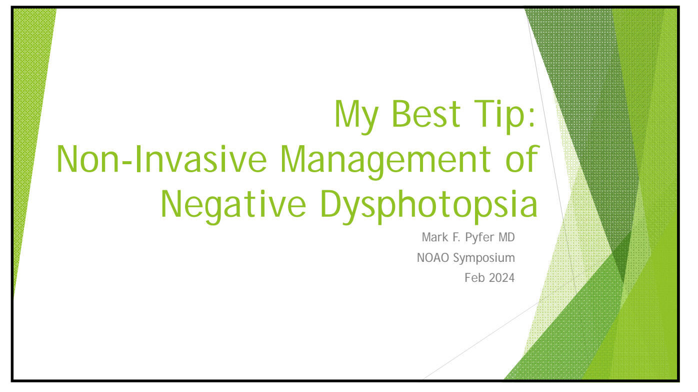
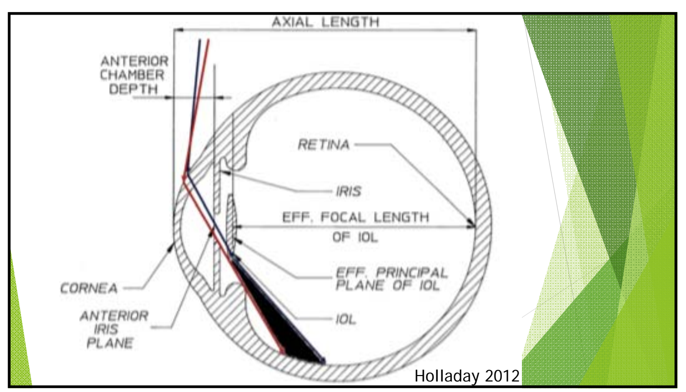
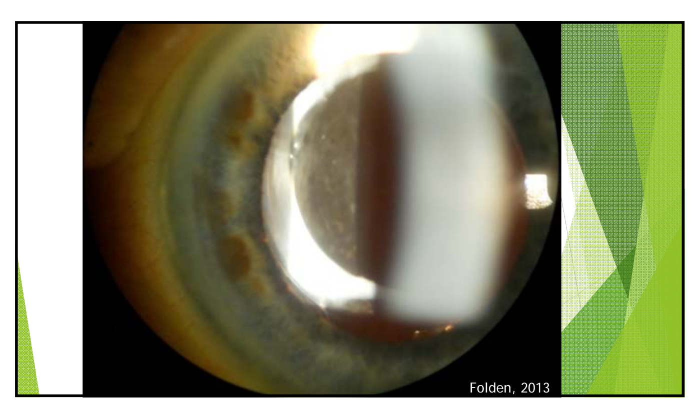


Negative Dysphotopsia

- Patients complain of crescentic shadow in temporal field of view
- Caused by shadow on nasal retina between light refracted by IOL and light passing between iris and IOL



Holladay 2012


Folden, 2013

Surgical Outcomes

Surgical management of negative dysphotopsia

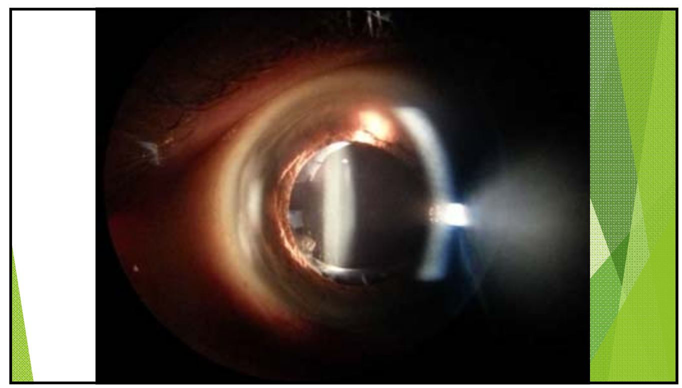
Samuel Masket, MD, Nicole R. Fram, MD, Andrew Cho, BS, Isaac Park, BA, Don Pham, BS

J Cataract Refract Surg 2018; 44:6–16 © 2018 Published by Elsevier Inc. on behalf of ASCRS and ESCRS.

Surgical Method	Resolution of symptoms
In-the-bag IOL exchange	0/5
Iris suture fixation of bag complex	0/1
Piggyback secondary IOL	8/11
Secondary reverse optic capture	21/22
Sulcus IOL exchange	7/8

How about Nd:YAG Laser Anterior Capsulotomy?

