eFocus
a PVI publication for the Bay Area Optometric Community
PACIFIC VISION INSTITUTE
Eye Doctors Choice
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Pacific Vision Institute and the Science of Eyesight Foundation were proud to welcome Bay Area optometric community to the **20th Annual Advances in Eye Care San Francisco Symposium** held at the St. Regis Hotel in the heart of San Francisco. Nearly 200 doctors attended this iconic continuing education Symposium. Once again, we were honored to host world-renowned speakers who delivered timely and exciting presentations. The speakers came from outstanding local practices as well as other parts of US and Canada. This Annual Symposium represents an incredible collaboration between specialists in different areas who come together to shape the future of our patients' eye care.

Practical Guide to Co-Managing Today's Advanced IOL Patients: 5-Step Approach to Successful Outcomes and Happy Patients

We live in the most phenomenal time where technological advances allow us to offer our patients exceptionally clear vision regardless of their age, prescription, or ocular anatomy. With increasing advances in surgical eye care, we need to be especially attentive to understanding patients' needs, corneal and ocular nuances, and current IOL technology to insure that the right procedure and the right lens is chosen for each patient. Just this year alone there has been a shift from EDOF lenses to trifocals, such as PanOptix Pro and the expansion of Light Adjustable Lenses. Each patient has a unique life journey where their vision needs to be exceptionally customized to help them realize their full potential. When we counsel thoughtfully, chose meticulously, and treat precisely, we can deliver outstanding vision to our patients. These are some of the most grateful patients who fill our hearts with joy every time we see them.

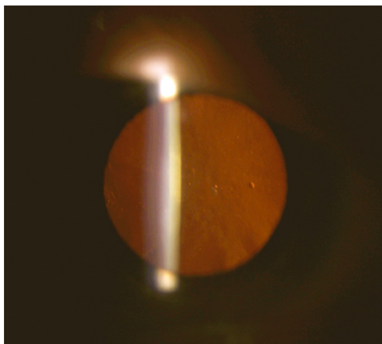
At Pacific Vision Institute, we developed a 5-Step approach to successfully guide today's advanced IOL patient on their journey to great postoperative vision.

Step 1. Diagnosis and treatment recommendation: OD's office

Each patient's journey begins at the office of their primary eye care doctor. These are often patients who have been seen in the office for years and matured together with the practice and the practice owner. They trust their doctor who may also be taking care of their other family members. The patients may not necessarily initiate a conversation with their doctor about surgical vision correction, such as RLE/CLR or cataract surgery. They may not want to take up doctor's time or may feel they can get the information on-line or from their friends. When is the right time to bring up surgical vision correction to older patients? We have identified three groups of patients with whom vision correction surgery can be discussed to open a conversation and position the practice as the source of knowledge and support for these patients. These patients are 50 plus years old (1) who are in **multifocal contact lenses** and/or (2) whose **prescription is changing**, and/or (3) who **can't get satisfactory vision with glasses and contacts**, especially at night.

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.

The second most common group of patients we are seeing are patients who are **50+ years old and whose prescription has been changing**. In an older patient, this typically means that the crystalline lens is changing and they have a cataract. Lens changes can look mild on exam, but if they effect prescription, they are visually significant. Here are some signs of lenticular changes - vacuoles (even a few), anterior cortical opacities, posterior cortical opacities, mild nuclear sclerosis, and oil droplet cataract (best seen on retroillumination). The lens may appear normal or with a mild "age-appropriate" nuclear sclerosis, but in the absence of other ocular reasons to explain prescription change, the lens is the likely culprit. RLE/CLR or cataract surgery is the definitive treatment for these patients. Earlier surgery is also an easier surgery, which means fewer possible complications than surgery on advanced cataracts.



