

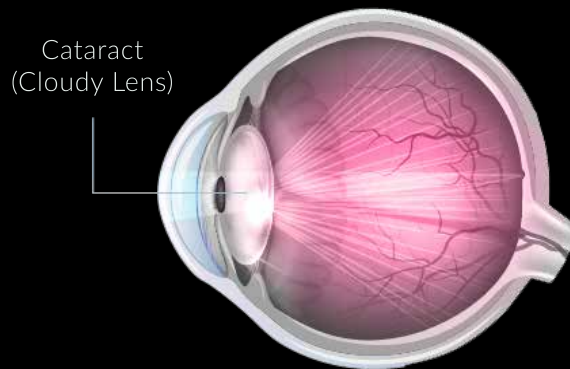


HOOPES VISION

What You Should Know About

Cataract, Lens Implants, and LASERS

A Guide for Patients and Their Families



written by

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13th edition

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FOREWORD

It is estimated over three million cataract operations are performed annually in the United States, making it one of the most frequently performed surgical procedures. Yet, for many patients and their families, there is a lack of understanding about cataracts and cataract surgery. It is the intent of this book to help individuals better understand what lies ahead in their treatment. The more informed a patient is, the easier it will be for them to make proper decisions about cataract surgery, such as, when to operate, what lens implant to choose, where to be operated on, and which doctor and procedure to select. Those who are close to or who will help take care of the patient, will also benefit from this book.

If you are experiencing blurred vision interfering with your activities, the most important step is to make an appointment with your eye doctor to test your vision and evaluate your eyes. This will include reading the eye chart, an eye examination, and review of your medical history to find and uncover any other problems you might have. If advancing cataracts is the cause of your blurry vision, your doctor will then refer you to a competent eye surgeon, who can fix the problem.

The biggest decision a patient must face is choosing the right surgeon. We believe one of the most important factors, besides good surgical technique and ability, is to find someone who genuinely cares about you, and is willing to put your health and welfare above everything else. Many surgeons can perform good surgery but may not be able to respond to you as an individual. Techniques are changing and evolving monthly, and your surgeon must keep current, even if it means spending a considerable amount of time and money attending courses, seminars, and meetings.

Make sure the surgeon you choose is a board certified eye surgeon and trained at a reputable residency program. Your surgeon should have access to excellent equipment and facilities. * The team of surgeons at Hoopes Vision in Draper, Utah, offers the most advanced cataract surgery techniques and equipment, combined with the most extensive list of implant options you will find anywhere in the Intermountain West region. When considering cataract surgery, it is very important to understand your lens implant options, so you can select a lens that best aligns and matches your lifestyle. Hoopes Vision surgeons, past and current, have performed more than 150,000 cataract surgeries.

The fees charged should be reasonable and in line with others in the area. Today, there are several technically superb surgeons around the country; and no one single surgeon or group of surgeons should charge astronomical fees out of line with what others charge. Ask if they accept Medicare assignment. If they do, it will be a tremendous financial savings to patients who have Medicare and tells you the doctor is genuinely concerned about your personal financial situation. It also shows that the doctor is doing their part to help decrease rising healthcare costs.

Today, there is no reason to delay treatment and surgery until the cataract completely takes away vision. With present technology and improved techniques, cataract surgery should be welcomed, not feared. Today, surgery depends on how much the resulting blurred vision affects your current lifestyle and everyone's safety.

**Does your surgeon have, or participates in, a clinical research center where new technologies, implants, techniques, and equipment are studied and compared?*

CHAPTER I

TYPICAL PATIENT ENCOUNTER

James Barnett nearly ran the stop sign. He didn't see it clearly until it was almost too late. As he and his wife, Eileen, continued down a street they had taken so many times before, Eileen pointed to a sign announcing new construction. "Look what they are building in the old ball field," she said.

James squinted at the large sign, but the letters were blurry. "I didn't see what it said," James responded, "It went by too fast."

Eileen knew her husband's vision was poor, and for months she refused to go anywhere with him at night unless he let her drive. Now she knew his vision was really getting worse. However, it wasn't something he wanted to talk about. He was afraid something was seriously wrong with his eyes and remembered what his mother had gone through when she had cataract surgery many years ago.

Not only was glare bothering James' eyes, especially from headlights and streetlights when he drove at night, but also colors seemed more faded. The roses Eileen grew did not appear nearly as bright red this year as years before. James was also having trouble seeing small letters and words in the newspaper, as well as feeling embarrassed by misreading a number in the telephone directory. He initially had thought his bifocals needed strengthening, but a recent change in glasses didn't seem to help.

After dropping Eileen off at home (much to her relief), James drove to the golf course. He watched more carefully for stop signs and found he was awfully close to an intersection before the sign was clear. On the golf course, James drove the

golf ball down the fairway but lost track of it after about thirty yards. The other members of his group applauded loudly, so he assumed he had made a good shot, smiled thankfully, and waved. He drove the golf cart straight down the fairway hoping he was going towards where his golf ball might be. He wasn't even close, and one of the foursome mocked, "Are you blind, Jim?"

James knew then it was time to make an appointment to see Dr. Mitchell and have his eyes checked.



CHAPTER II

THE EYE EXAMINATION



James' son-in-law drove him and Eileen to Dr. Mitchell's office. Once there, they had a brief wait in the reception area before being escorted to an examination room filled with machines and equipment. As Dr. Mitchell entered the room he asked, "How are things going, James?"

"Just fine, Doc. Except everyone is bugging me about my poor vision," he replied.

Dr. Mitchell asked, "Do you think your sight has gotten worse since I last saw you?"

“Well, reading is harder, and it takes a real effort, but I didn’t think things were too bad until I noticed I was having trouble seeing the road signs when I was driving the other day,” he said.

“It sounds as if your cataracts are progressing,” said Dr. Mitchell, “But let’s make sure nothing else is wrong.”

After covering James’ left eye, Dr. Mitchell instructed him to read the eye chart at the end of the room.

“Huh,” exclaimed James. “I can only see the second line from the top.”

“That’s 20/100 vision. How about the other eye,” asked Dr. Mitchell, as he covered James’ right eye?

“That’s much better,” said James. “E, G, N, U, S.”

“That’s the 20/50 line, which means you can see letters at 20 feet that the average person can see at 50 feet,” explained Dr. Mitchell.

“That sounds pretty bad,” said James.

“It’s gotten worse since the last time I saw you, James. Legally, 20/40 vision is required for driving during both day and nighttime, so you really shouldn’t be driving anymore,” said Dr. Mitchell.

Dr. Mitchell then checked James’ eyes with a small bright light, looking for problems related to eyelids, the size and reaction of his pupils, muscle balance,

and eye movement. He next asked James to place his chin in an instrument called a slit-lamp; a type of microscope that allowed Dr. Mitchell to look at James' eyes under high magnification with a slit of light coming in from the side. After using the slit lamp and swinging it to one side, Dr. Mitchell placed anesthetic drops in James' eyes.

"That stings a little bit," said James.

"Yes," said Dr. Mitchell, "but it will only last a few seconds. Now, gently blot your eyes with this tissue. I'm going to perform a glaucoma test, which measures the fluid pressure in your eye."

After that test, Dr. Mitchell said, "In order for me to get a look inside your eyes and to see your cataracts more fully, I need to place a drop in each eye to dilate your pupils. This drop will take about 30 minutes to work."

