Risks and benefits leaflet
Cataract/Refractive lens Surgery

Mr Aasheet Desai
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Please read through the following information slowly, carefully and **several** times.
Please ask Mr Desai or the Optometrists if you don't understand any aspects of this document or want more clarification.

It is important to remember that you are opting for an operation on one of the most important parts of your body and while the majority are extremely pleased with results. Please take the time to understand the risks and benefits of the surgery and various options available.
Please also see the following link from the Royal College of Ophthalmologists.
https://www.rcophth.ac.uk/wp-content/uploads/2020/05/Refractive-Lens-Exchange-Patient-Information.pdf

After the age of 40 the natural lens starts losing its flexibility and is unable to focus at different distances (presbyopia). This progressively keeps getting worse and worse (often needing stronger and stronger prescription as ageing progresses), and eventually people develop cataracts.

Refractive lens exchange (RLE) or Natural lens replacement (NLR) or clear lens extraction is **essentially the same operation as Cataract surgery**. The terms are used interchangeably.

Options available:

Not having an operation is certainly a valid option and as this is an elective surgery, Mr Desai would want you to reflect long and hard on all options available.
Alternatives to surgery including spectacles, contact lenses including multifocal contact lenses, monovision with contact lenses, laser vision correction. For any of these options please speak to your optometrist or laser vision clinic.
From a surgical perspective, the operation is exactly the same as a cataract operation and the only difference is the choice of lens we use:

Monofocal lenses provide a very sharp image and are extremely good and perhaps optically superior to your own natural lens. They are fixed at one focal point. This means that additional correction is required in the form of spectacles for near and intermediate distance for the majority of patients.

For Privately funded patients,if finances are not a factor, Mr Desai would urge for use of enhanced monofocal lenses in preference to monofocal lens as the benefits of near/intermediate vision are superior compared to monofocal lenses and there is very little risk with enhanced monofocal lenses.

Enhanced monofocal IOLs. Theoretically they are monofocal IOLs but are designed to give intermediate vision in addition to distance vision. We rely on the eyes working as a pair and quite often one of the eyes is made slightly short-sighted so that the maximum range that can be tolerated is achieved. Quite often people do

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get very good near vision even though they are not designed for this. If there are any concerns with ocular health, enhanced monofocals would be far safer to use than multifocal IOL. About **60% get reliable intermediate** vision in addition to distance vision and **about 37% even get good near** vision with these lenses.

Monovision (with Enhanced monofocal IOL) where the IOL in one eye is made to focus at near object and the other eye for distance objects. This means that the 2 eyes are asymmetric, with one eye focusing for distance and the other eye focusing for near. As the processing of the vision is done by the brain, it relies on the brain to take the sharp image and make it out as if it is coming out of both eyes (by suppressing the other eye) There is a limit to how much the brain can cope with the imbalance, and this varies in different people.

This is particularly suited for people who have other eye diseases or conditions where multifocal IOLs are contraindicated or if they do not want the disadvantages posed by Multifocal IOLs.

This is a good compromise for people who don't want multifocal IOLs and particularly for those who are worried about glare and haloes. Obviously, they are not as reliable as the Multifocal IOls. There is also a potential disadvantage of not getting binocular vision and depth perception can be altered.

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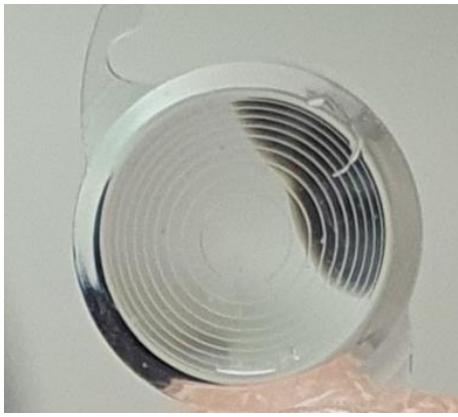
Multifocal IOLs: If you require the range of vision, for distance, intermediate and near, the multifocals are perhaps the **most reliable** way of providing this range. Currently there are approximately 100 different designs and shapes of Multifocal IOLs and there is no consistency even in medical literature on how they are named.



