Stereopsis and Patient Satisfaction in Myopic and Hyperopic Individuals Selecting Monovision Correction by LASIK or LASEK

I Tuwir, C Kirwan, MS Mustafa and M O'Keefe

1Consultant Ophthalmic Surgeon, Ireland
2Mater Private Hospital, Dublin, Ireland
3Moorfields Eye Hospital, Dubai
4Childrens University Hospital, Dublin, Ireland

Corresponding author: Ismail Tuwir, Consultant Ophthalmic Surgeon, Ireland, Tel: 00353852063738; E-mail: ituwir@gmail.com

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Abstract

Purpose: This study was designed to measure binocular function, patient satisfaction and to evaluate postoperative outcomes of presbyopic patients selecting monovision correction either by laser in situ keratomileusis (LASIK) or Laser Assisted Sub-Epithelial Keratomileusis (LASEK).

Methods: We carried out a Retrospective chart review of 86 selected patients 40 years and older, treated with refractive laser monovision correction by LASIK or LASEK. Laser was performed with a Bausch & Lomb Technolas 217 (Zyoptix or PlanoScan) Excimer laser. All patients had the dominant eye corrected for distance. The parameters used were distance & near corrected visual acuity, manifest refraction before and after surgery and near stereopsis postoperatively. Patient satisfaction was evaluated by questionnaire.

Results: Eighty six patients (51 hyperopes, 35 myopes) were included. Hyperopic mean refractive spherical equivalent (MRSE) in the distance-corrected eye was +1.90 ± 0.79 D and for the eye corrected for near vision MRSE +2.62 ± 0.93. Myopic (MRSE) in the distance corrected eye was -4.15 ± 1.06 D and for the eye corrected for near vision MRSE -2.37 ± 1.06 D. All hyperopes and 7 myopes were treated with LASIK and the rest were treated with LASEK. After surgery 94% had distance binocular uncorrected visual acuity of 0.00 logmar or better and 93.2% of the patients had near binocular uncorrected visual acuity of N6 of better. The mean near stereoacuity was 248 ± 244S D seconds of arc. All patients chose their dominant eye to be corrected for distance. Of 35 myopes treated one patient underwent enhancement of the near eye to distance vision and one underwent enhancement for near after 4 months. Eighty-two patients were happy with their vision. Sixty-five percent of all patients had a mean near stereoacuity of ≥ 100 seconds of arc. Despite this eighty two patients are happy with their vision, satisfaction graded with a standardized questionnaire.

Conclusion: There is no ideal surgical approach to presbyopia. The ideal procedure is still at present monovision after LASIK or LASEK, although it is a long way off reduces stereopsis it results in high satisfaction for both myopic and hyperopic presbyopic individuals.

Keywords: Monovision; Stereopsis; LASIK; LASEK; Presbyopia

Introduction

Presbyopia remains the biggest challenge in laser refractive surgery. Monovision is to decrease glasses dependence. It is achieved through contact lens, corneal laser surgery, conductive keratoplasty, corneal inlays and intraocular lenses. Contact lens monovision has a success rate of 76% [1]. But intolerance limits its usage. By contrast refractive surgery may provide better tolerance to monovision due to improved binocular adaptation with constant optical correction and less residual aniseikonia.

In this retrospective study we measured binocular function, patient satisfaction and evaluated postoperative outcomes of presbyopic patients selecting monovision correction either by laser in situ keratomileusis (LASIK) or Laser Assisted Sub-Epithelial Keratomileusis (LASEK).

Materials and Methods

86 patients (172 eyes) underwent refractive surgery for monovision between May 2007 and July 2008. Inclusion criteria was age 40 years and above, no previous refractive surgery, and no previous squint surgery. We also excluded patients with certain occupations such as professional drivers and those who used microscopes, or spent most of their working day using computers. We recorded age, occupation, distance & near corrected visual acuity, manifest refraction before and after surgery ocular dominance and near stereopsis postoperatively. Stereopsis was measured using a multitarget red-green anaglyph stereo vision test and titmus fly test Data was analyzed using SPSS 16.0 software (Table 1).

