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TECNIS SYNERGY™ IOL IN MODERN PRACTICE

Continued Excellence via State-of-the-Art Engineering

The panelists are paid consultants for Johnson & Johnson.

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BY ERIC DONNENFELD, MD; EDWARD HU, MD, PHD; VANCE THOMPSON, MD; WILLIAM WILEY, MD; AND ELIZABETH YEU, MD

INTRODUCTION

At the 2022 ASCRS annual meeting, Vance Thompson, MD, chaired a roundtable discussion about the TECNIS Synergy™ IOL (Johnson & Johnson Vision), with panelists Eric Donnenfeld, MD; Edward Hu, MD, PhD; William Wiley, MD; and Elizabeth Yeu, MD. During their conversation, these surgeons discussed patient selection in a real-world environment, reviewed the engineering aspects of the TECNIS Synergy™ IOL that underpin its unique performance, and summarized their approaches to patient examinations, IOL power calculations, and surgical alignment.

Given their extensive experience with the TECNIS Synergy™ IOL, their insights on matters ranging from preoperative patient consultations to intraoperative pearls will be useful for modern surgeons seeking to provide the best vision possible for their patients.

This fall, Johnson & Johnson Surgical Vision will debut the InteliLight™ portfolio including TECNIS Synergy™ and TECNIS Synergy™ Toric II IOLs. InteliLight™ technology comprises three proprietary innovations: violet light filtration, a new high-resolution echelette design, and achromatic technology. When added to Johnson & Johnson's line of presbyopia-correcting IOLs, InteliLight will close the gap in contrast and low light performance.

Vance Thompson, MD: When I think about the major changes to our field over the past several years, my mind turns to patients' desire for spectacle independence. Twenty years ago, the number of patients who wanted to be free of glasses represented a single-digit percentage of my patient population. Today, approximately 40% of the patients I see in my clinic want to rid themselves of glasses—and I expect that we are only a few years away from the majority of patients entering our clinic and asking us how we can help them be free of glasses. Are my observations unique to my practice, or are you all seeing a similar trend?

Eric Donnenfeld, MD: My experience is similar to yours, Dr. Thompson. When I see a patient during initial consultations, I frame our discussion by asking what visual goals they wish to achieve for the rest of their life. More and more, patients tell me that they never want to wear glasses again. When that occurs—and after I am sure that the patient is eligible for presbyopia-correcting technology—I begin a discussion about lens options that provide quality vision at distance and intermediate ranges, excellent vision at near range, and obviate the need for glasses. I remind patients that the convenience of this technology is matched by quality-of-life improvements, such as a reduced risk of falls and trauma that become more important as we age.[1]

In my experience, the TECNIS Synergy™ IOL provides the best combination of near, intermediate, and distance vision. It is my go-to IOL for patients who wish to be free of glasses. If a patient expresses a desire for improved distance vision, I always remind them that it will come at the expense of any vision within arm's length unless they wish to explore use of an enhanced-technology lens such as the TECNIS Synergy™ IOL.

Edward Hu, MD, PhD: The expectation that we provide patients with a spectacle-free lifestyle has been present for many years. Thanks to the TECNIS Synergy™ IOL, I'm able to meet the expectations of many of my patients who want to live a life without spectacles.[*,†,2] As someone who practices in the Midwest and sees a number of patients whose careers rely on their ability to work outdoors and have crisp vision across multiple distances, I find that the TECNIS Synergy™ IOL has changed my patients' lives for the better.

Elizabeth Yeu, MD: In general, patients are surprised and pleased with how quickly their range of vision settles in. Postoperatively, patients are able to comfortably read their cell phones, books, and resume all computer-range tasks without adjusting their natural or habitual 'sweet spot' for those near tasks.[*,†,2] I no longer have to reinforce the need to move their arms back and forth to

[*] Individual results will vary. Some TECNIS Synergy IOL patients may require spectacles post-surgery.
[†] Based on interim data collected at 6 months post-operative. 92% of subjects reported they didn't wear glasses.

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find the 'new sweet spot' that I often did when implanting a bifocal/multifocal IOL in the past.

