

# Clinical outcomes after femtosecond laser assisted cataract surgery with implantation of the TECNIS Symphony intraocular lens

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## Abstract

• **AIM:** To evaluate the clinical outcomes in terms of vision across distances (near, intermediate, and far), contrast sensitivity and subjective patient satisfaction after femtosecond laser-assisted cataract surgery (FLACS) with implantation of an extended range of vision (ERV) intraocular lens (IOL).

• **METHODS:** Forty patients (55 eyes) undergoing bilateral or monocular FLACS with implantation of the ERV IOL TECNIS Symphony (Johnson & Johnson Vision) were enrolled. Uncorrected distance (UDVA), intermediate (UIVA) and near visual acuities (UNVA) were evaluated at 3mo after surgery, as well the defocus curve, contrast sensitivity, patient satisfaction and spectacle independence.

• **RESULTS:** No severe complications occurred. All eyes showed a central position of the IOL in the capsular bag without tilting at 3mo after surgery. 3mo postoperative mean logMAR visual acuity at 5 m, 67 cm and 40 cm were  $-0.04 \pm 0.08$ ,  $-0.17 \pm 0.22$ ,  $0.37 \pm 0.17$ , respectively. All patients obtained satisfactory UDVA and UIVA, as well as functional UNVA, meeting the needs of daily life. Spectacle independence rate was 94.55%. Contrast sensitivity results did not differ from those obtained with monofocal aspheric lenses. Likewise, no moderate and severe photic phenomena were reported. Mean patient satisfaction scores with distance, intermediate and near vision were 9.0, 9.0, and 7.0, respectively.

• **CONCLUSION:** FLACS with implantation of the ERV IOL TECNIS Symphony provides a successful visual restoration at far, intermediate distance and a functional-range near

vision acuity, with minimal level of disturbing photic phenomena, and high rates of spectacle independence and patient satisfaction.

• **KEYWORDS:** cataract; extended range of vision IOL; FLACS; TECNIS Symphony; multifocal IOL; glare; presbyopia

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## INTRODUCTION

Presbyopia affects the quality of life (QoL) of elderly people<sup>[1]</sup>. The compensation of this condition has become a major research focus in recent years. Due to increasing visual demands among elderly patients and the continuous development of cataract surgery technologies, the surgical correction of presbyopia has advanced significantly, the combination of cataract surgery with multifocal intraocular lens (MIOL) implantation being one of the most recommendable options<sup>[2]</sup>. An increasing number of MIOLs have been developed and used in clinical practice.<sup>[2]</sup> According to the 2014 statistical report from 1,502 members of the American Society of Cataract and Refractive Surgery (ASCRS), the use of presbyopia-correcting IOLs was still lower than 8%, primarily due to worries of patients and physicians about the potential induction of poor postoperative vision, decreased contrast sensitivity, and disturbing photic phenomena, such as glare and halos<sup>[3]</sup>.

In June 2014, the intraocular lens (IOL) TECNIS Symphony (Johnson & Johnson Vision, Santa Ana, California, USA) was introduced. This IOL has the peculiarity of being the first extended range of vision (ERV) IOL, with a specific design based on the combination of the compensation of spherical and chromatic corneal aberration<sup>[4-6]</sup>. This optical design provides a continuous range of vision allowing a postoperative functional near, intermediate and distance vision and therefore high levels of spectacle independence<sup>[7-9]</sup>. One advantage of this ERV IOL over MIOLs is that it provides a continuous range

Table 1 Baseline data of all patients

Mean age (y)	Gender (M/F, %)	Preoperative mean UCVA	Preoperative mean axial length (mm)	Preoperative mean astigmatism (D)	IOL mean power (D)	IOL mean reserved powder (D)
70.82	45.0/55.0	0.25	24.10	0.69	19.09	-0.21

of high-quality vision, with good levels of contrast sensitivity and minimal induction of disturbing photic phenomena that are commonly reported with MIOLs<sup>[8] [9]</sup>. Studies published to date have demonstrated that TECNIS Symfony IOL can provide 0.0 logMAR or better visual acuity at a distance far than 67 cm, while 0.3 logMAR or better visual acuity at a distance far than 40 cm<sup>[7-9]</sup>. Furthermore, Hamid and Sokwala<sup>[10]</sup> found that the ERV TECNIS Symfony IOL provided better contrast sensitivity than MIOLs, with higher levels of postoperative patient satisfaction.