After Dr. Mitchell had put in the drops, he left to examine another patient. When he returned, he checked James' eyes with a light. This time with an instrument called an ophthalmoscope. Later, he put on a strange-looking headband with a bright light on it (an indirect ophthalmoscope) and looked inside each of James' eyes through a small hand-held lens. He asked James to gaze in various directions so he could see into the corners of James' eyes. He took the head lamp off and said, "The back of your eyes and the optic nerves look healthy. You don't have glaucoma or any other form of deterioration in the macula or the retina."

"The macula," James inquired?

"The macula is an area near the center of your retina," said Dr. Mitchell. "It

provides the sharpest, straight ahead, central vision. I can't improve your sight any more by changing your glass prescription. I think the time has come for you to consider having your cataracts removed."

"You mean surgery?" Eilene and James asked together.

"Yes. There are no medicines, diets, vitamins, or exercises that will help a cataract," said Dr. Mitchell. "Because I don't perform surgery, I want to send you to a specialist who does nothing but eye surgery and is up on all the best and newest treatments."

"Dr. Baker is the eye surgeon I usually refer my patients to," Dr Mitchell said. "He specializes in surgery on the anterior portion of the eye, which includes cataract surgery, implants, corneal transplants, and laser surgery. I refer to him because I believe he is one of the most skilled surgeons I know, and his employees always treat my patients well."

"Most of my patients thank me for sending them to Dr. Baker and his staff. Unless you prefer someone else, I'll ask my secretary to make an appointment with Dr. Baker. While you're waiting to see him, I want the two of you to talk this over and if you decide to have the operation, start thinking about a convenient time. I will leave the details about the operation to Dr. Baker and his staff. After your operation and when your condition appears stable, Dr. Baker will send you back to me so I can monitor your postoperative course and change the lenses in your glasses if necessary. I will also continue to follow you and your family for routine eye care."

James decided to see Dr. Baker; and an appointment was set up for two weeks

later. On that day, after Dr. Baker completed an examination of James' eyes (like the one Dr. Mitchell had done), he talked with the Barnetts in his office.

"Mr. Barnett, I agree with Dr. Mitchell's assessment about your eyes and the changes of your cataracts," said Dr. Baker. "I think you would benefit from cataract surgery. Your eyesight isn't going to get better until your cataracts are removed."

"I am sure you have a lot of questions about cataracts and cataract surgery," said Dr. Baker. "To answer those, we have prepared special booklets and information on cataracts and cataract surgery. After you read them, I will answer any remaining questions you might have and discuss the surgery further, so you won't have any surprises on the day of your surgery."

The next two chapters cover the information James and Eilene Barnett received at Dr. Baker's office.

CHAPTER III

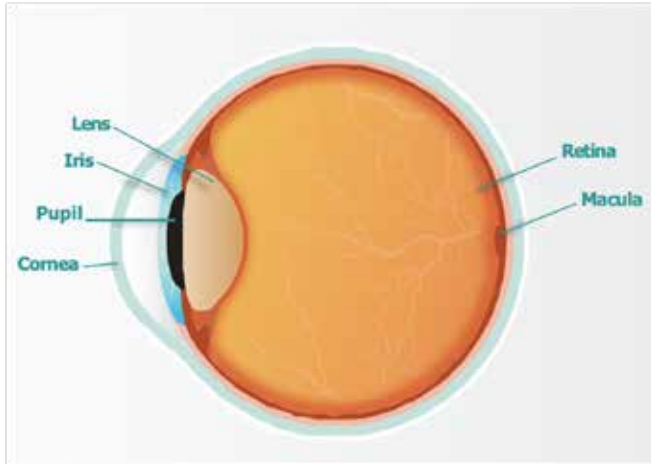
WHAT ARE CATARACTS?



For most of our lives, our eyes provide us with good vision; although many of us, in time, require glasses to sharpen that vision. We take good vision for granted until it changes or is threatened, then we quickly learn to appreciate the precious gift of sight. Surveys have shown, fear of blindness is second only to fear of cancer.

Cataracts are by far the most common treatable cause of poor vision. To better understand what a cataract is, it is helpful to know something about the eye and how it works.

The eye is actually a very complex structure, which is closely related to the structures of the brain. To put it simply, the eye is like a camera. Light enters



through the clear front of the eye (the cornea), passes through the pupil (the opening in the center of the iris, or colored portion of the eye), and is focused by the lens, which lies just behind the pupil and the iris, onto the retina. The pupil is like the aperture or opening of a camera. It gets larger or smaller depending on how much light the eye is exposed to.

The clear lens of the eye is like the lens of a camera, in that, it focuses light to provide clear distinct detail. In the back of the eye is the retina, which is like the film in a camera. It receives the light, but instead of sorting it to be developed into a photograph, it transmits the light to the brain through the optic nerve. If the retina is in good condition, the picture will be clear; if the retina is damaged or has aged considerably, the picture may not be so clear.

The lens is normally clear and surrounded by a special capsule that holds it in place and helps it change shape to focus an image. When this lens becomes cloudy, a cataract is present. The entire lens does not need to be cloudy. A cataract can have cloudiness or opacities anywhere in the lens.

Most cataracts are a natural part of the aging process and are found to some degree in up to 65 percent of persons in their sixties, and in over 80 percent

of persons older than 70 years of age. In one recent large study, 15 percent of persons 52 to 85 years of age had cataracts that reduced their visual acuity to below normal. It is estimated that 5 to 10 million persons throughout the world become visually disabled each year because of cataracts. In this country alone, some 3,000,000 cataract operations are performed each year. Patients who refuse surgery for cataracts constitute the second largest group of blind persons in the United States.

Some cataracts advance rapidly and impair vision in a matter of months, while others progress slowly and take years before they cause any significant problems. A cataract may be present in only one eye, or if present in both eyes, may worsen at different rates. Those that develop on the back or center of the lens are the ones typically responsible for vision being blurrier in the bright sunlight rather than in dim light.

Cataracts can be responsible for glare, haziness, difficulty in reading, driving, other activities, and halos around lights at night. If a cataract is more developed in one eye than the other, there may be a loss of depth perception. Only when a cataract is in an extremely advanced stage does it produce pain, discomfort, or red eyes.

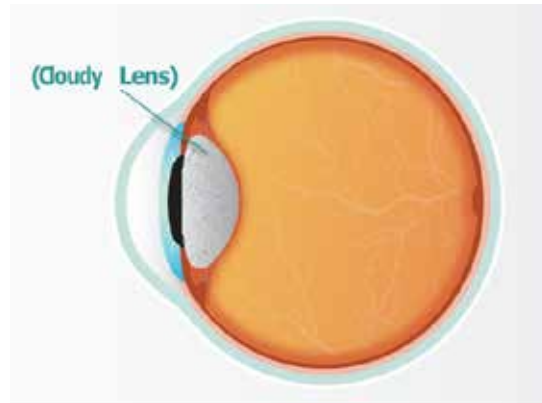
Although cataracts are more common in older persons, people in their thirties or forties can develop cataracts. Some cataracts are associated with injuries, medications (steroids), inflammation, and certain systemic diseases, such as diabetes.