Dr. Thompson: Let's put the TECNIS Synergy™ IOL in a historical perspective. Dr. Wiley, can you provide a quick rundown of where we've been and how we got here?

William Wiley, MD: With the first generation of presbyopia-correcting IOLs, accommodating lenses offered some intermediate and distance visual quality, but not much was gained in terms of near vision. Later, multifocal technology allowed good vision at near and distance ranges, but intermediate dropout meant that patients still needed to wear glasses for common daily activities. With these types of technologies, discussions with patients about expectations required us to emphasize that pure spectacle independence was unlikely to be achieved.

In the era of extended depth-of-focus (EDOF) IOLs, we have finally hit a sweet spot in that we can offer many patients good distance at all levels of vision. In short, enhanced technology means that we can deliver on a wider range of expectations. Technically, the TECNIS Synergy™ IOL achieves a range of vision at distance, computer-length, and cell phone reading-range through a combination of EDOF and multifocal approaches. Optically, it would be similar to combining a TECNIS Symfony™ EDOF IOL with a TECNIS Multifocal IOL (both Johnson & Johnson Vision). Regardless of its specific classification, the TECNIS Synergy™ IOL provides the type of top-tier visual function that patients increasingly expect.

PATIENT SELECTION FOR TECNIS TECHNOLOGIES

Dr. Thompson: We all know how critical patient selection is: if we select the right patients for a particular technology, we're very likely to end up with satisfied patients, meaning that we've ultimately achieved our goal of improving our patients' lives. What patient trends have you observed regarding the TECNIS Synergy™ IOL?

Dr. Wiley: I've seen an increasing number of younger patients coming to the clinic for IOL consultations. These younger patients are eager to address presbyopia. If I am placing an IOL in a young patient, I want to make sure that the material is going to be reliable long term. I have been impressed with the consistent short- and long-term clarity the TECNIS® platform provides. This is a testament to the TECNIS® family's base material.

Dr. Donnenfeld: Further, the TECNIS® platform has high negative asphericity, high Abbe number, and low chromatic aberration—all leading to better quality of vision and contrast during day and night.

Dr. Wiley: The engineers responsible for the TECNIS® line of products have a track record of listening to patients and surgeons when initiating innovative adjustments. The current iteration of the TECNIS embodies that history. The original TECNIS Symfony™ IOL offered impressive distance and intermediate vision, but left room for improvement in near vision. The Johnson & Johnson team responded by combining the design of the TECNIS Multifocal (which offered excellent near vision) with the TECNIS Symfony™ Legacy IOL, thereby creating a next-generation product (ie, the TECNIS Synergy™ IOL) that brought the best of both technologies without skimping on safety or long-term durability concerns.

Dr. Thompson: Dr. Wiley's astute observations about younger presbyopic patients seeking cataract surgery will help surgeons stay alert to an emerging patient population. Still, younger patients do not make up a majority of the patient population that undergoes IOL placement. What patient selection pearls does the panel have regarding patients who present to the clinic with a typical cataract?

Dr. Donnenfeld: There are a few key data points to gather when evaluating options for a patient who presents for cataract surgery. First, I want to know the patient's refractive error, as my approaches to a patient with -3.00 D error differ greatly from a patient with +3.00 D error. Second, I want to know the patient's surgical goals. Without an articulated purpose, I cannot adequately suggest a lens for any patient.

After securing data on refractive error and patient goals, I examine the patient to determine whether they are eligible for a premium IOL such as the TECNIS Synergy™ IOL. I assess the ocular surface, conduct corneal topography and OCT imaging, determine whether they have signs of glaucoma, and gather general ocular history. That last point is key: many of my patients seeking spectacle independence have had refractive corneal surgery, and we must establish any relevant surgical history before recommending an IOL.

Dr. Wiley: I agree with Dr. Donnenfeld's protocol. I advise that surgeons carefully examine OCT imaging results to rule out retinal pathology, as even slight anatomic disruptions such as small epiretinal membranes can have an outsize effect on final vision. Clinics with meibographers should consider assessing meibomian gland function to determine if future tear film issues could arise.

