Clinical Connection

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Bringing partners together to deliver exceptional patient care

SUMMER 2026

Welcome to the inaugural edition of EyeCare Partners *Clinical Connection*!

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VEC Director of Professional Relations and Education

This newsletter is built around a simple idea: When we share knowledge and perspectives, we deliver better care for our patients.

Clinical Connection is designed to help you care for patients locally, efficiently and with access to the latest capabilities. Each issue will feature timely topics in eye care explored by our optometric residents and complemented by insights from local ophthalmology and optometry colleagues, bringing both emerging thinking and real-world application into focus. You'll also find introductions to our newer doctors and updates on educational opportunities, new technologies, clinical research and practical ways to stay connected.

We hope this serves as a meaningful way to stay informed, strengthen connections and support our shared goal of delivering the best possible care to the patients and communities we serve.

We welcome your ideas and suggestions for future issues. Thanks for joining us on the *Clinical Connection* journey.

HOT TOPIC

Life in Focus: The Rise of Premium Intraocular Lens (IOL) Technology

Cataract surgery is among the most commonly performed surgical procedures worldwide, with approximately 3.8 million operations conducted in the U.S. each year.[1,2] Since its origin in 1949, monofocal IOLs served as the undisputed standard of cataract care, reliably restoring distance vision while accepting that patients would remain dependent on spectacles for near and intermediate tasks.[3] Though effective, this approach increasingly fell short of evolving patient expectations.

As the global population ages and active lifestyles become the norm across older demographics, demand for spectacle independence at all distances has grown substantially. Patients presenting for cataract surgery today are better informed, have greater visual demands and are more likely to request functional near vision than ever before. Toric, multifocal and extended depth of focus (EDOF) IOL options now offer clinicians powerful tools to meet individualized patient goals. Optimal patient satisfaction begins

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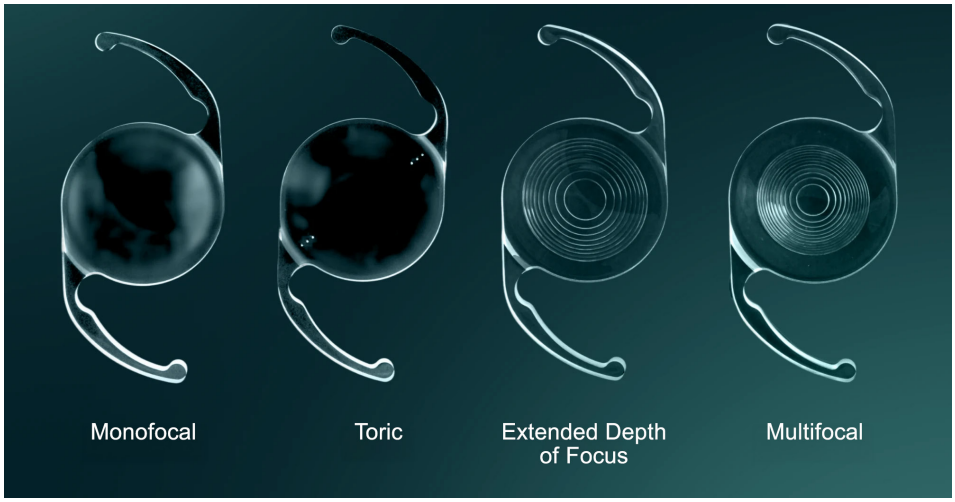
long before the operating room with evidence-based IOL selection tailored to the patient's lifestyle and visual demands.

Lens Categories

Monofocal IOLs represent the foundational design in cataract surgery, featuring a single fixed focal point. The target of this focal point is most commonly set for distance. Unlike premium lens designs, monofocal IOLs do not address pseudo-presbyopia, meaning patients should be counseled preoperatively that reading glasses or bifocals will be required for near and intermediate tasks following surgery. For those patients with the goal of good near vision uncorrected, particularly myopic patients who habitually remove their spectacles to read, it is possible to set the target for near. In this case, spectacle correction would continue to be necessary for clear distance vision. A monovision strategy that targets the dominant eye for distance and the fellow eye for near can be considered in patients who are accustomed to monovision correction prior to cataract surgery. Extensive education regarding binocular vision and intermediate distance limitations is imperative with this methodology.

