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## Slides

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   History of Early Cornea Transplants

2. Moones Abdalla
   Combined ICR and CxL for Moderate Keratoconus

3. Mark Terry
   A Comparison of DSAEK to DMEK: Vision, Complications and Endothelial Survival
   Slides are included

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   Ultra-thin DSAEK: What is it really, and is it as good as DMEK?
   Slides are included

6. Moones Abdalla
   SMILE for Post-keratoplasty Astigmatism

7. Abhay Vasavada
   Customised IOL Solutions for Your Patient
8 Johann Krüger

South African results of visual outcomes and patient satisfaction of cataract surgery with implantation of the Caregroup iDiff Plus Presbyopic IOL.

Dr Johann A Krüger

Aim: To assess the post-operative visual outcomes for distance, intermediate and near vision, as well as patient satisfaction in patients undergoing cataract surgery and implantation of the Caregroup iDiff Plus Presbyopic IOL.

Methods: 20 eyes of 10 patients had cataract surgery with implantation of the Caregroup iDiff Plus Presbyopic IOL. Eyes with any affection other than cataract were excluded from the study. IOL calculation was done with Holladay II. Post-operative uncorrected visual acuity and best-corrected visual acuity for distance, intermediate and near vision were recorded at 6 weeks post-operatively. A patient satisfaction questionnaire was also recorded 6 weeks post-operatively.

Results: At 6 weeks post-operatively the mean uncorrected distance visual acuity achieved was 0.8, the mean uncorrected intermediate visual acuity was 0.5 and the mean uncorrected near visual acuity was 0.8. The individual assessment of post-operative patient satisfaction revealed that the majority of patients were spectacle independent, would choose the lens again and recommend it to others.

Conclusion: The Caregroup iDiff Plus Presbyopic IOL is a safe and effective lens choice to provide good distance, intermediate and near vision with little or no night vision problems.

9 Lourens van Zyl

Visual Acuity and Patient Satisfaction Results with the New Zeiss AT LISA Trifocal Diffractive IOL

Lourens van Zyl, MBChB, FCOphth(SA), FRANZCO

South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia.

Anil Arora, MBBS, FRANZCO

Medical Director, Laser Vision Clinic Central Coast, New South Wales

Funding statement: This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Competing Interests Statement: There are no competing interests.

Purpose: The aim of the study was to evaluate the visual acuity outcomes and patient satisfaction results of a new diffractive trifocal intraocular lens.

Methods: 64 eyes of 32 patients underwent bilateral implantation with the AT LISA 839MP (Carl Zeiss Meditec). Patients had their unaided distance, intermediate and near vision measured at about 8 to 12 weeks post-op and were asked to complete a questionnaire on post-op spectacle independence, occurrence and severity of glare and haloes and overall satisfaction.

Results: 88% of patients had a monocular and 93% of patients had binocular unaided near visual acuity of N5 or better. 80% of patients had a binocular intermediate visual acuity of 6/7.5 or better. Unaided monocular distance visual acuity was 6/6 or better in 75% of patients but increased to 90% when tested binocularly. Patient satisfaction was high. 93% of patients regarded their results as very good to excellent. 88% of patients were completely spectacle independent and 91% reported that they don’t use spectacles for computer use.

Conclusion: The new trifocal IOL gives very good visual acuity and patient satisfaction results. Near vision results were all N6 or better and for the first time true intermediate distance clarity is possible. Despite photopic phenomena the Zeiss AT LISA is well tolerated.

Slides are included
Clinical outcomes of Micro-monovision with Tecnis Symphony intraocular lens.

Purpose: To assess the safety and efficacy of a new Tecnis Symphony ZXR00 intraocular lens.

Methods: In this study, 102 eyes of 51 patients bilaterally implanted with a Tecnis Symphony intraocular lens were evaluated. Micro-monovision was intended in all cases with dominant eye aimed for emmetropia and non-dominant eye aimed for a slight myopia (-0.50 D). The mean age of the study group was 57 ± 7 years and the mean preoperative spherical equivalent ranged between -6.00 and +4.13 D. Three months data are presented in this study.

Results: The mean binocular distance visual acuity was -0.06 ± 0.08 logMAR, and the mean binocular near visual acuity was 0.25 ± 0.12 logMAR. Of all patients 88% achieved binocular UDVA of 0.0 logMAR (6/6) or better, and 57% achieved binocular UNVA of 0.2 logMAR (aprox J3) or better. No eye lost 2 or more lines of best spectacle corrected visual acuity.