All the patients had their dominant eye corrected for distance and the non-dominant eye was corrected for near. The dominant eye was identified by the hole-in-card test; the patient's holds a card with a hole in the middle using both hands and is asked to view a 6 meters target through the hole in the card. The subject moves the card slowly toward...
his face without losing the alignment with the fixation point until the hole is over an eye. This is considered to be the dominant eye. We aim for 2.25 DS or less anisometropia in all the patients.

Patient satisfaction was evaluated by a visual function questionnaire (VFQ14). The VF-14 is a reliable, valid index of a patient’s ability to perform 14 visual activities [2,3]. The score was based on all activities and the amount of difficulty reported in performing those activities [2]. Scores on all activities were then averaged, and the average score was multiplied by 25, resulting in a final score ranging between 0 (worst level of visual function) and 100 (best level of visual function). The VF-14 questionnaire was sent to all patients.

The overall success with monovision in this study was 93%. The refractive success and acceptance of monovision was similar in both hyperopic and myopic patients. There was no significant correlation between age and monovision success and there was no statistical difference between the LASEK and LASIK groups (Figure 2).

**Discussion**

Monovision reduces the dependence on glasses for the presbyopic population by the ability to suppress interocular blur at various distances in either eye [4].

Success rates for monovision refractive laser correction range from 72% to 92.6%.

It’s difficult to quantify monovision success. And most studies report different methods.

Wright et al. used a scale of 1% to 100% to measure patients’ satisfaction on 21 patients with monovision following myopic photorefractive keratectomy (PRK) [5]. The study demonstrated 86% satisfaction. Goldberg et al. in their questionnaire ask patients to rate their satisfaction on a scale from 1 to 10 [6]. In Goldberg questionnaire, study of 114 patients 96% was satisfied with monovision after LASIK.

Jain et al. used the patients general opinions and feelings regarding their visual outcome as a proxy for success of monovision and reported a success rate of 88% in a series of 42 myopic patients who underwent refractive surgery for monovision [7].

Reilly et al. success in refractive monovision as those patients who choose not to have their monovision reversed and who had [2 near vision or better. Therefore they reported a 97% success rate [8].

We achieved a 97% success rate. Study patient satisfaction was evaluated by a visual function questionnaire (VFQ14). The VF-14 is a reliable, valid index of a patient’s ability to perform 14 visual activities [2,3]. The score was based on all activities and the amount of difficulty reported in performing those activities [2]. Scores on all activities were then averaged, and the average score was multiplied by 25, resulting in a final score ranging between 0 to 100. There was a 97% success rate.

Successful monovision is associated with a good visual outcome and reduction of stereopsis by less than 50 sec of arc. Several studies of binocular function in presbyopes with monovision corrections report disrupted binocular vision by a reduction of stereopsis. Although Wright et al reported mean stereopsis of 160 seconds of arc (range 40 to 800 seconds of arc), this was higher than our study that found the mean near stereopsis to be 248 ± 244 seconds of arc (range 40 to 800 seconds of arc).

Many refractive surgeons prefer lower degrees of anisometropia range from -0.5 to -1.50 diopters. Jain et al. note that lower degrees of anisometropia improve interocular blur suppression, stereopsis and contrast sensitivity [9]. The results of this study reinforced the finding of Goldberg et al., who found that some patients with greater induced anisometropia tolerated monovision very well [10-12]. He also noticed that none of his monovision rejection was due to high degrees of anisometropia.

There was similar refractive success and acceptance of monovision in both hyperopic and myopic groups alike. Braun et al. who also reported hyperopic and myopic monovision patients have equal refractive success and acceptance of monovision [13].