Retroillumination can help visualization of subtle lens changes consistent with cataracts, such as lens vacuoles. Presence of vacuoles indicates cataract changes in the lens and cataract surgery may be recommended to patients, especially if patients experience changes in prescription, difficulty driving at night, and the need to increase light when they read. Retroillumination should

The third group of 50+ year old patients with whom lens surgery conversation can be initiated are patients whose best corrected vision decreased or who are complaining of being **unable to get good vision with glasses or contacts**. There could be, of course, other reasons for decreased best corrected vision in an older patient, such as dry eyes or unstable tear film, corneal abnormalities such as EBMD, and a commonly seen finding of epiretinal membrane. Unless these are new findings, the possibility of lens being responsible for decreased vision should be considered. If a patient has pre-existing ocular surface or retinal findings and vision starts to worsen, even mild lens changes can have significant effect on vision.

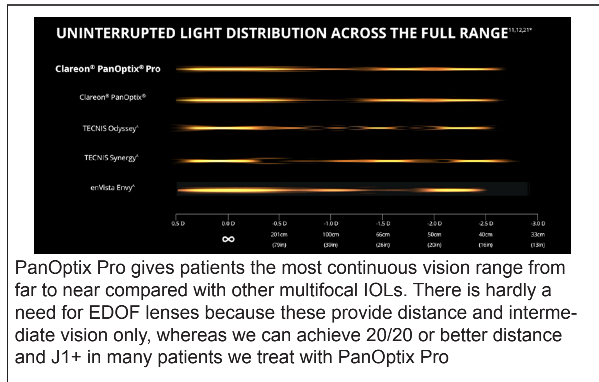
Once the diagnosis is made, treatment options can be discussed with the patient. In lens replacement surgery, either CLR/RLE or cataract surgery, this discussion needs to include advanced IOLs. We recommend discussing three types of IOLs - multifocal, light adjustable lenses (LAL), and toric lenses. All these lenses will give patients better vision than basic IOLs. Multifocals will give patients the widest range of vision and the best near vision. LALs will give the most precision and a possible opportunity for computer vision as well as distance, and toric lenses will improve uncorrected vision in patients with high astigmatism who are not candidates for either multifocal or LALs. All things being equal, there is no doubt that advanced IOLs will give patients better vision than standard monofocal lenses. Especially as the patients get older, their risk of fall is reduced significantly when they have good uncorrected vision.

Step 2. Surgical planning: surgeon's office

The collaborative care between patient's primary eye care doctor and the surgeon is the foundation of the best outcome for the patient. Even when the patients come to the surgical practice through online search or patient recommendation, we always reach out to their primary eye care doctor and discuss the case with them. Such collaboration allows the surgeon to better understand patient's ocular history, their optical preferences, such as history of monovision contacts or glasses or multifocal lenses, for example, and any eye conditions they experienced or treatment they received. Such collaboration is essential to IOL selection and planning of postoperative refractive goals.

5 ESSENTIAL TESTS FOR ADVANCED IOL PLANNING	What we are looking at
1. Biometry x2	K's and Axial Length have to be similar between the two sets of scans. High K's may lean us to ward toric IOL vs. LAL and multifocal
2. Trend-with-time topography	Variability between the scans may suggest unstable ocular surface that will require threatment before finilizing IOL recommendation. Three out of four symmetric and stable scans may suggest good candidate for multifocal lens despite one abnormal outlier.
3. Tomography to measure Corneal Spherical Aberation	Will reveal previous corneal refractive surgery. Also helpful in evaluating ocular surface to determine if treatment is needed prior to IOL selection
4. Macular OCT	ERM, AMD, VMT may lean us toward LAL or Toric IOL vs. multifocal
5. Optic Nerve OCT	Glaucomatous changes, atrophy may lean us toward LAL or Toric IOL vs. multifocal. Patient may also benefit from MIGS combinedwith their lens surgery