Dr. Yeu: Although we have optics of excellent quality, we still need to be mindful of lid margin and ocular surface disease. Both of these contribute very significantly to tear film characteristics,

which in turn affect a patient's quality of vision. I cannot stress enough the value of healthy meibum with a steady, sealed tear film. I use infrared meibography on every cataract patient to evaluate meibum structure. I also compress the central lower-lid glands for 5 seconds and note the quality and rate of expression of the meibum secreted, both of which are markers of meibum function. If patients have meibum structural loss greater than 25%, then they already have loss of reserve, and I will not implant any diffractive multifocal IOL. Anecdotally, this has made a huge difference in decreasing the number of unhappy post-op multifocal IOL patients.

Dr. Wiley: Sometimes patients want to know why I'm conducting so many tests during a consultation. If they've expressed an interest in a premium IOL such as the TECNIS Synergy™ IOL, I tell them that we need to ensure that their anatomy is prepared to receive a high-tech IOL. I liken it to the purchase of a high-performance car: before they buy it, we should check the oil, the tire pressure, and the brakes. Without those fundamentals, their experience cannot be maximized.

Dr. Thompson: I educate patients who are receiving a TECNIS Synergy™ IOL that the lens scatters light in measured, regulated fashion, and that anything that causes light to scatter in an irregular fashion will degrade visual performance. Unstable tear film is a leading cause of irregular light scatter. Armed with this knowledge, patients with dry eye disease (DED) who are receiving the TECNIS Synergy™ IOL may be more patient with preoperative treatments that address ocular surface conditions because they know they are investing in the future success of their visual quality.

Two other causes of light scatter that can degrade this quality optic are residual refractive error and posterior capsule opacification. I tell patients that my goal is to make their tear film optically and therapeutically happy, their refractive error as close to plano as possible, and, if their capsule is not clear, to perform a YAG laser capsulotomy.

When cataract surgeons do a traditional monofocal surgery, typically any residual refractive error is treated to plano with glasses. We need to treat residual refractive error in advanced implants the same way. If our manifest refraction gives them a better image quality, they should be offered a refractive enhancement. In a patient with otherwise healthy eyes, the rate of very happy patients is very high if we accomplish these things.

I also think it is important to talk with the patient about neural adaptation. I explain to them that after the image is optimized to 20/20 uncorrected in each eye alone, whether they achieved that with just the implants or they also needed their tear film, refractive error, and capsule treated, that there is a time period of their brain getting used to their new optical system. The happiest patients are the ones who realize the importance of these steps plus brain adaptation time.

When I identify a patient who I think is a good fit for the TECNIS Synergy™ IOL, I use terms and concepts that they can grasp. Patients easily connect the terms such as trifocal with my explanation that distance, intermediate, and near vision are the points of the visual range that we seek to address with the TECNIS Synergy™ IOL. Next, when I tell patients that what sets the TECNIS Synergy™ IOL apart from other lenses is that it's an extended hybrid multifocal or a high-performance hybrid IOL, thereby allowing a range of vision,[‡] they typically comprehend why this lens is an excellent fit for their needs.

Dr. Hu: That said, we don't want to overpromise and underdeliver. An essential part of the preoperative conversation is establishing parameters for success. Surgeons who outline what a lens can do should also outline what a lens cannot do. Defining what a patient can expect regarding postoperative visual function will pay dividends after surgery.

Dr. Donnenfeld: Whenever a patient expresses an interest in a presbyopia-correcting IOL, I tell them that they have the opportunity to receive a lens that may reduce or eliminate the need for glasses,[*,†] and that this lens may increase glare and halos in their vision. We have to make sure that every patient understands this, regardless of the specific presbyopia-correcting technology under consideration.

I advise keeping a family member in the exam room during conversations about lens selection. In some cases, I've had a patient complain of dysphotopsia in the postoperative period, and then claim that I didn't outline such phenomena during the consultation. In those instances, the patient's family member reminds them that we did, in fact, discuss glares and halos, and it puts the patient at ease to know that what they're experiencing was expected.

Dr. Thompson: Patient personalities have long been one of the several factors weighed when selecting an IOL. Historically, we have shied away from recommending premium IOLs to patients who have unrealistic expectations or whose demanding personalities may otherwise be difficult to please. Do you find that this is still the case?

