

## Navigating the “Unhappy 20/20” Patient: Managing Expectations in the Era of Premium IOLs

Suresh K Pandey<sup>1\*</sup>, Vidushi Sharma<sup>1</sup> and Ishita Pandey<sup>2</sup>

<sup>1</sup>*SuVi Eye Institute and Lasik Laser Centre, Kota, Rajasthan, India*

<sup>2</sup>*Annenberg School of Journalism and Communication, University of Southern California, Los Angeles, CA, USA*

**\*Corresponding Author:** Suresh K Pandey, SuVi Eye Institute and Lasik Laser Centre, Kota, Rajasthan, India.

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The paradigm of cataract surgery has undergone a seismic shift in the last decade. It has transitioned from a procedure primarily focused on the restoration of visual clarity to a refractive surgery aimed at spectacle independence. With the proliferation of premium intraocular lenses (IOLs), including trifocal, extended depth of focus (EDOF), and hybrid designs, ophthalmic surgeons now have the technological capability to offer patients a visual experience that closely mimics the accommodation of youth. However, this technological prowess has birthed a new clinical paradox: the “unhappy 20/20” patient. These are individuals who, despite achieving perfect Snellen acuity and flawless surgical technique, remain dissatisfied with their quality of vision or their overall experience. As we move deeper into 2026, the challenge for the ophthalmic surgeon is no longer just surgical precision but the sophisticated management of patient psychology, ocular surface health, and neural adaptation.

The root of dissatisfaction often lies not in the operating room but in the consultation lane, long before the first incision is made. The modern cataract patient is often well read, tech savvy, and holds expectations driven by marketing rather than physiology. A critical disconnect frequently exists between what an ophthalmic surgeon defines as success, typically 20/20 visual acuity without complications, and what a patient defines as success, which is often the effortless, high contrast vision they possessed in their thirties. Recent commentary by Sologub in 2025 highlights this “last mile” problem and notes that dissatisfaction often stems from a misalignment of goals where patients value visual quality and lack of dysphotopsia over the raw ability to read a chart [1]. Therefore, the cornerstone of preventing the unhappy patient is a rigorous preoperative “expectations audit.” This involves identifying not just the ocular health but the personality type of the patient. The perfectionist, the engineer with a high demand for precise optics, or the night driver may not be the ideal candidates for diffractive optics that induce halos, regardless of their desire to be glass free.

Furthermore, the integrity of the ocular surface has emerged as a non negotiable determinant of success in the premium IOL era. Even the most advanced optical engineering cannot compensate for a tear film that scatters light irregularly. A 2025 study by De Gregorio and colleagues identified “Ocular Surface System Failure” as a primary driver of dissatisfaction in patients with otherwise perfect surgical outcomes [2]. Their research suggests that subtle, often undiagnosed dry eye disease can degrade the performance of multifocal lenses significantly more than monofocal lenses. Consequently, treating the ocular surface aggressively before biometry and surgery is not merely an optional optimization but a mandatory surgical step. Surgeons must view the tear film as the first refractive surface of the eye. Ignoring it in a premium IOL candidate is a setup for postoperative fluctuation in vision and patient frustration.

Once the biological variables are controlled, the surgeon must address the neurological component of vision: neuroadaptation. The implantation of a diffractive or EDOF lens imposes a new optical code on the visual cortex and requires the brain to suppress simultaneous

superimposed images or process an elongated focal point. While most patients adapt within months, some struggle with this cortical processing. This leads to persistent complaints of “waxy” vision or bothersome dysphotopsias. Recent clinical assessments by Miki and associates in 2025 have begun to quantify this “brain adaptation” and suggest that older patients or those with rigid personality traits may have a slower neuroadaptive curve [3]. Counseling patients explicitly about this “neural learning curve” prevents panic during the early postoperative period. When a patient understands that their brain is learning to see again, they are more likely to view visual disturbances as temporary training signals rather than permanent surgical failures.

Finally, the tolerance for residual refractive error in premium IOL patients is virtually zero. In the era of monofocal lenses, a residual 0.75 D of astigmatism was often acceptable. In a trifocal eye, it can be the difference between a happy patient and a furious one. The degradation of image quality from residual astigmatism is compounded by the light splitting nature of diffractive optics. As noted in a 2025 editorial on enhancing patient outcomes, even minor residual errors must be aggressively managed, whether through limbal relaxing incisions, femtosecond laser enhancements, or lens exchange [4]. The surgeon must be committed to the “20/happy” outcome, which often requires a willingness to perform touch up procedures. Ultimately, navigating the era of premium IOLs requires the surgeon to be part psychologist, part physicist, and part physician. By rigorously screening candidates, optimizing the ocular surface, managing expectations regarding neuroadaptation, and committing to refractive zero, we can ensure that the technology we implant translates into the life changing vision our patients desire [5].

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