We do not yet know exactly what causes the cataracts of aging, but we can summarize a lot of things we do know about them:

1. Cataracts would most likely develop in every person if he or she lived long enough.

2. Cataracts are not tumors or cancers. They cannot spread. They are not contagious.

3. A cataract is not a film or a growth over the surface of the eye, and thus it cannot be removed simply by peeling a film off the eye. A cataract is clouding in the lens, which is inside the eye.



4. Cataracts are not caused by eyestrain or using your eyes too much, such as in reading or watching television.

5. Cataracts progress differently in different people. They progress at their own rate regardless of whether the eyes are used or not. Not using your eyes will not slow down the progress or development of a cataract.

6. There is no proof cataracts are related to diet or that special diets will prevent cataracts.

7. Cataracts are not caused by normal exposure to sunlight.

The only treatment for cataracts currently is surgical removal. Other treatments, such as eye exercise, vitamins, diets, and special eye drops have not yet proven effective.

CHAPTER IV

TREATMENT OF CATARACTS & IOL OPTIONS

Cataract surgery has improved and advanced dramatically during the last several decades. Many patients recall how frightened their parents or grandparents were at the thought of having a cataract operation. Not only were they in the hospital for as long as several days, but the eye was usually painful after the operation, and they had to lie still for several weeks and remain inactive for many months. Furthermore, their vision was not fully recovered until they had been fitted with thick, heavy cataract glasses. Often, after the first eye was operated on, the visual symptoms were worse due to the confusion of the vision between the eye seeing through a thick cataract lens on the operated side and the eye seeing through a regular thin lens on the other side. This often required covering one eye or the other to prevent double vision.

However, with today's modern surgical techniques and scientific advances in technology, cataract surgery has become practically painless, is much easier on the patient, and provides better vision. The operation can be performed on an outpatient basis most of the time. The eye feels relatively comfortable soon after the operation, and the patient can return to regular activities quickly.

If you decide to have cataract surgery, yours will be one of the more than three million cataract operations performed each year in this country. The best way for you to see well after cataract surgery is to receive a man-made substitute for the natural lens that was removed. Three kinds of substitutes for the natural lens of the eye are currently available:

1. Spectacles (thick cataract glasses).

2. Contact lenses.
3. Intraocular lens implants (IOLs).

Each of these three substitutes for the natural lens have certain advantages and disadvantages.

Cataract glasses are the oldest and most conservative way to restore sight after cataract surgery. Usually, these glasses are only used comfortably after a patient has had the cataract removed from each eye. Cataract spectacles have several drawbacks: they are extremely thick and heavy; they make objects appear about one-third larger than they really are; they make straight objects seem curved and distort side vision; and, they can be difficult to get used to and some people never adjust to them. They can also cause difficulties when the wearer is going up or down stairs. No one really requests this method of correction and surgeons have abandoned this old method.

Contact lenses are small thin lenses that ride on a layer of tears on the eye's surface. Several kinds of contact lenses are now available - hard, soft, and extended-wear soft contact lenses. However, many older patients are unable to wear contact lenses because of discomfort and irritation in addition to insertion and removal problems.

The third kind of man-made substitute for the eye's natural lens is the **Intraocular Lens (IOL)**. This is a tiny synthetic lens made of plastic, silicone, or acrylic that is permanently inserted in the eye and will last indefinitely. Since this lens is set in about the same place as the cloudy natural lens had been, the restored vision is more natural. Side vision and image size are normal and there is no discomfort. There is no foreign body to irritate the surface of the eye.

IOL implants have been performed in increasing numbers over the last 35 years. Older lens types and techniques were not uniformly successful, but with modern, high quality IOLs and highly sophisticated surgical techniques, most patients can achieve excellent vision. Almost all patients now receive a lens implant at the time of their cataract surgery. The most recent IOL advancements are multifocal or pseudo-accommodative lenses, allowing patients to see close up and in the distance. Technology continues to improve implants and there will be changes and improvements yet to come.

Standard IOLs – Single focus (monofocal) lens implants focus correction at one main point - distance, intermediate, or near. These implants allow for the sharpest possible vision at its set point – usually distance. Because the monofocal lens is typically set to focus at distance, reading glasses or bifocals are usually necessary to give patients the best possible near vision. Our standard monofocal lenses are the most advanced in their category, designed for distance and improving image quality.

Monovision is where one eye (usually the dominant) receives a distance implant, and the other eye receives an implant focused for reading. This is also referred to as blended vision, and many cataract patients choose this arrangement for their implant lenses.

The exact shape and size of each implant can vary from eye to eye, but all are held in place by small flexible loops called haptics that are attached to the lens. Implants are intended to last a lifetime and made of materials like silicone and acrylic that will not irritate your eye.

Newer IOLs - In the spring of 2005, the FDA approved several new lens implants

allowing patients to see both in the distance and close up. The usual standard implant would only allow distant vision and the patient would have to use reading glasses for reading. These new implants are referred to as Multifocal IOLs. Clinical studies used to support the March 2005 FDA approval, showed 70-80 percent of patients who received these lenses didn't use glasses for most activities after their cataract surgery; 84 percent who received the lens in both eyes had distance vision of 20/25 or better with near vision of 20/30 or better - good enough to read newspaper print.

However, these newer implants can be associated with glare, shadowing, and halos at night; and some need to be removed to eliminate these problems. If these issues are not there all the time but come and go, or just happen under certain lighting conditions, most patients will adapt and not require anything to be done. Most of these problems are resolved within a year.

There are no guarantees with any implant that patients will be able to see perfect after surgery and for the rest of their lives! Most all cataract patients see better after surgery than they did before. Also, if not removed, the cataracts will only worsen and eventually lead to blindness.

Astigmatism is a common eye condition and refractive error marked by an irregular curvature of the cornea and occurs in nearly everyone to some degree. If the cornea is significantly irregular, the condition must be treated to see better. A person's eye is usually spherical or round in shape. However, the eye of a person with astigmatism is shaped more like a football or the back of a spoon, and when light enters the eye, it is refracted or bent more in one direction than the other, allowing only part of the object to be in focus at a time. Objects at any distance can appear blurry and wavy.

As methods and ways of removing cataracts changed and improved over the years, surgeons also made attempts to reduce and correct these irregularly shaped corneas at the same time to produce better uncorrected vision in their patients after surgery. Initially, these attempts consisted of making deep incisions into the cornea in the steeper portions. These incisions were called T-incisions and limbal relaxing incisions (LRIs). These were quite successful but often inconsistent and varied in reducing the astigmatism and rounding up the center of the cornea. These techniques are still in use today.

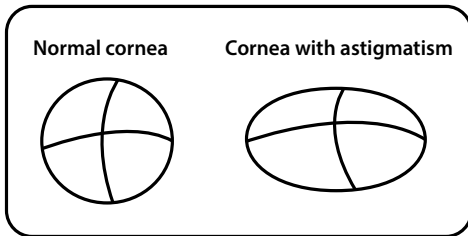


Monofocal, Multifocal, Accommodating, and Toric Multifocal IOLS

Toric IOLs are newer implants that correct **astigmatism**. Until recently, patients with cataracts and astigmatism were still reliant on glasses or contacts for clearer vision after surgery. Toric lenses were approved in 2007 and are specially designed to help reduce or eliminate astigmatism and provide excellent distance vision. There are now foldable lenses which allow placement through a smaller incision, and usually no stitches are required. Because astigmatism has an axis, it is important the lens is placed on the correct axis at the time of surgery and stay there for the life of the lens. Axis marks are placed on the lens to help guide the surgeon in rotating the lens to the precise location in the eye.