This study aimed at evaluating the clinical outcomes in terms of visual acuity (near, intermediate and far), contrast sensitivity and subjective patient satisfaction after femtosecond laser-assisted cataract surgery (FLACS) with implantation of the TECNIS Symfony IOL.

SUBJECTS AND METHODS

**Patients** A total of 40 patients (55 eyes) were enrolled in this study. All of them underwent FLACS with implantation of the ERV IOL TECNIS Symfony IOL since July 2016. Inclusion criteria were definite diagnosis of age-related cataract and/or presbyopia, correctable ametropia with or without cataract, demand for spectacle independence, and reasonable expectations regarding the postoperative outcome. Exclusion criteria included astigmatism of more than 1.5 D, keratoconus or other keratopathies affecting visual acuity, fundus lesions, pupil diameter is more than 6mm or less than 2 mm under natural light, professional drivers and those who often drive at night, history of previous eye surgery, patients suffering anxiety or paranoia, and patients with systemic disease (baseline data of all patients in Table 1).

**Examination Protocol** All patients underwent a preoperative examination including measurement of uncorrected distance visual acuity (UDVA), best corrected distance visual acuity (BCDVA), uncorrected near visual acuity (UNVA), split-lamp examination, non-contact measurement of intraocular pressure (IOP), optical biometry (IOL-Master 500, Carl Zeiss Meditec, Jena, Germany), corneal and anterior segment analysis (Pentacam, Oculus Optikgeräte GmbH, Wetzlar, Germany), and fundus evaluation. The power of IOL was selected according to the calculations provided by the optical biometer using the following formulas: Hoffer Q formula is adopted for the ones with eye axial length (AL) below 22.0 mm, Haigis formula is adopted for the ones with AL between 22.0 mm and 25.0 mm, Holladay formula is adopted for the ones with AL between 25.0 mm and 26.0 mm, and SRK-T formula is

Name:Gender:Age:

Questionnaire on visual performance after implantation of presbyopia-correcting IOL (3 months postoperative)

1. Do you need to wear eyeglasses or contact lenses after the operation?  
A. Often B. Sometimes C. Negative (please skip to Question 5)

2. Do you need to wear eyeglasses or contact lenses to see objects at far distance (seeing the sight, or a movie, watching TV) after the operation?  
A. Negative B. Rarely C. Sometimes D. Usually E. Often

3. Do you need to wear eyeglasses or contact lenses to see objects at intermediate distance (using a computer) after the operation?  
A. Negative B. Rarely C. Sometimes D. Usually E. Often

4. Do you need to wear eyeglasses or contact lenses to see objects at near distance (using a cell phone, reading newspaper) after the operation?  
A. Negative B. Rarely C. Sometimes D. Usually E. Often

5. If rated on a scale of 1 to 10 from least satisfied to most satisfied, how will you rate your postoperative visual satisfaction?

6. How much difficulty do you have with any of the following? Please circle the point that best describe your situation. A point of 0 indicates there is no difficulty.

Glare (due to strong light or car headlights)	0	1	2	3	4	5
Night vision	0	1	2	3	4	5
Color distinguishing (e.g., unable to distinguish a specific color)	0	1	2	3	4	5
Depth sensing (e.g., going down stairs, pouring water, and arranging articles in a line)	0	1	2	3	4	5
Halos (streetlight is surrounded by a light ring)	0	1	2	3	4	5

7. How much difficulty do you have to perform the following activities without correcting glasses? Please circle the point that best describe your situation. A point of 0 indicates there is no difficulty.

Daily activities	NA	0	1	2	3	4	5
Watching a movie or TV	•	0	1	2	3	4	5
Working	•	0	1	2	3	4	5
Reading newspaper	•	0	1	2	3	4	5
Using a computer	•	0	1	2	3	4	5
Cooking	•	0	1	2	3	4	5
Shopping	•	0	1	2	3	4	5
Using a cell phone	•	0	1	2	3	4	5

Figure 1 Questionnaire on patient satisfaction administered to all patients at 3mo after surgery.

adopted for the ones with AL over 26.0 mm. Furthermore, the needs of the patient were also considered when selecting the IOL power, with a planned residual refraction of -0.50 D for eyes with AL of more than 26.0 mm and often using near vision, and -0.30 D for the rest of the patients. Postoperatively, patients were examined at 1d, 1wk, 1mo and 3mo after surgery, with measurement of uncorrected and corrected visual acuity at all visits. At 3mo, the patient examination also included measurement of contrast sensitivity (Glare Tester CGT-1000, Takagi, Seiko) and defocus curve. Likewise, patients completed a satisfaction questionnaire (Figure 1).