Conclusion: Tecnis Symphony is a good alternative to multifocal IOLs, providing good distance vision with some functional near vision.

Financial Interest: None
17 Faruk Örge

Implications of IOL Management in Infants, Recent Results from the Infant Aphakia Treatment Study

18 Andrzej Grzybowski

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Do IOL Glistenings Affect Vision?
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Fine Tuning of Light-Adjustable IOLs: Capsular Shields Protecting the Retina During Radiation Exposure

Volker Rasch

Purpose: After implantation of LAL exposure to UV radiation is necessary for the fine tuning of the refractive power of the intraocular lens. To avoid undesired dysphotopsia after the required UV radiation of implanted LAL additionally to the IOL, a capsular tension ring with iris segments was implanted in the same procedure. This reduced the amount of UV light at the retina when fine tuning the LAL.

Methods: Case report of one patient implanted with LALs: First eye without, second eye with additional CTR with iris replacing segments.

Results: After UV radiation of LAL most of the patients complain about photopsia / colourful visual sensations lasting for one day or even longer. What kind of retinal damage or disorder is created by UV radiation of LAL is not understood so far. As UV radiation is necessary with this product we wanted to reduce the amount of UV light transmitted to the retina as much as possible. As the patient complained heavily about visual disturbances after implanting LAL in the first eye, we used a conventional CTR with iris replacing segments to protect the peripheral retina in the second eye. There were no complaints by the patient in this case.

Financial Interest: No
21 Mike Holzer

Reading performance following implantation of a diffractive trifocal intraocular lens using the Salzburg Reading Desk

Mike P Holzer, MD, FEBO Safwat-Attia M, MD Linz K, MD Khoramnia R, MD, FEBO Kretz, FTAK, MD, FEBO Auffarth, MD, FEBO

Univ of Heidelberg, Dept of Ophthalmology, IVCRC, Heidelberg, Germany

Purpose: Clinical evaluation of a trifocal-toric diffractive IOL including evaluation of reading performance using the Salzburg Reading Desk.

Methods: Prospective clinical study evaluating cataract patients 3 months after implantation of the trifocal AT LISA TRI or its toric version (Carl Zeiss Meditech). Follow-up examinations included UDVA, CDVA, UNVA, DCNVA and intermediate visual acuities (UIVA, DCIVA). Bilateral uncorrected reading acuity, speed and preferred reading distance for near and intermediate vision were evaluated using the Salzburg Reading Desk.

Results: Median UDVA was 0.02 logMAR (0.16 to -0.08 logMAR) and median CDVA was -0.09 logMAR (-0.04 to -0.16 logMAR). Median UNVA was 0.07 (0.36 to -0.10 logMAR) and median DCNVA was 0.03 logMAR (0.24 to -0.06 logMAR). Median UIVA was 0.00 logMAR (0.08 to -0.14 logMAR) and median DCIVA was 0.02 logMAR (0.38 to -0.10 logMAR). Binocular distance-corrected reading performance in was -0.02 logMAR (0.11 to -0.06 logMAR) in 69.90 cm (51.30 to 77.80 cm) for preferred intermediate distance and 0.10 logMAR (0.18 to 0.02 logMAR) in 38.05 cm (34.10 to 39.80 cm) for preferred near distance.

Conclusions: The trifocal AT LISA tri IOL provides good functional results regarding far, intermediate and near vision with high percentage of spectacle independence and patient satisfaction.

