Clinical Connection

Bringing partners together to deliver exceptional patient care

SUMMER 2026

Welcome to the inaugural edition of EyeCare Partners *Clinical Connection*!

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This newsletter is built around a simple idea: When we share knowledge and perspectives, we deliver better care for our patients.

Clinical Connection is designed to help you care for patients locally, efficiently and with access to the latest capabilities. Each issue will feature timely topics in eye care explored by our optometric residents and complemented by insights from local ophthalmology and optometry colleagues, bringing both emerging thinking and real-world application into focus. You'll also find introductions to our newer doctors and updates on educational opportunities, new technologies, clinical research and practical ways to stay connected.

We hope this serves as a meaningful way to stay informed, strengthen connections and support our shared goal of delivering the best possible care to the patients and communities we serve.

We welcome your ideas and suggestions for future issues. Thanks for joining us on the *Clinical Connection* journey.

HOT TOPIC

Life in Focus: The Rise of Premium Intraocular Lens (IOL) Technology

Cataract surgery is among the most commonly performed surgical procedures worldwide, with approximately 3.8 million operations conducted in the U.S. each year.[1,2] Since its origin in 1949, monofocal IOLs served as the undisputed standard of cataract care, reliably restoring distance vision while accepting that patients would remain dependent on spectacles for near and intermediate tasks.[3] Though effective, this approach increasingly fell short of evolving patient expectations.

As the global population ages and active lifestyles become the norm across older demographics, demand for spectacle independence at all distances has grown substantially. Patients presenting for cataract surgery today are better informed, have greater visual demands and are more likely to request functional near vision than ever before. Toric, multifocal and extended depth of focus (EDOF) IOL options now offer clinicians powerful tools to meet individualized patient goals. Optimal patient satisfaction begins

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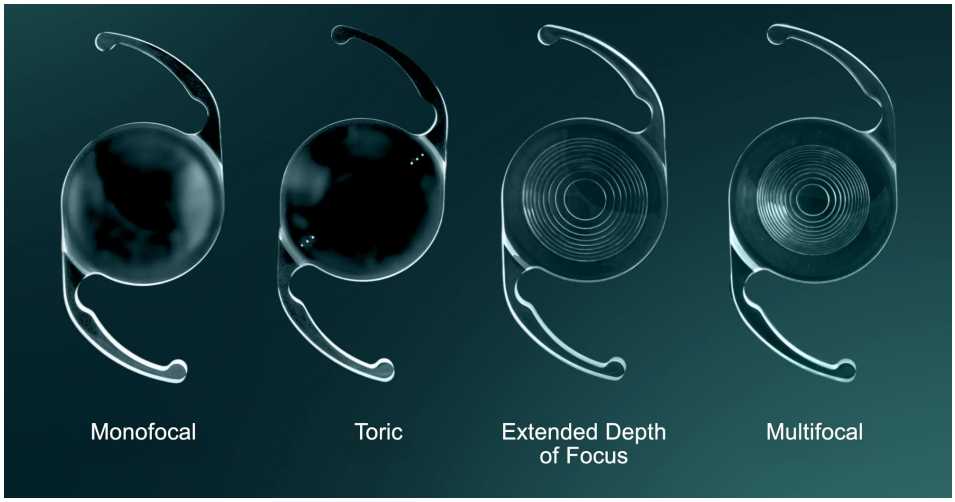
long before the operating room with evidence-based IOL selection tailored to the patient's lifestyle and visual demands.

Lens Categories

Monofocal IOLs represent the foundational design in cataract surgery, featuring a single fixed focal point. The target of this focal point is most commonly set for distance. Unlike premium lens designs, monofocal IOLs do not address pseudo-presbyopia, meaning patients should be counseled preoperatively that reading glasses or bifocals will be required for near and intermediate tasks following surgery. For those patients with the goal of good near vision uncorrected, particularly myopic patients who habitually remove their spectacles to read, it is possible to set the target for near. In this case, spectacle correction would continue to be necessary for clear distance vision. A monovision strategy that targets the dominant eye for distance and the fellow eye for near can be considered in patients who are accustomed to monovision correction prior to cataract surgery. Extensive education regarding binocular vision and intermediate distance limitations is imperative with this methodology.