**Surgical Protocol** All surgical procedures were performed by the same experienced surgeon. Surgery was initiated with the creation of a continuous annular capsulorhexis with a 5.2 mm diameter using the femtosecond laser platform LenSx (Alcon, Fort Worth, Texas, USA), followed by nucleus chopping and the creation of a 2.2 mm transparent corneal incision at 12 o'clock and an auxiliary incision at 9 o'clock. In those eyes with corneal astigmatism of more than 0.75 D, corneal relaxing incisions were performed with the femtosecond laser, with position, arc and depth selected according to the web based calculation of the femtosecond laser astigmatism correction (Alcon, Fort Worth, Texas, USA). Afterwards, ordinary phacoemulsification was initiated using the Infinity system (Alcon, Fort Worth, Texas, USA), followed by

injection of viscoelastic substance into the lateral incision. Phacoemulsification was continued and followed by suction of cortex, injection of viscoelastic substance, implantation, and centration of the IOL. Removal of viscoelastic substance was the last step of the surgical procedure. Prophylactic medication was prescribed to be applied during the initial postoperative period: Tobramycin/Dexamethasone eye drops (4 drops daily) for 4wk, being gradually reduced each week, and Bromfenac Sodium Hydrate ophthalmic solution (2 drops daily) for 4wk.

**Statistical Analysis** SPSS 19.0 statistical software was used for data analysis. The results of all variables were expressed as mean±standard deviation (SD). Paired Student *t* test was used for the evaluation of changes in visual acuity and refraction between preoperative and postoperative visits, with  $P<0.05$  indicating that differences reached statistical significance.

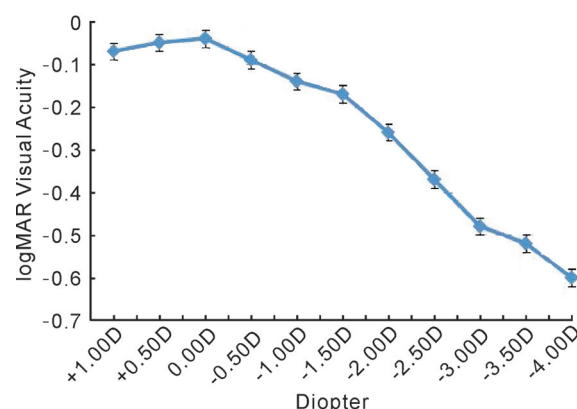
## RESULTS

The sample included a total of 22 males (27 eyes) and 18 females (28 eyes), with a mean age of 70.8y. Mean preoperative corneal astigmatism was 0.69 D, with mean preoperative axial length (AL) was 24.10 mm and uncorrected distance visual acuity (UDVA) was 0.25. Mean IOL power was 19.1 D. All patients completed the surgical procedure successfully, without experiencing any serious complication during the operation.

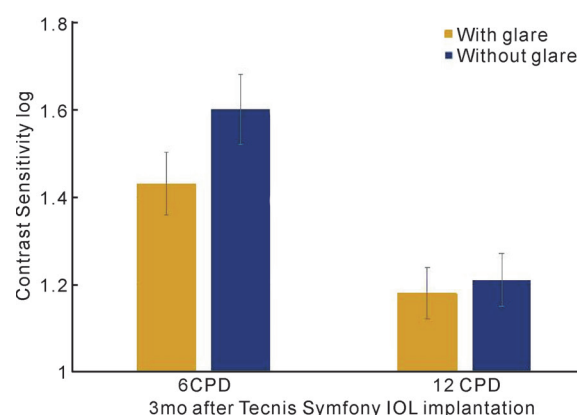
**Visual and Refractive Outcomes** A statistically significant improvement in both UDVA and refractive astigmatism was observed after surgery ( $P<0.001$ ). Residual refraction was measured by comprehensive optometry 3months after surgery with a result that residual spherical ranged from -0.01 to -0.49 D (with an average  $-0.21\pm0.11$  D) and mean residual astigmatism ranged from -0.12 to -1.35 D (with an average  $0.46\pm0.40$  D). The defocus curve observed at 3mo after surgery showed a satisfactory visual acuity for all patients, with a continuous range of good performance from distance to vergence levels of 1.50-2.00 D (equivalent to objects at 66 cm-50 cm; Figure 2).