- Nd:YAG anterior capsulotomy of nasal anterior capsule resolves negative dysphotopsia in a 70 year old man - Cooke, 2012
- Nd:YAG anterior capsulotomy → complete (3/6) or partial (2/6) resolution of negative dysphotopsia - Folden, 2013



Laser Anterior Capsulotomy for Negative Dysphotopsia

- 2 clock-hour nasal anterior capsulotomy via Nd:YAG laser
- Often results in complete or near-complete resolution of negative dysphotopsia symptoms
- Does not preclude surgical management in the future if necessary (reverse optic capture or IOL exchange to sulcus)

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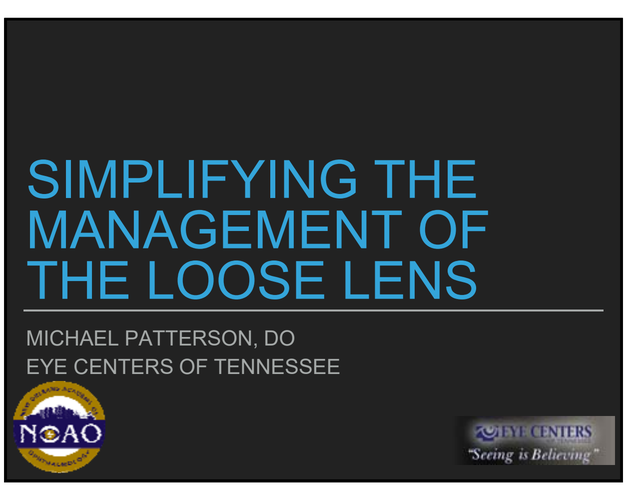
- Vámosi P, Csákány B, Németh J. Intraocular lens exchange in patients with negative dysphotopsia symptoms. Journal of Cataract & Refractive Surgery. 2010 Mar 1;36(3):418-24.



FINANCIAL DISCLOSURES:

