

ORIGINAL RESEARCH

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Visual, Refractive, and Patient-Reported Outcomes Following Bilateral Implantation of an Enhanced Monofocal IOL: An Exploratory Comparison of Achieved Mini-Monovision and Bilateral Emmetropia

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ABSTRACT

Purpose: To compare the clinical and patient-reported outcomes following bilateral implantation of partial-depth-of-field enhanced monofocal IOL in subjects achieving bilateral emmetropia versus mini-monovision.

Patients and Methods: This prospective, non-interventional, multicenter, cross-sectional study included subjects who had undergone cataract surgery and implantation of enVista Aspire IOL. For the post hoc analysis, patients were classified into bilateral emmetropia (BE) or mini-monovision (MM) based on achieved postoperative manifest refraction. Postoperative assessments included visual outcomes, manifest refraction, defocus curve, contrast sensitivity function, and patient-reported outcomes of questionnaires (AIOLIS and NAVQ).

Results: In the BE group (N = 49), the mean MRSE in the first and the second operated eye was -0.18 ± 0.26 D and -0.11 ± 0.26 D, respectively, and the mean UDVA was 0.07 ± 0.11 logMAR and 0.05 ± 0.12 logMAR, respectively. Mean UIVA in the first- and second-operated eyes of the BE group was ~ 0.23 logMAR, and mean UNVA was ~ 0.46 logMAR. In the MM group (N = 21), with the mean MRSE of -0.33 ± 0.17 D, the mean UDVA in the distance eye was 0.11 ± 0.12 logMAR. With a mean MRSE of -0.96 ± 0.34 D, mean UIVA and UNVA of the intermediate eye were 0.13 ± 0.09 logMAR and 0.29 ± 0.16 logMAR, respectively. The defocus curve showed 0.2 logMAR or better visual acuity up to a myopic defocus of ~ -1.25 D. A higher proportion (~ 14 to 31%) of subjects in the MM group reported “no or little difficulty” with various intermediate- to near-vision-related tasks. The frequency and bothersomeness of visual symptoms were similar between the two groups. A total of 85.7% of subjects in the MM group were “completely to very satisfied” with their overall postoperative vision compared to the BE group (77.6%).

Conclusion: The MM group demonstrated improved intermediate and near visual performance and favorable patient-reported outcomes.

Keywords: Partial-depth-of-field enhanced monofocal IOL; Cataract surgery; Emmetropia; Mini-monovision; Visual and patient-reported outcomes.

61 Introduction

62 Cataract surgery is the most frequently performed ophthalmic procedure to restore vision.¹
63 While monofocal intraocular lenses (IOLs) are the most commonly used IOLs during cataract
64 surgery due to their relatively low cost, excellent vision at distance, and a low risk of photic
65 phenomena, patients still need spectacles for intermediate and near.^{2,3}

66 With rapid digitalization, the visual needs of cataract patients have changed. The
67 widespread adoption of digital devices such as tablets, computers, and smartphones has
68 increased the importance of intermediate vision. As such, monofocal IOL patients now desire to
69 achieve not only good unaided vision at far distance but also at intermediate distance. A new
70 category of IOLs known as partial-depth-of-field enhanced monofocal IOLs is an ideal choice for
71 patients desiring improved intermediate vision while maintaining distance vision and
72 dysphotopsia profile of the standard monofocal IOLs.^{4,5}

73 Enhanced monofocal IOLs increase the depth of field (DOFi), primarily by modifying the
74 central lens optics to create a continuous, elongated range of focus, rather than a single focal
75 point. This optical design allows patients to enjoy good distance and functional intermediate
76 vision.⁶ However, patients still need to rely on spectacles for improving near acuity.

77 Monovision is an effective approach to further enhance the uncorrected DOFi of IOLs.⁷
78 Mini-monovision with enhanced monofocal IOLs is better than standard monofocal IOLs
79 because their inherently broader DOFi narrows the gap in functional vision and smooths the
80 transition between the focal points of the distance eye and the intermediate/near eye.⁸

81 enVista Aspire IOL (EA, Bausch + Lomb, Inc., Clearwater, FL, USA) is a partial-depth-
82 of-field enhanced monofocal IOL built on the same platform as the enVista monofocal IOL and
83 utilizes higher-order aspheric coefficients on its posterior surface to generate a continuous
84 curvature change. This creates a central 1.5 mm intermediate-optimized optic zone that
85 broadens the depth of focus, providing intermediate vision.⁹ A recent study evaluating the
86 effectiveness of enVista Aspire IOL reported good outcomes.¹⁰ In this study, we compared

clinical and patient-reported outcomes between patients who achieved bilateral emmetropia and mini-monovision after bilateral implantation of Aspire IOLs.

