

MY WEIRD PROMPTS

Podcast Transcript

EPISODE #275

Beyond LASIK: The New Era of Vision Correction

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EPISODE SYNOPSIS

If you were told a decade ago that you weren't a candidate for laser eye surgery, it is time to reconsider your options in the rapidly evolving landscape of 2026. In this episode, Herman and Corn discuss the move from traditional "subtractive" surgeries to "additive" solutions like the ICL, offering a lifeline to those with severe myopia and contact lens intolerance. They break down the science of SMILE Pro, the safety of biocompatible implants, and the advanced AI diagnostics that are making "impossible" cases a thing of the past.

DANIEL'S PROMPT

Daniel

"I have severe myopia with a prescription of around -8 and can no longer tolerate contact lenses. About ten years ago, I was told I wasn't a good candidate for laser eye surgery. Given the advancements by 2026, what is the current state of play for someone with my level of myopia? What is the standard process for evaluation, and what should I ask an ophthalmologist? Have the risks of long-term complications, such as chronic dry eye, decreased over time? Also, what are the typical costs for these procedures now?"

TRANSCRIPT

Corn

Hey everyone, welcome back to My Weird Prompts. I am Corn, and I am sitting here in our living room in Jerusalem with my brother, looking out at a surprisingly clear view of the Old City walls today.

Herman

Herman Poppleberry, reporting for duty. It is a beautiful day here, Corn, but honestly, I have been looking forward to getting into this week's topic since the audio file hit my inbox. Our housemate Daniel sent us a really personal and, frankly, high stakes question about something a lot of people deal with but rarely talk about in this much depth. It is about the literal lenses through which he sees the world.

Corn

Yeah, Daniel was asking about his eyes. He is dealing with severe myopia, a prescription of minus eight, which for those who do not know, is pretty significant. He is at that point where contact lenses are just not working for him anymore. His eyes are constantly red, they feel like they have sand in them by two in the afternoon, and he is just done. But the kicker is that he was told ten years ago, back in twenty sixteen, that he was not a candidate for laser surgery. He has been carrying that rejection around like a life sentence of wearing heavy glasses.

Herman

It is a tough spot to be in. When you are at a minus eight, the world is basically a beautiful, impressionist blur past your own nose. You cannot see the alarm clock, you cannot see who is walking toward you in the hallway, and you certainly cannot navigate a dark room safely. The frustration of not being able to wear contacts after years of relying on them is a real quality of life issue. It is what doctors call contact lens intolerance, and it can feel very isolating. But the good news for Daniel, and for anyone else in this position, is that the landscape of refractive surgery has changed dramatically between twenty sixteen and today, January twenty-third, twenty twenty-six.

Corn

That is what I want to dig into. Because ten years ago, if a doctor said no, that was usually the end of the road. You just accepted your fate. But technology does not sit still. I am curious, Herman, why would someone like Daniel have been rejected back then? Was it just the prescription being too high, or is there more to the biology of it?

Herman

It is usually a combination of factors, but the primary culprit is almost always the cornea. Think of the cornea as the clear window on the front of your eye. In traditional laser surgeries like LASIK, the laser reshapes the eye by removing tissue from that window. If your prescription is high, like a minus eight, the laser has to remove a lot of tissue to flatten the cornea enough to correct the vision. It is like sanding down a piece of wood. If the wood is already thin, or if you have to sand too deep, you compromise the structural integrity of the whole house. If your cornea is naturally thin, or if the surgery would leave it too thin to be structurally sound, a responsible surgeon in twenty sixteen would have said, sorry, we cannot do this safely because you might develop something called ectasia, where the eye actually starts to bulge outward because it is too weak.

Corn

So it is essentially a math problem. You have a limited amount of material to work with, and the correction requires more than you have. It is a supply and demand issue where the currency is your own eye tissue.