Spherical monofocal IOLs are the lens of choice for patients looking for a lens design fully covered by medical insurance. Spherical monofocal IOLs do not correct for astigmatism, meaning patients will likely require spectacle correction for best vision at all distances following surgery. The exception to this rule is patients with minimal corneal astigmatism, who can expect good distance vision uncorrected. Toric multifocal IOLs are a premium lens option for patients with greater than or equal to 0.75D to 1.00D of corneal astigmatism who wish for spectacle independence at distance. Limbal relaxing incisions (LRIs), small arc-shaped peripheral corneal incisions, can be performed to correct for mild corneal toricity not meeting the threshold for a toric IOL.[4]



Re:Vision. (n.d.). Premium lenses. https://www.revision.nz/premium-lenses

Despite their limitations, monofocal lenses remain an excellent choice for many candidates, including those with coexisting ocular pathology such as macular degeneration, diabetic retinopathy or significant dry eye disease that would preclude reliable outcomes with premium IOLs. Monofocal lenses are also well-suited for patients who prioritize the highest possible optical quality at distance, such as those who drive frequently or work in visually demanding environments, and for whom spectacle dependence for near tasks is an acceptable trade-off to pristine distance vision.

Multifocal IOLs represent a significant advancement in IOL technology, designed to provide functional vision across a range of distances by dividing incoming light into two or more discrete focal points. This is achieved through either diffractive or refractive optical designs. Diffractive multifocal lenses use a series of concentric rings etched onto the lens surface to split light between distance and near focal points, while refractive designs rely on alternating optical zones of differing power. Trifocal IOLs represent the current standard among premium multifocal designs, adding a dedicated intermediate focal point to address computer and arm's length tasks that bifocal multifocals historically underserved.[5] The primary advantage of multifocal IOLs is the potential for meaningful spectacle independence across all distances, which carries high appeal for active, visually demanding patients. However, clinicians must engage in thorough preoperative counseling regarding the inherent optical trade-offs of multifocal designs, most notably the increased incidence of photic phenomena including halos, glare and starbursts, particularly under mesopic conditions. Contrast sensitivity may also be modestly reduced compared to monofocal IOLs. Ideal candidates are highly motivated patients with healthy macular function, minimal corneal irregularity and realistic expectations. Patients with significant ocular comorbidities, pupillary abnormalities or a history of prior refractive surgery should be approached with caution or steered toward alternative lens platforms.[6]

Overview of Lens Categories

	Insurance Coverage	Spectacle Dependence	Ideal Candidate
Spherical Monofocal IOLs	Typically fully covered	Expect spectacle correction for best vision at all distances	• Distance target: anyone • Near target: myopes preferring to continue to read without spectacles • Monovision target: established monovision contact lens wearers
Toric Monofocal IOLs/Limbal Relaxing Incisions	Out-of-pocket cost	Good distance (or near) vision without glasses, will need spectacle correction for all tasks arm's length or closer	
Multifocal IOLs	Out-of-pocket cost	Greatest independence from spectacles, may need small reading prescription for fine print	• Patients wanting the greatest independence from spectacles • Established multifocal contact lens wearers • Absence of ocular pathology
Extended Depth of Focus (EDOF) IOLs	Out-of-pocket cost	Moderate independence from spectacles, good distance and intermediate vision, some functional near vision, expect small reading prescription for near work	• Patients wanting moderate independence from spectacles • Concern for difficulty adapting to multifocal design • Absence of ocular pathology

Extended depth of focus (EDOF) IOLs represent a compelling middle ground between monofocal and multifocal designs, engineered to elongate the eye's focal range into a continuous corridor of vision rather than creating discrete, separate focal points. This is achieved through a variety of optical strategies depending on the platform, including wavefront manipulation, pinhole optics and non-diffractive refractive technologies.[6] The primary clinical advantage of EDOF IOLs is a significantly reduced incidence of halos and glare compared to multifocal lenses, making them particularly attractive for patients who are concerned about nighttime driving or work in low-light environments. Ideal candidates include patients seeking meaningful reduction in spectacle dependence for distance and intermediate tasks, and who are unwilling to accept the dysphotopsia risk associated with multifocal IOLs. EDOF lenses are also well-suited for patients with mild macular changes or modestly reduced contrast sensitivity in whom a multifocal IOL would be contraindicated, as well as those with active lifestyles who prioritize visual quality over complete near spectacle independence. Patients should nonetheless be counseled that reading glasses will likely still be required for prolonged or demanding near tasks.