Material and Methods

This prospective, non-interventional, multicenter, cross-sectional study included subjects aged ≥ 22 years who had undergone cataract surgery and bilateral implantation of enVista Aspire IOL at 7 clinical sites in the United States during the study period from May 2024 to March 2025. In the real world, patients at the participating sites were generally targeted for bilateral emmetropia, with a refractive aim of plano to first minus in both eyes. In this prospective observational study, we recruited patients postoperatively based on their achieved postoperative MRSE. This post hoc analysis classified patients into either bilateral emmetropia group (i.e., postoperative manifest refraction spherical equivalent (MRSE) within ± 0.50 D in each eye) or mini-monovision group (i.e., postoperative MRSE within ± 0.50 D in one eye and more than 0.50 D of myopia (MRSE < -0.50 D) in the fellow eye). The study was conducted in accordance with the tenets of the Declaration of Helsinki and was approved by the Advarra Institutional Review Board (IRB) (IRB#00000971), Columbia, MD. Written informed consent was obtained from all subjects using the IRB-approved informed consent form before any study-related assessments were performed.

Inclusion criteria were subjects who were implanted with IOL powers ranging from +6.0 D to +34.0 D, had postoperative corrected distance visual acuity (CDVA) of 20/40 or better, were able to understand and provide written informed consent, and were willing and able to comply with follow-up study visits. Additionally, subjects with a visually significant posterior capsular opacification (PCO) (CDVA worse than 20/40) were included if they had undergone an yttrium aluminum garnet (YAG) capsulotomy at least 30 days before enrolment and had a post-YAG CDVA of 20/40 or better.

Exclusion criteria were any serious ocular pathology or underlying systemic medical disease (e.g., uncontrolled diabetes) or conditions such as severe dry eye, significant higher-order aberrations, irregular corneal astigmatism, optic nerve disease, or macular pathology, etc.,

that may have confounded the results of the study. Subjects with bilateral residual myopia, bilateral hyperopia, or refractive outcomes outside the defined range for bilateral emmetropia or mini-monovision or for whom a toric IOL was indicated to achieve emmetropia were excluded from the study.

The enVista Aspire IOL is a single-piece, ultraviolet light-absorbing, hydrophobic, acrylic, posterior chamber IOL with a 360° posterior square edge and modified-C loop haptics. The enVista Aspire IOL features an intermediate optimized central zone with a 1.5 mm diameter, using higher-order aspheric coefficients on the posterior surface to achieve a broader (~1.25 D) depth of focus.⁹ The controlled curvature change (3C) technology in the enVista Aspire optics harmonizes the geometric power profile between the central base power and the peripheral power.

The preoperative and operative data of eligible subjects were obtained retrospectively from case records, and subjects were assessed prospectively at a scheduled single follow-up visit for clinical outcomes. Upon obtaining informed consent from eligible candidates, subjects were asked to attend a single study visit (Visit 1, which was at least 2 months after IOL implantation in the second eye) to complete the following ocular assessments: uncorrected distance visual acuity (UDVA, 4 m), uncorrected intermediate visual acuity (UIVA, 66 cm) and uncorrected near visual acuity (UNVA, 40 cm) using Early Treatment Diabetic Retinopathy Study (ETDRS) charts, manifest refraction, binocular distance-corrected defocus curve, monocular distance-corrected mesopic contrast sensitivity function (with and without glare).

The assessment of visual acuity, defocus curve, contrast sensitivity function, and manifest refraction was performed with CTS (M&S Technologies, Niles, IL, USA). For refraction, the principle of maximum plus prescription that provides optimum VA was followed. Binocular defocus testing was performed under photopic lighting conditions, and from their best distance-corrected manifest refraction, each subject was defocused with spherical trial lenses between +1.50 D and -3.50 D in 0.5 D increments, except in the range of +0.50 D through -0.50 D, which was in 0.25 D increments.