Herman

Exactly. And back then, we really only had LASIK and PRK as the mainstream options. PRK is where they brush off the surface layer of the cornea, and LASIK is where they create a flap. Both require that tissue removal. But fast forward to twenty twenty-six, and we have entered what I like to call the era of additive and ultra-precise refractive surgery. We have moved from just sanding the wood to actually being able to reinforce the structure or even add new components entirely.

Corn

Additive surgery. That sounds like a complete shift in philosophy. Instead of taking stuff away, you are putting something in? That feels much less... destructive?

Herman

Precisely. And that is likely the biggest game changer for someone with Daniel's prescription. But before we get to the additive stuff, we should probably talk about how the laser tech itself has evolved, because even the subtractive methods are way more sophisticated now. We are not using the same blunt instruments we used a decade ago.

Corn

You are talking about SMILE, right? I have been seeing that name everywhere lately. Small Incision Lenticule Extraction. It sounds like something out of a science fiction novel.

Herman

You got it. SMILE has really come into its own over the last decade. By twenty twenty-six, we are actually using the second and third generations of this tech, like SMILE Pro. Unlike LASIK, there is no flap. In LASIK, you cut a big circular flap, flip it over, laser the middle, and flip it back. That flap never truly heals to its original strength. With SMILE, a femtosecond laser creates a tiny, lens-shaped piece of tissue called a lenticule inside the cornea, and the surgeon pulls it out through a microscopic incision that is less than four millimeters wide. Because there is no flap, the structural integrity of the cornea is preserved much better. It is like keyhole surgery for the eye.

Corn

So, for someone who was told their cornea was too thin for a flap, SMILE might actually be an option because it leaves the surface stronger? It is not compromising the whole front of the eye?

Herman

It can be. It is much less invasive. But here is the thing for Daniel specifically. At a minus eight, even SMILE is pushing the limits of corneal tissue removal for a lot of people. It is a great procedure, and it has a much lower risk of chronic dry eye, which was one of Daniel's big concerns, because it does not sever as many corneal nerves. But if the cornea is truly thin, or if the shape is slightly irregular, we have to look past the laser entirely. We have to stop thinking about reshaping the eye and start thinking about upgrading it.

Corn

Okay, so let's talk about the thing Daniel mentioned in his prompt. He said he heard something about, and I am quoting him here, staples in your eyes. That sounds terrifying. It sounds like something from a medieval torture chamber. I assume he is talking about the ICL, or the Implantable Collamer Lens?

Herman

Yes, and I really want to clear that up because staples is a frightening word to use for something so elegant. There are no staples, no metal, no sharp edges. The ICL is essentially a permanent, microscopic contact lens that is surgically placed inside the eye, behind the iris but in front of your natural lens. It is held in place by its own shape and the natural structures of the eye. No stitches or staples required.

Corn

So it is like a lens sandwich? You have your cornea, then the ICL, then your iris, then your natural lens?

Herman

That is a very Corn way of putting it, but yes. It is made of a material called Collamer, which is a collagen copolymer. It is extremely biocompatible, meaning your body does not see it as a foreign object. It actually contains a ultraviolet light filter too. By twenty twenty-six, the EVO ICL has become a standard of care for high myopia. The EVO version is particularly important because it solved a lot of the problems the older versions had.

Corn

Why is it better for someone like Daniel than laser surgery? If he has a minus eight, why go for the internal lens instead of the laser?

Herman

Because it does not touch the cornea. You are not thinning the eye at all. You are just adding a corrective element. It can treat myopia up to minus twenty. So Daniel's minus eight is actually right in the sweet spot for this technology. It is like putting a high-definition filter inside the eye. And the best part? It is reversible. If your prescription changes or if something better comes along in twenty years, a surgeon can just take it out. You cannot put corneal tissue back once it is lasered away. That tissue is gone forever. With the ICL, you keep all your biological options open for the future.