These are variously described as bifocal, higher add IOL, trifocal IOL, extended depth of focus IOL (EDOF) etc. with each manufacturer claims their lenses are the best in the world.

Broadly they are *Diffractive* IOLs or *Refractive* IOLs.

Property of light is for it to bend when it hits an interface. All Multifocal IOLs work by forming **more than one image on the retina**. The brain then processes the images and chooses to focus on the desired image.

The **Diffractive** multifocal lens has concentric ridges on the IOL (attached photo). These bend the light coming in. The ridges make it possible to focus on near and intermediate distance. However, the trade-off with the ridges is that there may be ***glare, haloes and other quality of vision*** problems that are experienced and may not give as sharp a vision as the monofocal lenses as the light is distributed over a larger range of vision.

There are various designs of diffractive multifocal IOLs, in general, the more the rings the more near vision you get and the more chance of visual problems of glare and haloes. **The rule of thumb: higher risk equates higher benefits!**

Blink several times before e diagnostic test is done.

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Refractive IOLs have zones of refractive surfaces. The current lens that we use is the SBL IOL. This is described as a bifocal IOL as it has two zones of focus. (attached photo) They are described as rotationally asymmetric IOL as they need to be inserted in specific direction. They still appear to give intermediate vision as well and seem to work as well as the diffractive Multifocal IOL. The results appear to be as good as the diffractive IOL but has potentially a lower risk of glare and haloes and quality of vision problems as there is only one interface area and no rings.

If there is pre-existing astigmatism, specialised lenses that correct astigmatism are needed

Intolerance to Multifocal IOL.

A small minority of people do feel that they just cannot tolerate these lenses and some do stop driving at night as a result. To help with the intolerance, drops with pilocarpine and spectacles need to be tried first. If after all trials and in 6 months after op, if still intolerant to the lenses, they will need to be removed and replaced with monofocal or enhanced monofocal lenses. We have not yet found any predictable way of knowing which patients would not tolerate the lens. The incidence of exchange to monofocal or enhanced monofocal lens because of intolerance to multifocal IOL is below 1%. The number of people who are unhappy are in the region of 5 in 100 and 1 in 100 are so unhappy with the lenses that they want these changed to a monofocal lens. The risks of changing the lens is higher than the first surgery, but Mr Desai has a huge experience and still manages to get extremely good results even when explanted. You can opt for the lens to be changed to enhanced monofocal or monovision if intolerant to the lenses. There is also a higher proportion who need to wear glasses/need laser vision correction/ piggy back IOL after explant, because astigmatism can be induced after second surgery.

Mechanics of vision and importance of the brain.

Vision is incredibly complex. We are operating only on one element of vision and trying to get as sharp a focus on the retina as possible. The retina then converts the image to electrical impulses for the brain to interpret as images. The brain then modulates, and further processing is incredibly complex and poorly understood. We know that some people may choose not to wear glasses even if the glasses substantially improve vision as the brain can cope with the information presented, while some people can notice and are bothered with very small changes in their vision. What we know is that some people with 6/6 or 20/20 vision may be very unhappy and some with poor vision may be very happy.

Irrespective of the personality or the brain's mysterious ways of working, we also know that with time the overwhelming majority do get used to the new state and become quite happy with their vision.

The mechanics of vision is particularly important to understand as some people get used to the new state instantly and some may take a long time. It is also important to put a disclaimer as Mr Desai has operated on

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several people who classed themselves as perfectionist and got used to the lenses instantly.

"Spectacle Freedom"

Nature doesn't allow us to see for distance and near after we reach our 40's.

