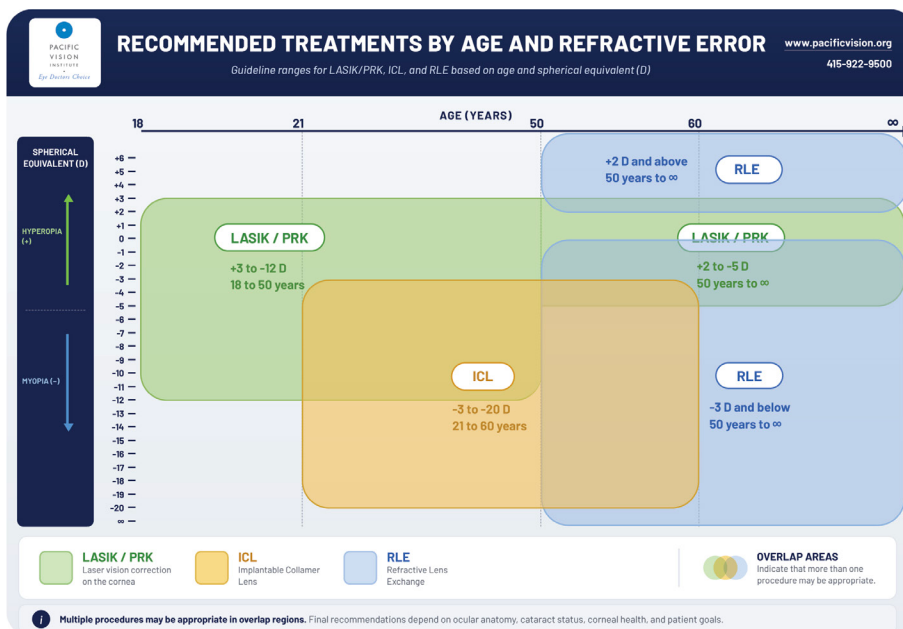
A: You can share what the evidence supports for their specific age and prescription range while making clear that additional testing at the surgeon's office will confirm their treatment plan. Most patients under 60 default to asking for LASIK by name; you can explain that the right procedure depends on their age, refraction, and eye health, not on which name is most familiar to them.

Q: What is the single most useful question for patients to ask their surgeon?

A: ‘What are your personal outcomes with this specific procedure and technology?’ Published benchmarks establish what a technology can achieve on average across many surgeons and centers. A surgeon's own tracked rates of 20/20 and BETTER, percentage within target refraction, and enhancement rate tell a patient what to expect from that specific surgeon.

Q: A 47-year-old patient wants LASIK but is asking about presbyopia. What should I tell them?

A: LASIK corrects distance vision; it does not prevent or delay the biological development of presbyopia. Patients in their forties who achieve excellent distance vision with LASIK will still need reading correction as presbyopia progresses — just like their peers who never had LASIK.



Q: When should I consider referring a presbyopic, non-cataract patient for RLE rather than continuing to manage them with contacts or glasses?

A: Patients who are in multifocal contacts or glasses and express interest in a permanent solution, RLE is worth discussing — particularly for patients with hyperopia or high myopia, whose preoperative dependence on optical correction predisposes them to appreciate postoperative gains most. Patients under 50 without a cataract may be better served waiting, depending on their refraction.