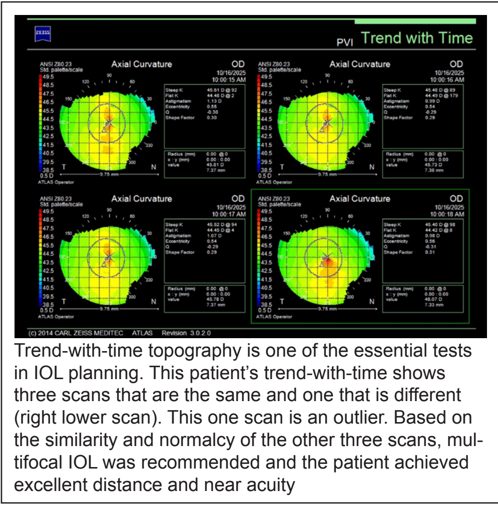
After obtaining refractive and ocular history from the optometrist's office, we initiate a series of Five Essential Tests for Advanced IOL Planning. The purpose of the tests is to determine if there are any ocular abnormalities that will steer the patient toward LAL or T-IOL rather than multifocal IOL; to determine whether ocular surface treatment will be needed prior to IOL surgery; what IOL type will correct patient's corneal astigmatism best, and whether adjunctive surgery with MIGs will be required.



PanOptix Pro gives patients the most continuous vision range from far to near compared with other multifocal IOLs. There is hardly a need for EDOF lenses because these provide distance and intermediate vision only, whereas we can achieve 20/20 or better distance and J1+ in many patients we treat with PanOptix Pro

For patients to enjoy great vision with multifocal IOLs, corneas have to be symmetric, tear film has to be stable, retina and optic nerve have to be healthy, the patient has to want great near vision, great range of vision, and they have to be OK with a small chance of dysphotopsia. Currently, PanOptix Pro is an excellent choice for patients who are good candidates for multifocal lOLs. Patients whose corneas are irregular, whose tear film is unstable despite treatment, who have epiretinal membrane (ERM), retinal dystrophy, or optic nerve abnormalities will benefit from either LAL or toric lOLs.

Trend-with-time topography can be helpful in determining if an irregular corneal scan is simply an outlier or representative or corneal and/or tear film abnormality. Here is a 4-scan topo on a patient showing three out of four scans as normal and symmetric and one outlier in the right lower corner. Based on this (as well as other essential tests showing normal cornea, tear film, and posterior pole, patient was determined a good candidate for multifocal IOL.



Trend-with-time topography is one of the essential tests in IOL planning. This patient's trend-with-time shows three scans that are the same and one that is different (right lower scan). This one scan is an outlier. Based on the similarity and normalcy of the other three scans, multifocal IOL was recommended and the patient achieved excellent distance and near acuity

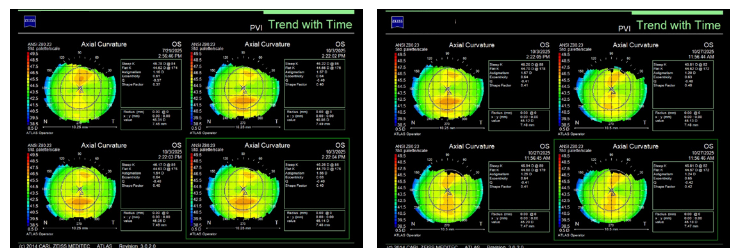
If scans are variable and/or patient has signs of blepharitis/meibomian gland dysfunction, we initiate our treatment protocol to normalize ocular surface. We then see the patient one month after and repeat biometry, trend-with-time topography and tomography to measure corneal spherical aberrations.

BLEPHARITIS/MGD TREATMENT PROTOCOL

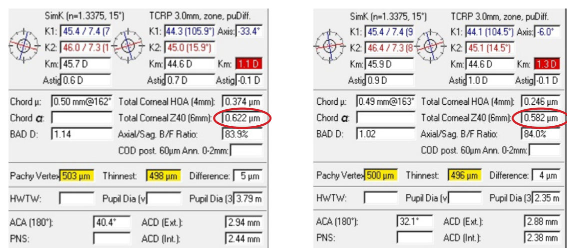
- Azithromycin 1 gm po QWeek x3
- Ofloxacin TID x 10 days
- FML 0.1% TID x 10 days
- OCuSOFT Hypochlor wipes BID
- Omega 3's 2,000-3,000 mg BID
- If Demodex (sleeves on lashes), add XDemvy Q12 hours x 6 weeks to the above protocol

Healthy ocular surface is important in both IOL choice and IOL power calculation. It is especially important when patient wishes to have multifocal IOL. If the tests normalize after ocular surface treatment and the patient is otherwise a good candidate and wants multifocal IOL, we proceed with this lens choice. Ocular surface is also important in LAL surgery. Light Delivery Device (LDD) can be very accurate in treating prescriptions as low as 0.25D. It is, therefore, important that refraction is accurate and stable after surgery so that accurate treatment is delivered. although this lens is less sensitive than a multifocal lens to tear film/corneal aberrations.