What we are trying to do is to make use of technology to achieve what nature doesn't allow. ☺

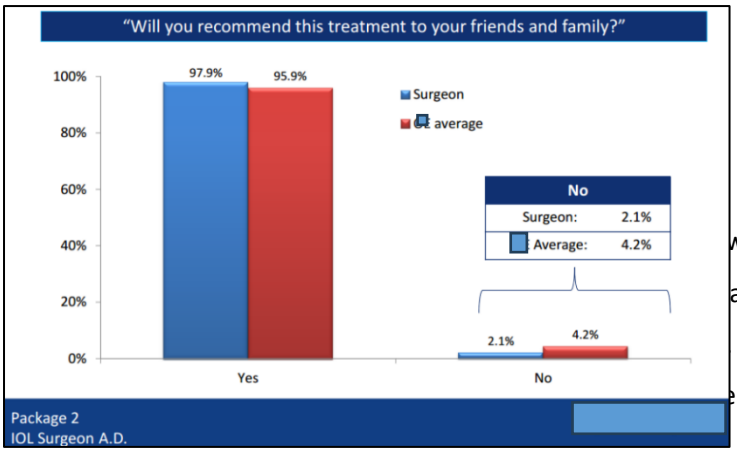
It is impossible to replicate the young human lens or become younger! ☺

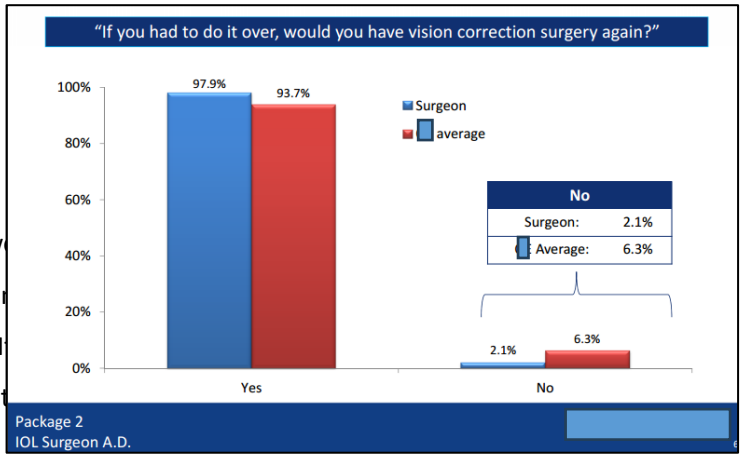
There are no perfect solutions, and all solutions have their own disadvantages!

Most people are left with small residual refractive error, people choose not to wear glasses because the vision is good enough.

The statistics and evidence are variable depending how the question is framed. The feedback from patients is extremely reassuring. Please find the statistics below. More than 95% patients would recommend the treatment to friends and family and similar numbers would have the procedure again.

It is not unusual to hear patients describing the operation as the best decision they made and wishing they had it done sooner. A small minority do feel otherwise.





Astigmatism (eye commonly being described as being rugby ball shaped). While most people have some form of astigmatism, a substantial minority of people have astigmatism that may be clinically relevant. We have become very good at reducing astigmatism at the time of surgery. This is commonly achieved by means of extra incisions on the cornea or selecting specialised toric lenses. But to correct astigmatism completely is impossible as there are far too many factors that cannot be controlled. If you have higher degrees of astigmatism, there is a higher risk of needing further "enhancement" with laser vision correction or surgery.

2019	Estimated Enhancement Rate
Mr Desai	3.30%
OE average	5.00%
Mr Desai: 619 operations over 6 months	

Apart from some limitations in technology (even though it is extremely accurate), RLE is a surgical intervention and like any surgery there are risks. It would be very difficult to list the complete range of complications, but if we were to stratify risk, the global risks with cataract surgery are as follows: there is a 1:500 to 1:10,000 risk of major complications with severe visual loss; 1:100 risk of moderate complications where the recovery is