Dr. Donnenfeld: I don't worry about personality types as much as I used to if I'm implanting the TECNIS Synergy™ IOL. In fact, I've found that my most demanding patients have experienced excellent postoperative quality of vision and become the best ambassadors for high-performance hybrid lenses. We no longer live in a world where there is a perfect patient profile for receiving premium technology.

Dr. Wiley: I agree with Dr. Donnenfeld. In fact, I am more concerned with a patient's career obligations than personality type. If a patient's job requires them to interact with outdoor

[*] Individual results will vary. Some TECNIS Synergy IOL patients may require spectacles post-surgery.
[†] Based on interim data collected at 6 months post-operative, 92% of subjects reported they didn't wear glasses.
[‡] 20/32 or better visual acuity across the range

lights at night—say, if they're a truck driver or an airline pilot—then I rule out a lens that may induce dysphotopsia. Still, patients typically understand what they will and won't tolerate, and probing for specifics to determine their threshold for side effect tolerance will lead to a proper IOL recommendation.

Dr. Hu: We used to rule out patients with demanding personalities not because the patients were the issue, but rather because the IOLs available to us were unable to provide a wide enough range of continuous vision[‡] from distance to near. With the TECNIS Synergy™ IOL, this is no longer the case.

Dr. Thompson: I want to emphasize how revolutionary this is: patients who have high expectations are no longer automatically ruled out for high-performance lenses thanks to the TECNIS Synergy™ IOL.

Dr. Donnenfeld: Many of my patients are most impressed that they have excellent near vision in dim light. Practically, this means they no longer have to use the flashlight on their phone to read the menu at a restaurant.

Dr. Yeu: It also means that varied tasks such as reading in bed, looking at multiple monitors in mesopic conditions, or using backlit technology in the evening are easier. When you consider the range of activities that patients can perform after implantation of the TECNIS Synergy™ IOL, you understand why my peers and I believe that it offers a continuous range of vision at the highest quality of presbyopia-correcting IOLs.[‡]

Dr. Hu: My staff and I tracked an initial cohort of patients who received the most current iteration of the TECNIS Synergy™ IOL at my clinic. Before the TECNIS Synergy™ IOL, we aimed for particular sweet spots for patients. Now, we have a technology that spans a continuous range of vision,[‡] leaving our patients happier and our clinics' reputations strengthened.

HOW MANY PATIENTS ARE A FIT FOR THE TECNIS SYNERGY™ IOL?

Vance Thompson, MD: What percentage of the cataract patients in your clinic are eligible for the TECNIS Synergy™ IOL based on anatomic findings and patient expectations?

Edward Hu, MD, PhD: I practice in a tertiary referral center, and many of the patients I see have comorbidities or other complications. Even under such conditions, I estimate that 33% of my patients are eligible for the TECNIS Synergy™ IOL.

William Wiley, MD: Given my patients' expectations, I, too, estimate that about 33% of the cataract patients I see are a good fit for the TECNIS Synergy™ IOL.

Eric Donnenfeld, MD: My approximations are a bit higher. I estimate that 50% of the cataract patients I see qualify anatomically for the TECNIS Synergy™ IOL; of that group, another 50% have goals that align with the IOL's offerings. This means that I'm placing the TECNIS Synergy™ IOL in approximately 20% to 25% of my patients.

Elizabeth Yeu, MD: Anatomically, I would say one-third of my patients have healthy enough eyes to undergo the TECNIS Synergy™ IOL. I am placing the TECNIS Synergy™ IOL in about 20% of my cataract surgery patients.

APPROACHES TO EXAMINATION AND POWER CALCULATIONS

Dr. Thompson: Walk me through an examination of a patient with a routine cataract who has expressed interest in a presbyopia-correcting IOL.

Dr. Donnenfeld: Several years ago, my testing protocol for patients who were undergoing monofocal IOL placement differed from those who wanted a premium IOL. In 2022, however, I approach both patient subpopulations similarly.