Macular OCT and optic nerve OCT are also essential components of the work up to determine what IOL is best for the patient. Epiretinal Membrane



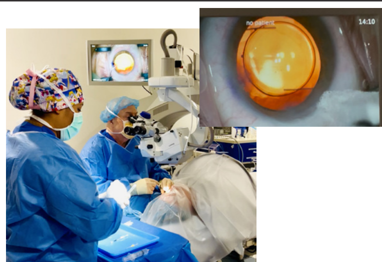
Patient 1. Time-with-trend topography before (R) and one-month after (L) blepharitis/MGD treatment protocol. Ocular surface appearance improved. Astigmatism is symmetric and regular. This patient is a good candidate for either a multifocal lens or LAL. She elected LAL with monovision target in non-dominant eye.



Patient 2. Pentacam showing corneal higher aberrations before (R) and one-month after (L) Demodex blepharitis treatment protocol. Ocular surface appearance improved. HOAs decreased from 0.622 to 0.582. Astigmatism is symmetric and regular. This patient is a good candidate for either a multifocal lens or LAL. She elected LAL with monovision target in non-dominant eye.

(ERM) is not necessarily a contraindication to multifocal IOL, depending on the stage and the status of the underlying retina. When in doubt, we recommend LAL or toric IOL. Optic nerve OCT measurements are benchmarked against normative database using sophisticated AI software. Patients with nerve fiber layer loss and glaucoma do best with LAL and torics, rather than multifocals.

Step 3. Surgery



Light Adjustable Lens implantation in a 59 year old patient undergoing RLE surgery to correct her high myopia and presbyopia. Pupillary dilation of at least 6 mm is required postoperatively to visualize the lens haptics and perform light adjustments. We include dilated pupillometry with a Colvard pupillometer in our preoperative assessment to determine if a patient is a good candidate for LAL.

Outstanding surgical fundamentals are very important to achieving precise vision outcomes for patients, regardless of Advanced IOL choice. These include extraordinary attention to detail as well as embracing the modern techniques - such as topical anesthesia (no blocks), bilateral sequential surgery performed on the same day, and seeing the patient later in the afternoon for their immediate postoperative exam. Special techniques may need to be utilized in patients with small pupils (various iris retraction devices, including Malyagin ring and/or iris retractors), patients with floppy iris (proper settings on phaco machine need to be utilized), patients with small eyes (intravenous mannitol), etc. Dr. Seibel developed an extensive program to manage and troubleshoot special considerations in patients with atypical presentations to help patients undergo surgery safely.

At PVI, our **Director of Lens and Cataract Surgery, Dr. Barry Seibel** authored a popular textbook on cataract and lens surgery fundamentals (currently in its 4th edition, translated into multiple languages worldwide). His sophisticated techniques are widely used by both experienced and novel surgeons.

Step 4. Postoperative care: surgeon's office

POD #1- this is the immediate postoperative exam (can also be done at the end of the day after same day surgery) - monocular UCVA is tested, both far and near. Also, IOP is checked with non-applanation tonometry. Corneal incision is checked and cell and flare is recorded. We typically expect patients' vision to be outstanding on POD#1 - with most patients seeing 20/20 far and J2 to J3 near after PanOptix Pro.

Doing very well, thanks doctor. Yesterday went well and I'm enjoying clear vision. Thanks doctor much. Hope all is well with you.

Great to hear!