Results have been excellent for patients receiving bilateral toric implants (one in each eye). In this group, 97 per cent of patients saw 20/25 or better without glasses for distance vision, compared to 77 percent of patients receiving standard implants without the toric correction.

Light Adjustable Lens (LAL) is the latest advancement in implants. Hoopes Vision's clinical research center participated in the FDA testing and study of this amazing



IOL. It is a revolutionary lens technology that gives patients a new and innovative way for creating sharper vision after surgery. It offers additional flexibility and customization to the patient's lens selection process. With standard cataract surgery, the surgeon takes

measurements to help estimate the proper implant power of the lens. However, afterwards, as the eye heals, the implant might slightly shift position within the eye producing some left-over prescription which limits the surgeons' options to further customize your vision. Glasses might have to be prescribed to sharpen the vision further.

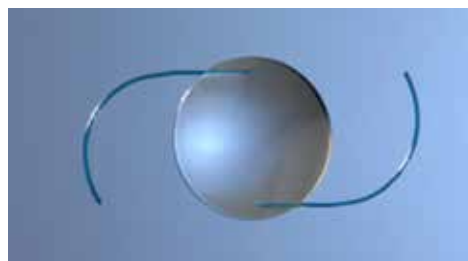
The Light Adjustable Lens (LAL) has completely changed the cataract surgery process and experience to create more customization for the patient and surgeon. Instead of choosing your lens and visual outcome before surgery, you and the surgeon can work together to customize your vision after surgery using a revolutionary light-adjusting technology.

Using the LAL, your surgeon will place this implant in your eye during the cataract surgery. Then, in a few days and weeks following, the surgeon will use ultraviolet (UV) light treatments on the implant to fully customize your vision until it meets your visual needs. The light treatments alter the shape of the lens. So, once your vision is adjusted to your satisfaction, a final light treatment is used to lock in the final results.

This ability to customize your vision after surgery through the LAL is an amazing

benefit to patients that can help them achieve the vision outcome fitting their goals and lifestyle. The FDA clinical studies (Hoopes Vision surgeons participated in) showed most patients receiving the LAL achieve uncorrected vision of 20/20 or better after 6 months.

Medicare pays the cost of the standard implant but does not pay the additional cost associated with these newer multifocal, toric, and LAL implants. In the beginning, the FDA would not even allow Medicare recipients to have these new implants. They did not want to create a system that would allow those who could afford the new implants to pay the extra, while those who couldn't afford it would not be able to receive them. However, they now allow those who want these new high-technology implants to pay extra for them.



Currently (2023), the extra costs and expenses per eye to the patient for these newer implants at Hoopes Vision are:

- \$1,999 for Toric (astigmatism) Lens Package
- \$2,499 for Multifocal Lens Package
- \$3200 for LAL Lens Package

How Are Cataracts Removed?

Modern cataract surgery is made possible by the operating microscope. This high-powered microscope allows the surgeon to see better to remove the cataract and implant the IOL into the eye. In addition to using the operating microscope, the

modern cataract surgeon uses an extracapsular surgical technique. This means the surgeon removes the lens contents but leaves the back portion of the natural lens capsule in place. Although this technique is much more difficult for many surgeons to perform, it provides the patient with many benefits.

The old cloudy lens can be removed by several different techniques. The technique chosen depends on the type of cataract and other factors about the patient. The whole lens can be removed (intracapsular technique) or only the cloudy central portion removed (extracapsular technique).

Another extracapsular technique is phacoemulsification, where a tiny ultrasonic vibrating instrument is placed into the cataract to break it up into small fragments that are liquefied and suctioned out through a small incision in the eye. This is sometimes mistakenly called the laser technique, but is not an accurate description.

Phacoemulsification (ultrasonic) cataract removal with intraocular lens implantation gives excellent visual results for most patients, but the ophthalmologist must weigh all factors before they can tell their patients which technique will be best for them. We personally favor performing phacoemulsification because it requires a smaller incision and usually no stitches.



Removal of cataract via phacoemulsification

Dr. Hoopes, Sr., did his fellowship training (1982) in phacoemulsification cataract removal and was the first Kansa City eye surgeon to use it routinely with implant

surgery. When he turned 60 years old, he stopped performing cataract surgery and now concentrates on refractive (LASIK) surgery. Our other four cataract surgeons: Dr. Hoopes Jr., Dr. Bradley, Dr. Moshirfar, and Dr. Buckner are among the busiest and most experienced surgeons in the country and are recognized as experts. They lecture and share their cataract techniques both in the U.S. and internationally.

Recently, lasers have been introduced to perform some of the steps of cataract surgery. Hoopes Vision is a leader in this new method and the first eye clinic in the world to have two such cataract lasers.

With outpatient cataract surgery, it is sometimes possible to resume most normal activities days after surgery. Follow-up visits to the eye doctor over the next four to eight weeks are extremely important. In many cases, vision can be restored to normal levels long before the end of that time, but the healing process, regardless of the technique, will take about four to six weeks. Observation and counseling of the patient during the postoperative visits are critical.

Anesthesia

Either local anesthesia (a painless injection beneath and behind the eye) or a topical anesthetic eye drop (typical method) are used. After talking with the patient and the patient's family, the ophthalmologist will choose the type of anesthesia that is going to make the patient most comfortable.

For most patients, the simplest and easiest is topical anesthetic drops. In all cases, a specialist in anesthesia monitors the patient's safety during the period of surgery, and relaxing medicines can be given to help make the patient comfortable and relaxed. The actual operation usually takes about ten minutes or less.

CHAPTER V

LASER CATARACT SURGERY

There has never been a surgery that has changed and improved as much as cataract surgery. When Dr. Hoopes, Sr. first learned how to remove cataracts (1979), the technique was to make a long 180-degree incision along the upper cornea, open the eye wide and freeze the cataract and pull it out. The incision was then closed with a dozen stitches. There were no implants and so patients had to wear extremely thick magnifying lenses (cataract glasses) afterwards to see. This method was called Intracapsular surgery, where the entire lens/cataract was removed.

Later, the Extracapsular technique became popular, where an opening capsulotomy was made in the anterior capsule. The inside nuclear portion of the cataract was removed and the softer portion, the cortex, was suctioned out. This was a much better method, particularly when implants became popular, as there was a place for the lens to rest and stabilize.

The next big improvement was more controversial and consisted of placing a small ultrasonic needle into the center of the cataract to break it up and emulsify it. This technique was called phacoemulsification and was adopted early on by only a handful of surgeons, who were publicly criticized and derided by the more conservative group of doctors. They felt this new method was too risky and would cause major problems later. However, these early pioneers embraced the procedure and made it better and safer. Dr. Hoopes Sr. recognized the advantages of this smaller incision method and accepted additional fellowship training in this technique, in Georgia, in 1982. He became the first phacoemulsification surgeon to routinely combine this with posterior chamber implant procedures

in the Kansas City area, where he practiced for 15 years. Some surgeons used deceptive advertising to promote this as laser cataract surgery when it was really an ultrasonic method.