Financial Interest: Travel and research Support Carl Zeiss Meditec

22 Lourens Coetzee

Evaluating the Accuracy and Predictability of Limbal Relaxing Incisions Using the De Lange Nomogram
23  Lourens van Zyl
Refinement of Pre-set Corneal Epithelial Thickness and Stromal Ablation Rate in One-step Trans-epithelial Ablations
Lourens van Zyl, MBChB, Dip Ophth, FC Ophth, MMed(Ophth), FRANZCO, Grad Dip(Refr. Surg) South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia
Peter Stewart, MBBS, FRANZCO Brisbane Laser Sight Clinic, Brisbane, Australia
Vikija Andersons MBBS, FRANZCO, FRACS Ashford Advanced Eye Care, Adelaide, Australia
Michael Goggin, FRCSI (Ophth), FRANZCO, FRCOphth, MS South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia
Data analysis support was provided by iVis Technologies, Taranto, Italy
Purpose: Verification and fine tuning of the effective depth and rate of ablation in customized trans-epithelial one step superficial excimer refractive surgery by the comparison of effective post-operative ablation depths with planned ablation depths.
Methods: 88 consecutive eyes in 64 patients undergoing trans-epithelial superficial excimer ablation for either myopic/astigmatic or hyperopic/astigmatic refractive error between January 2012 and September 2012. Each patient had at least 3 months of post-operative follow-up. Tomographic examination of all eyes was carried out pre-operatively and at 3 months post-operatively using the Precisio scheimpflug tomography system. Comparison of these two measurements yielded values for depth, volumes and rates of ablated corneal tissue. By determining the different ablation rates of stroma and epithelium, a refinement of the depth of epithelium to be removed before stromal ablation was calculated.
Results: The calculated pure stromal ablation rate was less than the average epithelium/stroma ablation rate used in planning the treatments by a factor of 0.96. The epithelial thickness constant ablation assumption used to plan removal of the epithelium was adjusted on the basis of the measured ablation and a radial adjustment function established for fine tuning of the laser radial efficiency and allowing for the normal thickening of the epithelium in the peripheral cornea.
Conclusion: Comparison of accurately measured pre and postoperative tomography yields accurately established ablation rates of stroma and epithelium in trans-epithelial one step superficial ablation.
Financial Interest: The authors report no financial interest in any of the products.
Slides are included

24  Johann Krüger
Results and Pearls with New IPCL and Toric IPCL
Dr Johann A Krüger
Aim: To discuss the implantation technique, as well as the post-operative visual outcomes and pearls with the new single piece foldable acrylic IPCL and Toric IPCL from Caregroup.
Methods: 20 eyes of 10 patients had surgery with implantation of the Caregroup implantable phakic contact lens. Post-operative uncorrected visual acuity and best-corrected visual acuity for distance vision was recorded at 6 weeks post-operatively.
Results: At 6 weeks post-operatively the mean uncorrected distance visual acuity achieved was 0.8 and the mean best-corrected visual acuity was 1.0.
Conclusion: Caregroup IPCL and Toric IPCL implantation is safe, effective and predictable and provides good distance vision in patients with moderate to high degrees of hyperopia and myopia, as well as moderate astigmatism.
25 Mike Holzer
Comparison of two combined cohesive and dispersive ophthalmic viscoelastic devices during cataract surgery

Holzer MP, MD, FEBO Auerbach FN, MD Thomas BC, MD Khoramnia R, MD, FEBO Kastlunger L, MD Rabsilber TM, MD Auffarth GU, MD, FEBO

Purpose: To compare postoperative intraocular pressure (IOP) and endothelial cell count (ECC) using 2 different combined cohesive and dispersive ophthalmic viscoelastic devices (OVDs): Twinvisc (Carl Zeiss Meditec) vs DuoVisc (Alcon Laboratories).

Methods: 54 cataract patients (age 51 - 86 years) have been enrolled in this prospective, randomized, comparative, investigator-masked trial. One eye of each patient was randomized to receive either Twinvisc or DuoVisc during cataract surgery. IOP was measured pre- as well as 6 hours, day 1, 7, 30 and 90 postoperatively. ECC measurements were done pre- and 90 days postoperatively.

Results: Median IOP 6 hours after surgery was 21.0 mmHg (Twinvisc, n=26) and 20.8 mmHg (DuoVisc, n=28). IOP peaks ≥30 mmHg have been found in 2 of 26 eyes (7.7%) for Twinvisc compared to 5 of 28 eyes (17.9%) for DuoVisc. Median ECC loss was -98.20 cells/mm² (Twinvisc, n=21) and -107.40 cells/mm² (DuoVisc, n=21) 3 months postoperatively which equals 3.79 % (Twinvisc) and 4.40 % (DuoVisc). The differences were not statistically significant (p>0.05, Mann-Whitney-U-Test).

Conclusions: Twinvisc showed less IOP peaks ≥30 mmHg than DuoVisc and a comparable minor ECC loss of approximately 4% in median. Twinvisc application was as secure as DuoVisc during cataract surgery.