Patients with LAL typically see 20/20 to 20/25 far and may see J3 to J6 near in their distance eye. Special considerations: if IOP is elevated, we recommend Simbrinza or Combigan BID

POW#1-2 - the same tests as on POD#1. We expect vision to be outstanding. If there is corneal edema, we recommend increasing frequency of steroids to Q2 hours, followed by a four week taper. If IOP is elevated, chose Combigan or Simbrinza BID. If IOP is related to steroid use, continue IOP lowering meds a week after steroids are discontinued. Steroid taper is typically over 4 weeks, cont IOP meds for 5 weeks. Patients with LAL lenses need to continue wearing UV blocking glasses. We typically start adjusting at 4 week postop, with patients being in the practice for about 3 months. After adjustments are completed and locked, patients will follow up with their co-managing doctor.

Postop Day 1 after bilateral RLE with LAL in a patient with preoperative myopia of -18D. Visual acuity is 20/15. Patients are instructed to wear special UV light blocking glasses until final lock in is performed.

Step 5. Postoperative care: OD's office

Postoperative care at the OD office typically begins at 1 to 2 months following multifocal and toric IOL surgery. LAL patients typically complete their adjustments by 3 months postop and then they are seen at their co-managing doctor's office.

POM #1 - These tests need to be performed: UCVA distance and near, IOP (may be applanation or tonopen), slit lamp exam of the anterior segment. We typically expect UCVA to be good, cornea to be clear, and anterior chamber to be quiet with perhaps an occational cell. Some patients may experience light sensitivity - this may be treated with topical steroids Q2 hours followed by a four week taper. Increased IOP may be treated as above.

POM #3 - If patients with multifocal implants have dysphotopsia, refraction needs to be performed. These patients may benefit from laser vision correction enhancement to improve quality of vision even if refractive error is small. We include laser enhancement in the Advanced IOL fee for our patients. Typically, we wait for stability and then do it, if necessary. Our enhancement rate for Advanced IOL patients is less than 1%. If BCVA is decreased, examine retina and posterior capsule. Consider YAG posterior capsulotomy if you see posterior capsular opacity (PCO).

POM #6 - In addition to the test performed at POM#1 and #3, patients should be dilated and retina should be examined. Annual exams should be encouraged to monitor eye health and any medical conditions patients may have.

Symposim Highlights Over the Years

Celebrating 20 years of Continuing Education for San Francisco Bay Area Optometric Community

Highlights of the 2nd Annual San Francisco Cornea Symposium

- **Intacs for Keratoconus,** *Brian Boxer Wachler, M.D., Director Boxer Wac hler Vision Institute, Beverly Hills, CA.*
Up to 2 year follow up data was presented on patients with keratoconus who underwent Intacs procedure. Intacs was shown to be safe and effective in improving both uncorrected and best spectacle-corrected visual acuity in patients with keratoconus. The data presented at the 2nd Annual San Francisco Cornea Symposium is now published in the April issue of *Ophthalmology* 2003;110:1031-1040

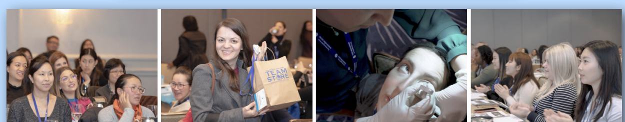
2nd Annual Cornea Symposium at the Four Seasons Hotel in San Francisco

- **Wavefront Laser Vision Correction: Comparison of Results from Different Technology Platforms,** *Ella G. Faktorovich, M.D., Director Pacific Vision Institute, San Francisco, CA.*
Fundamentals of Wavefront-guided laser vision correction were reviewed. Technology specifications and laser vision correction results were compared for CustomCornea with LADARVision/LADARWave vs. CustomVue with VISX StarS4/ WaveScan vs. Bausch and Lomb Zywave/ Technolas 217Z. The units of wavefront measurements were analyzed to facilitate accurate comparison of results.

- **Current Concepts in Antibiotic Resistance,** *David G. Hwang, M.D., Co-Director of UCSF Vision Correction Center, Professor of Clinical Ophthalmology, UCSF School of Medicine, San Francisco, CA.*
The emerging patterns of antibiotic resistance were discussed as well as the appropriate use of fluoroquinolones, including the new 4th generation. Caution was urged in tapering the fluoroquinolones beyond qid dosage to minimize development of resistance.