Before I open a discussion about IOL options, I review corneal topography and OCT imaging of the macula and conduct a tear film evaluation with the patient. I show the patient their OCT, and in most cases, their retinal anatomy is healthy. Next, I examine their topography results and educate them about astigmatism if it is present. Any tear film analysis comes next, again with an explanation of my findings. I make it a point to speak directly to the patient during this process, allowing a scribe to display relevant tests and take notes as needed. Only after these three topics are addressed do I begin discussing the specifics of which IOLs are a fit for them.

Dr. Thompson: How concerned are you about corneal higher order aberrations (HOAs)?

Dr. Wiley: In eyes with cataracts that are otherwise healthy and have no history of trauma, I do not expect HOAs to

[‡] 20/32 or better visual acuity across the range

play a significant role in visual quality after implanting the TECNIS Synergy™ IOL. In my experience, eyes with a history of trauma, refractive surgery, or other ocular conditions are more likely to experience postsurgical visual disruption due to HOAs than healthy eyes—even if those healthy eyes have astigmatism.

Dr. Thompson: We all agree that a healthy ocular surface is a prerequisite for implantation of a high-tech lens such as the TECNIS Synergy™ IOL. What are the key features of your ocular surface exams?

Dr. Donnenfeld: If the patient reports visual fluctuation, then I consider them to have DED until proven otherwise. Further, if results from the modified SPEED questionnaire I provide patients indicate that DED may be present, my technician team is empowered to order relevant tests to gather more data. I review the results of these tests before meeting the patient. Any patient with active corneal staining is ineligible for a premium IOL at the time of consultation, but may be eligible if therapy proves effective at resolving disease.

Dr. Thompson: And what about your approach to IOL power calculations?

Dr. Donnenfeld: I elect to use the Barrett Formula, with the Holladay 2, Haigis, and Hoffer Q as my backups. I aim for plano to +0.20 D; if two formulas disagree slightly, I tend to err on the side of making the patient hyperopic. I use a personalized 119.2 A constant. Our refractive outcomes have been excellent. I typically perform LASIK enhancements on 1% to 2% of patients, along with limbal relaxing incisions to address 0.50 D to 0.75 D of cylinder. These enhancements have often taken patients from 20/happy to 20/ecstatic.

Dr. Hu: When implanting the TECNIS Synergy™ IOL, I also use the Barrett Formula, as it gives me the most consistent and accurate refractive outcomes. I also target plano to +0.20 D.

Dr. Thompson: How does the axial length affect which formula you use?

Dr. Yeu: In eyes with average axial length, I use the Barrett Universal Formula. I also use it for eyes of extreme myopes (ie, axial length of 26 or 27 mm). In eyes that are 22 mm and shorter, formula choice is more difficult. The Hill-RBF Formula may be best for these patients, but the Olson has been a great one too for me. In eyes of shorter patients, I find that assessing postoperative refraction in the first eye can guide our decision-making in the second eye.

ALIGNMENT PEARLS

Dr. Thompson: What pearls for IOL centration might be useful to our peers who are using the TECNIS Synergy™ IOL?

Dr. Donnenfeld: Centering on the first Purkinje image is an important first step. I have the patient look at the light and center it on that lens. I turn the lens horizontally at 270° and 90° to make sure it is properly aligned. Do not center the capsulotomy or the TECNIS Synergy™ IOL in the dilated pupil, as the center will shift after the eye is no longer dilated.

Dr. Wiley: I have observed that, due to its stiff material, the TECNIS Synergy™ IOL naturally centers itself in the bag. Compare this with other technologies that use more flexible materials, which can sometimes inadvertently become decentered.

Dr. Yeu: I advise that surgeons place the IOL directly on target or even a little bit to the right of the target when aligning the TECNIS Synergy™ IOL. This lens is easy to rotate both clockwise and counterclockwise when fine-tuning into the final position.

Dr. Hu: A smooth delivery from the loader is a small but important step that shouldn't be overlooked. Surgeons should be patient after injecting the lens. Allow time for the haptics to fully open.