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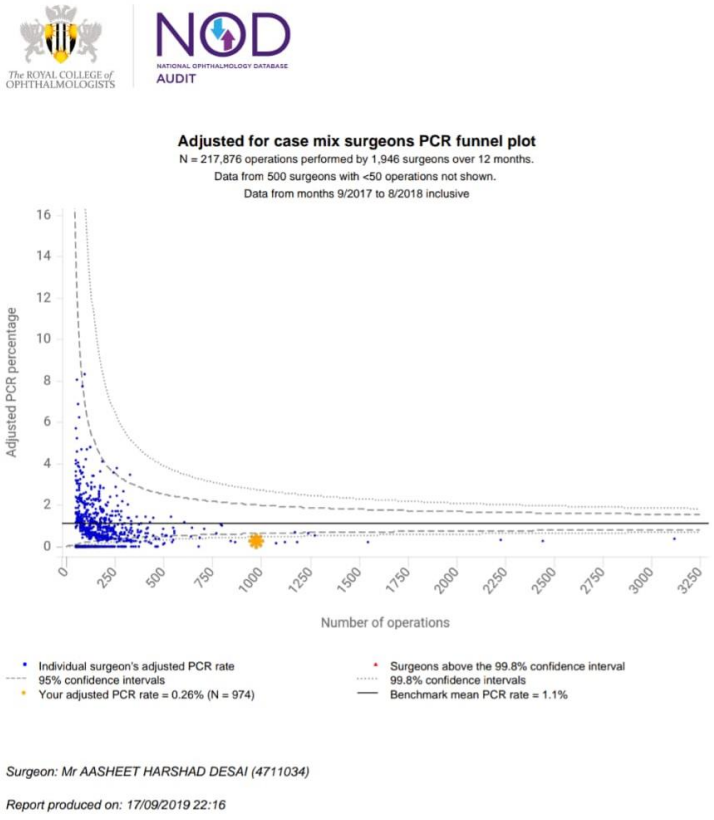
prolonged, but the vision eventually is very good in the majority of cases, and 1 :10 risk of patients of being unhappy where the vision is objectively good, but unhappy due to various factors including dry eyes.

Mr Desai is highly skilled surgeon and has performed approximately **35,000 operations** until the end of 2023. He has been involved in training of over 75 doctors in cataract surgery and has published a book on cataract surgery.

He has also performed over 350 IOL exchanges in the past 3 years. **Currently, Mr Desai's expertise is being utilized to train the future Consultant Ophthalmologist of the UK to excel in cataract surgery.**

The chart adjacent is the National Audit Data for cataract surgery showing Mr Desai's nearly 1000 cataract operations with one of the lowest complication rates in the country.

Complication with cataract surgery in Mr Desai's care is one complication for every 385 operations, whereas the national average is one complication for every 91 patients.



While these risks are with cataract surgery in general, RLE would potentially have lower risk. With risk of posterior capsular tear as described above to be approx. 1:1000 or less.

The following are some of the common risks associated with cataract/NLR/RLE operations.

1) **Unrealistic expectations.** While the **majority of patients are extremely happy** and it is not unusual for people to say it is one of the best things they have ever had and wished they had done it sooner, please do remember that nothing works better than your natural lens. All artificial lenses work in artificial ways and while they are extremely good, they are not perfect. Mr Desai would very strongly urge you to respect the limits of what technology allows us to do. It is impossible to predict what an individual gets but suffice it to say that the vast majority are extremely happy. **Please also appreciate that there is zero correlation between money and risks**.
2) **Posterior capsular rupture.** See National Ophthalmic Database (NOD) graphic and above. If this complication were to unfortunately occur, safety would be a priority and, in most cases, a multifocal IOL insertion would not be possible. With RLE, Mr Desai's personal risk is less than 1:1000
3) There is also a very small risk of the support to lens breaking and the lens material falling to the back of

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the eye (**dropped lens**) this would need a further operation and a prolonged recovery. The risk of this is approximately 1:1000 with cataract, Mr Desai has not yet had this complication with RLE. In the unfortunate case of posterior capsule rupture or dropped lens, we have to try and make it as safe as possible and the priority would be to use only monofocal IOL as it is much more safer than multifocal. Rarely it may not be possible to insert any IOL at all at the time of initial surgery if any of these complications were to occur.