ALLERGAN
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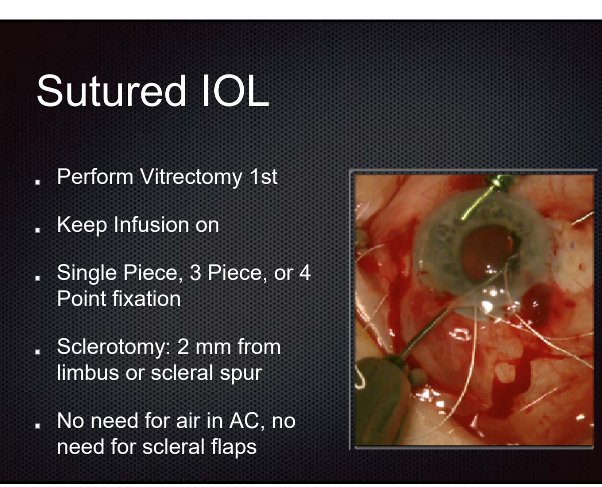
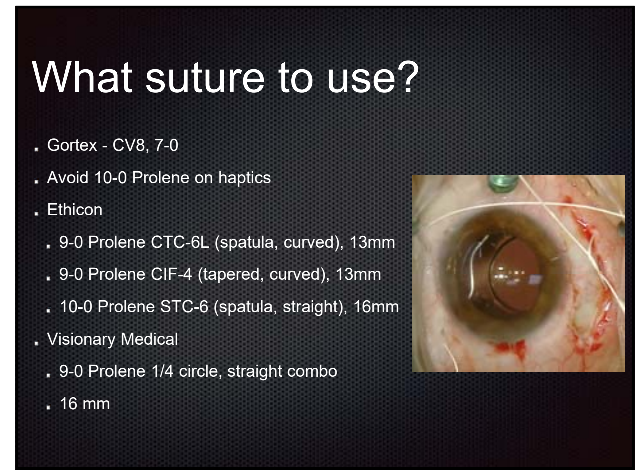
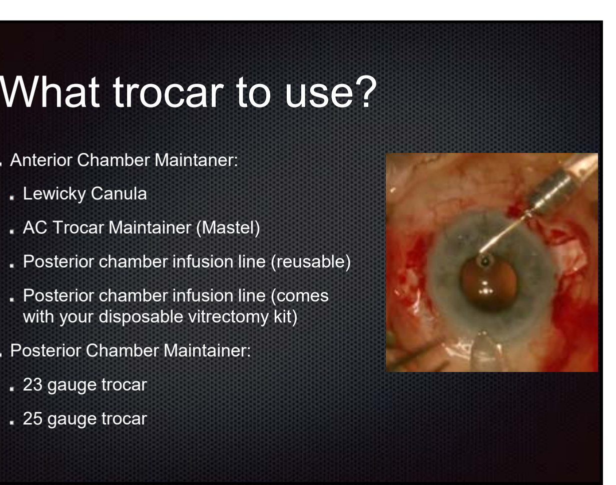
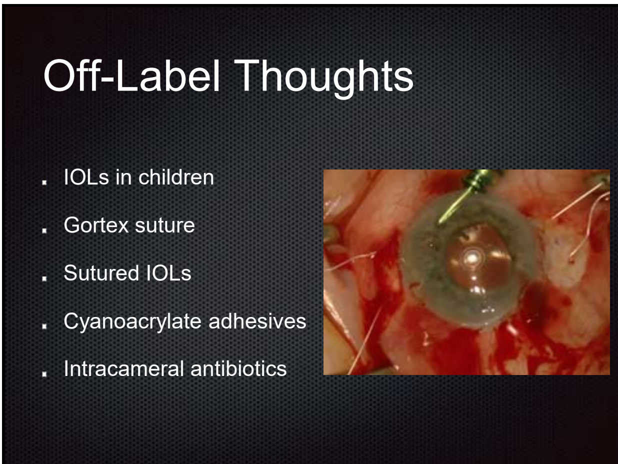
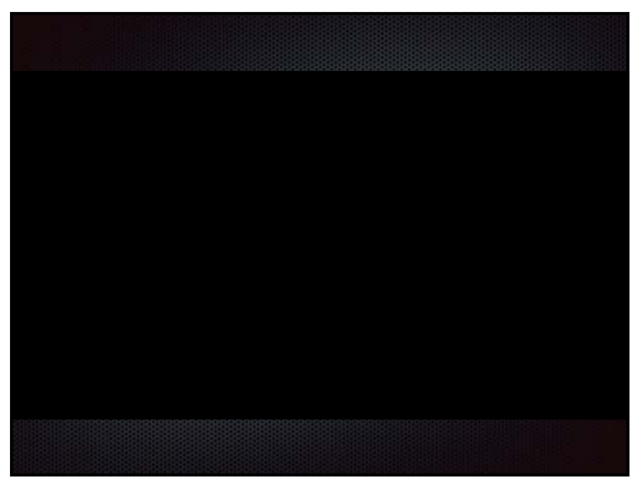
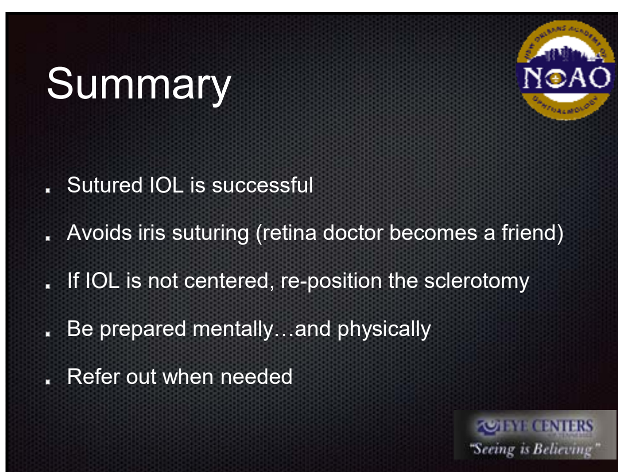


