

ablation pattern. If no abnormality is found on topography, consider wavefront analysis to determine if any significant higher-order aberrations have been induced. If so, a customized or wavefront-guided ablation can be performed, with the goal of resolving the patient's symptoms and improving the overall quality of vision.

#### After refractive lens exchange

Complications are uncommon, with risks that are similar to a cataract operation with insertion of an intraocular implant. The most serious complication is endophthalmitis; fortunately, the incidence is <1 in 10,000 eyes. Other complications include corneal edema (transient or permanent), subluxation of implant, cystoid macular edema, toxic keratopathy from eye drops, capsular opacification, and retinal detachment. Detecting these complications is critical for early rehabilitation. A residual refractive error can be treated by either a secondary implant in the sulcus to correct hyperopia or myopia, limbal relaxing incision to reduce astigmatism, or laser vision correction.

#### After phakic IOL

As with all intraocular procedures, there is a small risk of endophthalmitis. A more common complication with a posterior chamber phakic IOL is pupillary-block glaucoma. The patient presents with pain, elevated intraocular pressure, and a shallow anterior chamber. The previous laser iridotomies may be closed, requiring emergency retreatment. In general, the complications vary, depending on the phakic IOL and include subluxation of the implant (Verisyse > ICL); transient corneal edema (Verisyse > ICL); cataract (Verisyse < ICL); pigmentary glaucoma (Verisyse < ICL); and pupillary-block glaucoma (Verisyse < ICL). A residual refractive error can be treated with laser vision correction.

#### The bottom line

Refractive surgery patients require a high level of attention from the eyecare team, from the first phone call to the last follow-up visit. Determining a patient's suitability for refractive surgery is based on both objective criteria and an evaluation of their motivation and personality. Patients who cannot tolerate less than a 20/15 result, are pregnant, or have vision-threatening retinal disease, should be discouraged. Candidates for refractive surgery should undergo external eye, slit lamp, and fundus examinations, manifest and cycloplegic refractions, determination of pupil size, computerized videokeratography, pachymetry, and wavefront-imaging. The patient's general health and sensitivity to medications are important parts of the history. Monovision should be discussed with all presbyopic and early presbyopic patients. The surgeon must help patients to make informed decisions about the best procedure for them, be it laser vision correction, refractive lens exchange, or phakic IOL, and should take care not to promote unrealistic expectations. Clear guidelines and an efficient protocol will make refractive surgery rewarding for the refractive surgeon, the eyecare team, and the patient.

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