**Contrast Sensitivity Outcomes** Figure 3 displays mean contrast sensitivity values at 3mo after surgery for the spatial frequencies of 6 and 12 cycles/degree (cpd), measured with and without glare. As shown, contrast sensitivity value was separately 1.43 and 1.6 with and without glare under 6 cpd, while the value there were separately 1.18 and 1.21 under 12 cpd. The result shows a significant reduction of contrast sensitivity when measured with a glare source ( $P<0.001$ ).

**Patient Satisfaction Outcomes** Only 3 patients (5.45%) had to wear glasses for reading or using cell phone, whose spectacle./AppData/Local/youdao/dict/Application/7.5.0.0/resultui/dict/?keyword=lens ../AppData/Local/youdao/dict/Application/7.5.0.0/resultui/dict/?keyword=power were +2.0 D, +2.5 D and +2.0 D respectively, with an overall spectacle



**Figure 2** Postoperative monocular defocus curve at 3mo after surgery.



**Figure 3** Mean contrast sensitivity at 3mo after surgery for the spatial frequencies of 6 and 12 cycles/degree measured with and without glare.

independence rate of 94.55%. None of the patients reported the need of glasses for watching television or using the computer (Table 1). Likewise, no disturbing photic phenomena including glare, halos and chromatic distortion were reported by most of patients at 3mo after surgery, with only 2 patients (3.64%) complained of halos, and only 1 patient (2.50%) complained of glare during night driving, but the patient's overall QoL was not affected. The patient satisfaction score for visual performance achieved at far, intermediate and near distance was 9, 9 and 7 respectively (0–“totally unsatisfied” and 10–“very satisfied”) (Table 2).

**Complications** On the first postoperative day, mild corneal edema was observed in one eye (1.82%) that disappeared within the next 3d with treatment. Furthermore, high IOP was observed in two eyes (3.64%) on day 1, with a return to normal values at 3d after anterior chamber lavage. Obvious corneal edema, uncontrolled IOP, endophthalmitis, obvious posterior capsule opacification, or pupil deformation was not observed in any patient at 1wk, 1mo, or 3mo after surgery. Mydriasis test was performed for all patients at 3mo postoperatively, showing that all IOLs were well centered in the capsule, with no IOL displacement or tilting, or signs of capsular contraction syndrome.



**Table 1 Questionnaire on spectacle independence and subjective satisfaction of all patients regarding various functions 3mo post-operation**

Function	Watching TV	Using a computer	Reading or cell phone
Use of eyeglasses (eyes, %)	0	0	3 (5.45)
Satisfaction score	9	9	7

Patient satisfaction was rated on a scale of 0-10 points: 0- “totally unsatisfied” and 10- “very satisfied” Satisfaction score is the median calculated.

**Table 2 Photic phenomena observed in all patients 3mo postoperatively**

Parameters	Glare	Halos	Chromatic aberration
Visual interference (eyes, %)	1 (2.50)	2 (3.64)	0

DISCUSSION

Conventional diffractive MIOLs use the principle of diffraction to generate two or more focal points, and therefore provide some level of pseudophakic accommodation. In eyes implanted with this type of IOL, light coming from an object at far or near distance is focused on the retina<sup>[11]</sup>. This allows the patient to have a good near, intermediate and distance visual performance, with high levels of spectacle independence<sup>[2-3]</sup>. However, MIOLs also have some limitations. The most common is the induction of some level of photic phenomena, such as glare and halos<sup>[12]</sup>. Indeed, the presence of this type of phenomena is the main cause of dissatisfaction after cataract surgery with MIOL implantation<sup>[13]</sup> as well as the main cause leading to the explantation of this type of lens<sup>[14-16]</sup>. The TECNIS Symphony IOL which is a new option is an ERV IOL aimed at providing a continuous range of vision and reducing the induction of photic phenomena. The optical design of this ERV IOL is based on the combination of the compensation for the corneal spherical and chromatic aberration with a diffractive technology, allowing a good refractive correction, optimized visual quality and an increase of the range of vergences, for which a not significantly degraded image is obtained<sup>[4-6,8]</sup>. The patented echelette diffraction grating design of its posterior surface is a new light diffraction mode for IOLs, providing constructive interference of light in different zones to enhance depth of focus by optimizing the diffraction gradient width, height and profile. In the current series, we have evaluated the clinical outcomes in terms of vision across distances (near, intermediate, and far), contrast sensitivity and subjective patient satisfaction with this IOL after its implantation using a FLACS procedure.