Dr. Thompson: Surgeons who have been using the TECNIS Synergy™ IOL already understand its benefits, and have likely found implantation intuitive. Those who have not yet adopted this advanced technology may wish to consider how it could improve their patients' postoperative satisfaction and joy, and should reach out to peers who have experience with the TECNIS Synergy™ IOL to hear about pearls for onboarding this exciting new lens into their practice. ■

1. Lord SR, Dayhew J, Howland A. Multifocal glasses impair edge-contrast sensitivity and depth perception and increase the risk of falls in older people. *J Am Geriatr Soc*. 2002;50(11):1760-1766.
2. Johnson & Johnson Vision Data on File.

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INDICATIONS: The TECNIS Simplicity® Delivery System is used to fold and assist in inserting the TECNIS Synergy™ IOL, which is indicated for primary implantation for the visual correction of aphakia in adult patients, with less than 1 diopter of pre-existing corneal astigmatism, in whom a cataractous lens has been removed. The TECNIS Simplicity® Delivery System is used to fold and assist in inserting the TECNIS Synergy™ Toric II IOLs that are indicated for primary implantation for the visual correction of aphakia and for reduction of refractive astigmatism in adult patients with greater than or equal to 1 diopter of preoperative corneal astigmatism, in whom a cataractous lens has been removed. Compared to an aspheric monofocal lens, the TECNIS Synergy™ IOLs mitigate the effects of presbyopia by providing improved visual acuity at intermediate and near distances to reduce eyeglass wear, while maintaining comparable distance visual acuity. The lens is intended for capsular bag placement only.

WARNINGS: Intraocular lenses may exacerbate an existing condition, may interfere with diagnosis or treatment of a condition or may pose an unreasonable risk to the eyesight of patients. Patients should have well-defined visual needs and be informed of possible visual effects (such as a perception of halo, starburst or glare around lights), which may be expected in nighttime or poor visibility conditions. Patients may perceive these visual effects as bothersome, which, on rare occasions, may be significant enough for the patient to request removal of the IOL. The physician should carefully weigh the potential risks and benefits for each patient. Patients with a predicted postoperative residual astigmatism greater than 1.0 diopter, with or without a toric lens, may not fully benefit in terms of reducing spectacle wear. Rotation of the TECNIS Synergy™ Toric II IOL from its intended axis can reduce its astigmatic correction. Misalignment greater than 30° may increase postoperative refractive cylinder. If necessary, lens repositioning should occur as early as possible, prior to lens encapsulation. The lens and delivery system should be discarded if the lens has been folded within the cartridge for more than 10 minutes. Not doing so may result in the lens being stuck in the cartridge. Do not attempt to disassemble, modify, or alter the delivery system or any of its components, as this can significantly affect the function and/or structural integrity of the design.

PRECAUTIONS: Interpret results with caution when using autorefractors or wavefront aberrometers that utilize infrared light, or when performing a duochrome test. Confirmation of refraction with maximum plus manifest refraction technique is strongly recommended. The ability to perform some eye treatments (e.g., retinal photocoagulation) may be affected by the IOL optical design. The surgeon should target emmetropia, as this lens is designed for optimum visual performance when emmetropia is achieved. The TECNIS Synergy™ IOLs should not be placed in the ciliary sulcus. Carefully remove all viscoelastic and do not over-inflate the capsular bag at the end of the case. Residual viscoelastic and/or over-inflation of the capsular bag may allow the lens to rotate, causing misalignment of the TECNIS Synergy™ Toric II IOL. All preoperative surgical parameters are important when choosing a TECNIS Synergy™ Toric II IOL for implantation, including preoperative keratometric cylinder (magnitude and axis), incision location, the surgeon's estimated surgically induced astigmatism (SIA) and biometry. Variability in any of the preoperative measurements can influence patient outcomes and the effectiveness of treating eyes with lower amounts of preoperative corneal astigmatism. The effectiveness of TECNIS Synergy™ Toric II IOLs in reducing postoperative residual astigmatism in patients with preoperative corneal astigmatism < 1.0 diopter has not been demonstrated. Patients with a predicted postoperative astigmatism greater than 1.0 D may not be suitable candidates for implantation with the TECNIS Synergy™ and TECNIS Synergy™ Toric II IOLs, as they may not obtain the benefits of reduced spectacle wear or improved intermediate and near vision seen in patients with lower predicted postoperative astigmatism.

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