

# PRACTICAL PERCEPTION

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BLOG 2014 – 02

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## Seeing again, after cataracts

The chemotherapy I received for Hodgins Lymphoma (in 2007) was wonderfully successful in terms of treating the lymphoma, but it did have some side effects. The particular side effect I want to describe here is the influence on my vision. Basically, within a few months, the very mild cataracts that I had had previously were kicked “into high gear.”

After trying various solutions to improve the clarity of my vision, I discovered that I could see pretty clearly, if I wore my standard trifocal glasses – with an older set of bifocals behind them, thus resting the one frame “inside” the other. Of course, wearing two sets of glasses at once was not a long-term solution. If nothing else, it produced a seriously comical (even bizarre) appearance.

I was lucky in having both some basic knowledge of cataracts and what one can do about them. (See two full articles on *Cataracts*.....) I was also fortunate in having already contacted the ophthalmic surgeon whom I wanted to do the job. (I had originally gone to see him, because he was one of the few local surgeons who would handle a type of variable-focus implant known as the Crystalens<sup>®</sup>, which I was then considering.) He turned out to be a very patient physician, who was willing to answer the many questions I had and to discuss the comparative benefits and shortcomings of different types of intra-ocular replacement lenses.

Among the factors that I considered relevant for myself were: a) how much advantage would the claimed variability actually give me on a day-to-day basis; b) if an implant involved physical flexing, what was known about its durability (an intra-ocular lens not being the easiest thing to replace, if it broke); c) for that matter, how straightforward would it be to replace any of the possible lenses, if they wore out?

Glare was also a concern. Other things being equal (ha, ha!), a larger diameter lens should allow relatively less of the incoming light to get around the edge of the lens. Rays that fail to pass through the lens will lack the focusing provided by the lens and will contribute to glare. Glare may be noticed as star-burst streaks from isolated bright sources like a street light or an oncoming car’s headlamps, or as just a general haze across the scene. Neither effect is helpful during night driving. Hence, the larger the lens, the better in minimizing glare.

To summarize the situation, at the time I was making a decision, all the approved variable-focus lenses available suffered from one or more shortcomings. All of those I considered were smaller in diameter than a traditional fixed-focus implant, increasing the risk of dysfunctional glare. Those which flexed, in order to achieve their variability, had undergone extensive testing, but not as much as might occur during a possible 10-20 years of use. Worse, it appeared to be more

difficult to replace non-traditional lenses, if such were needed. Finally, it did not appear that the benefits of available variable-focus implants would offer more than a modest improvement in actual function (REF: 105th Meeting, Ophthalmic Devices Panel, Center for Devices and Radiological Health, Medical Devices Advisory Committee, U.S. Department of Health and Human Services, Food and Drug Administration, May 23, 2003, Gaithersburg, MD).

Finally, there was an issue (for me) of what my goals for seeing with the new implants were. Having been significantly nearsighted my entire life, and not having much interest in outdoor sports – for which glasses could admittedly be a nuisance – I decided that I would prefer to remain nearsighted, although less so than before. After more discussion with my surgeon, and several calculations of my options, I requested that my implants be selected so that my best (uncorrected) vision would be at approximately 50 cm – the distance at which I position my computer screen.

Since I have to wear glasses anyway (to provide some “prism correction” for a separate problem), it would be simple enough to work from this starting point, in order to achieve a *distance* correction for driving and one or more *near* corrections for reading or for even closer work. My glasses would be much thinner and lighter than those I had worn previously and, if necessary, I could manage easily enough, even without glasses, to read or to write a check, etc.

In short, my goals would not have been achieved by having variable-focus lenses implanted and the above-described concerns would have remained. I opted for the traditional, single-vision lenses. I have remained very pleased with them. (In addition, I saved some thousands of dollars, because – at least at that time – most health insurance plans would not fully cover the more exotic, flexible-focus implants.)

In BLOG 2014 - 3, I describe the experiences of the surgery itself and of awaking with renewed vision.

*Note: This Blog Entry simply describes my own process of deciding – in collaboration with my surgeon – upon the best selection (for me) of intra-ocular implants. I welcome readers to use it as a starting point for their own investigations/decisions. It is **not** intended to argue for a particular option. Rather, I believe that one key to a successful outcome is the realization that there are many options, more all the time, and that one should be able to discuss the pros and cons comfortably with one’s surgeon.*

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