Issue 003 March 2006

Pacific Vision Institute held its 5th Annual San Francisco Cornea, Cataract & Refractive Surgery Symposium on March 17th at the Four Seasons hotel. Top doctors gave a very informative and entertaining seminar. For those of you who attended the Symposium, we thank you for coming and hope you enjoyed yourselves. For those who were unable to join us, we have summarized the main points from each speaker for you.
Scott Lee, O.D. Director of Clinical Care, Pacific Vision Institute; Editor-in-Chief eFocus; drlee@pacificvision.org



Pacific Vision Institute hosted the **16th Annual San Francisco Cornea, Cataract, and Refractive Surgery Symposium** at the Four Seasons Hotel in San Francisco on January 27th. Bay Area optometrists enjoyed a full day of lectures and workshops, earning 8 hours of FREE CE approved by California State Board of Optometry. Four prizes were raffled off at the end of the Symposium. The top prize winner received two tickets to a Warriors Game and the team swag.

Pearls for the Modern Optometric Practice:
Highlights of the 16th Annual San Francisco Cornea, Cataract, and Refractive Surgery Symposium

Issue 108 Fall 2005

The attendance at the 4th Annual San Francisco Cornea, Cataract, and Refractive Surgery Symposium held earlier this year reached an all-time high. PVI affiliated doctors Eliot Kaplan (Mill Valley, CA) and Gina Day (Larkspur, CA) [left] during the break. Dr. Steven Schallhorn [middle] of the U.S. Naval Medical Center concludes that large pupils are not a risk factor for night-time glare. Dr. Barry Seibel (Director, Cataract and lens surgery, PVI) and Dr. George Waring (Editor-In-Chief, Journal of Refractive Surgery) [right] discuss phakic IOL designs.

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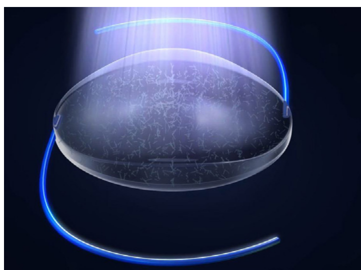
San Francisco Cornea, Cataract, and Refractive Surgery Symposium

Patient management pearls from the 10th Annual San Francisco Cornea, Cataract, and Refractive Surgery Symposium

Highlights of the 11th Annual San Francisco Cornea, Cataract, and Refractive Surgery Symposium

Vision for the Future:
Highlights of the 18th Annual San Francisco Cornea, Cataract, and Refractive Surgery Symposium

Pearls for co-managing the 3 types of Advanced IOL patients



Do's and Don'ts of Co-managing LAL patients

- **Do** have a thoughtful discussion with patients preoperatively about near vision. If a patient wants to see very small print and does not tolerate high add with monovision, multifocal IOL may be a better choice.
- **Do** expect the first postoperative visit at your practice to be about 3 months after the LAL surgery. It takes about 3 months for the full course of adjustments and lock ins at the surgeon's office. Some patients may take longer
- **Don't** stop optimizing ocular surface after the patient is back at your office to maintain good optical quality of vision

Do's and Don'ts of Co-managing Toric IOL patients

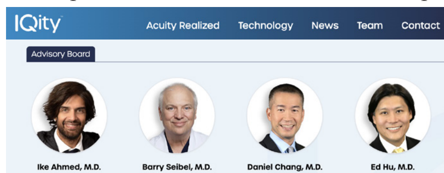
- **Do** consider toric IOLs in patients with corneal astigmatism more than 3D who are not candidates for multifocal IOLs. For patients with less than 3D of astigmatism, we can typically implant LALs with great success, adjusting the astigmatism postoperatively. Patients with more than 3D of astigmatism who are not candidates for multifocal lenses (irregular cornea, epiretinal membrane, glaucoma, etc), will do very well with toric IOLs, providing the preoperative measurements and surgery are done with meticulous attention to detail.
- **Do** distinguish corneal vs. refractive astigmatism preoperatively. Since lenticular astigmatism will be gone with lens replacement or cataract surgery, the only astigmatism that matters is corneal astigmatism. A patient with 5D of refractive astigmatism, may only have 2D of corneal cylinder and may qualify for LAL.
- **Don't** hesitate to refer patient back to the surgeon if postoperative astigmatism changes significantly. This may be due to lens rotation, which is rare and typically happens within the first couple of weeks. Once the capsule heals, the rotation is very unlikely