Spherical monofocal IOLs are the lens of choice for patients looking for a lens design fully covered by medical insurance. Spherical monofocal IOLs do not correct for astigmatism, meaning patients will likely require spectacle correction for best vision at all distances following surgery. The exception to this rule is patients with minimal corneal astigmatism, who can expect good distance vision uncorrected. Toric multifocal IOLs are a premium lens option for patients with greater than or equal to 0.75D to 1.00D of corneal astigmatism who wish for spectacle independence at distance. Limbal relaxing incisions (LRIs), small arc-shaped peripheral corneal incisions, can be performed to correct for mild corneal toricity not meeting the threshold for a toric IOL.[4]



Re:Vision. (n.d.). Premium lenses. https://www.revision.nz/premium-lenses

Despite their limitations, monofocal lenses remain an excellent choice for many candidates, including those with coexisting ocular pathology such as macular degeneration, diabetic retinopathy or significant dry eye disease that would preclude reliable outcomes with premium IOLs. Monofocal lenses are also well-suited for patients who prioritize the highest possible optical quality at distance, such as those who drive frequently or work in visually demanding environments, and for whom spectacle dependence for near tasks is an acceptable trade-off to pristine distance vision.

Multifocal IOLs represent a significant advancement in IOL technology, designed to provide functional vision across a range of distances by dividing incoming light into two or more discrete focal points. This is achieved through either diffractive or refractive optical designs. Diffractive multifocal lenses use a series of concentric rings etched onto the lens surface to split light between distance and near focal points, while refractive designs rely on alternating optical zones of differing power. Trifocal IOLs represent the current standard among premium multifocal designs, adding a dedicated intermediate focal point to address computer and arm's length tasks that bifocal multifocals historically underserved.[5] The primary advantage of multifocal IOLs is the potential for meaningful spectacle independence across all distances, which carries high appeal for active, visually demanding patients. However, clinicians must engage in thorough preoperative counseling regarding the inherent optical trade-offs of multifocal designs, most notably the increased incidence of photic phenomena including halos, glare and starbursts, particularly under mesopic conditions. Contrast sensitivity may also be modestly reduced compared to monofocal IOLs. Ideal candidates are highly motivated patients with healthy macular function, minimal corneal irregularity and realistic expectations. Patients with significant ocular comorbidities, pupillary abnormalities or a history of prior refractive surgery should be approached with caution or steered toward alternative lens platforms.[6]

Overview of Lens Categories

	Insurance Coverage	Spectacle Dependence	Ideal Candidate
Spherical Monofocal IOLs	Typically fully covered	Expect spectacle correction for best vision at all distances	• Distance target: anyone • Near target: myopes preferring to continue to read without spectacles • Monovision target: established monovision contact lens wearers
Toric Monofocal IOLs/Limbal Relaxing Incisions	Out-of-pocket cost	Good distance (or near) vision without glasses, will need spectacle correction for all tasks arm's length or closer	
Multifocal IOLs	Out-of-pocket cost	Greatest independence from spectacles, may need small reading prescription for fine print	• Patients wanting the greatest independence from spectacles • Established multifocal contact lens wearers • Absence of ocular pathology
Extended Depth of Focus (EDOF) IOLs	Out-of-pocket cost	Moderate independence from spectacles, good distance and intermediate vision, some functional near vision, expect small reading prescription for near work	• Patients wanting moderate independence from spectacles • Concern for difficulty adapting to multifocal design • Absence of ocular pathology