Financial Interest: Travel & research support by Carl Zeiss Meditec

26 Andrzej Grzybowski
Controversies Regarding Antibiotics Use in Cataract Surgery

27 Mark Packer
The Physician-Patient Relationship in a Digital World

28 Andrzej Grzybowski
The First Idea of IOL Implantation

29 Mark Packer
What Can a Femtosecond Laser Do for Your Cataract Surgery?
Slides are included

30 Calvin Roberts
Femtosecond Assisted Phaco Free Surgery
Slides are included
31 Lourens van Zyl
Femtosecond Laser Assisted Cataract Surgery: Initial Experience From a Recent Convert
Slides are included

32 Abhay Vasavada
Femtocataract Surgery: How It Has Affected My Practice

33 Klaus Ditzen
Femto-Flap problems: Incomplete flap with suction loss
Klaus Ditzen, MD  Ophthalmic Department  Bahnhofstr 18  Weinheim, 69469  Germany
Introduction: Analyses of incomplete flap procedure working with femtosecond laser.
Materials & Methods: Working with the Visumax and Intralase Femtosecond Laser we observed 3 cases with flap difficulties. The reason were sudden eye-movements, vacuum loss or insufficient aplanation.
Results: All the 3 complicated cases could be finished with either replacement of the flap, or completing the flap with a small knife. No postoperative difficulties were noted.
Conclusion: Cases of incomplete flap could be finished with completing the flap through a small knife, or replacement.
Financial Interest: No

34 Osama Ibrahim
Femto-assisted ICR Implantation for Irregular Astigmatism: KC, post-PKP and post-RK

35 Mark Packer
Digital Imaging in the Clinic and the Operating Room
Slides are included

36 Dylan Joseph
Refractive Fellowship Course - When Irish Eyes Are Smiling
Dr DA Joseph  FC Ophth SA  MMed Ophth SA
Introduction: To give feedback on my fellowship course in lasik surgery, a course run by Alcon in Dublin, Ireland.
Methods: Discuss the technology and practical use of the Alcon Wavelight Suite in refractive surgery, and highlight pearls picked up from Mr Cummings with regards lasik surgery.
Results: Convey important learning points from a clinical and surgical perspective with regards lasik surgery.
Conclusion: A well run, superb course, giving one insight and confidence with regards the beautiful science of refractive laser surgery.
Financial Interest: None
Rookaya Mather

Corneal Pain without Stain: Neurosis or Neuropathy? A Case Report

Rookaya Mather, MBCh  Rami Abo Shasha, MD  Ivey Eye Institute  Western University  London, Ontario, Canada

Managing patients with unexplained corneal pain has been both confounding and challenging. These patients are frequently misdiagnosed as having dry eye since they experience foreign body sensation, photophobia, burning and sharp pain. Despite severe and often debilitating symptoms, there are no objective signs of dry eye. Furthermore, symptoms do not respond to conventional dry eye therapies so many of these patients are labelled as being neurotic when in fact they may be suffering from a different condition - Corneal Neuropathy. We present the case of a 54 year old female who presented with extreme photophobia, burning and pain. She was diagnosed with dry eye; using artificial tears every 5 minutes without relief. Her OSDI score was 63. Slit lamp examination was normal as was her Shirmer’s test, TFBUT and corneal sensation. Treatment with non-preserved steroid failed to improve any of her symptoms. Interestingly, she reported that her symptoms were much better with contact lens wear. Other telling symptoms of neuropathy included exaggerated pain response to touch, air and drops. Pregabalin therapy was trialed with improvement in her symptoms and OSDI score. If patients do not respond to dry eye treatments such as artificial tears and anti-inflammatories, suspect corneal neuropathy.

Financial Interest: None

James Hays

How the iTrace Helps You in Cataract Surgery

Jim Hays MD  Woolfson Eye Institute  Atlanta, Georgia USA

Although designed initially as an aid to corneal disease diagnosis, the iTrace aberrometer/topographer is very useful in cataract surgery. Obtaining a good refractive result following cataract surgery in eyes with corneal disease or previous corneal surgery can be challenging. The iTrace can separate out surface aberrations from internal aberrations, aiding in patient selection. It can help in toric lens alignment and power choices. It can aid in choosing the best lens for correcting spherical aberration. The new Dysfunctional Lens Index program helps patients better understand the benefits of refractive lens exchange. The iTrace is a handy tool for the more complicated eyes needing lens surgery.