In addition, Assessment of Intraocular Lens Implant Symptoms (AIOLIS) scores and Near Acuity Visual Questionnaire (NAVQ) were used to assess patient-reported outcomes. Preoperative data obtained from case records included demographic and baseline characteristics such as mesopic and photopic pupil size, keratometry, intraocular pressure (IOP), slit lamp exam, dilated fundus exam, PCO, concomitant medications, and adverse events.

Statistical analysis

Data analysis was performed using SPSS software, version 27.0 (SPSS Inc., Chicago, Illinois, USA). No formal sample size calculations were performed, and all analyses were based on available data, with no imputation for missing data. Outcomes were compared between subjects who achieved bilateral emmetropia (BE) and those who achieved mini-monovision (MM). Descriptive statistics on continuous variables included mean and standard deviation (SD). Categorical variables were summarized using counts and proportions.

Snellen visual acuity was converted to logarithm of the minimum angle of resolution (logMAR) units for analysis. When reporting Snellen's visual acuity of 20/x or better, subjects were considered to have read the line if 3 or more of the 5 ETDRS chart letters were identified correctly. The uncorrected visual acuity was measured monocularly, and descriptive statistics were presented at eye level.

Since assessments of the defocus curve and contrast sensitivity function were performed after correcting the patients to distance, the descriptive results of the binocular defocus curve and monocular contrast sensitivity function were presented collectively for the overall dataset (combining BE and MM groups).

The outcomes of the AIOLIS questionnaire assessing the frequency and bothersomeness of various visual symptoms, the other spectacle independence outcomes, and the NAVQ questionnaire assessing near vision-related outcomes were compared between the two groups using the Chi-square test or Fisher's exact test, as applicable (if 25% of the cells

had expected counts less than 5, the Chi-square test was not applicable, so a Fisher's exact test was used). A p-value <0.05 was considered statistically significant.

Results

There were 49 subjects in the BE group and 21 in the MM group. The mean age of subjects in the BE group was 70.8 ± 6.8 years (range 53 to 88 years), and in the MM group was 69.4 ± 7.4 years (range 54 to 85 years). Table 1 summarizes the demographic and baseline characteristics of subjects in both groups. The mean postoperative follow-up time was 5.1 ± 2.0 months (range 2.5 to 9.9 months) in the BE group and 4.2 ± 1.9 months (range 2.3 to 9 months) in the MM group.

Visual and refractive outcomes

Table 2 summarizes the visual and refractive outcomes achieved in the two groups. In the first operated eye of the BE group, the mean MRSE was -0.18 ± 0.26 D (range -0.50 D to $+0.50$ D) and the mean UDVA was 0.07 ± 0.11 logMAR, with 93.9% of eyes achieving UDVA of 20/32 or better, postoperatively. In the second operated eye, the mean MRSE was -0.11 ± 0.26 D (range -0.50 D to $+0.50$ D) and the mean UDVA was 0.05 ± 0.12 logMAR, with 95.9% of eyes achieving UDVA of 20/32 or better. In the MM group, the distance eyes had a mean MRSE of -0.33 ± 0.17 D (range -0.50 D to 0.0 D), the mean UDVA was 0.11 ± 0.12 logMAR, and 85.7% of eyes achieved UDVA of 20/32 or better.

The mean logMAR UIVA in the first operated eye of the BE group was 0.24 ± 0.16 logMAR, with 49.0% of eyes achieving UIVA of 20/32 or better. In the second operated eye, UIVA was 0.23 ± 0.14 logMAR, and 55.1% achieved UIVA of 20/32 or better. In the MM group, in the intermediate eye, with a mean MRSE of -0.96 ± 0.34 D (range -1.88 D to -0.63 D), the mean UIVA was 0.13 ± 0.09 logMAR, with 90.5% eyes achieving UIVA of 20/32 or better, postoperatively.

The mean logMAR UNVA in the first operated eye of the BE group was 0.47 ± 0.17 logMAR, with 10.2% of eyes achieving UNVA of 20/32 or better. In the second operated eye,

UNVA was 0.46 ± 0.17 logMAR, and 10.2% achieved UNVA of 20/32 or better. In the intermediate eye of the MM group, the mean UNVA was 0.29 ± 0.16 logMAR, with 47.6% of eyes achieving UNVA of 20/32 or better postoperatively.