Extended depth of focus (EDOF) IOLs represent a compelling middle ground between monofocal and multifocal designs, engineered to elongate the eye's focal range into a continuous corridor of vision rather than creating discrete, separate focal points. This is achieved through a variety of optical strategies depending on the platform, including wavefront manipulation, pinhole optics and non-diffractive refractive technologies.[6] The primary clinical advantage of EDOF IOLs is a significantly reduced incidence of halos and glare compared to multifocal lenses, making them particularly attractive for patients who are concerned about nighttime driving or work in low-light environments. Ideal candidates include patients seeking meaningful reduction in spectacle dependence for distance and intermediate tasks, and who are unwilling to accept the dysphotopsia risk associated with multifocal IOLs. EDOF lenses are also well-suited for patients with mild macular changes or modestly reduced contrast sensitivity in whom a multifocal IOL would be contraindicated, as well as those with active lifestyles who prioritize visual quality over complete near spectacle independence. Patients should nonetheless be counseled that reading glasses will likely still be required for prolonged or demanding near tasks.

Screening and Preparing Patients

Careful patient screening is essential prior to premium IOL implantation. Significant macular pathology including age-related macular degeneration, diabetic macular edema and epiretinal membrane formation represents a primary contraindication to multifocal and EDOF lenses, as compromised retinal function will limit visual

potential and amplify dissatisfaction. Irregular corneal astigmatism, as seen in keratoconus, is another contraindication for premium IOL designs. While not an outright contraindication, ocular surface disruption secondary to dry eye disease will limit visual quality, especially in patients with premium lens options. Optimization of the ocular surface will allow for best vision potential following surgery. Dry eye disease should be aggressively managed prior to surgical planning, as it can destabilize preoperative measurements and reduce postoperative outcomes. A history of refractive surgery can also affect the quality of preoperative measurements and has the potential to limit the accuracy of hitting a specific postoperative target.

Clinical outcomes data for premium IOLs are encouraging, though the importance of appropriate patient selection and preoperative counseling is critical. Spectacle independence confers benefits that extend well beyond the exam lane. Patients consistently report improved quality of life, greater freedom in daily activities and a reduced burden of corrective eyewear that many describe as transformative.

James McHale, M.D., Director of Cataract Surgery at Columbus Ophthalmology Associates, captures this sentiment well, noting: "The revolution of lens implant development has been critical in providing patients with the best possible vision they can obtain given their visual potential through cataract surgery. Astigmatism correction is a given today and can be achieved through toric IOL implantation or limbal relaxing incisions for lower amounts of astigmatism. I have been infinitely impressed with patients' acuities and focusing capabilities regarding modern day, multifocal lens implants. We try to provide patients with a complete and improved range of focus, which reduces or completely absolves a patient's dependence on glasses."

U.S. FDA clinical trial data echoes this optimism, demonstrating that 99% of patients who received multifocal IOLs would choose the same lens again — although those same data reveal that 12.6% of multifocal IOL patients reported severe difficulty with halos, compared to just 0.9% of monofocal IOL patients.[5] This contrast is not a contradiction; rather, it reflects the reality that when patients are appropriately selected and thoroughly counseled, even lenses with inherent optical trade-offs can deliver outstanding satisfaction. Ultimately, these figures reinforce a central theme in premium IOL practice: Exceptional outcomes are achievable, but remain contingent upon matching the right lens to the right patient and anchoring expectations in clinical reality.

Setting Patients up for Success

The expanding landscape of IOL technology has transformed cataract surgery into an opportunity to meaningfully optimize a patient's lifelong visual function. As available IOL design options continue to grow, so too does the responsibility of every clinician involved. By initiating identifying conditions that may influence candidacy, managing ocular surface disease preoperatively and calibrating patient expectations well in advance of the surgical consultation, the referring clinician can dramatically streamline the process and set both the patient and surgeon up for success. In an era of rapidly advancing IOL technology, the clinicians who invest in staying current with the evidence will be best positioned to guide their patients toward the visual outcomes they deserve.