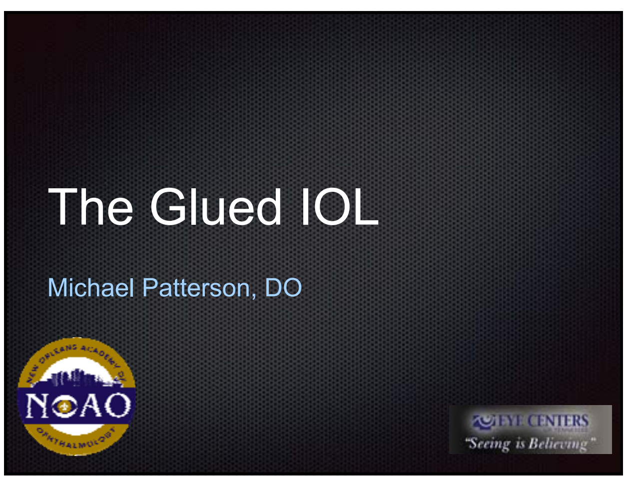


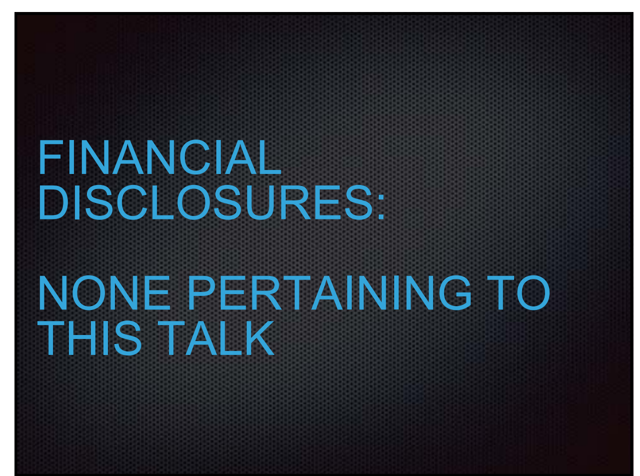


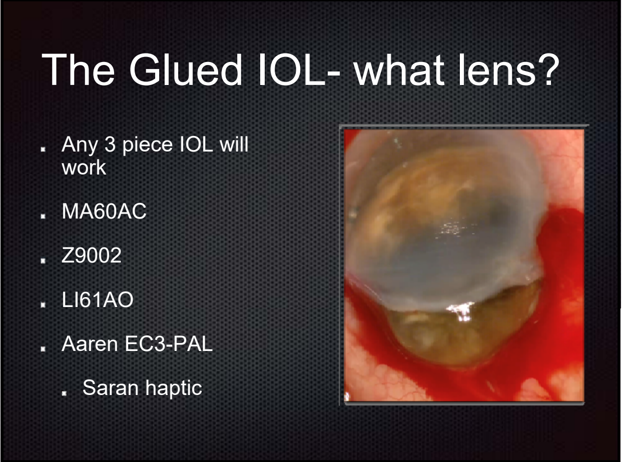

Off-Label Thoughts
IOLs in children
Gortex suture
Sutured IOLs
Cyanoacrylate adhesives
Intracameral antibiotics

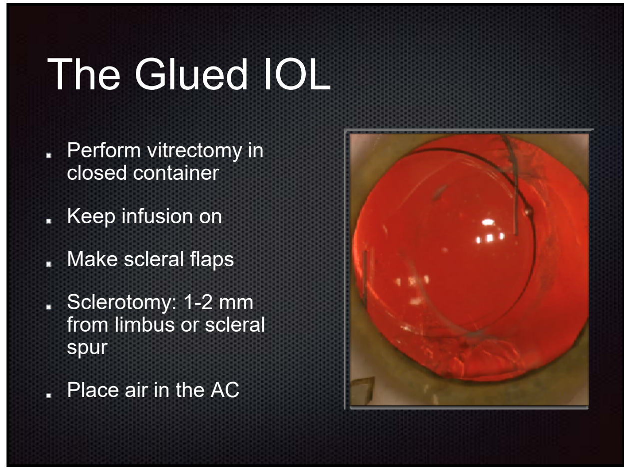


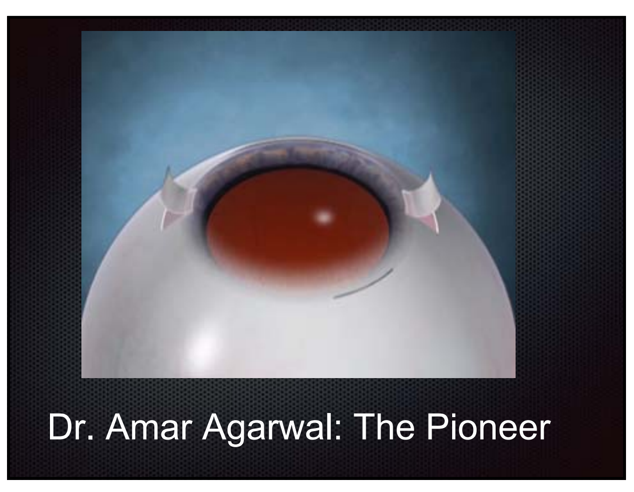

Summary
NOAO
Sutured IOL is successful
Avoids iris suturing (retina doctor becomes a friend)
If IOL is not centered, re-position the sclerotomy
Be prepared mentally…and physically
Refer out when needed
EYE CENTERS
"Seeing is Believing"