4) There is approximately 1:2000 to 1:10,000 risk of severe visual loss including the risk of infections (**endophthalmitis**). The risk of endophthalmitis has dramatically dropped in the last several years. If you get a severe pain which progressively gets worse, associated with decreased vision and upper eyelid swelling in the first 3-4 days of surgery, you must see an eye specialist as a matter of urgency.
5) **Dry eyes**. This is manifest by dry gritty sensation and is **extremely common** after surgery. This normally settles down after a few months, but rarely can unmask a previously undiagnosed dry eye and can be quite troubling. Use of lubricating eye drops in the form of artificial tears can be helpful.
6) **Flashes of light and Floaters**: Behind the lens of the eye, the space is filled with a jelly like material. The jelly like structure is maintained by collagen fibres which trap water/liquid. With age, injury, surgery, etc. the collagen fibres may not be able to maintain the architecture of the jelly and the fluid moves out, causing the fibres to separate from the fluid. This causes sensation of floaters which move **against** the direction of movement of the eyeball. The floaters in itself are very common, with 2 out of 3 people experiencing these as they get older. Occasionally the collagen strands of the jelly can tug on the retina, causing flashes of light or even a **retinal tear or a detachment**. It is important to get **any new** floaters or flashes of light to be looked at as a matter of urgency by your optometrist or local hospital.
7) **Retinal Detachment:** the risk of retinal detachment is higher for people less than 60 years of age and especially in patients who are short sighted and in the male population and can be higher over a 5 year period. This risk exists because with surgery or trauma or inflammation, the jelly at the back of the eye loosens. The loosened collagen fibres within the jelly can tug on the retina and can cause a break in the retina. While this risk cannot be avoided or minimised, if you do see a sudden rush of fresh floaters, flashes of light or a shadow coming across your visual field, please seek urgent attention within 24 hours either in the eye casualty or with an optometrist who is trained to see the back of the eye. Even if you do not have the operation, the risk is true for all of us through our lives and it is important to get new floaters/flashes/ shadows in vision checked out urgently.
8) **Posterior capsular opacity:** the capsule of the lens is left behind to support the IOL and prevent it from dislocating backwards. However, this tissue is a living tissue and with time it can become thickened. If the vision is affected because of this, you would need YAG Laser treatment to cut a window in the membrane and let more light through. The risk of this developing is approximately 20% over 5 years.
9) **Glare , Haloes, quality of vision problems**. These are more common with multifocal IOLs but can occur even with monofocal IOLs. The reason for getting glare and haloes, is that the light gets deflected from

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the ridges of multifocal IOLs or the edge of monofocal IOLs or other structures within the eye. This is more prevalent in the night as the pupil is dilated at night and there are more ridges and an incident spot of light can be deflected more than diffuse light in the day.
The brain rapidly adapts to this and just as we all stop noticing things that become part of our body (rings/clothes/shoes etc), the brain normally stops noticing the glare or haloes (they never go away as it is in response to the physical rings). This is true for the majority of people, however very rarely it may be disabling, and some people report giving up driving at night as a result.

10) **Residual refractive errors.**
The measurements are done by machines and are extremely good for majority of patients and there is potential for being left with residual refractive errors in almost everyone. Thankfully the residual refractive error quite often is small enough that people chose not to wear glasses. Approx. 7% require further laser vision correction; piggy back lenses or IOL exchange or spectacles to correct the residual refractive error.
11) **Cystoid macular oedema:** this can occur several days/ weeks or even months after surgery. There is no definitive understanding of why this occurs, but one theory is that the micro movement of the new lens can create currents in the eye and cause the retina to swell with fluid. The odds of this complications are in the region of 1-2%. It manifests by vision reducing a few days or weeks after surgery, with vision appearing distorted or pinched in. This normally resolves without consequences in the majority of cases. There may be a need to use drops and tablets to hasten recovery.
12) **Iritis**: the lens protein is shielded from the body's defence mechanism, after surgery some patients may experience either an exaggerated inflammatory response or a milder more chronic response. This normally is controlled with steroid eye drops.
13) Less than 1% of patients who have multifocal IOL find it impossible to cope with the **side effects of the ridges of the intraocular lens**. They prefer to have the lenses removed and replaced with a monofocal IOL. This IOL exchange is possible but has high risk and can potentially leave you worse off. The reason is that the IOL embeds in the delicate structures of the eye and to remove the lens, would involve cutting the IOL inside the eye with potential risks. There are very few surgeons in the country who undertake these IOL exchanges.
Mr Desai is an experienced surgeon and the complication rates of even IOL exchanges under Mr Desai's care is extremely low.
14) People who are short sighted, quite often are unhappy about the near vision post-surgery, this is because short sighted people, tend to take their glasses off for reading and this produces not only a clearer image, but also a magnified image. After surgery the magnification is lost, and it can take some time to get used to the new image size.
15) People who have pre-existing good vision for distance and need the op only for reading vision need to understand that there is a compromise to be struck to get the best overall vision and we cannot just fix

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the near vision. With all the lenses, the priority is to fix the distance vision and the modifications in the lenses help with near and intermediate vision.