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Life in Focus: The Rise of Premium Intraocular Lens (IOL) Technology

The Surgical Perspective

Which ATIOLs do you most commonly use, and what drives your selection?

Cameron Paladino, M.D.: The type of premium lenses I use is based on the type of patient and the amount of independence from glasses they want. Astigmatism correction is great for patients who want excellent distance vision without glasses and also provides some intermediate vision in certain patients. Reading glasses are required. The enVista Aspire toric is better for slightly irregular corneas, and the Eyhance toric has a great track record.

Extended Depth of Focus (EDOF) lenses are great for patients who want excellent distance and intermediate vision with some functional near vision. They often require reading glasses for extremely small print, but are a great option for refractive lens exchange or to minimize dependence on glasses.

The Light Adjustable Lens (LAL) is great for post-refractive patients who want the ability to customize their degree of blended vision. Most patients get great distance and reasonable intermediate vision. The LAL Standard is better for irregular corneas or post-hyperopic ablation, while LAL+ is better for normal corneas or post-myopic ablations and offers a slightly increased depth of focus. For multifocals, I almost exclusively use the PanOptix Pro given its continued great results. Nearly all good candidates are out of glasses at all distances.

For specialty lenses, the IC-8 Apthera is used with caution in patients with irregular corneas who have had previous corneal transplant or keratoconus. The pinhole effect cuts down on distortion, ghosting and halos.

What preoperative testing or data do you rely on most when evaluating ATIOL candidacy?

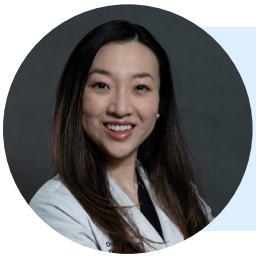
Cameron Paladino, M.D.: For astigmatism correction, I look at a variety of measurements and consistency across the Pentacam, Lenstar and Cassini. The Cassini often helps me make the final decision based on a wavefront analysis. I also use the Cassini to assess higher order aberrations, which can predict who will do well with a multifocal lens.

Since spherical aberration (SA) is highly influenced by previous refractive surgery, I tailor lenses to address this. Patients with high myopic ablations previously have high positive SA. I use lenses with high negative SA like Eyhance or LAL+ to counteract this.

Cameron Paladino, M.D.

What are the most common reasons a patient is not a good candidate for ATIOLs?

Cameron Paladino, M.D.: A patient may not be a good candidate, particularly for multifocal intraocular lenses (MFIOL) like PanOptix, if they have significant dry eye or irregular astigmatism, as these often impact vision quality with a MFIOL. If these patients still want a "premium" experience, I often recommend LAL+ or EDOF if their dry eye or corneal irregularity is mild. If severe, I recommend a standard monofocal lens such as enVista EE. Retina pathology (macular degeneration or cystoid macular edema) almost always means a monofocal IOL is safest.



Jane Spadaro, M.D., Pharm.D.

virginiaeyeconsultants.com/doctors/jane-spadaro-md-pharmd

Q&A

What led you to this career?
When I was in medical school, I treated a woman in the emergency room who presented with optic neuritis. She lost vision in one eye and was incredibly scared and devastated about the diagnosis. Her foremost concern was that she would be unable to take care of her young kids.

This situation impressed upon me the importance of the visual system and how much of an impact ophthalmologists make on someone's life. As a surgeon, I prepare diligently for every patient to make sure they have the best possible outcomes.

How would you describe your style with patients?
I take time to understand my patients' concerns and answer all their questions. It's important that they feel comfortable with their surgeon and know what to expect. I ask myself, "Is this how I would want to be treated as a patient?" and "Is this what I would do for my mom or my child?"

What is the best part of your job?
The best part of what we do is helping others. I love when I can make a positive difference in someone's life. My job as a surgeon is incredibly rewarding.

When you're not in the clinic, how do you like to unwind?
I love spending time with my husband and son. I also enjoy hiking and relaxing at the beach.