Corn

That reversibility factor seems huge. It takes a lot of the anxiety out of the decision. If you hate it, you can go back to baseline. But what does the process look like now? If Daniel decides to walk into a clinic tomorrow, what is the standard operating procedure for evaluation in twenty twenty-six? I imagine it is more than just reading letters off a wall.

Herman

It is much more rigorous than it used to be. They do not just check your vision and measure your cornea thickness with a simple ultrasound probe anymore. They use something called anterior segment OCT, which is optical coherence tomography. It creates a high-resolution, three-dimensional map of the front of your eye, showing exactly how much space there is between your structures. They also use epithelial mapping to see if there are any irregularities in the very top layer of cells that might suggest early-stage issues like keratoconus. We also have AI-driven screening now that compares your eye maps to millions of other patients to predict how you will heal.

Corn

I remember we touched on keratoconus briefly in episode two hundred and ten when we were talking about medical imaging. It is that thinning and bulging of the cornea, right? That used to be an automatic disqualification for everything.

Herman

Exactly. And detecting that early is why so many people were rejected ten years ago. Back then, if the map looked even slightly off, they would say no because they could not be sure if it was a disease or just a weirdly shaped eye. Today, our mapping is so precise that we can distinguish between a naturally oddly-shaped cornea and a diseased one. We also have corneal cross-linking now, which can actually stop keratoconus in its tracks, making some people candidates for surgery who never would have been before.

Corn

So, when Daniel goes in, what should he actually be asking the ophthalmologist? He mentioned he wanted a checklist or a standard process to follow. He wants to walk in there feeling like he knows the secret handshake.

Herman

That is a great question. First, he should ask for his specific corneal thickness numbers, usually measured in microns. A normal cornea is around five hundred and fifty microns. If he is under five hundred, LASIK is probably a bad idea. Second, he should ask about his angle depth. For an ICL, you need enough physical space between your iris and your natural lens to fit the new lens. This is called the vault. If the space is too shallow, the lens could touch your natural lens and cause a cataract. Third, he should ask about his scotopic pupil size—that is how big his pupils get in the dark. If his pupils get very large, he might be more prone to seeing those halos at night.

Corn

That makes sense. You do not want to cram something in where it does not fit, and you want to know how the light is going to hit the lens. What about the dry eye issue? That was a huge part of his prompt. He is worried that he will trade his contact lens discomfort for a lifetime of chronic dry eye from surgery. He does not want to be addicted to eye drops forever.

Herman

This is where the news is really good. Chronic dry eye was the big boogeyman of LASIK for a long time. When you cut that corneal flap, you are cutting nerves that tell your eye to produce tears. It is like cutting the telephone line between the eye and the brain. It usually gets better, but for some people, it never quite returns to baseline. But with SMILE and ICL, that risk is significantly lower. In twenty twenty-six, we also have much better pre-operative treatments. We do not just operate on dry eyes anymore.

Corn

Why is that? What changed in the prep work?

Herman

Well, with SMILE, the incision is so tiny that most of the nerves stay intact. And with the ICL, you are not touching the corneal nerves at all. You are making a tiny incision on the side that heals almost instantly. But the real shift is in diagnostics. We now use LipiView to see the oil layer of your tears and Meibography to look at the glands in your eyelids. If a patient has underlying dry eye issues, we treat that for months with things like intense pulsed light therapy or thermal pulsation—basically a spa treatment for your eyelids—before we ever let them near a laser. We get the ocular surface healthy first.

Corn

So the goal is to get the eye healthy before the surgery, rather than just operating and hoping for the best. It is like prepping a canvas before you start painting.

Herman

Exactly. It is a proactive approach. Daniel should ask his doctor, do I have any signs of meibomian gland dysfunction right now? If the answer is yes, he needs to fix that before he considers any refractive surgery. If he fixes the dry eye first, his surgical outcome will be ten times better.

Corn

Let's talk about the long-term stuff. Ten years is a long time in a human life, but it is a short time in the life of an eye. What are the risks we are looking at now that we have more long-term data on these newer procedures? We have had a decade of people walking around with these things.