16) Patients who have a large degree of astigmatism, may require more need for glasses for near as the extended depth of focus IOLs don't give as much near vision as the standard multifocals.
17) Even though the vast majority are extremely pleased with the operation, please remember that variability is to be expected and the idea of the operation is to give the best overall vision and not perfect vision.
18) The operations will not get rid of any previous eye problems (apart from cataracts) and does not prevent future eye diseases from developing. It is therefore very important to attend annual recall by your optometrists.
19) If you have a previous **Laser vision correction** or a lazy eye/ squint operation **you MUST inform Mr Desai** of this ahead of the day of surgery.

The following are the most common questions that are asked to Mr Desai

1) Why are you still wearing glasses?

People have surgery for all sorts of reasons and the decision-making is very different for different individuals. There are dentists who want the operation as they find it difficult to wear protective glasses; there are divers who struggle to put on their gear on top of glasses; there are mountain climbers who, from a safety perspective, worry that if the spectacles fall off they are not able to see close objects. A large number of car mechanics/ plumbers/ brick layers/snooker players etc find the operation invaluable as the spectacles are not suitable when looking above the horizon. There are people who want it for convenience, some want it for vanity and are happy to admit it!

Mr Desai has a high need for precision of vision to get the best outcome for patients. Surgery is predominantly for overall vision are not for the precision that Mr Desai requires. Mr Desai has been wearing spectacles since he was 13 and does not want an operation on his eye.

2) My distance vision is already good, I only want operation for near.

The operation is on your natural lens and we cant fix one without the other. In fact when multifocal lenses are used the distance vision is somewhat compromised as the total light energy going into the eye is distributed over a larger area. Please see point 15 above.

3) I am concerned about the risks of glare, halos, quality of vision driving at night, etc? which lens should I choose? Which options should I choose?

We are using technology to get something which nature doesn't allow us to get. While the majority of patients are extremely pleased with results of the operation, it is important to remember that we cannot alter risk, and it is quite helpful to think backwards about the choices available. The options are in order of risk: low to high are:

1. No treatment /Spectacles/Contact lens/Laser vision correction.

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2. Enhanced monofocal lenses for distance. But need for glasses for near and perhaps for intermediate as well.

3. Monovision where one eye is made good for distance and the other eye made slightly better for near. This can work as good as multifocal IOL, but are less reliable and also there is some losss of depth of focus.

4. Multifocal IOLs. These are the most reliable options in terms of getting the range of vision as the lenses physically manipulate light. But they are the highest risk. While there are multiple choice of lenses, if you want specific lens please discuss with Mr Desai before surgery so that a joint decision can be made, otherwise you can let Mr Desai decide on the lenses which would be most appropriate in his view.

4) Will I feel pain? What will I experience during surgery? I am worried about seeing someone coming towards my eye!

The anaesthetic drops take away the sensation of any sharp pain. The sensation of touch and pressure is not taken away. There is a lot of water/saline which is used during surgery. You do not see any instruments, what you do notice is a lot of colours and shapes, people say it is like looking through a kaleidoscope. There are normally 3 light sources in the microscope, you need to look towards the centre of the light. Some describe it like the shape of mickey mouse!

5) I am very anxious!

The eyes are one of the most sensitive organs of the body and is one of the most precious. It is natural to be anxious before any surgery, but the operation averages only 7 minutes in Mr Desai's care and almost everyone after the operation says it was nothing to be worried about.

6) What will my vision be like immediately after the operation?