Hoopes Vision surgeon Dr. Majid Moshirfar performing laser cataract surgery

Finally, in 2010, femtosecond lasers were developed that could be used to perform many of the five steps required in cataract surgery. Shortly thereafter, Hoopes Vision became one of the first practices in the country to perform laser cataract surgery and was the first clinic in the world to acquire two different cataract lasers - the Alcon LenSx® and the Optomedica Catalys® femtosecond lasers. This placed us in the unique position to compare and study the results of these different lasers.

Lasers used in cataract surgery currently can perform three of the five steps normally required. Lasers can make the initial incisions into the eye, as well as incisions to reduce astigmatism. They can perform the all-important circular capsulotomy (or opening) in the anterior capsule surrounding the cataract. Finally, these lasers can fragment or break up the inner hard part of the cataract - the nucleus. This makes it possible to use less ultrasonic energy when suctioning the cataract out of the eye, which can produce clearer corneas initially. The surgeon still needs to suction the softer cortex out of the eye, as well as manually place the IOL within the capsular bag.

In their 12 years of use, only about 15 percent of all cataract surgeons utilize the laser routinely. Reasons for this lack of enthusiasm relates to:

1. Skilled surgeons found the laser didn't improve results that much
2. It added additional time to the surgery
3. Most patients could not afford the additional costs

Sadly, Medicare and most insurance companies, refuse to pay the additional costs to provide this newer technique to remove cataracts. They will, however, allow patients who can, to pay the extra cost and expenses to have laser cataract surgery.

CHAPTER VI

WHEN TO HAVE SURGERY

After reading and studying the materials on cataracts and cataract surgery, James and Eilene felt they had a much better understanding about his condition and choices. However, James still had some unanswered questions.

“When do you advise that I have surgery?” he asked Dr. Baker.

“Cataract surgery is not like surgery for an emergency appendicitis attack,” said Dr. Baker. “It can be done almost any time at your convenience, and there is no rush. If you would like, seek another surgeon’s opinion. Surgery always carries some risk and should not be undertaken unless it is necessary. The final decision is yours, because you, and you alone, know how much difficulty you are having with your vision and whether you need to see better.”

“As a rule, cataract surgery is a good idea only if your vision has worsened to the point that you are having trouble carrying on your normal daily activities,” he continued. “The person with special visual needs, such as an airplane pilot, watchmaker, truck driver, or accountant will usually need cataract surgery sooner. Often, patients with a cataract in one eye functions well with the vision provided by the better eye. Others find the poor vision in the blurred eye worrisome.”

“Choosing cataract surgery is an individual decision. If a person has a cataract but can still see well enough to live and work normally, we recommend that he or she think about putting off surgery until the cataract really starts to hinder daily life.”

“In your case, Mr. Barnett, it is obvious that the cataracts are interfering

significantly with the quality of your life and keeping you from doing and enjoying many of the things you normally do, such as driving, playing golf, and reading,”



Hoopes Vision surgeon Dr. Phillip C. Hoopes, Jr., performing cataract surgery

said Dr. Baker. “Your cataracts certainly won’t get any better; they will only get worse. You’re 67 years old, in good health, and should have many years ahead of you. The sooner you have them removed, the sooner you will have a return of useful vision. Also, if you wait, you will probably just worry and fuss about your vision.”

James grinned ruefully at Eilene and said, “You’re right, Dr. Baker. I know I need the cataracts removed to see better, but I’ve been concerned about the operation

itself. I had a friend who had a cataract removed last year and didn't see well afterwards."

"Unfortunately, Mr. Barnett, although cataract surgery is one of the most successful and safest of all operations, some patients end up not seeing any better after surgery," said Dr. Baker. "There usually is an answer for this. It might be due to conditions that existed before the cataract was removed, such as macular degeneration, glaucoma, or diabetes. We will talk more about those problems when we go over possible complications."

James replied, "That's fine, let's go ahead and schedule surgery. Which eye will you do first, Doc?"

"We almost always do the worst eye first, which in your case would be your right eye, the one with the 20/100 vision," said Dr. Baker.

"I don't want to wear those thick cataract glasses, said James. "Do you suggest that I have an implant or a contact lens?"

"Your eye is perfectly healthy and there is no reason why you couldn't have an implant," explained Dr. Baker. "In fact, it is by far the best of the three choices for you and most patients. Your eyes seem to be somewhat dry, and you have some arthritis in your fingers. Those two things would probably make it difficult for you to use a contact lens. With an implant, your vision will be more like what you were used to. I would strongly suggest an implant, and a posterior chamber IOL would be best. It will be placed behind the pupil and will not be visible."

James asked, "Will you operate at the hospital?"

"Thirty years ago, we always operated at the hospital" said Dr. Baker. "We then

began operating on patients on an outpatient basis, so they came into the hospital on the morning of the operation and left shortly after their operation. Twenty years ago, we equipped our own surgery center apart from the hospital. It is located conveniently next to our office and is devoted solely to eye surgery and eye surgery patients. Your operation will usually be performed in the morning, and you can usually leave for home shortly thereafter. The total amount of time you will spend in the surgery center is about two hours. Our patients have preferred this arrangement to the extent that we are now performing most of our operations there.”

“The surgery center has comfortable furnishings and the best operating equipment and instruments available,” he continued. “Only if a patient has serious medical problems or if he or she specifically requests it, do we perform surgery at the local hospital. Your insurance carrier may also dictate or force you go to one of their “provider hospitals” to have surgery. This makes no financial sense since it usually costs two to three times as much to have your surgery at their hospital than at our surgery center. Also, most hospitals currently do not have the newer cataract lasers and equipment we have. You should also be aware some of those insurance panels could also restrict which surgeons and hospitals and surgery centers you have to go to.”

“In your case, Mr. Barnett, because you are healthy and because I understand that you are not very fond of hospitals, I would suggest that your operation be performed at our own outpatient surgery center.”

“That sounds great,” said James. “But let’s go over again how long I will be laid up and when my eye will be fully recovered.”

“The operation usually takes less than ten minutes, and with outpatient surgery, you should be able to resume most of your normal activities by the next day or two. The eye is generally healed and the vision stable between four to six weeks after the operation. At this time, the lens in your old glasses may have to be changed for you to see as clearly as possible,” Dr. Baker answered.

“All this sounds good, Dr. Baker, and I’m sure I’ll be helped by the surgery,” James paused and cleared his throat. “However, I can’t help but worry about how much it is going to cost.”

“And, we read about complications,” said Eilene. “You’ve mentioned complications, even though you’ve said the operation is safe. I think we need to know what could go wrong.”

“You need the answers to both of those questions before you can make a final decision,” said Dr. Baker. “If you don’t mind, I’ll ask our surgery counselor, Mrs. Green, to go over the cost with you since she can explain the ramifications of Medicare much better than I can. Then you’ll come back here, and we’ll go over the complications.”

CHAPTER VII

PAYING FOR CATARACT SURGERY



“First let me say, Mr. Barnett, we’re glad you felt free to ask about the cost of your operation,” said Mrs. Green (surgical counselor). “Knowing the approximate amount and how it will be paid should help you feel less concerned about the operation itself.”