Screening and Preparing Patients

Careful patient screening is essential prior to premium IOL implantation. Significant macular pathology including age-related macular degeneration, diabetic macular edema and epiretinal membrane formation represents a primary contraindication to multifocal and EDOF lenses, as compromised retinal function will limit visual

potential and amplify dissatisfaction. Irregular corneal astigmatism, as seen in keratoconus, is another contraindication for premium IOL designs. While not an outright contraindication, ocular surface disruption secondary to dry eye disease will limit visual quality, especially in patients with premium lens options. Optimization of the ocular surface will allow for best vision potential following surgery. Dry eye disease should be aggressively managed prior to surgical planning, as it can destabilize preoperative measurements and reduce postoperative outcomes. A history of refractive surgery can also affect the quality of preoperative measurements and has the potential to limit the accuracy of hitting a specific postoperative target.

Clinical outcomes data for premium IOLs are encouraging, though the importance of appropriate patient selection and preoperative counseling is critical. Spectacle independence confers benefits that extend well beyond the exam lane. Patients consistently report improved quality of life, greater freedom in daily activities and a reduced burden of corrective eyewear that many describe as transformative.

James McHale, M.D., Director of Cataract Surgery at Columbus Ophthalmology Associates, captures this sentiment well, noting: "The revolution of lens implant development has been critical in providing patients with the best possible vision they can obtain given their visual potential through cataract surgery. Astigmatism correction is a given today and can be achieved through toric IOL implantation or limbal relaxing incisions for lower amounts of astigmatism. I have been infinitely impressed with patients' acuities and focusing capabilities regarding modern day, multifocal lens implants. We try to provide patients with a complete and improved range of focus, which reduces or completely absolves a patient's dependence on glasses."

U.S. FDA clinical trial data echoes this optimism, demonstrating that 99% of patients who received multifocal IOLs would choose the same lens again — although those same data reveal that 12.6% of multifocal IOL patients reported severe difficulty with halos, compared to just 0.9% of monofocal IOL patients.[5] This contrast is not a contradiction; rather, it reflects the reality that when patients are appropriately selected and thoroughly counseled, even lenses with inherent optical trade-offs can deliver outstanding satisfaction. Ultimately, these figures reinforce a central theme in premium IOL practice: Exceptional outcomes are achievable, but remain contingent upon matching the right lens to the right patient and anchoring expectations in clinical reality.

Setting Patients up for Success

The expanding landscape of IOL technology has transformed cataract surgery into an opportunity to meaningfully optimize a patient's lifelong visual function. As available IOL design options continue to grow, so too does the responsibility of every clinician involved. By initiating identifying conditions that may influence candidacy, managing ocular surface disease preoperatively and calibrating patient expectations well in advance of the surgical consultation, the referring clinician can dramatically streamline the process and set both the patient and surgeon up for success. In an era of rapidly advancing IOL technology, the clinicians who invest in staying current with the evidence will be best positioned to guide their patients toward the visual outcomes they deserve.

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Life in Focus: The Rise of Premium Intraocular Lens (IOL) Technology

The Surgical Perspective

Sergei V. Dmitruk, M.D.

Shiraaz Rahman, M.D.

Which ATIOLs do you most commonly use and what drives your selection?

Sergei V. Dmitruk, M.D.: I encourage patients to approach cataract surgery as an opportunity to change their lifestyle. My primary trifocal platform is the Clareon PanOptix Pro for a full range of vision. With a history of refractive surgery or complex corneas, I prefer the Light Adjustable Lens (LAL), with or without variable monovision offsets, to allow post-operative refinement.

I frequently use monofocal toric lenses for patients with moderate-to-severe regular astigmatism who prioritize crisp distance vision and don't mind reading glasses. FLACS (fractional laser-assisted cataract surgery) can ensure perfectly centered capsulotomies and treat mild astigmatism, which is vital for any advanced technology lens.

Shiraaz Rahman, M.D.: In addition to toric lenses for astigmatism correction, I've had good success with the TECNIS Odyssey IOL and the Clareon PanOptix Pro.

Patients with greater than 0.5D of corneal astigmatism should be offered astigmatism correction. I really like toric lenses for greater than 1D of astigmatism.

I tailor multifocal lenses choices to the patient. I find the Odyssey more forgiving with distance vision quality at the expense of slightly less stellar, uncorrected near vision. For patients who want to be free of glasses for most "near" activities, I lean toward the PanOptix Pro and counsel there is a slightly higher chance of unwanted visual phenomena.