Do's and Don'ts of Co-managing Multifocal IOL patients

- **Do** evaluate for residual postoperative refractive error as a possible cause of dysphotopsia or less than desired distance or near vision. Small refractive errors can be corrected with LASIK or PRK to improve vision. At Pacific Vision Institute, advanced IOL fee includes laser vision correction touch ups if necessary.
- **Do** monitor for posterior capsular opacity and refer back to the surgeon for YAG capsulotomy
- **Don't** feel compelled to recommend a particular brand of a multifocal IOL. Many different companies manufacture the lenses and some brands may be better than others for particular patients.

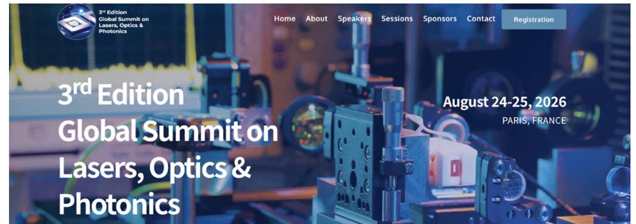
NEW TECHNOLOGY CORNER

At Pacific Vision Institute, we have unique opportunities to demo new diagnostic and treatment devices for corneal and lens surgery. Dr. Barry Seibel leads the field of robotic microsurgery through his innovative work in multiple companies, ranging from Zeiss to the newer tech companies, such as IQity. As the Board Member of this innovative company, Dr. Seibel helps develop novel devices, such as IQMeter to perform AI-driven YAG laser capsulotomy as well as the next-gen operating microscope system with AI assistance. His further work in novel IOL technology with Z-optics allows us to bring the most up-to-date technical advances to patients seeking the safest, most precise treatments, including cataract surgery, RLE/CLR, and EVO ICL. In bridging engineering and clinical work, we get away from marketing and focus on clinically relevant



Developments that make a true difference in patient outcomes.

- **PVI** is voted **The Best LASIK Eye Center of Bay Area** by ***SF Gate Best of the Bay 2025***. This prestigious honor is awarded to only one LASIK Eye Center in the Bay Area.
- **Dr. Faktorovich** is selected for the ***San Francisco Magazine* Top Doctors 2025 list**. The doctors chosen for the list were nominated by their peers when asked a question of whom they would chose for themselves or their family members.
- **Castle Connolly** selects **Dr. Faktorovich** and **Dr. Seibel** for their 2025 Top Ophthalmologists list. The list represents top 7% of 63,000 board-certified physicians in all specialties in the US.
- ***Ophthalmology Times*** interviews **Dr. Faktorovich** on the advances in laser technology for customized LASIK/PRK, including the new robotic technology Wavelight Plus
- **Dr. Seibel** inducted into the **Super Doctors Hall of Fame** for his continuous 20 year history of being nominated by his peers for excellence in cataract and lens surgery outcomes.
- **Dr. Seibel** is honored for his co-directing one of the top courses at the ***American Academy of Ophthalmology*** Annual Meeting "Learning Phaco Chop."
- **Dr. Faktorovich** is invited as Keynote Speaker to the ***3rd Global Summit on Lasers, Optics, and Photonics*** in Paris, France. Her keynote presentation "Novel applications of laser technology in refractive surgery: vision to infinity and beyond" will focus on new lasers in practice and development.



