I would like to introduce myself as the newest Chief Medical Editor of CRST Europe, effective as of this issue. I am delighted to transition into this role from my prior post as Associate Chief Medical Editor. My position as the Medical Director of Medipolis in Antwerp, Belgium, provides background that will allow me to serve my latest role well. This journal transfers ideas and concepts and introduces new technologies directly into the scope of every European ophthalmologist. The how-to format of CRST Europe keeps readers aware of the never-ending evolution in our specialism. I am eager to learn new technologies and bring them into daily use to benefit my patients—a message I will continue to infuse into my contributions to this publication.

The enthusiastic exchange of ideas that occurs between the distinguished editorial board and the staff of CRST Europe is highly motivational. I am inspired by the dedication from Khiun F. Tjia, MD; and Sheraz M. Daya, MD, FACP, FACS, FRCS(Ed), in their role as Co-Chief Medical Editors and look forward to joining and collaborating with them. They continually offer innovative ideas and provide the energy and constructive criticism necessary to elevate CRST Europe to its current level. I hope that my service to this publication is as effective as theirs.

I would like to highlight a few topics from this month's interesting cover focus on presbyopia. The correction of presbyopia was a difficult task in the past, but recently new approaches are available to our portfolio. Although this series of articles describes the advantages and disadvantages of each approach, patient selection and setting expectations are even more critical in the treatment of presbyopia. I am going to adopt the term environmental vision, as described by Claes Feinbaum, MSc, ECS, FAAO from Sweden, because this is really what we should take into account when treating patients.

I have always taken great care in listening to patients and trying to understand their motivation and expectations for surgical intervention. I have learned through the years that what we surgeons think is the best option for our patients does not always coincide with their needs. Perhaps we should all adopt the motto: Customize the best overall solution for each patient.

Is changing the corneal curvature to enhance near vision the best approach for the correction of presbyopia even though only pseudoaccommodation is achieved? Several laser manufactures have developed presbyopic LASIK algorithms such as presby-LASIK (Technolas Perfect Vision, Munich, Germany), PresbyMAX (Schwind eye-tech-solutions, Kleinostheim, Germany), PresBvis (CustomVis, Balcatta, Australia), and laser blended vision (Carl Zeiss Meditec, Jena, Germany). LASIK surgery has been well established and has proven its safety and efficacy. Different asymmetric laser ablation profiles extend corneal presbyopia correction to laser centers around the world.

Antonio Calossi, Dip Optom, FBCLA, FIACLE, writes (Continued on page 15)
Wilmer protocol (cortical cataract: opacity ≥ 4/16; nuclear cataract: ≥ 2.0 grade) were collected. The associations between dietary carbohydrate and risk for cataract for eyes with no or a single type (pure) of cataract were examined.

After multivariate adjustment, women in the highest quartile of total carbohydrate intake had a significantly greater risk of having pure cortical cataract. The association was similar, although not as strong, between nuclear cataract and dietary glycemic index. Researchers concluded managing carbohydrate intake could prolong the health of the lens; however, further study is warranted.


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**No-Touch Treatment Combines Stromal, Epithelial Ablation**

No-touch surface ablation with transepithelial PRK may allow highly precise and easy removal of the epithelium and refractive laser treatment in one step.

TransPRK performed with the Amaris laser (Schwind eye-tech-solutions, Kleinostheim, Germany) uses the ORK-CAM software module to automatically consider the ablation volume of the epithelium in the refractive ablation profile. It also accounts for changes in epithelial thickness in the corneal periphery and center and incorporates different tissue ablations for the epithelium and the stroma into the calculation. These steps prevent induction of unwanted refractive effects during epithelium ablation.

In this all-laser technique the eye does not require contact with an instrument, according to a company news release. The laser is used to ablate the epithelium, a removal technique that the company describes as more precise and easier than manual abrasion with a faster healing process.

“Both the epithelium and the stroma are ablated in a single procedure,” the news release said. “This shortens the overall treatment time significantly and minimizes the risk of corneal dehydration.”

TransPRK can be combined with any Schwind treatment method and, according to the company, is suitable for treatments or retreatments based on corneal wavefront data. Epithelium and stroma are not separated as with other current methods.

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*(Continued from page 7)*

of a customizable reverse geometry lens that induces negative spherical aberration while the patient sleeps. Orthokeratology is well known to correct myopia, but in experienced hands and with motivated patients, it now can be a reversible alternative for presbyopes.

IntraCOR flapless presbyopia treatment is a relatively new approach in presbyopia reversal. The Technolas femtosecond laser alters the biomechanical properties of the cornea without removing corneal tissue or disturbing Bowman’s layer and Descemet’s membrane. Sinan Goker, MD, describes the indications and advantages compared with other presbyopic laser techniques. I have been using this approach in my own clinic for more than 6 months. The results have been excellent so far with very high patient satisfaction.

Corneal inlays are gaining momentum with newer designs. In the past, most needed to be explanted due to deposits around the inlay, decentration, or disturbance in the corneal flow. Now a flap or a pocket is created with the femtosecond laser, and smaller inlays with newer materials such as the PresbyLens (ReVision Optics, Inc., Lake Forest, California) or Flexivue MicroLens (Presbia Coöperatief UA, Amsterdam, Netherlands), are available, as described by Ioannis Pallikaris, MD, PhD, and colleagues. My clinic is also involved in the study of the PresbyLens, with clinical trials starting soon.

Corneal approaches mean the natural lens remains untouched and will continue to undergo changes. Refractive lens exchange with premium lenses such as multifocal and accommodating IOLs are performed regularly and were discussed extensively in the January issue. Elizabeth A. Davis, MD, FACS; and Francesco Carones, MD, revisit lens-based strategies for presbyopia correction. I certainly expect many new presbyopia-correcting procedures to emerge in the near future. In the end, the most successful presbyopia treatment will be the one providing good near vision with only a minimal compromise in distance. You will certainly be updated through future issues of Cataract and Refractive Surgery Today Europe.

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*Compiled by Stephen Daily, Contributing Editor*

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Erik L. Mertens, MD, FEBOPht
Chief Medical Editor