Herman

For laser surgery, the biggest long-term concern is regression. Your eye can still change as you age. If you get lasered at twenty-five, you might need a touch-up at forty. For the ICL, the historical concern was the risk of early cataracts or increased eye pressure, which could lead to glaucoma. That was the big worry in the early two thousands.

Corn

That sounds serious. Has that been addressed in the twenty twenty-six versions of the lens?

Herman

It has. The older versions of the ICL required a separate procedure to poke a tiny hole in the iris to help fluid flow. It was called a peripheral iridotomy, and it was a bit of a hassle. The new EVO lenses have a tiny hole built right into the center of the lens itself. It is called a KS-AquaPort. It is so small you cannot see it, but it allows the natural fluid of the eye to circulate freely. This has almost entirely eliminated the risk of those pressure spikes and reduced the cataract risk to nearly zero in the long-term studies we have seen leading up to twenty twenty-six. It is a triumph of micro-engineering.

Corn

That is incredible. It is such a simple engineering fix for a complex biological problem. Just a tiny hole to let the eye breathe, essentially.

Herman

It really is. And it has opened the door for so many people who were previously told they had no options. But we should be realistic about the trade-offs. No surgery is without risk. There is always the chance of seeing halos or glare at night, especially with a high prescription like Daniel's. If you are a minus eight, the laser has to blend a very steep curve into a flat one, and that transition zone can catch light in weird ways.

Corn

I have heard about that. The light catches the edge of the treatment zone or the edge of the lens, right? Like a lens flare in a movie?

Herman

Right. If your pupil dilates wider than the area that was treated by the laser or the size of the implantable lens, you are going to see some artifacts. Modern tech has minimized this by using larger treatment zones and better lens designs, but if you do a lot of night driving or work in low light, it is something you have to discuss with your surgeon. You have to weigh the benefit of seeing clearly all day against the possibility of seeing a few rings around streetlights at night.

Corn

Okay, let's get down to the brass tacks. Daniel asked about the cost. I know this varies by city and by clinic, but what is the ballpark in twenty twenty-six? Is this something you need a second mortgage for?

Herman

It is not cheap, but it has stabilized as the technology has become more common. For high-quality LASIK or SMILE, you are looking at roughly two thousand five hundred to three thousand eight hundred dollars per eye. If you go the ICL route, which is likely what Daniel would need given his history, it is more expensive because you are paying for the custom-manufactured lens itself and the surgical suite time. That usually runs between four thousand five hundred and six thousand dollars per eye.

Corn

Wow. So for both eyes, we are talking about potentially nine thousand to twelve thousand dollars for the ICL. That is a used car or a very fancy vacation.

Herman

Yes. It is a major investment. But you have to weigh that against the lifetime cost of high-index glasses, which can be eight hundred dollars a pair, and contact lenses, and solutions over the next thirty years. For someone with a minus eight, those glasses are never cheap, and they are never quite as good as natural vision. Plus, there is the safety factor—being able to see in an emergency at night without finding your glasses is priceless.

Corn

Not to mention the psychological benefit. Being able to wake up and see the clock on the wall or your partner's face without fumbling for plastic on your nightstand is a huge deal. It changes how you move through the world. It is a freedom issue.

Herman

It really is. Daniel also asked about what he should look for in a surgeon. My advice there is simple: do not go to a high-volume LASIK mill that advertises on the back of bus tickets. You want a surgeon who specializes in refractive surgery but offers multiple platforms. If all they have is a LASIK laser, they are going to try to fit you into a LASIK box. You want someone who does LASIK, SMILE, and ICL. That way, they can give you an unbiased recommendation based on what is actually best for your anatomy, not just what they have the equipment for.

Corn

That is such a good point. If your only tool is a hammer, every eye looks like a nail. You want someone with a full toolbox and the wisdom to know which tool to pick. You want a craftsman, not a factory worker.

