

ACRYSOF® SINGLE-PIECE MONOFOCAL IOLS

IMPORTANT PRODUCT INFORMATION

CAUTION: Federal law restricts these devices to sale by or on the order of a physician. **INDICATION:** The family of AcrySof® single-piece intraocular lenses (IOLs) includes AcrySof® UV-Absorbing IOL, AcrySof® IQ, AcrySof® IQ Toric and AcrySof® IQ ReSTOR® and AcrySof® IQ ReSTOR® Toric IOLs. Each of these IOLs is indicated for visual correction of aphakia in adult patients following cataract surgery. In addition, the AcrySof® toric IOLs are indicated to correct astigmatism at the time of cataract surgery. The AcrySof® IQ ReSTOR® IOLs are for cataract patients with or without presbyopia, who desire increased spectacle independence with a multifocal vision. All of these IOLs are intended for replacement in the capsular bag.

WARNINGS/PRECAUTIONS: GENERAL CAUTIONS FOR ALL ACRYSOF® IOLS:

Careful preoperative evaluation and sound clinical judgment should be used by the surgeon to decide the risk/benefit ratio before implanting any IOL in a patient with any of the conditions described in the Directions for Use that accompany each IOL. Caution should be used prior to lens encapsulation to avoid lens decentration or dislocation. Viscoelastic should be removed from the eye at the close of surgery. **CAUTIONS ASSOCIATED WITH**

ACRYSOF® IQ RESTOR® IOLS: Some patients may experience visual disturbances and/or discomfort due to multifocality, especially under dim light conditions. Visual symptoms may be significant enough that the patient will request explant of the multifocal IOL. Spectacle independence rates vary with all multifocal IOLs; as such, some patients may need glasses when reading small print or looking at small objects. Clinical studies indicate that posterior capsule opacification (PCO), when present, may develop earlier into clinically significant PCO with multifocal IOLs. **CAUTIONS ASSOCIATED WITH ACRYSOF® IQ TORIC AND RESTOR®**

TORIC IOLS: Optical theory suggests that, high astigmatic patients (i.e. > 2.5 D) may experience spatial distortions. Possible toric IOL related factors may include residual cylindrical error or axis misalignments. Toric IOLs should not be implanted if the posterior capsule is ruptured, if the zonules are damaged, or if a primary posterior capsulotomy is planned. Rotation can reduce astigmatic correction; if necessary lens repositioning should occur as early as possible prior to lens encapsulation. Prior to surgery, physicians should provide prospective patients with a copy of the appropriate Patient Information Brochure available from Alcon informing them of possible risks and benefits associated with the AcrySof® IQ Toric, AcrySof® IQ ReSTOR® and AcrySof® IQ ReSTOR® Toric IOLs. Do not resterilize. Do not store at temperatures over 45° C. Use only sterile irrigating solutions to rinse or soak IOLs. **ATTENTION:** Refer to the Directions for Use labeling for the specific IOL for a complete list of indications, warnings and precautions.



AcrySof® IQ IOL Family

Alcon A Novartis
Division

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Letters

Support Groups for the Visually Impaired

It is the role of all of us in ophthalmology to lift a portion of the burden of those who are losing—or who have lost—vision. We do this with increasing efficiency and success. There are, however, those patients who still descend into situations in which they can no longer meet their life goals.

That said, all of us would do well to watch the Academy's video on low vision featuring the Academy CEO, David W. Parke II, MD (aao.org/low-vision-and-vision-rehab). It, coupled with the Academy's handout "Low Vision" (store.aao.org/low-vision-brochure.html), is tremendously important. But there comes a time when we clinicians are at our wits' end, and the tendency might be to say that "nothing more can be done." That is not true: Something can be done.

Neither the video nor the low vision brochure mention support groups for the visually impaired. At the Detroit Institute of Ophthalmology (DIO), we have had successful support groups for over 4 decades. Some believe these to be the largest such groups in the United States, which would attest to their value to those who attend. If they are run properly, support groups for the visually impaired give hope, create a compassionate and understanding community, and have tremendous social and psychological importance.

The DIO would be happy to discuss such groups with anyone who is interested—please call 313-824-4710.

*Philip C. Hessburg, MD
Detroit*

CRAO: Further Thoughts

In "Diagnosis and Management of Central Retinal Artery Occlusion" (Pearls, August), the authors correctly emphasize the systemic evaluation as critical for identifying embolic sources. Many of the emboli that cause CRAO are platelet thrombin emboli that are related to damage of the blood cells and platelets by trauma at a site of calcified and noncalcified plaque in the carotid artery. Neither carotid duplex ultrasound nor cervical magnetic resonance imaging can resolve these areas as well as computed tomography angiography can; thus, the latter should be the initial study. If such areas are found in a patient with a documented embolic event, carotid endarterectomy may be considered despite clinically insignificant narrowing. By the same reasoning, the increased resolution of transesophageal echocardiography is preferred to identify small valvular vegetations or intracardiac thrombi. This should be performed even if imaging of the major arteries has disclosed a problem area.

*Michael A. Rosenberg, MD
Chicago*