Defocus curve

Binocular distance-corrected defocus-curve performance of the Aspire IOL showed a mean logMAR visual acuity of -0.05 logMAR at 0.0 D and visual acuity of 20/32 or better (0.2 logMAR) up to a myopic defocus of $\sim$ -1.25 D (Figure 1).

Contrast sensitivity function

The mesopic monocular contrast sensitivity function, with or without glare, for the overall dataset at various cycles per degree (cpd) is shown in Figure 2.

NAVQ Questionnaire

A higher proportion (17 to 31% higher) of subjects in the MM group reported “no or little difficulty” in writing and reading their own handwriting, in conducting near vision tasks without spectacles, reading labels/instructions, small prints, and post/mail, compared to the BE group (Figure 3).

For intermediate to near vision tasks such as seeing the display and keyboard on a computer or mobile devices, seeing close objects, and engaging in hobbies, a higher (14 to 20% higher) proportion of subjects in the MM group reported “no or a little difficulty” compared to patients in the BE group (Figure 4).

With NAVQ, when asked whether patients were satisfied with their near vision, 76.2% of subjects in the MM group and 59.2% in the BE group responded that they were “moderately to completely satisfied” with their postoperative near vision ($p = 0.174$).

AIOLIS Questionnaire

Table 3 summarizes the proportions of subjects reporting frequency of visual symptoms and Table 4 summarizes the proportions of subjects reporting bothersomeness with visual symptoms in the BE and MM groups. The frequency and bothersomeness of various visual symptoms were similar between the BE and MM groups (all $p > 0.05$).

Furthermore, a nearly 16% higher proportion of subjects in the MM group reported that they can see “pretty to perfectly well” without glasses than in the BE group (100% in the MM vs 83.7% in the BE group, $p = 0.095$).

For distance vision, the proportion of subjects rating their eyesight as good to excellent was similar between the MM and BE groups (95.2% vs 95.9%, $p = 1.000$). For seeing things at close as well, a significantly higher proportion of subjects in the MM group reported their vision to be good to excellent for looking up at close compared to the BE group (57.10% vs 28.60%, $p = 0.023$).

With the AIOLIS questionnaire, the subjects were also asked if they were satisfied with their overall vision at distance, intermediate and near, spectacle independence, and experience with dysphotopsia; 85.7% of subjects in the MM group and 77.6% in the BE group responded that they were completely to very satisfied with their vision ($p = 0.529$).

Adverse events

No device or procedure-related adverse events were reported in the study.

Discussion

Mini-monovision with the enhanced monofocal IOL is an effective strategy to further improve intermediate visual outcomes and reduce spectacle dependence while maintaining distance clarity.^{6,7} Mini-monovision broadens the functional range of vision by adjusting the refractive targets between eyes;⁶ one eye is targeted for emmetropia, and the fellow eye is targeted for slight myopia, ranging from -0.75 D to -1.50 D.¹¹

The present study evaluated and compared the outcomes of the partial-depth-of-field-enhanced enVista Aspire monofocal IOL in the BE and MM groups. Overall, Aspire IOL subjects in the BE group demonstrated excellent distance vision and good intermediate vision, along with a favorable dysphotopsia profile. The mini-monovision approach further improved visual acuity outcomes at intermediate while maintaining distance vision. The incidence of photic phenomena, as assessed with the AIOLIS questionnaire, was low and comparable to that in the BE group. Additionally, as evidenced by NAVQ questionnaire results, a relatively higher proportion of subjects in the MM group could perform near vision-related tasks with no or little difficulty compared to subjects in the BE group. Subjects reported good satisfaction and spectacle independence.

Descriptive analysis of the visual outcomes showed that subjects in the MM group demonstrated better intermediate visual acuity, with a mean UIVA of ~20/27 in the intermediate eyes, and 90.5% of these eyes achieving a postoperative UIVA of 20/32 or better. These proportions were 35-40% higher than the proportions achieved in the BE group. While the distance visual acuity (mean UDVA) was similar in the distance eyes of the MM and BE groups, it trended to be ~2 to 3 letters higher in the BE group than in the MM group. This might be attributed to the MRSE being closer to emmetropia in the BE group (-0.18 to -0.11 D) than in the MM group (-0.33 D in the distance eyes). The present study outcomes of UDVA and UIVA achieved in the BE,¹²⁻¹⁸ as well as the MM groups,^{19,20} were comparable to literature-reported outcomes with other enhanced or standard monofocal IOLs.^{21,22} Studies directly comparing the mini-monovision approach with enhanced or standard monofocal IOLs found significantly better visual acuity outcomes at intermediate ranges and significantly better quality of life when targeting mini-monovision with enhanced monofocal IOLs.^{6,23} This is expected because the broader depth of field of enhanced monofocal IOLs in the emmetropic and intermediate eyes allows better overlap of the visual profiles, creating a smoother transition between the eyes. The authors believe that mini-monovision with enhanced monofocal IOLs also facilitates binocular summation, thereby mitigating asthenopia and improving patient experience with mini-monovision.