If you weren't working in eye care, what would you do?
I've always loved the idea of being a paleontologist or archaeologist and digging up interesting finds, like Indiana Jones. Those movies are some of my favorites from childhood.

What is your favorite sports team?
I am from the Philadelphia area and am a huge Eagles fan. Go Birds!

Kelly Faulkner, O.D.

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Q&A

Which areas of eye care are you passionate about?
I am most passionate about caring for patients experiencing eye emergencies, recovering from eye surgery, or those diagnosed with glaucoma.

What can patients expect when they see you?
I strive to be very open and communicative with my patients. It's important that my patients understand what is going on with their eyes and feel comfortable asking me any questions.

What is the best part of your job?
The eyes play such a vital role in our everyday lives. Through caring for the eyes, I am thankful for the opportunity to improve patients' functionality and quality of life.

What was your most unusual job?
My most unusual job was working as a lifeguard and pool manager.

When you are not in the clinic, how do you like to unwind?
When I'm not with patients or at work, you can find me reading, exploring walking and hiking trails, and spending time at the beach.

If you weren't working in eye care, what would you do?
If I wasn't working in optometry, I would be a math or science teacher. Both were among my favorite subjects in school.

What is your favorite sports team?
I would say the Auburn University Tigers. War Eagle! ("War Eagle" is the iconic battle cry cheer and universal Auburn greeting).

Sierra Tisdelle, O.D., F.A.A.O.

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Q&A

Why did you join Virginia Eye Consultants (VEC)?
Coming out of residency training, I wanted to join a high-volume, high-disease clinic. My residency was at a U.S. Department of Veterans Affairs hospital in South Carolina, where I worked closely with optometrists and ophthalmologists on primary care and severe disease cases, and was on call for emergency room cases. I am a big believer that we all learn and grow each day, so I love being surrounded by such a large group of experienced colleagues across all eye care disciplines who are eager to share their knowledge.

Tell us about your path here. What areas of eye care are you especially passionate about?
I am not one of those people who always knew they wanted to be an optometrist. In my undergraduate studies, I was pre-med and knew I wanted to go into healthcare, but I didn't know exactly where I wanted to end up. I did know that I did not want to be a dentist like my dad because I think spit is disgusting. I shadowed different doctors and did volunteer trips to figure out what discipline I liked. I was first exposed to eye care on a Remote Area Medical service trip. As a biology major with a double minor in chemistry and neuroscience, optometry was a perfect blend of medicine, physiology and patient care. I immediately fell in love with eyes.

What can people expect when they see you?
In residency I realized many patients, especially older patients, can feel rushed, anxious or overlooked during medical visits, so I try very hard during my exams to make every patient feel comfortable and heard. I take my time, listen and explain why I choose and tailor certain treatments for them. The biggest thing I try to do for my patients is to laugh; I am a big fan of dad jokes, puns and sarcasm to keep the mood light during exams.

Tell us about your family and any pets.
I got married in May 2026 to my husband, Justin. Our family is small with us and our 4-year-old, frisbee-obsessed border collie named Oliver (I am happy to share wedding and puppy pictures any time).

If you weren't in eye care, what would you do?
I love art and design, so I think I would be in the fashion world in some capacity – maybe as a photographer or couture designer. I draw inspiration from the Rococo era and Ancient Greek and Roman mythology.

When you're not in clinic, how do you unwind?
I am a hardcore couch potato after a long clinic day. I love to throw on a good reality TV show (for research, obviously) and snuggle with Oliver before falling asleep at 9:00 p.m. My weekends are for outings to the farmers market, walks at First Landing State Park and sunset drinks on a patio by the beach.

Neha Srinivasan, O.D.

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Q&A

Why did you join Virginia Eye Consultants (VEC)?
During my residency in ocular disease, I worked at an eye hospital that had every ocular subspecialty. I saw the pros of being in an environment where you could consult with any specialty in just minutes and be assured patients would receive great care. While looking into career paths, I saw VEC was a multispecialty practice that provides a similar setting that was not a hospital. After working here for a year, I continue to be astounded by how collaborative VEC is and am happy to work with these amazing doctors.