The Glued IOL
Michael Patterson, DO
NOAO
EYE CENTERS
"Seeing is Believing"


FINANCIAL DISCLOSURES:
NONE PERTAINING TO THIS TALK


The Glued IOL- what lens?
Any 3 piece IOL will work
MA60AC
Z9002
LI61AO
Aaren EC3-PAL
Saran haptic


The Glued IOL
Perform vitrectomy in closed container
Keep infusion on
Make scleral flaps
Sclerotomy: 1-2 mm from limbus or scleral spur
Place air in the AC

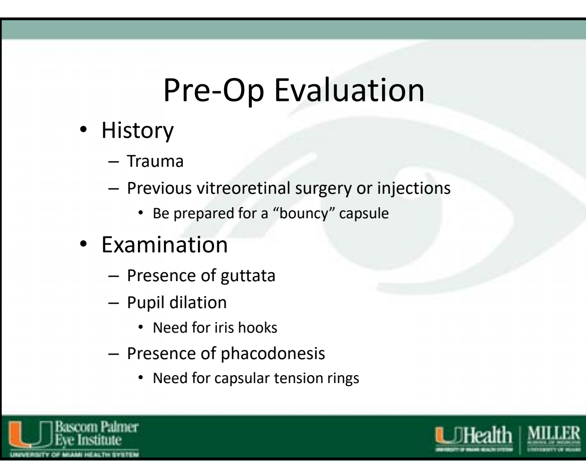

Dr. Amar Agarwal: The Pioneer

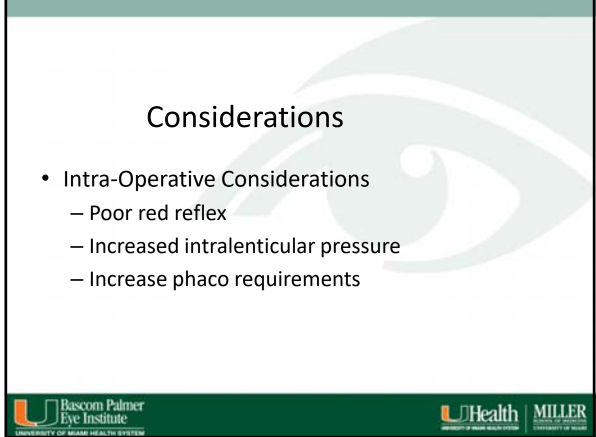
Summary

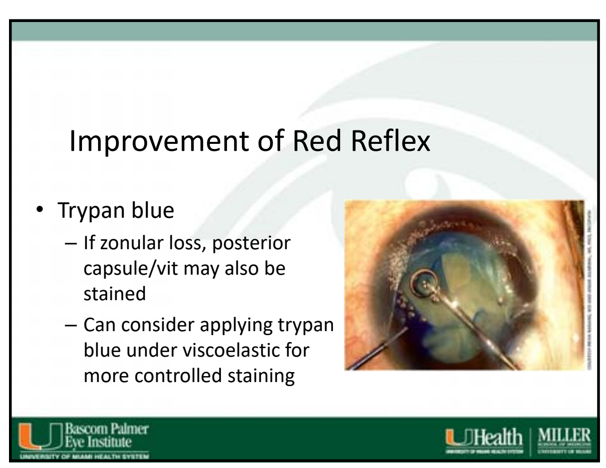
- Glued IOL is a great stable long-term option
- Avoids iris suturing (retina doctor becomes a friend)
- If IOL is not centered, re-position the sclerotomy
- Be prepared mentally…and physically
- Refer out when needed