For patients with prior laser-vision correction and/or monovision, Light Adjustable Lenses shine. These patients can achieve a customized full range of vision, provided they can accommodate the extra visits for adjustments and lock-ins.

How do you match a patient's lifestyle and expectations to a specific IOL?

Shiraaz Rahman, M.D.: Patients fill out a lifestyle questionnaire that we review before they meet with the doctor to gain a better understanding of their priorities and lifestyle, including activities and hobbies.

I like to know whether the patient's goals involve being glasses-free always, sometimes or not at all. Will they compromise on certain activities like nighttime driving to achieve more freedom from glasses?

What are the most common reasons a patient is not a good candidate for ATIOLs?

Sergei V. Dmitruk, M.D.: Any significant macular pathology makes a patient a poor candidate for diffractive optics. Many corneal issues are also "red flags," but many can be treated. A patient with a "perfectionist" personality who cannot accept visual trade-offs or a neuroadaptation period is often better suited for a standard monofocal lens or LAL.

What do you wish referring optometrists would consistently address before sending a cataract patient for a surgical consult?

Sergei V. Dmitruk, M.D.: I would love to see more aggressive management of the asymptomatic dry eye patient. If a patient arrives with a disrupted tear film, I cannot get reliable biometry, which delays surgery. Addressing meibomian gland dysfunction and starting a regimen of high-quality artificial tears or immunomodulators two to four weeks before the consult is helpful.

Co-managing optometrists should encourage patients to continue using preservative-free artificial tears throughout the perioperative period to minimize the risk of chronic nerve sensitization.

Shiraaz Rahman, M.D.: The most important thing is to have patients start thinking about their goals and expectations for after cataract surgery. For patients who currently wear glasses or contacts, this could mean asking, "Do you want to change anything?"

Ocular surface management is also critical for accurate measurements. Daily artificial tears and warm compresses (ideally the Bruder Moist Heat Eye Compress) have the largest impact. If a patient has monovision, it is very helpful to know their dominant eye and specify which eye they use for near vision. This opens the conversation to all ATIOL options.

What should patients realistically expect with ATIOL outcomes, adaptation and potential trade-offs?

Sergei V. Dmitruk,M.D.: No IOL perfectly replicates the eye of a 20-year-old.

With standard monofocal lenses and monofocal torics, they likely will be partially dependent on glasses. With trifocals, they should expect a neuroadaptation period where the brain learns to prioritize images and halos, especially with bright lights at night. With the LAL, they need to commit to wearing UV-protective glasses and the adjustment process.

What preoperative testing or data do you rely on most when evaluating ATIOL candidacy?

Shiraaz Rahman, M.D.: Along with talking about patients' goals, we do a thorough examination and take measurements. Ocular biometry using the Alcon Argos and Zeiss IOLMaster is the most critical to help pick lens power. I also obtain topography using the OCULUS Pentacam to determine whether the astigmatism is asymmetrical and measure corneal higher order aberration. Chord length can confirm that the pupillary axis and real visual axis are in line.

Is there anything else you would like to add?

Shiraaz Rahman, M.D.: It is an exciting time to be a refractive cataract surgeon, thanks to all the technologies we can offer. It is important to have a goals-oriented conversation with each patient and screen each individual thoroughly to ensure "20/happy" outcomes.

NEW FACES: BEYOND THE BIO

William T. Gibson, O.D., F.A.A.O.

eyecenters.com/doctors/william-gibson-od

Q&A

What led you to this career?
From a young age, I wanted to do something in healthcare because I enjoy helping others. I chose eye care because the eye is such a fascinating organ and so much of how we experience life happens through our vision.

What is the best part of your job?
Being able to improve someone's quality of life through treatments and procedures that restore vision or comfort makes my job very rewarding.

Why did you join Bennett & Bloom?
I love that I get to work with so many great physicians. Bennett & Bloom truly feels like a family of close-knit providers who all have a common goal of providing the best patient care.

Tell us about your family and your pets.
My wife, Morgan, and I have an amazing 2.5-year-old daughter named Sophia, as well as two dogs (a yellow lab and a golden retriever) and a cat.

If you weren't working in eye care, what would you do?
If I wasn't working in eye care, I would design and build custom homes.