What is the best part of your job?
I love meeting and getting to know new patients. I love seeing resolution in acute conditions and the genuine joy patients feel with effective treatments. Working at VEC, I also stay up-to-date on the latest ocular care and perform laser treatment.

Which areas of eye care are you especially passionate about?
Clinically, I am most passionate about retina and love working with our retinal specialists to co-manage surgical cases and manage non-surgical retinal cases. I've been passionate about this area since optometry school, and my passion has only grown through residency and my work at VEC.

I'm also passionate about community-based optometry. There are a lot of people who cannot afford eye care. During school, I worked at a local community-based clinic to care for these patients. I continued working in another underserved community during residency and found it to be fulfilling. As a new member of the Tidewater Optometric Society, I loved participating in vision screenings in collaboration with Lion's Clubs International. I can't wait to see how else we are able to help our community.

When you're not in clinic, how do you unwind?
I love playing pickleball with friends and finding new places to hike. I most recently hiked an active volcano in Guatemala.

If you could travel anywhere in the world, where would you go?
I'm currently on a journey to visit all Seven Wonders of the World. My next stop is Machu Picchu, Peru.

What is your favorite sports team?
Dallas is my hometown, and I grew up playing basketball (which you wouldn't be able to tell from my height). I'm a huge Dallas Mavericks fan. I was disappointed when Luka Doncic was traded, so I'm trying to slowly put my trust back in the team.

CLINICAL TRIALS NEAR YOU

These clinical trials are actively enrolling patients.
Questions? Email: megankingdon@eyecare-partners.com.

Condition	Sponsor	Description
Corneal Scars	Claris Bio	A Two-Arm Open-Label Study to Evaluate the Safety and Efficacy of CSB-001 Ophthalmic Solution 0.1% in Subjects with Corneal Scars
Persistent Corneal Epithelial Defect (PCED)	Dompé	Phase 3, Multicenter, Randomized, Double-Masked, Vehicle-Controlled, Parallel Group Study to Evaluate the Safety and Efficacy of Recombinant Human Nerve Growth Factor Eye Drop Solution in Participants With Persistent Corneal Epithelial Defect
Neurotrophic Keratopathy (NK)	ReGenTree	A Phase 3, Multicenter, Randomized, Parallel, Double Masked, Placebo-Controlled Clinical Study to Assess the Safety and Efficacy of 0.1% RGN-259 Ophthalmic Solution for the Treatment of Neurotrophic Keratopathy (SEER-2)
Neurotrophic Keratopathy (NK)	Krystal Biotech	A Phase 1/2, Multicenter, Double-Masked, Placebo Controlled Study of KB801 in Subjects with Stage 2 or 3 Neurotrophic Keratitis
Persistent Corneal Epithelial Defect (PCED)	Glaukos	A Randomized, Multicenter, Double-Masked, Vehicle -Controlled Phase 2 Study to Evaluate the Safety and Efficacy of NEXAGON® (Lufepirsen Ophthalmic Gel) in Subjects with Persistent Corneal Epithelial Defects (NEXPEDE-1)
Uveitis	Novaliq	Phase 2 Trial for Non-Infectious Anterior Uveitis in Adult Patients
Neurotrophic Keratopathy (NK)	Viatris	Phase 1/2, Multicenter, Open-Label, Single-Dose, First-in-Human Dose-Escalation Trial. A total of up to approximately 30 participants will be enrolled in this trial, which will consist of two parts: Part 1, dose-escalation trial consists of 3 different dose cohorts, and Part 2 consists of an expansion cohort

MARK YOUR CALENDAR

Save the date for our fall **continuing education event**.
Be on the lookout for more details coming soon.

OCTOBER
18

YOUR CLINICAL CONCIERGE

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