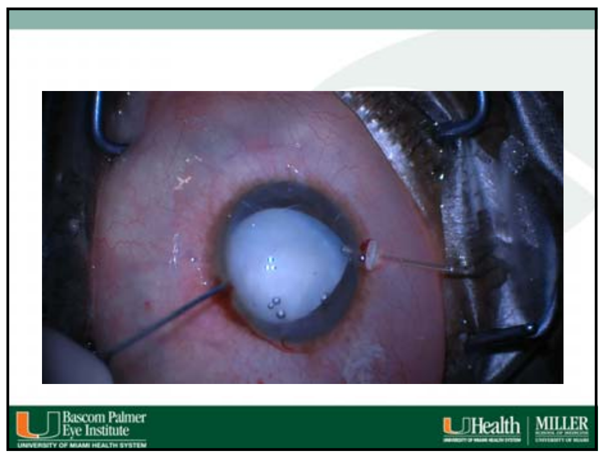
The White Cataract
Sonia H. Yoo, MD
Professor of Ophthalmology
Greentree Pruett Hickman Chair in Ophthalmology
Associate Medical Director Bascom Palmer Eye Institute
University of Miami Miller School of Medicine

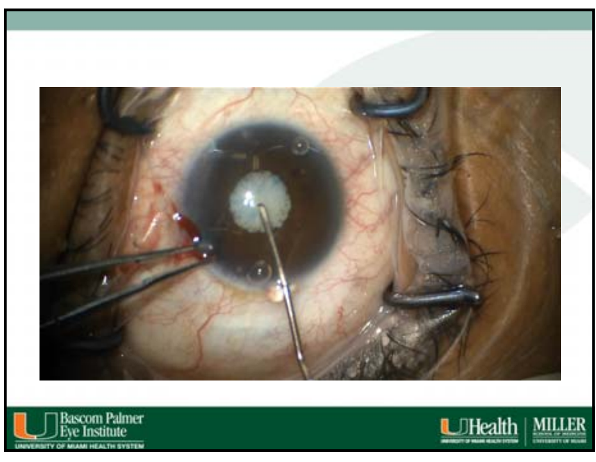
Financial Disclosures
I have the following financial interests or relationships to disclose:
Oyster Point Pharma
Carl Zeiss Meditec
Dermavant
No relevant financial disclosures to this talk


Pre-Op Evaluation
History
Trauma
Previous vitreoretinal surgery or injections
Be prepared for a "bouncy" capsule
Examination
Presence of guttata
Pupil dilation
Need for iris hooks
Presence of phacodonesis
Need for capsular tension rings


Considerations
Intra-Operative Considerations
Poor red reflex
Increased intralenticular pressure
Increase phaco requirements

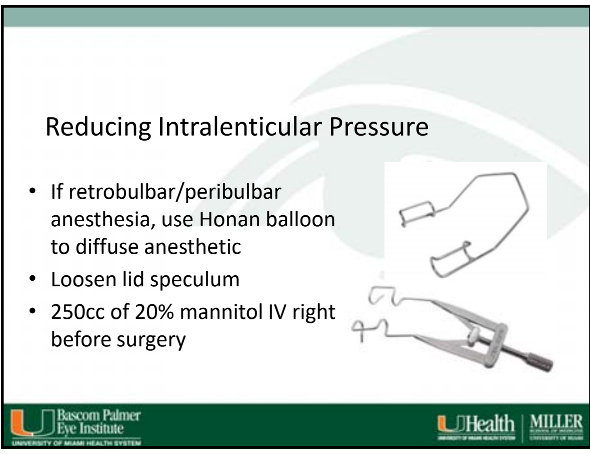

Improvement of Red Reflex
Trypan blue
If zonular loss, posterior capsule/vit may also be stained
Can consider applying trypan blue under viscoelastic for more controlled staining