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**Table 1:** Demographic data of patients that underwent monovision therapy (RE: Right Eye; LE: Left Eye, LASIK: Laser-Assisted In Situ Keratomileusis; LASEK: Laser Epithelial Keratomileusis; BCVA: Binocular Corrected Visual Acuity; MRSE: Manifest Refractive Spherical Equivalent.

| Demographics            | 29 Male : 59 Female |
|--------------------------|---------------------|
| Age range: 40 – 67 yrs old Mean Age: 52.8 yrs old |
| Hyperopes: 51 | Myopes: 35 |
| Dominance: RE – 55 LE – 28 |
| LASIK: 58 patients (51 Hyperopes and 7 Myopes) |
| LASEK: 28 patients (Myopes) |
| Pre-op Right BCVA (LogMar) range: -0.8 to 0.17 |
| Pre-op Left BCVA (LogMar) range: -0.8 to 0.17 |
| Pre-op Near Acuity range: N5 – N36 |
| Pre-op MRSE RE Range: -6.35D to +3.25D |
| Pre-op MRSE LE Range: -6.25D to +3.25D |

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Figure 1: Graphs showing binocular visual acuity for distance and near 12 months after treatment.

We found no significant correlation between age and monovision success and there was no difference between the LASEK and LASIK groups. Goldberg et al. noted hyperopic monovision patients had slightly higher enhancement than both myopes and bilateral distance correction [12]. By contrast none of our hyperopic patients had any enhancement which is due to the fact that in our practice we treat...
dominant eyes first follow by the non-dominant a week apart. This allowed us to check the result of the first eye and treat the second eye accordingly.

The questionnaire return rate was 75.5% (65 patients). Sixty-five percent of all patients had a mean near stereoacuity worse than 100 seconds of arc. Despite this 93% patients are happy with their vision.

**Summary**

Our study represents the largest reported patient series of hyperopic monovision LASIK patients to date. Lasik and Lasek surgery to create mononvision in hyperopic and myopic patients is very successful with careful patient's selection. There is Permanent loss of stereopsis but this does not create any functional problems [14].

**References**

1. Jain S, Arora I, Azar DT (1996) Success of monovision in presbyopes: review of the literature and potential applications to refractive surgery. Surv Ophthalmol 40: 491-499.
2. Cassard SD, Patrick DL, Damiano AM, Legro MW, Tielsch JM, et al. (1995) Reproducibility and responsiveness of the VF-14 an index of functional impairment in patients with cataract. Arch Ophthalmol 113: 1508-1513.
3. Steinberg EP, Tielsch JM, Schein OD, Javitt JC, Sharkey P, et al. (1994) The VF-14. An index of functional impairment in patients with cataract. Arch Ophthalmol 112: 630-638.
4. Schor C, Landsman L, Erickson P (1987) Ocular dominance and the interocular suppression of blur in monovision. Am J Optom Physiol Opt 64: 723-730.
5. Wright KW, Guemes A, Kapadia MS, Wilson SE (1999) Binocular function and patient satisfaction after monovision induced by myopic photorefractive keratectomy. J Cataract Refract Surg 25: 177-182.
6. Goldberg DB (2001) Laser in situ keratomileusis monovision. J Cataract Refract Surg 27: 1449-1445.
7. Jain S, Ou R, Azar DT (2001) Monovision outcomes in presbyopic individuals after refractive surgery. Ophthalmology 108: 1430-1433.
8. Reilly CD, Lee WB, Alvarenga L, Caspar J, Garcia-Ferrer F, et al. (2006) Surgical monovision and monovision reversal in LASIK. Cornea 25: 136-138.
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9. Jain S, Arora I, Azar DT (1996) Success of monovision in presbyopes: review of the literature and potential applications to refractive surgery. Surv Ophthalmol 40: 491-499.
10. Back AP, Holden BA, Hine NA (1989) Correction of presbyopia with contact lenses: comparative success rates with three systems. Optom Vis Sci 66: 518-525.
11. Erickson P, McGill EC (1992) Role of visual acuity, stereoaucuity, and ocular dominance in monovision patient success. Optom Vis Sci 69: 761-764.
12. Goldberg DB (2003) Comparison of myopes and hyperopes after laser in situ keratomileusis monovision. J Cataract Refract Surg 29: 1695-1701.
13. Braun EH, Lee J, Steinert RF (2008) Monovision in LASIK. Ophthalmology 115: 1196-1202.
14. Farid M, Steinert RF (2009) Patient selection for monovision laser refractive surgery Curr Opin Ophthalmol 20: 251-254.