Financial Interest: No commercial support other than slides for my slide deck

Slides are included

Osama Ibrahim

Schematic Approach to Keratoconus Management

Mohes Abdalla

Combined SMILE and CxL (SMILE extra) for Suspicious Corneas and Stabilized Keratoconus

Guy Kezirian

Kritzinger Safari Award Lecture: Refractive Surgery: Growth for Good
42 Mark Packer
Immediate Sequential Bilateral Refractive Lens Surgery
Slides are included

43 Dylan Joseph
Presbyopic solutions: The holy grail of Ophthalmology
Dr DA Joseph  FC Ophth SA  MMed Ophth UFS
Aim: To explore the mono vision options typically presented to patients in the Wellington Eye Clinic, Dublin, Ireland.
Methods: Discuss the various approaches to working up a patient for the mono vision that will best suit the individual.
Results: Thorough pre operative evaluation will maximize the post operative success of the mono vision modality used.
Conclusion: When it comes to targeting the best refractive outcome for a patient, the dictum "one size fits all" certainly
does not apply. Crucial planning and evaluation are critical in achieving a happy patient and in the end, a happy sur-
geon.
Financial Interest: None

44 Japie Vos
Initial Experience with Supracor for Corneal Presbyopia Treatment on the Technolas 217 Excimer Laser

45 Paul Roux
Capsular Bag Biocompatibility of a New Accommodating IOL

46 Frik Potgieter
Unique Aspects Related to an Accommodating IOL
Slides are included
47 Klaus Ditzen

Binocular Correction in Hyperopic Presbyopia

Dr Klaus Ditzen Ophthalmic Department Weinheim, 69469 Germany

Introduction: Binocular Correction for Hyperopic Presbyopia

Materials & Methods: LASIK was done bilateral simultaneously with the Schwind Pendular Microkeratom in combination with the Carl-Zeiss-Meditec Excimer laser MEL 80. There were treated 30 eyes: range from 41 - 54 years. The dominant eye was corrected to Zero, the non-dominant eye to max 1,5 D anisometropia. Control time one year.

Results: The outcomes after binocular correction with the mode of LASER BLENDED VISION showed a good subjective acceptance and satisfaction. There were a good stability, safety and predictability. Postoperatively all patients needed no reading glasses. No night vision and contrast-sensitivity problems were noted. Binocular vision was reduced only in the first post-op period.

Conclusion: Binocular correction of hyperopic presbyopia combines the advantage of micro-monovision, increased depth of field in both eyes. The full corrected dominant eye and the intended under-corrected non-dominant eye showed satisfactory results with neural adaption and -suppression.

Financial Interest: No

48 Marie-José Tassignon

Secondary Anterior Segment Repair of Aniridia and Aphakia

49 Andrzej Grzybowski

Iris-claw IOLs in Aphakia Management

50 Volker Rasch

Capsular Tension Rings With Coloboma-Correcting Segments - Less Stress With the Right Procedure for Implantation

Volker Rasch Maximilian Rasch

Purpose: The aim of our study was to investigate the order of implantation of a capsular tension ring (CTR) with (a) inserting iris segments first or (b) ring segment(s) first to minimize possible risk factors for capsular rupture.

Methods: Case series; so far 21 patients are enrolled in the current study.

Results: The artificial iris segments show good capability to compensate for iris defects. According to our experience the correct order of implantation is crucial for a successful implantation: The ring segment has to be implanted first, followed by the iris segment part of the device. Implanting it the other way around the procedure is more difficult with higher risk of capsular bag damage. For a safe implantation it is very important to use adequate viscoelastics (OVD).

Conclusion: Implanting the CTR with the ring segment first and using sufficient OVD will lead to a safe and uneventful procedure rather than starting the implantation with the iris segment part of the CTR.

Financial Interest: No
Lourens van Zyl
Scleral Tunnel Intraocular Lens Explantation
Lourens van Zyl, FCOphth(SA), FRANZCO South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia.
Lachlan Farmer, MBBS South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia.
Michael Goggin, FRCSI(Ophth) South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia.
Graeme Rogers, FCOphth(SA) Royal Victorian Eye and Ear Hospital, Melbourne, Australia.
This work is original and has not been presented at any meeting or published in any other journal.
The authors declare no financial conflicts of interest.

We describe an alternative method of removing an intraocular lens (IOL) without corneal incisions through a scleral tunnel. While a clear corneal incision may be favoured for IOL implantation, the current literature makes the universal assumption that this route should necessarily be favoured for explantation too. Up to date, the literature insists that the corneal wound be enlarged in order to perform an explant or proceeds to describe a technique requiring intraocular manipulation to explant an IOL through a small or pre-existing incision.

A 6 millimetre scleral tunnel is fashioned at the temporal limbus identical to a scleral tunnel in manual small incision extra-capsular cataract surgery (MSICS). The IOL is removed intact through this scleral tunnel without folding or cutting of the IOL. As the IOL is removed whole through a scleral tunnel without intra-cameral manipulation the risk of damage to anterior segment structures is minimised. Furthermore corneal incisions are not used which otherwise may stretch during the IOL explantation. The sine qua non of good surgery is adequate exposure. A scleral tunnel satisfies this priority while maintaining an astigmatically-unaltered ocular surface. This technique simultaneously provides superior exposure which may prevent complications. This technique has been proven to be astigmatically neutral with a summated vector mean of 0.014 dioptres calculated with vector analysis.