“The rising cost of healthcare is a major concern for everybody,” she continued. “And, with the recent passage of more government control, nobody really has a good idea of what might happen in the future with reimbursements for procedures. Also, large healthcare monopolies and systems have taken control and

decision-making away from doctors and, in my opinion, have made the situation even worse. To help you understand what to expect financially from undergoing cataract surgery, we'll go over both the cost of your operation, Mr. Barnett, as well as current Medicare and insurance policy."

"The total cost of cataract surgery across the country varies between \$2500.00 and \$5500.00, depending on where a person lives, where the operation is performed, whether a cataract laser is used, and the surgeon who does the operation," said Mrs. Green.

"The range in surgical charges does not necessarily reflect the skill or expertise of the surgeon," she said. "The fact that one surgeon charges \$500 or \$1000 more than another surgeon does not necessarily mean that he or she is that much better or that you will end up with a better result."

"Because most people have health insurance, few must pay the whole cost of the operation. However, most insurance companies, including Medicare, will not cover the full cost; therefore, you will be expected to pay the remainder."

"If you have Medicare and supplemental or tie-in insurance, usually all hospital and surgical fees will be paid after your deductible has been met," continued Mrs. Green. "If you have only Medicare, then 80 percent of the allowable will be paid by Medicare and you, or your supplemental insurance, will be responsible for the remaining 20 percent."

"Medicare is all I have," said James.

"That's fine," said Mrs. Green. "I'll go on to explain what assignment means.

To hold down the costs of medical care, Dr. Baker and other physicians in the office have signed an agreement with Medicare to accept assignment on surgical and office fees for Medicare patients. For you, Mr. Barnett, and all Medicare patients, this means that we will accept the amount that Medicare pays as full reimbursement for a specific procedure, even if that is less than we usually charge. You, of course, will still be responsible for paying 20 percent of the fee that has always been required by Medicare.”

“If a patient selects outpatient surgery, as I believe you have,” said Mrs. Green. “Medicare now only reimburses 80 percent of the allowable facility fee as well. Medicare and other insurances will now also pay toward the new premium multifocal implants, but usually only up to the same amount as for the traditional implants. The added expense for the premium multifocal lenses and associated additional services would be paid out-of-pocket by the patient.”

“Does that mean that we will have nothing to pay?” asked Eilene, looking puzzled.

“It is confusing, isn’t it,” said Mrs. Green? “Let’s look at an example. If the surgery fee is \$2000.00 and Medicare’s allowable is \$1500.00, Medicare will pay 80 percent of the \$1500.00 allowable (or \$1200.00), and the patient or secondary insurance is responsible for the remaining 20 percent (or \$300.00). Your out-of-pocket expense will be higher if you choose to have one of the new premium intraocular implants.”

“Unfortunately for surgeons, Medicare has unrealistically reduced payment for cataract surgery nearly 80 percent over the last 30 years,” said Mrs. Green. “Now they only pay a little over \$430 as the allowable fee. That is less than they paid eye surgeons 40 years ago! It is no wonder that so many ophthalmologists have given up performing cataract surgery or have retired early.”

“That’s terrible,” said James. “I would be willing to pay a lot more than that for good vision and a skilled surgeon!”

Mrs. Green then handed the Barnetts a sheet saying, “These are several questions that are commonly asked about Medicare coverage. They might help clarify some points.”

Questions and Answers

Q: What does it mean when a doctor says he will accept Medicare assignment?

A: Accepting assignment means the doctor agrees to accept the amount allowed by Medicare as the total fee for services performed. This means that even if the physicians’ fee is more than what Medicare allows, the doctor will accept the Medicare allowable amount, and the patient is only responsible for the 20 percent Medicare does not pay under its covered services.

Q: How does Medicare determine the amount that is approved on covered services?

A: Medicare used to determine coverage by considering the most frequently made charge by all physicians for the same service in the previous calendar year - allowing for inflation. Over the past several years, Medicare has cut their fee schedule for cataract surgery dramatically (close to 80 percent) with little consideration of the escalating costs of supplies and equipment that doctors face. Unfortunately, it has become a financial drain to many ophthalmology practices to continue offering this valuable service. Reimbursements now barely cover the personal costs for a surgeon to perform the surgery.

CHAPTER VIII

THE OPERATION AND POSTOPERATIVE INSTRUCTIONS



James Barnett was now fully prepared for his operation. He knew what a cataract was, what could be done about it, what a lens implant was, the costs involved, and the risks and complications. He was told he could not drive his own car home after his operation, and that he should arrange for a responsible person to take him home.

James was glad he did not have to go to a hospital. He was nervous enough, and he felt he would sleep and rest much better in his own bed. The only thing he was required to do that night was not eat or drink after midnight (many doctors allow their patients a liquid breakfast on the morning of surgery).

James awoke at 6:30 am and prepared for his drive to the center where his surgery was scheduled for 9:00 am. He showered, washing carefully around his face and eyes. After, he dressed in casual, comfortable clothing, James and his wife were picked up by their neighbor and driven to the center.

James stopped first at the receptionist's window, completed additional paperwork, and was taken back to the the preoperative area. He is given a hospital gown to wear over his clothes and is instructed to lay down on a comfortable stretcher. The nurses in the preoperative area helped him feel relaxed and comfortable. He received antibiotic and dilating eye drops in the eye being operated on. After about half an hour, the anesthetist and Dr. Baker entered the preoperative area.

“Good morning, Mr. Barnett. Are you ready for surgery?” asked Dr. Baker.

James answered, “Yeah, I’m about as ready as I’ll ever be.”

“Our anesthetist will go over the anesthesia risks with you,” said Dr. Baker. “As you remember, we discussed some of them in my office earlier.”

The anesthetist explained, “I’ll be giving you some medicine to help relax you. You have chosen numbing or anesthetic drops for your anesthesia; therefore, we will not be using any needles or local injections. We are simply going to place several different numbing and anti-inflammatory drops into the eye as well as dilating drops. It will be very important for you to hold your eye still during surgery and just look straight up into the operating microscope’s light. If you feel nervous or experience any discomfort or pain, make sure you tell the surgeon. We can give you more drops or even some light sedation to help you through the surgery. The doctor and his staff are very experienced, and surgery shouldn’t take more than thirty minutes. It will be over before you know it!”

After about twenty minutes, James was taken into the operating room and comfortably positioned on his back with his head slightly raised by a comfortable headrest. The microscope was brought into position above his eye and adjusted. Dr. Baker washed the area around the eye with a special antiseptic, which helped reduce the chances of infection. He then placed a clean sterile drape over James' face and eyelids and supplied oxygen under the drape so James could breathe comfortably.

As the operation began, James was amazed he felt no pain or discomfort. Occasionally, he could hear Dr. Baker talking, and he heard noise from some of the instruments and machines that Dr. Baker was using. After 10 minutes, the operation was over, and James was taken to the recovery area where postoperative instructions and care was provided by a nurse. She showed him how to apply the eye drops and tape to the protective shield he will wear at night. James is given a set of the following instructions:

1. You will be seen in the office tomorrow after your operation.
2. You will need to protect your eye. Special sunglasses are included in the package for this purpose, with the postoperative eye medications, and tape we have. Regular sunglasses or clip-on sunshades are permissible if you prefer them.