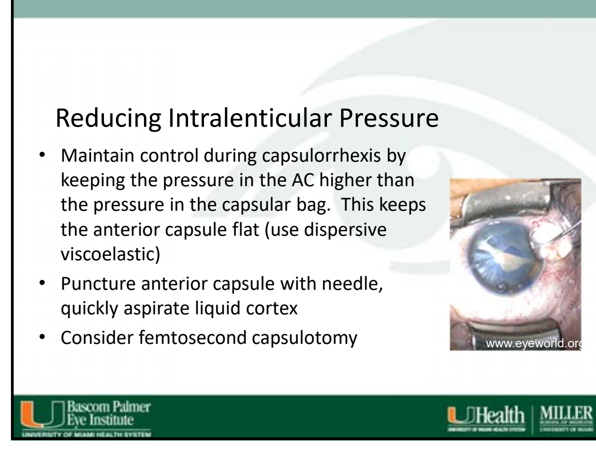


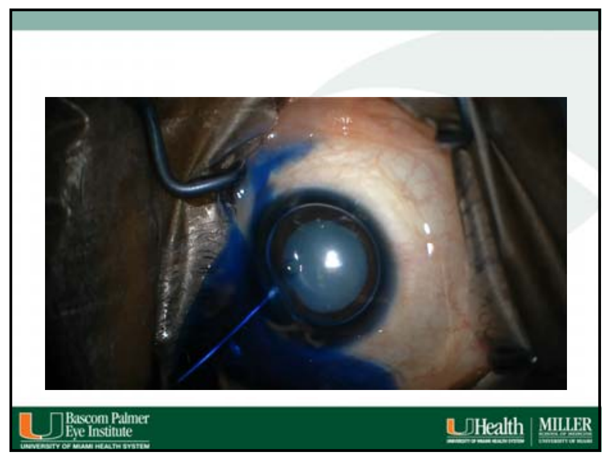


Considerations

- Intra-Operative Considerations
  - Poor red reflex
  - Increased intralenticular pressure
  - Increase phaco requirements



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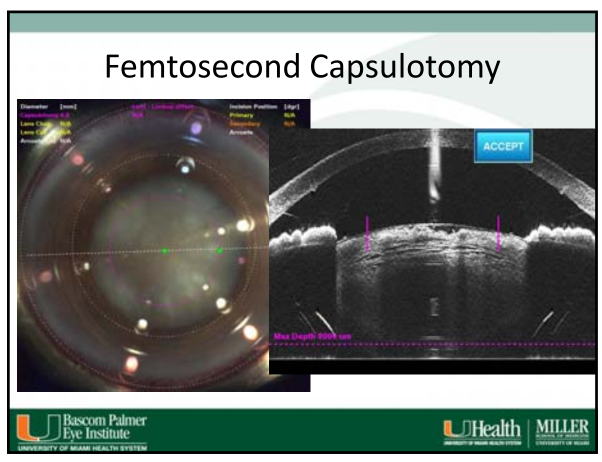
Femtosecond Capsulotomy
ACCEPT
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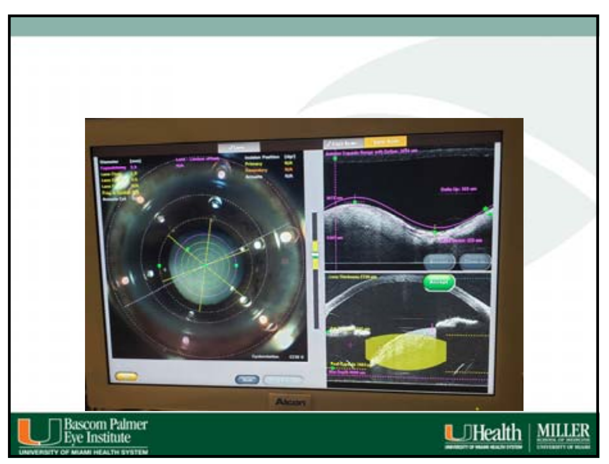
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Rhexis Recovery
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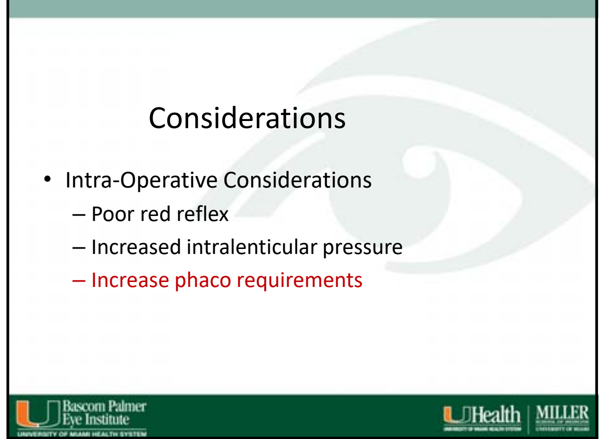
Considerations
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Summary

- Identify **preoperatively** small pupils, fibrosed capsules, loose zonules, open PC, etc…
- Stain capsule with **trypan blue**
- **Overpressurize the chamber** when performing rhexis and **maintain stability of the chamber** as much as possible with a OVD, aspirate liquid cortex
- Be aware of the **"type" of white cataract** you are dealing with

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