With bilateral emmetropia, the uncorrected monocular defocus curves of the two enhanced monofocal IOL-implanted eyes essentially overlap, and excellent distance vision and a functional intermediate vision can be achieved. On the other hand, using a mini-monovision approach with enhanced monofocal IOLs broadens the uncorrected defocus curve towards more myopic defocus levels, thereby providing good intermediate and functional near vision compared to bilateral emmetropia. In the present study, although we did not study the uncorrected monocular defocus curve, the binocular distance-corrected defocus curve of the Aspire IOL provided a broad range of functional vision, demonstrating 0.2 logMAR or better visual acuity over a myopic defocus range of approximately -1.25 D for the overall dataset combining the BE and MM subgroups.

A smaller pupil limits the contribution of rays passing through the eye's outer optical zones, reducing the impact of optical aberrations and increasing depth of focus, which may improve visual acuity under certain conditions.²⁴ As such, pupil size plays a significant role in determining the depth of focus. In the present study, the photopic pupil size in the MM eyes trended slightly larger than that in the BE group (Table 1). Despite this, the MM group achieved better intermediate vision than the BE group, confirming that the better intermediate outcomes were not attributable to a smaller pupil size.

While visual acuity tests objectively assess IOL performance after surgery, subjective patient questionnaires assess patients' subjective impressions of their vision after IOL implantation. The use of these questionnaires alongside standard visual acuity assessments provides a comprehensive evaluation of treatment outcomes from both the patient's and the surgeon's perspectives. In this study, the visual outcomes in both groups corroborated the patient-reported outcomes measured with the AIOLIS and NAVQ questionnaires.

The NAVQ outcomes, which measure activity limitations related to near-vision tasks, were encouraging. With mini-monovision, not only did the intermediate visual acuity improve, but subjects also demonstrated functional near vision. A significantly higher (~29% higher) proportion of subjects in the MM group could perform near-vision tasks without spectacles than

in the BE group (71.4% vs 42.9%, $p = 0.028$). Similarly, for other near-vision tasks, a higher proportion of subjects in the MM group reported “No or little difficulty” than in the BE group.

The two groups were similar in the frequency and bothersomeness of 15 key visual symptoms assessed using the AIOLIS questionnaire. Over 95% of subjects did not experience visual symptoms or rarely did, and more than 90% were hardly bothered by these symptoms. The proportion of subjects reporting their eyesight as “good to excellent” for seeing at far distance was comparable between the MM and BE groups. At close distances, a higher proportion of subjects in the MM group rated their eyesight as “good to excellent” compared with the BE group (57.1% vs 28.6%, $p = 0.023$). Although spectacle independence was higher in the MM group, with all (100%) reporting they could see “pretty to perfectly” well without glasses, compared with 83.7% in the BE group, the differences were not statistically significant.

Patient satisfaction with the postoperative vision was evaluated using both AIOLIS and NAVQ questionnaires. While the NAVQ focused on patient satisfaction with near vision, AIOLIS evaluated overall satisfaction with far, intermediate, and near distances, as well as patients’ experience with dysphotopsia. With NAVQ, the MM group reported higher satisfaction (although not statistically significantly higher) than the BE group, with 76.2% of MM group subjects reporting being “moderately to completely satisfied” with their postoperative near vision, compared with 59.2% in the BE group. Likewise, when analyzed using AIOLIS, patient satisfaction was higher (though not statistically significantly higher) in the MM group than in the BE group, with 85.7% in the MM group and 77.6% in the BE group reporting being “completely to very satisfied” with their overall vision. This is potentially because the visual outcomes aligned with their specific daily lifestyle and occupational needs.