Herman

Exactly. And ask them about their enhancement rate. How often do they have to go back in and do a second procedure? A good surgeon will be very transparent about those numbers. They should also be able to show you your own eye maps and explain them to you in plain English. If they seem rushed or dismissive of your dry eye concerns, walk away. There are plenty of great surgeons out there who will take the time.

Corn

I am curious about the recovery time too. If Daniel gets this done, how long is he out of commission? He is a busy guy, he is always working on something, usually three things at once.

Herman

For SMILE and ICL, the recovery is remarkably fast. Most people are seeing well enough to drive the very next day. With the ICL, because there is no corneal healing involved, the vision often snaps into focus almost immediately. It is often called the wow effect. There is some scratchiness for a few days, and you have to be very diligent with your eye drops—antibiotics and steroids—for a few weeks, but you are not looking at weeks of downtime. You just have to avoid swimming and rubbing your eyes for a bit.

Corn

That is a far cry from the old days where people had to sit in a dark room for a week with bandages on their eyes.

Herman

Oh, absolutely. The engineering has just gotten so much more refined. Even the way the lasers track the eye has improved. They now have eye-trackers that can compensate for the tiny, involuntary movements your eye makes thousands of times a second. If your eye moves even a fraction of a millimeter too much, the laser just shuts off instantly. It is incredibly safe. The margin for human error has been shrunk down to almost nothing.

Corn

It sounds like Daniel's experience ten years ago was just a snapshot in time, and that snapshot is now totally outdated. It is like comparing a flip phone to the latest neural-link interface.

Herman

It really is. I think the biggest takeaway for him should be that being a bad candidate for laser surgery in twenty sixteen does not mean you are a bad candidate for vision correction in twenty twenty-six. The definition of what is possible has expanded. We have moved from reshaping what you have to adding what you need.

Corn

So, to recap the checklist for Daniel: get an evaluation that includes epithelial mapping and anterior segment OCT. Ask about corneal thickness in microns and angle depth for an ICL. Inquire about pre-existing dry eye and meibomian gland health. And specifically ask, why am I a better candidate for one procedure over the other? Do not let them just give you the standard pitch.

Herman

That is a perfect summary. And I would add one more thing. Ask the surgeon how many ICLs they have implanted in the last year. It is a more technically demanding surgery than LASIK because you are actually entering the eye, so you want someone who does them regularly and has a steady hand. Experience matters when you are working in spaces measured in microns.

Corn

This is all so fascinating. It is one of those areas where technology feels like it is actually improving the human condition in a very direct, tangible way. It is not just an app or a gadget; it is your literal perception of reality.

Herman

It really is. We spend so much time talking about AI and software, but the mechanical and biological engineering required to safely put a lens inside a human eye and have it stay there for forty years is just staggering. It is one of the quietest revolutions in medicine.

Corn

It makes me think about what comes next. If we are doing this in twenty twenty-six, what does twenty thirty-six look like? Are we going to have smart lenses that can zoom in and out or record what we see?

Herman

Honestly, we are not that far off from some of that. There is already research into accommodative lenses that can change shape like your natural lens does when you are young. That would solve the problem of presbyopia, the need for reading glasses as we get older. Imagine being sixty years old and having the vision of a twenty-year-old at both distance and near. We are also seeing the first trials of light-adjustable lenses where the prescription can be changed with a beam of light after the lens is already in your eye.

Corn

That would be the dream. No more bifocals, no more hunting for the readers you left in the other room. Just perfect vision for life.

Herman

We are getting there. But for now, for someone like Daniel, the current state of play is better than it has ever been. It is a high-cost, high-reward move, but the safety profiles are at an all-time high. If he has the means and the motivation, it is definitely worth a second look.

Corn

Well, I hope that gives Daniel some peace of mind. It is a big decision, but at least now he knows that the door that was slammed in his face a decade ago might be wide open now. He just needs to walk through it and get a new set of maps made.

