

Clinical & Refractive Optometry is pleased to present this continuing education (CE) article by Dr. Langis Michaud entitled **Cataract Surgery: Contact Lenses' Best Friend**. In order to obtain a 1-hour Council of Optometric Practitioner Education (COPE) approved CE credit, please refer to page 62 for complete instructions.

Cataract Surgery: Contact Lenses' Best Friend

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INTRODUCTION

As primary care providers, optometrists should realize that there are many options available for them in properly taking care of the specific needs of their patients. This means that the practitioner should advise the patient about the best options available for them each and every time.

In contact lenses, this may translate into adapting a certain type of material to the patient, or proposing a more appropriate schedule of wear. It can also mean the recommendation of ocular surgery, making the referral, and ensuring the follow-up of the patient. The following case falls under this category of clinical approach.

SUBJECTIVE

FD, a 60-year-old Caucasian female, had been wearing contact lenses for more than 30 years. Fitted initially with rigid lenses, she adopted gas-permeable contact lenses after a few years. In 1998, she was fitted with conventional soft lenses but reverted back to gas-permeable contact lenses in 2003 to improve the quality of her visual acuity.

Over the years she had tried several combinations of lenses: monovision, bifocal soft lenses, multifocal gas-permeable lenses, and finally, spherical lenses. She had preferred to maintain sharp, clear, uncompromised vision at far, relying on a reading pair of glasses for near. She is a dietician who works most of the time at near distance but has to achieve good vision for driving and other outdoor activities.

In December 2005, she was seen for her annual contact lens exam. At this time, she complained about a marked reduction of her visual acuity, affecting both eyes for the previous few months. Her symptoms were present

to a greater degree during her contact lens wear especially during near activities (reading, computer). She also admitted to being bothered when driving under intense light conditions (sunny days). Since her symptoms were reduced with glasses, even if they persisted, she ceased to wear her contact lenses in April 2006. She is interested in resuming her regular wear if we can improve her condition. Her last pair of lenses prescribed was PureVision spherical lens for OD (-2.75) and PureVision Toric lens for OS (-4.00 -0.75 x 170).

She takes medication for arterial hypertension (Altace) and for anxiety (Prozac). No other elements were remarkable during the case history.

OBJECTIVE

Preliminary tests showed normal binocular condition, and both pupils were reactive to light and accommodation. Subjective refraction was evaluated as follows: OD -2.25 -1.00 x 90 6/7.5 (20/25) and OS -3.75 -1.50 x 165 6/9- (20/30-). Under induced miosis (through increased lighting), visual acuities dropped to 6/9 (20/30) and 6/12- (20/40-).

Biomicroscopy revealed clear corneas, calm anterior chamber OU and a few opacities under the posterior capsule of the crystalline lens, more on the left side. Intraocular pressures were slightly elevated at 22 mm Hg OU but pachymetry values were high as well: 595 and 600 μ m. Central and peripheral visual fields were complete and normal.

Dilated fundus examinations were performed and we found no difference prior to previous results: lattice and cobblestone degeneration in periphery of both retinas without any hole, traction or detachment. After this test, we took a second look at the crystalline lenses and the opacities on the posterior crystalline lenses appeared more clearly, directly on the visual axis of both eyes.

ASSESSMENT

The reduced visual acuities as reported by the patient were obviously linked with the development of the lens opacities. These early cataracts disturb the perception of the images and their location, in the middle of the visual axis. This correlated to the fact that the symptoms were

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more present during miosis, either due to the lighting conditions or to the accommodative process.

In our opinion, there was only one way to resolve these opacities and we recommended to the patient that she consult an ophthalmologist in order to remove the cataracts.

PLAN

The surgeon was consulted in March 2006. He recommended that the patient consider a monovision approach or correction with multifocal implants, however, considering her previous experience with contact lenses, the patient did not accept these recommendations. Therefore, regular cataract surgery was performed and regular implants, correcting for far only, were inserted.

FOLLOW-UP

I saw the patient again in December 2006. She was very happy with her situation. The surgery had gone very well — greater than her expectations — and she used reading glasses alone to correct her near vision. She began to consider a correction at far, as she was becoming involved more frequently in driving and outdoor activities. She is investigating to be fitted again in contact lenses.

POSTOPERATIVE FINDINGS

- OD +1.25 -0.50 x 20 6/6 (20/20) (non-dominant)
- OS +1.00 -0.50 x 175 6/6+ (20/20+) (dominant)
- Add +2.50 0.37 M

After discussion with our patient, we decided to again try multifocal contact lenses, based on a design she had not tried before and that is working exceptionally well for hyperopic patients. We selected PureVision Multifocal lenses, first trying +1.25 high add OD and +1.50 low add OS.

Silicone hydrogel material is mandatory in providing hyperopes sufficient oxygenation to the cornea. More, on a traumatized eye (following surgery) we should try to minimize the side effects of the contact lens wear; silicone hydrogel lenses definitely contribute to this. Habitually, my empirical fitting with PureVision lenses relies on the use of a higher add on the non-dominant eye and a

reduced addition power on the dominant side. After stabilization of the lens, I equilibrate the lenses by adjusting the sphere component, depending on the needs of the patient.

In this case I had to proceed differently, as sometimes occurs for some hyperopes. After my initial fit, the patient did not feel comfortable at near. I tried to increase the plus sphere power on the non-dominant side (+0.25 and +0.50) but this did not greatly improve the outcome. Increasing the sphere (more plus) on the left side blurred the distant vision too much. The only option remaining was to change the addition on the left side for the high power. That worked well and the patient was satisfied with her visual acuities, both at far and at near. She felt the lenses were very comfortable and easy to handle. I prescribed a hydrogen peroxide care regimen (Clear Care) and explained a progressive schedule to re-initiate contact lens wear.

I saw the patient for a follow-up two weeks later and she confirmed that the lenses were just perfect. They provided good vision at far, at near and at intermediate distance, and she was able to wear them for more than 14 hours a week. Her care regimen was well tolerated. Examination revealed binocular vision of 6/6+2 (20/20+2) at far, 0.5 M+ at near. Biomicroscopy revealed no anomalies and no corneal or conjunctival staining.

CONCLUSION

Optometrists should be open to recommending ocular surgery to their contact lens patients. This is true for cataract surgery, when it is needed. It is even truer for refractive surgery in patients who comply with their contact lens wear. Even if patients are asymptomatic, it is good practice to expose the patient to all the options available, to offer optometric expertise in the process, and to follow the patient adequately following surgery.

If optometrists are not proactive in this area, they should be prepared to lose a significant number of their patients. Instead, by providing their patients complete and unbiased information, they significantly increase the confidence of their patients, who will then remain in the practice for postoperative care instead of simply leaving without explanation. That is part of the reality of a modern contact lens practice approach. □