3. Please wear your eye shield at night or when napping during the day for the next week to avoid accidentally poking or rubbing your eye while you sleep. Do not wear an eye pad under the shield.
4. You may do most of your normal activities, if done in moderation. Bending over for short periods is allowed, such as to put on your shoes. Try to avoid lifting more than 25 pounds in the first week after surgery. You may wipe your eyelids gently with a clean, moist face cloth. Please keep your hands washed and clean when touching around your eye.
5. About one month after your operation, your glasses will probably need adjusted. It usually takes that long for the measurements to become stable and consistent. The new glasses you get will not be the thick cataract glasses that used to be required. Until you get your new glasses, you may wear your old glasses or go without glasses, whichever seems to give you better vision. Sometimes, the old lens from your glasses will need to be removed temporarily. The optometrist or ophthalmologist who referred you here for surgery can do the measurements for your new glasses. If you don't have a referring doctor, we can recommend one.
6. You may attend social activities, do light yard work, do light housekeeping, and shower and shampoo your hair. If you go to a beauty salon, make sure you wear the shield while the stylist is working with your hair.
7. You may read and watch television. You may sleep either on your side or on your back. You may ride in a car, bus, or airplane. You may also go up and down stairs.

8. If you are from out of town, we need to know where you will be staying during the period surrounding your surgery. Please phone the office with your phone number as soon as you know it. This will enable us to contact you if necessary.

After being seen on the first postoperative day, the patient is usually seen one week, three to four weeks, and two to three months after surgery for follow-up examinations.

Common Concerns:

1. It is normal to feel some mild discomfort and a scratchy sensation immediately after cataract surgery. It is also common to have excessive tears and a slightly droopy eyelid, as well as greater sensitivity to light in the operated eye. These problems all tend to go away quickly. They should not cause alarm or concern, and if they are minor, they do not necessitate a call or visit to the doctor. If they persist or worsen, a call to your doctor is warranted.

2. It is not uncommon to have or notice floaters (particles floating in the eye). However, if there are a great many floaters, or if there is a very large floater or persistent dark shade, you should call the doctor immediately. A black curtain or shadow progressing across the field of vision of the operated eye should receive prompt and immediate attention to make sure that this is not a retinal detachment or a similar problem.

3. The sensation of having a foreign body under the upper eyelid or to the side is common. This sensation usually goes away after several weeks. Most of our surgeries are now performed with the no-stitch (sutureless) technique and you will not usually experience this problem. However, if severe pain persists in the eye,

especially pain associated with blurred vision, call the doctor immediately. If your vision was good initially but rapidly gets worse, this too should be investigated.

4. It is not unusual to have a mild discharge in the eye after surgery, but if there is excessive matter, crust, or crystals on the eyelashes and that condition does not clear up after several days, you may need to have your medications changed.

5. Some patients notice a red, orange, or yellow tint in the operated eye for a few days. This will go away and is nothing to be worried about.

6. Although complications are rare following surgery, you do need to use common sense and certainly you should call the doctor's office if you have any doubt or concern about the condition of your eye.

CHAPTER IX

RISKS AND COMPLICATIONS

With the Barnetts back in his office, Dr. Baker began, “The chance of having a significant complication from cataract surgery is extremely small, but it does exist. You should realize cataract surgery is one of the safest and most successful operations known to man. I want to go over the possible complications as they are listed here.”

Anesthetic Risk

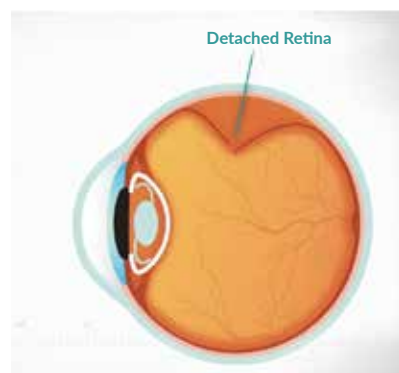
A small portion of patients undergoing surgery may have a reaction to the anesthetics given before or during the operation. Therefore, we have qualified personnel and an anesthesiologist to constantly monitor the patient during the operation. The anesthesiologist will discuss those reactions with you on the day of the operation.

Macular Edema

The macula is a small area located in the retina that is responsible for clear vision. This fluid swelling of the macula following cataract surgery occurs in about five percent of all cases. It usually goes away after several months, and medication can clear it up sooner. Sometimes patients are referred to retinal specialists to see if they can help clear up and confirm this swelling.

Retinal Disease

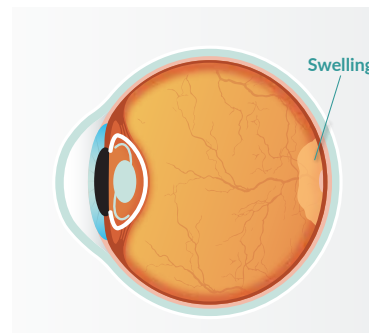
A retinal detachment or separation occurs in less than one of every 200 cases. This separation can cause a dark curtain to come across the vision and may be accompanied by flashing lights or floaters.



Retinal detachments occur in people who do not have cataract surgery, but they are more common after a cataract operation. Approximately 90 percent of these detachments are treated successfully by additional surgery. Therefore, it is extremely important that you contact your physician if you notice any of the above symptoms after your cataract operation.

Corneal Disease

This usually causes a swelling and clouding of the cornea, which is the clear front of your eye. If it does not improve with time, a corneal transplant may be required in order to restore good vision. This was more common twenty to thirty years ago, but with improved lenses and techniques patients today rarely require corneal transplants.

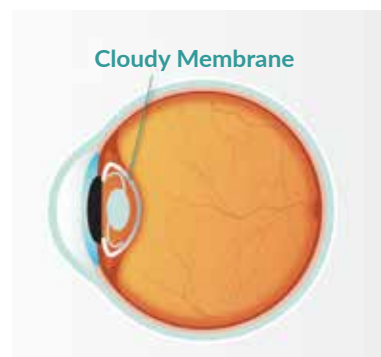


Inflammation and Infection

Severe infections after cataract surgery are very rare (1 in 2,000), but they can happen. We, of course, will take every precaution to prevent them during the operation, and will give you instructions on how to care for your eyes afterwards. Patients can help by keeping hands washed and cleaned before using their eye drops or touching near the eye.

Cloudy Membrane/Capsule

With the modern extracapsular cataract techniques, the posterior lens envelope is usually left in place to hold the implant in place and protect it. There are technical reasons for this, and it is ordinarily done to increase the safety of the operation. In some cases



(10-25 percent) this membrane may later become cloudy and blur vision. A simple and quick laser procedure can be done several months to years later to open this opacified membrane. This procedure, called a YAG laser capsulotomy, is performed in our surgery center and is painless and quick. It is covered by Medicare and insurance plans.

Glaucoma

Glaucoma is high fluid pressure in the eye. With special techniques and careful follow-up, eyes with glaucoma can undergo any type of cataract operation and can usually take any type of postoperative lens. Occasionally, following cataract extraction, the pressure can elevate. This elevated pressure is successfully treated with medication, usually only eye drops. This pressure rise following cataract surgery is brief, and the pressure usually returns to normal after a few days.

Abnormal Pupil

Most eye surgeons attempt to keep the pupil round. However, it is not unusual for the pupil to be somewhat oval or peaked postoperatively. This minor complication can occur with or without the implantation of the intraocular lens. Any abnormal pupillary position resulting from surgery rarely affects the final visual result.