Herman

Exactly. And honestly, even if he just goes in for the consultation, he is going to learn so much more about his eyes than he knew ten years ago. The diagnostic tools alone are worth the visit. He might find out his dry eye is fixable regardless of whether he gets surgery.

Corn

This has been a great deep dive, Herman. I feel like I have a much better handle on this now, and hopefully, our listeners do too. I might even go get my own eyes checked after this.

Herman

I enjoyed it. It is always fun to see how these specialized fields evolve. It is easy to miss the progress when it happens in increments, but when you step back and look at a ten-year gap, it is truly impressive. It is like watching a glacier move and then realizing it has carved out a whole valley.

Corn

Before we wrap up, I want to give a quick shout-out to everyone who has been following the show. We have been doing this for a long time now, two hundred and seventy-one episodes, and we really appreciate the community that has built up around these weird prompts. You guys keep us curious.

Herman

Yeah, it is the best part of the job. If you are enjoying the show and you find these deep dives helpful, we would really appreciate it if you could leave us a review on your podcast app or on Spotify. It genuinely helps other curious people find us in the sea of content out there.

Corn

And if you want to get in touch, or if you have a prompt of your own that you want us to explore—whether it is about eyes, space, or the history of buttons—you can find us at myweirdprompts.com. We have a contact form there and the full archive of our past episodes.

Herman

Including the one on open heart surgery Daniel mentioned at the start of his audio! That was a fun one to record, though a bit more graphic than this one.

Corn

It was. Alright, I think that covers it for today. Daniel, good luck with the eyes. Let us know what the doctor says if you end up going in for that evaluation. We are rooting for you.

Herman

Definitely keep us posted. This has been My Weird Prompts.

Corn

Thanks for listening, everyone. We will see you next week.

Herman

Take care of those eyes!

Corn

So, Herman, one last thing before we go. If you had to choose, would you rather have perfect vision but you have to wear a tiny, ridiculous hat at all times, or your current vision but you never have to wear shoes again for the rest of your life?

Herman

Corn, you know I love my leather boots. I will stick with my current vision and my footwear, thank you very much. I am not a hat person.

Corn

Fair enough. I think I would take the hat. I could pull off a tiny fedora if it meant I could see a bird on a branch a mile away.

Herman

You already wear enough hats, brother. Literally and figuratively.

Corn

True. Alright, bye everyone!

Herman

Bye!

Corn

I was thinking about the cost again. Ten thousand dollars is a lot, but if you think about it, people spend that on a used car that lasts maybe five to seven years. Your eyes are for life. You use them every waking second.

Herman

That is exactly how I frame it. It is an investment in your most important sensor. If your car breaks down, you get a new one. If your vision goes, it changes everything about how you interact with the world. It is the highest return on investment you can get.

Corn

It is a perspective shift. Literally.

Herman

Nice pun. You have been waiting to use that one all hour, haven't you?

Corn

I try. Alright, we should probably actually end the episode now before we start talking about bionic eyes.

Herman

Right. See you later.

Corn

Actually, before we go, I just remembered something else. Did you see that study from late twenty twenty-five about the liquid-filled lenses that can be adjusted with a smartphone?

Herman

Oh, the ones that use a special light to change the shape of the lens weeks after the surgery? That is the RxSight technology evolving.

Corn

Yeah! It removes the pressure of getting the measurement perfect on the day of surgery. You can fine-tune it based on how the patient actually sees in the real world after they have healed.

Herman

That is the next frontier. It is called the Light Adjustable Lens, and while it is mostly for cataract patients now, the tech is trickling down to refractive surgery. It is incredible.

Corn

The future is bright, Herman. And hopefully very clear.

Herman

I see what you did there. Okay, now we are really done.

Corn

Catch you later.

Herman

This has been My Weird Prompts, a collaboration between two brothers and a very curious housemate.

Corn

And a lot of research. Bye!