- **Dr. Seibel** becomes a consultant for ***Zeiss***, training the engineers and scientists on application of phacodynamics principles to equipment development and contributing to the design of Zeiss microscopes and phaco machines for cataract and lens replacement surgery.
- **Dr. Faktorovich** is an invited guest speaker at ***ageist.com podcast*** and ***shesez.com podcast***. Advances in IOL technologies are discussed as well as the concept of "aging forward".

Young OD Laser Workshop at PVI
"LASIK redifined: the role of WaveLight and CONTOURA in optimizing patient outcomes"

The hands-on workshop welcomed new grads and doctors who are early in their careers to experience doing laser vision correction with the latest technology

Refractive Surgery Advisor

Q: How soon can patients travel after their LASIK/PRK?

A: Patients can travel as soon as the next day after LASIK, after you see the eye doctor for postoperative Day1 visit. Patients can also travel the next day after PRK, but they will need to have the bandage contact lens removed 1 week after the procedure. We typically advise PRK patients to wait until after the lens is removed to travel. Air travel is fine but make sure to use Refresh Plus and Celluvisc on the plane, as the air tends to be dry on the plane.

Q: How do you decide what procedure to recommend to the patient?

A: Patients typically want our guidance in recommending the best procedure for them. Even when there are several procedures that may work well for the patient, they ask us "what would you do?" Most patient under the age of 60, come in asking for LASIK. LASIK is synonymous with "vision correction surgery." Based on patient's age and prescription, we have a pretty good idea what would work best for them. During their consultation, we perform 5 essential corneal tests to confirm the recommendation and plan the procedure. Many patients will do well with LASIK. Some will do better with PRK, EVO ICL, or RLE/CLR.

Q: What is the recovery like after EVO ICL?

A: Our patients' recovery is similar to LASIK. Right after the procedure we put transparent eye shields over the eyes to protect them. Patients then start using the antibiotic, steroid, and non-steroidal anti-inflammatory eye drops and continue them for 4 weeks after the procedure, tapering gradually. The next morning, our patients typically see 20/20 or better - similar to LASIK patients. We recommend patients don't get water or sweat in their eyes for two weeks after EVO. We also recommend no heavy lifting or forceful eye squeezing for two weeks after the procedure. Patients typically resume computer work the day after their procedure and can go back to work.

Q: What is the recovery like after RLE/CLR/Cataract procedure?

A: Our patients typically see well the day after their procedure, with some noticing significant improvement the day of. They can go back to work the day after their procedure. We recommend they avoid pressing, rubbing, or squeezing their eyelids for 3 weeks after surgery. They should avoid inverted yoga poses for 3 weeks after the procedure and try not to get water or sweat in their eyes. They can shower right away, and if some water gets in, they should gently blot it. Eye make up can be applied on the 3rd day after the procedure, providing it can be removed gently.

MOXIFLOXACIN	PREDNISOLONE	KETOROLAC
(antibiotic)	(steroid)	(anti-inflamatory)
Tan cap	Pink cap	Grey cap

DOSING SCHEDULE

WEEK	MOXIFLOXACIN	PREDNISOLONE	KETOROLAC
1	4 times a day	4 times a day	2 times a day
2	stop	3 times a day	2 times a day
3	stop	2 times a day	1 times a day
4	stop	stop	1 times a day

OPTOMETRIC CONTINUING EDUCATION & EVENTS

January 2026: OD Seminar "Practical Guide to Co-Managing Today's Advanced IOL Patients" - to be held in San Francisco, Marin, Peninsula, and East Bay

February, 2026: Hands-on OD Workshop "Optometrist's Guide to the Nuts and Bolts of Light Adjustable Lenses" will be held at Pacific Vision Institute with hands-on opportunity to learn Light Delivery Device adjustments of Light Adjustable Lenses

Ongoing: Live Surgery Observation for OD Staff (includes breakfast) - please contact us at comanagement@pacificvision.org to schedule the date and time for your staff to attend and learn

Ongoing: Lunch-and-Learn Education for OD Staff at your office (includes lunch provided by Pacific Vision Institute) - please contact us at comanagement@pacificvision.org to schedule the date and time for this fun and educational event for your office staff.

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