When you're not in the clinic, how do you like to unwind?
When I'm not in clinic, I enjoy playing basketball, working out and spending time with my wife and daughter.

Walter Williams IV, O.D., F.A.A.O.

eyecenters.com/doctors/walter-williams-od

Q&A

Why did you join Bennett & Bloom?
I joined after my residency experience with John-Kenyon Eye Center. I worked alongside some of the brightest minds in our strictly medical setting in an environment I truly enjoy. The hands-on experience with advanced optometric procedures, regular exposure to a wide range of ocular pathology and strong collaboration between optometry and ophthalmology make this practice unique and rewarding.

What led you to this career?
I was drawn through a passion for helping others in a meaningful and lasting way. While exploring healthcare opportunities, I became interested in optometry after extensive research during the summer between high school and college. My interest grew through shadowing local optometrists, where I saw firsthand the impact vision care has on a person's quality of life. With diverse opportunities within optometry such as patient care, research and working with industry, I am continually reminded I chose the right path.

How would you describe your style with patients?
My approach is professional and personable. I strive to be as thorough as possible. A few extra moments spent examining, listening and educating can greatly improve patient care, trust and compliance. I want every patient to feel heard, have concerns properly addressed, and leave with clear understanding of their eye health and confidence in their care.

What's something happening in eye care right now that you find really exciting?
One of the most exciting developments is the continued expansion of optometric scope of practice across many states. With significantly more practicing optometrists than ophthalmologists and a growing aging population, there is an increasing need for greater access to eye care services. This is especially true in rural and underserved communities. Scope expansion improves patient access to specialized care, reduces travel burdens and allows optometrists to play an even greater role in meeting the growing demand for eye care.

Tell us about your family and any pets.
My wife is also an optometrist, and we have an English Cream Golden Retriever puppy named Risley. We relocated to the Louisville area after graduating from optometry school.

What was your most unusual job?
During the summer between undergraduate studies and optometry school, I delivered ice throughout northwest Ohio. I drove a box truck to gas stations, convenience stores and grocery stores. It was an interesting experience during the COVID-19 pandemic that I still look back on today.

What is your favorite sports team?
My favorite teams are the New York Yankees and the University of Michigan Wolverines, especially football and basketball. You can find me cheering them on in my spare time.

What is one thing about you that might surprise your colleagues or patients?
I played baseball growing up and was a skilled pitcher in high school. During the travel baseball season before senior year, I even caught the attention of a Colorado Rockies scout.

Alexandra Pasley, O.D.

eyecenters.com/doctors/alexandra-pasley-od

Q&A

Tell us a little about your path here. Which areas of eye care are you especially passionate about?
I completed my residency in ocular disease and refractive/ocular surgery. I've always been drawn to the challenge and variety of ocular disease. I enjoy managing complex conditions and helping patients better understand their eyes and treatment options.

How would you describe your style with patients?
My style is educational and approachable. I want patients to feel informed and comfortable asking questions. When patients understand what's happening and why a treatment plan matters, they feel more empowered and engaged in their care.

Why did you join Bennett and Bloom?
I was impressed by the culture of collaboration and commitment to excellence. It was clear that the team stays at the forefront of eye care and shares a strong dedication to providing patients with exceptional outcomes.

What shows are you streaming now?
Right now, I'm watching *Love Island* and *Married at First Sight*. I'll admit that I'm a sucker for reality TV.

What are your favorite bands and sports teams?
I'm a big fan of Quinn XCII. His music always has great energy and good vibes. As for sports, I cheer for the Mississippi State Bulldogs and the Dallas Cowboys. I'm a bit of a glutton for punishment!

When you're not in the clinic, how do you like to unwind?
Outside of the clinic, I enjoy listening to true crime podcasts, reading psychological thrillers, playing video games and unwinding with a good TV show.

MARK YOUR CALENDAR

AUGUST

Be on the lookout for more details about summer gatherings with our referral community:

- August **continuing education** event
- **Kyle Rogers, M.D.** will be out and about meeting partners

SEPTEMBER
25-26

Kentucky Optometric Association (KOA) fall conference at the Marriott East Hotel. Hosted by KOA, the conference offers up to 20 hours of continuing education. Visit our booth throughout the event to meet our team. Registration opens this summer:

kyeyes.org/koa-events/fall-meeting

YOUR CLINICAL CONCIERGE

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