Hemorrhage

It is not unusual to have a few blood cells floating in the eye after the operation. These usually clear within a week. A more serious hemorrhage can occur during cataract operations, and vision from such a massive hemorrhage usually remains very poor. Fortunately, this type of hemorrhage is extremely rare and occurs only in about 1 out of every 2,000 operations.

Double Vision

Rarely, a patient might experience double vision after cataract surgery. This is usually temporary.

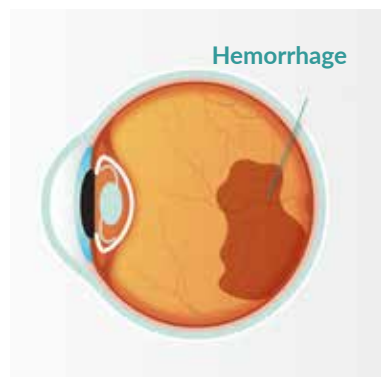
Other Complications

With an operation as complicated as this, there are a variety of things that can happen in theory and do occasionally happen in practice. Every effort is made to avoid these complications. We have access to the finest surgical equipment, and the operating staff is of exceptionally high quality. These factors greatly reduce the risk of complications.

“Mr. Barnett, no ophthalmologist can give you a 100 percent guarantee of a perfect return of vision following cataract surgery,” said Dr. Baker. “However, as was mentioned in our brochures, 90 to 95 percent of patients who have cataract surgery will have postoperative vision of 20/40 or better, depending on the health and condition of their retina. The complications we have just talked about resulting in poor vision after cataract extraction occur in less than one percent of all cataract operations. Therefore, patients facing cataract surgery today usually have everything to gain and almost nothing to lose.”

“Well,” said James, “let’s schedule the surgery as soon as possible.”

Dr. Baker continued, “I want you and Mrs. Barnett to read over this consent form for surgery. If you fully understand it, we need your signature at the bottom. This form is very concise and explicit. It is not meant to scare you, but since it does mention most of the complications we have talked about and the alternatives to this procedure, it does tend to sound quite legal. It is meant only to better inform you so you can make an intelligent decision and does not release us from our obligation to perform the best possible operation for you.”



James and Eilene returned home and talked about the events of the day. James, like most men in his situation, felt frustrated. It was hard for him to accept the fact that he had cataracts, a condition he had always associated with older people. Most of his questions had been answered, but there remained a few concerns. He was hopeful the booklet on cataracts that Dr. Baker had given him would answer these remaining questions.

“You know, James,” said Eilene. “We should feel lucky that something can be done to improve your vision. There are many afflictions people have, or develop, that can’t be helped.”

James replied, “You’re right, dear. Also, I really liked Dr. Baker and his staff. They were warm and caring and certainly seemed to know what they were doing.”

CHAPTER XI

FOLLOW UP CARE



It is important for patients to place their antibiotic drops in the eye at least four times a day for several weeks. They should wash their hands and keep the area around the eye clean when placing the drops in the eye. It is important for patients to call the doctor if they experience severe pain, a decrease in vision, and/or extreme sensitivity to light. This triad of symptoms is often associated with an infection in the eye. If caught early, the infection will most often clear up with proper medications and treatment. Some patients experience a rise or spike in eye pressure the day or night after surgery. This usually causes an ache or severe pain, and the doctor should also be called early on for this problem.

Patients are usually given a metal or plastic shield to wear when sleeping, so the patient does not accidentally rub their eye. This is typically worn during the first week. Wraparound sunglasses are also provided to wear during the first few weeks to months after surgery. This gives them some protection and comfort from sunlight.

Vision early on after surgery is usually blurry. This is often the result of normal swelling in the cornea related to the fluids used, and the shock waves generated from the ultrasonic needle during the cataract breakup and removal. This swelling usually goes away within a few days, which results in a clearing of the vision, if the medicated drops are used correctly. Vision usually improves during the first one to two weeks following surgery.

It is very important for patients to keep their follow-up visits. Patients are routinely seen the day after surgery, one week later, one month, and three months after surgery. This three-month postoperative period and the follow-up appointments are usually covered or are included in the cost of the original surgery. Usually, if glasses are needed afterwards, the glasses prescription is written after the one-month follow-up visit.

Some patients are referred to the surgeon for the surgery and early follow-up care. They are then sent back to their own optometrist, by the surgeon, after the patient appears to be stable and doing well. This type of referral arrangement is called comanagement and is recognized and paid for by Medicare and most private insurance companies. There is no additional cost for this type of care, and it assures the patient that continuity of care can continue with their own chosen eye doctor. It is important that the comanaging doctor is properly trained and credentialed to perform this type of care.

Many times, patients will have a cataract in the other eye. After the first cataract is removed and the vision has improved, the second eye with a cataract will suddenly seem worse and very bothersome. Patients are usually anxious to have the second eye operated on. Most doctors wait a few weeks before doing surgery on the second eye. They want to make sure the first eye is doing well and seeing better first. However, there are some surgeons nowadays who will operate on both eyes at the same time. This sounds like a good idea until an infection occurs inside both eyes that could lead to vision loss.

Cataracts do not grow back. However, quite often a clouding of the posterior capsule or membrane that holds the implant in place will occur. This can lead to vision becoming blurry. This is easily treated with a YAG laser capsulotomy or opening in the membrane that takes just a few minutes to perform. Once done, this membrane stays open and the film does not grow back.

CHAPTER XII

EYESURG OF UTAH

Hoopes Vision moved into our new building in January 2013. We incorporated many changes and improvements learned from previous facilities and locations. With the recent advent of laser cataract surgery, this gave us the unique opportunity to design and build our new outpatient ambulatory surgery center (ASC), EyeSurg of Utah, to accommodate all the newest developments in cataract surgery. It is the third surgical center Dr. Hoopes has built and owned over the years, all for the convenience of our patients.



The new surgery center, located on the north half of the first floor, incorporates a special laser room adjacent to our four large operating rooms. Patients can then have the preparatory steps completed and are then moved into one of the four operating rooms for the last two stages of the procedure.

This ultramodern facility is unlike any other surgery center in the state, if not the country. It houses the very latest and up-to-date equipment and lasers. It is spotlessly clean, and the patient flow is efficient and comfortable. Our surgery center staff are exceptionally well trained and caring individuals who contribute to a warm and friendly environment.

Perhaps the most compelling reason to have surgery at EyeSurg of Utah is the tremendous cost savings patients will experience compared to the much higher facility fees and charges routinely encountered and experienced at hospital-based surgery centers. The costs at area hospitals can be three to five times higher! We invite all potential surgery patients to visit and tour our amazing surgical facility!



Reception Area



Cataract Laser Surgical Room



Postoperative Room



Preoperative area in EyeSurg of Utah

AUTHOR'S COMMENTS

Our purpose in preparing this book is to explain what a cataract is, what can be done to correct it, what options are available to help a patient see well after an operation for a cataract, and what to expect during and after the surgical experience. As mentioned, cataract surgery is a relatively safe and effective operation to undergo, but it should be undertaken only if your vision has decreased to the point that it impairs your activities. We hope you have found this book helpful in making your decision about having cataract surgery.

NOTES