Immediately after the operation the vision is extremely variable as the pupils have been dilated, there is bright light that affects vision and several other factors. However, it is not uncommon to see patients looking at their phones and texting. It would be unusual not to have navigational vision after the operation.

7) When will I be able to drive?

In an informal audit conducted by Mr Desai (unpublished) almost 95% of patients met visual standards required for driving the next day morning itself. However, driving is a legal obligation and relies on self-certification. Mr Desai would encourage you to read the DVLA rules and self-certify. Please seek the help of the optometrist on your follow up visit if unsure.

8) When will I be able to get back to work? When can I exercise etc.

Mr Desai believe the basic principles as follows: The highest risk is the first 3 to 5 days especially with infection. The wound should have formed a reasonable seal by day 7 and a very good seal by 4 to 6 weeks.
Based on basic principles it would make sense to take things lightly for a week and go for exercises which jog the upper body only after 4 to 6 weeks.

9) Will I have to pay for a second procedure? Is everything included in the price?

Mr Desai doesn't undertake laser vision correction surgery and the risk of further laser vision correction

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enhancement is in the order of approx. 7% patients. please check the T&C documents.

10) How long will the replacement lens last?

The operation is **exactly the same as a cataract operation** and we do cataract surgery even in babies a few months old. The lens material is similar. While we cannot guarantee anything, it is almost certain that the lens will last for the rest of your life. Multifocal Lenses have been used in young babies and children with cataract as well.

11) How long will the operation last? Will it wear out after a few years?

After the age of 40 the natural lens becomes more and more rigid. This is the major reason that a frequent change of spectacles is needed. As the operation tackles the lens itself, theoretically the refraction should stabilise for the rest of your life, but obviously does not alter the normal ageing and health related changes. You must maintain yearly appointments with the optometrist for the above reason.

12) Can I have alcohol in the evening?

There is no evidence to restrict alcohol after surgery. The immediate 3-4 days after operation, the corneal wound is the weakest and you want to avoid anything which can lead to any form of trauma or infection. If you had a sedative, please discuss with the anaesthetist.

13) Can I wash my **hair**? When can I go **Swimming**?

It is best to avoid a head shower for a week and avoid swimming for about 4-6 weeks.

14) How long do I need to use **drops** for?

Unless otherwise specified, use the drops 4 times a day for 2 weeks and then twice a day till they run out. If the eye becomes sensitive to light, you might need to use the steroid eye drops for longer periods.

15) Will my eyes be covered?

There is a clear plastic **shield** to protect the eyes from accidents. You need to leave the shield on for 24 hours, and then every night for 5 days.

16) How do I **clean** my eyes?

You can boil some water with cotton and let it cool down, this sterilised cotton can be used to wipe the eyes over a closed lid and to keep it clean.

If you have any questions please write them below: (Any suggestion for improvement as well) and please don't hesitate to ask as many questions as possible.

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I confirm the following

- I understand the **various options** including spectacles, contact lenses (multifocal/monovision) Laser vision correction (including monovision) Surgical options of monofocal, enhanced monofocal, monovision and multifocal IOL
    - Sign here: _____
- I have had **enough time and opportunity** to ask any questions. You can use this as a clinic appointment and **reschedule** surgery, especially if you feel you need more time to think on any aspects or if you feel any new information was presented that you weren't aware of and wanted to think over this new information or if you have not met Mr Desai ahead of surgery
    - I understand the above and do not wish to reschedule surgery
        - Sign here: _____
- I understand the risks and benefits mentioned in this leaflet and the informed consent document. Specifically: That **outcomes of surgery can be unpredictable** and while the overwhelming majority of people are very pleased, there is a small risk of still needing spectacles for all ranges of vision and a very small risk of being dissatisfied with quality of vision (especially with multifocal lenses, but can be with any form of surgery)
    - I feel well informed and would **give a score of** _____ on 1-10 basis (10=extremely well informed) (if you do not feel well informed, do not proceed to surgery)
- If having Multifocal IOL: (There is very little outcome difference in various models of multifocal IOL.)
    - I am **happy for Mr Desai to choose** the Multifocal IOL he feels is best in my circumstance:
        - Sign here: _____
    - I wish to make my own choice: Multifocal IOL to be used is: _____
- I consent for recording of the videos which may be used for teaching and training purposes and for patient understanding and may be uploaded on social media. (there will be no patient identifiable information on the videos).
        - Sign here only if you consent (leave empty if you do not agree): _____
- All the questions have been answered to my satisfaction.
- I am happy for Mr Desai to proceed with my operation

Signed ---------- ---------- Date ……

print name ----------

Mr Desai signature and date.