Contrast sensitivity is essential for good functional vision, particularly in low-light conditions.²⁵ It significantly affects visual performance and the ability to distinguish objects and details in those challenging conditions. The overall contrast sensitivity function in the present study was similar to those reported in the literature for other enhanced monofocal IOLs.²⁶⁻²⁸

This study has certain limitations. This was a prospective observational cross-sectional study of subjects who had already undergone surgery and IOL implantation for whom

preoperative and operative data were collected retrospectively from case records, and only postoperative data were collected prospectively. As such, preoperative targeting varied by treating surgeons, and the residual refractive error could not be controlled. Therefore, subjects were divided into two groups based on achieved postoperative manifest refraction, and the outcomes of the study IOL were compared between subjects achieving bilateral emmetropia and those achieving mini-monovision.

Given the absence of binocular uncorrected visual outcome data, a direct comparison of uncorrected binocular visual performance between the two groups could not be performed. The uncorrected defocus curve, which may reflect the true benefit of the mini-monovision approach, was not assessed. Contrast sensitivity was also assessed after correcting patients for distance. As such, the individual effect of bilateral emmetropia and mini-monovision, or any disadvantage because of postoperative refractive error in the contrast sensitivity function, was not visible. The order in which the eyes were operated, i.e., whether the dominant or the non-dominant eye was operated first, and the adjustment of the refractive target of the second eye, the use of final spectacle correction were not standardized and the effect of stereopsis was not considered. Future studies with binocular uncorrected visual acuity assessment and monocular and binocular uncorrected defocus curves, assessment of uncorrected contrast sensitivity function may provide additional insights. While the comparison of the patient-reported outcomes between the two groups showed a trend of better outcomes in the MM group, the small sample size warrants cautious interpretation of results. Future prospective studies with larger datasets specifically targeting patients for mini-monovision are required to assess the role of mini-monovision in improving intermediate vision possible with enhanced monofocal IOLs.

Conclusion

To summarize, the descriptive analysis showed that the partial-depth-of-field-enhanced monofocal Aspire IOL yielded excellent visual outcomes in subjects who achieved bilateral emmetropia postoperatively and further improved intermediate visual acuity, together with functional near vision, in subjects who achieved mini-monovision. Both groups showed a favorable visual symptom profile, with no significant differences in the frequency and

bothersomeness of visual symptoms between the two groups. A higher proportion of subjects in the MM group reported satisfaction with the overall and near vision than subjects in the BE group; however, the differences did not reach statistical significance. These findings support further prospective evaluation of mini-monovision strategies with enhanced monofocal IOLs. Conclusions about the superiority in satisfaction, spectacle independence, or quality of life should be interpreted with caution, given the study design, limited sample size, and the absence of formal economic or quality-of-life analyses.

Abbreviations

IOL, Intraocular lens; DOFi, Depth of field; IRB, Institutional Review Board; CDVA, corrected distance visual acuity; PCO, posterior capsular opacification; YAG, yttrium aluminum garnet; UDVA, uncorrected distance visual acuity; UIVA, uncorrected intermediate visual acuity; UNVA, uncorrected near visual acuity; ETDRS, Early Treatment Diabetic Retinopathy Study; AIOLIS, Assessment of Intraocular Lens Implant Symptoms; NAVQ, Near Acuity Visual Questionnaire; IOP, intraocular pressure; BE, Bilateral emmetropia; MM, Mini-monovision; MRSE, manifest refraction spherical equivalent; SD, standard deviation; logMAR, Logarithm of the Minimum Angle of Resolution; cpd, cycles per degree.

Data Sharing Statement

The data that support the findings of this study are available from the corresponding author (CS), upon reasonable request.

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472 **Figure Legends**

473 **Figure 1:** Binocular distance-corrected defocus curve performance of the Aspire enhanced
474 monofocal IOL.

475 **Figure 2:** Contrast sensitivity function of the Aspire enhanced monofocal IOL under mesopic
476 with and without glare conditions.

477 **Figure 3:** Proportion of subjects reporting “no or little difficulty” in doing daily near vision tasks
478 assessed using the Outcomes of the Near Acuity Visual Questionnaire (NAVQ) in the Bilateral
479 emmetropia and the Mini-monovision groups.

480 **Figure 4:** Proportion of subjects reporting “no or little difficulty” in doing daily intermediate to
481 near vision tasks assessed using the Outcomes of the Near Acuity Visual Questionnaire (NAVQ)
482 in the Bilateral emmetropia and the Mini-monovision groups.