Our results show good levels of UDVA (-0.04±0.08 logMAR, 5 m) and UIVA (-0.17±0.22 logMAR, 67 cm) as well as relatively ..AppData/Local/youdao/dict/Application/7.5.0.0/resultui/dict/?keyword=good UNVA (0.37±0.17 logMAR,

40 cm), confirming the ability of the ERV IOL to provide an efficacious visual restoration after cataract surgery. This is consistent with the results of all previous studies evaluating outcomes of this ERV IOL, using a conventional phacoemulsification procedure<sup>[7-10]</sup>. These visual results obtained in our sample were associated to a relatively high levels of spectacle independence, as in previous series<sup>[7-10]</sup>. Specifically, in the CONCERTO international multicenter study<sup>[8]</sup>, the ERV IOL TECNIS Symphony showed excellent visual outcomes at all distances, with UDVA, UIVA and UNVA of logMAR were -0.03, -0.11 and -0.18 respectively, with some level of additional improvement in the near vision performance, when the IOL was implanted bilaterally using a micro-monovision approach. The prospective multicenter study of Kaymak *et al*<sup>[7]</sup> concluded that 3mo after implantation of the ERV IOL TECNIS Symphony UDVA of logMAR was -0.05±0.11and UIVA were logMAR -0.09±0.02, respectively, indicating that the same ERV IOL provided better far and intermediate vision than near vision, but the near vision is still in a functional range, which can meet the demands of daily living activities, which is in line with our research results.

One factor contributing to the good visual outcome obtained in our series and in previous studies is the high level of tolerance of the ERV IOL to mild to moderate residual astigmatism. It has been demonstrated that a residual astigmatism of 0.75 D after TECNIS Symphony IOL implantation has no significant impact on monocular and binocular UDVA<sup>[17]</sup>. Likewise, Carones<sup>[18]</sup> found that patients with pre-existing corneal astigmatism of 1.5 D can achieve good UNVA after implantation of this ERV IOL<sup>[18]</sup>. Besides this, the use of femtosecond-laser technology for the cataract procedure is another factor that may have contributed to the excellent results. It should be considered that a capsulotomy created with a femtosecond laser is associated with less IOL tilt and therefore better IOL optical performance<sup>[19]</sup>.

The incidence of photic phenomena in our series was low, with only 2 patients (3.64%) reporting halos inducing some level of visual discomfort, and one patient (2.50%) complaining of glare during night driving. No moderate or severe photic phenomena were reported by the patients. This rate of photic phenomena is comparable to that found in the multicenter CONCERTO study evaluating the same ERV IOL<sup>[8]</sup> and is markedly lower than those reported by other authors evaluating a great variety of multifocal IOLs<sup>[15-16]</sup>. Besides the low incidence of photic phenomena, the level of visual quality achieved with the ERV IOL in our sample was high, with levels of contrast sensitivity comparable to those obtained with a monofocal IOL, as in the work of Pedrotti *et al*<sup>[9]</sup>. In conclusion, our preliminary results at 3mo after implantation of the ERV IOL Tecnis Symphony show that satisfactory

far and intermediate vision as well as a functional near vision (40-45 cm) meeting the demands of daily activities can be achieved with this ERV IOL. The level of spectacle independence is high, with most of the patients not requiring spectacles for any activity. Likewise, this IOL provides a visual restoration at different distances with minimal incidence of photic phenomena and with no significant decrease in postoperative contrast sensitivity. The combination of FLACS with the implantation of the Tecnis Symphony IOL may be beneficial to ensure an optimized intracapsular centration and long-term stability of the IOL.

FLACS with implantation of the ERV IOL TECNIS Symphony provides a successful visual restoration at far, intermediate distance and a functional-range near vision acuity which can meet the demands of daily living activities, with minimal level of disturbing photic phenomena, and high rates of spectacle independence and patient satisfaction.

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