Patient Label

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SOME OF THE ANALOGIES THAT MR DESAI USES TO HELP BETTER UNDERSTAND CONCERNS RAISED.

I want the best…

It is like wanting the best husband/wife!
The best option is to become younger!

I am worried about…….:

Risks exist and can't be eliminated, there is a risk in crossing the street as well, but the risks don't stop us.
There are some who want to jump off a plane and others who don't want to get onto a plane.
The person who watches road accidents on youtube on a regular basis might have a different perception of risk than someone who has never seen or experienced an accident. The statistics do not change, our perceptions are different. Be aware of risks rather than worry, we do everything to minimise risk, but cant eliminate these.

I am worried about glare, haloes quality of vision….

It is quite right to be aware of these. They are 2 sides of the same coin. The same rings/interfaces in the lens that help will also cause the problems. You cant have one without the other.
The brain adapts to most things in life: People staying on the flight path rarely notice the sound of the plane after some time, we rarely ever notice the bonnet of the car, we rarely notice the rim of our spectacles. The brain has a tendency to ignore things which are on a permanent basis. We rely on this and the majority learn to ignore the problems after some time, a small minority find it disabling enough to want the lenses removed. If this is the case, it is back to square one where you have to wear glasses for near and intermediate (though we can try different designs of multifocal or monovision with enhanced monofocal if necessary)

I don't want to wear glasses…

While the vast majority do choose not to wear glasses for most tasks (a substantial majority never wearing glasses) It is impossible to predict what an individual gets. Mr Desai's response will be I want a full flock of hair! and a perfect life! but we have to respect what technology can do.

It is a lot of Money…

Money has no correlation to outcomes and risks. Paying £1 or a million will have no difference to what anyone gets. If money changed things, the rich would never have diseases or die!

One of the patients commented, that most would have spent more money on cars through their life and even a second-hand car would cost more and last less than this eye operation. Mr Desai agrees that it is a unique but accurate way of looking at money.

Mr Aasheet Desai
Consultant Ophthalmologist
MBBS; DOMS; MRCOphth; MRCSEd; FRCSEd; FRCOphth; FEBO

I am unsure…

Take as much time as necessary to be comfortable. The eyes are the most precious organs of the body and they are the most sensitive.

Thinking backwards helps crystallise thoughts.

The options are in order of risk

1) Doing nothing.
2) Monofocal (enhanced monofocal)
3) Monovision with the 2 eyes very slightly asymmetric (approximately -0.75 apart) (the brain can tolerate about 2D difference between the 2 eyes.
4) Multifocal lenses, these are the highest risk with the highest benefit.

(There are almost 100 different types of multifocal lenses, if you want to discuss specific types, please do ask Mr Desai.) in general, more risk equals more benefits, and less risk equates to less benefits like most things in life.

Dry eyes…..

Everyone gets some form of dry eye after surgery, this resolves in the majority in 4 months or so. If the hands go dry, we don't think twice about putting a moisturiser, the same way if eyes do become dry, use lubricating eye drops to moisturise.

Are your hands steady? Have you had a good night's sleep?

My daughter came up with the joke:" I can operate with my eyes closed, but for you I'll keep them open!"
But jokes apart, even though Mr Desai has done approximately 35,000 operations, gets referred the most complex of all patients, the vast majority of consultants do have very similar results and the results are normally extremely good irrespective of the quality of surgeon when it comes to cataract or lens replacement surgery. The key skills are that when complications do happen, the skilled surgeon is more likely than not to have better outcomes.

Please help Mr Desai improve care by providing your feedback on any additional things that can be included in this leaflet.