Scleral tunnel explantation is possibly safer than previously described explantation methods and causes minimal surgically-induced astigmatism making preoperative secondary IOL calculations appropriate and more accurate.

Video link: https://www.dropbox.com/s/qln9ze1x3jzgmzr/Short%20Publish%20with%20title.mov?dl=0
Slides are included

Sydney Sebiloane
Pearls and pitfalls of the bag-in-the-lens technique
Dr RKS Sebiloane, senior specialist, Sefako Makgatho Health Sciences University
Aim: A step by step description of a special intraocular lens (IOL) implantation technique is outlined. This concept is designed to prevent posterior capsule opacification (PCO).

Materials & Methods: Perfectly aligned anterior and posterior circular curvilinear capsulorhexes (CCC) are created in the anterior and posterior capsules respectively. The anterior hyaloid face is kept intact by injection of a cohesive visco-elastic. Anterior and posterior capsules are inserted into a groove of a special IOL, hence the term bag-in-the-lens. Scenarios of various challenges with the technique are described. These include wrongly-sized CCC’s, eccentric CCC’s and overzealous injection of visco-elastic.

Results: In cases of perfectly-sized CCC’s, both capsules are neatly stretched around the IOL optic. Visual axis remained perfectly clear over a five year period and beyond. In cases of wrongly-sized CCC’s, IOL slippage was observed. Overzealous visco-elastic injection caused unequal pressures anterior and posterior to the capsules leading to failed implantation.

Conclusion: This special IOL implantation concept has a steep learning curve but is very effective in preventing PCO. Of particular relevance will be patients at high risk of PCO and for future evaluation and treatment of posterior segment pathology.

Financial Interest: The author has no financial interests related to this presentation.
53 Marie-José Tassignon  
Bag-in-the-lens Implantation in Patients with Loose Zonules

54 Andrzej Grzybowski  
Floppy-iris Syndrome: Update 2015

55 Marie-José Tassignon  
Cataract Surgery in Rock-hard Cataracts

56 Mike Holzer  
Diagnostic and surgical specifications for toric IOL implantation and experiences with the Precizon Toric IOL  
Mike P Holzer, MD, FEBO  J Eisenmenger  V Friederich  S Laupp  B C Thomas, MD  
Univ of Heidelberg, Dept of Ophthalmology, IVCRC, Heidelberg, Germany  
Purpose: A high number of patients undergoing cataract surgery have a significant amount of corneal astigmatism ≥0.75 D that can be corrected with toric intraocular lenses (tIOL).  
Methods: Preoperative diagnostics and surgical specifications for tIOL usage and clinical outcomes following implantation of the hydrophilic Precizon Toric IOL (Ophtec) were evaluated. Intended versus achieved IOL position one week postoperatively and visual acuity outcomes were measured.  
Results: 33 eyes of 23 patients received a Precizon Toric IOL with a cylindrical power between 1.0 and 5.5 D. The median IOL rotation was 2° with a range from 0° to 8°. Uncorrected distance visual acuity increased from median 1.0 logMAR preoperatively to median 0.1 logMAR at 3 months postoperatively.  
Conclusion: Preoperative diagnostics, IOL selection and correct intraoperative positioning of tIOLs are essential for good outcomes and postoperative spectacle independence. Surgical guidance systems can help placing tIOLs precisely in the capsular bag and reduce postoperative re-rotation rates for these premium IOLs. Visual outcomes and rotational stability of the Precizon Toric IOL showed very good outcomes.  
Financial Interest: Ophtec: Research and travel support  Alcon: Research, travel support and lecture fees

57 Mark Packer  
Improving Accuracy with Toric IOLs  
Slides are included
58 Lourens van Zyl

Adjustment of Anterior Corneal Astigmatism Values to Incorporate the Likely Effect of Posterior Corneal Curvature for Toric IOL Calculation

Lourens van Zyl, FCOphth(SA) South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia.

Michael Goggin, FRCSI(Ophth) South Australian Institute of Ophthalmology, University of Adelaide, Adelaide, Australia.

This work is original and has not been presented at any meeting or published in any other journal.

The authors declare no financial conflicts of interest.

Funding statement: This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Competing Interests Statement: There are no competing interests.

Purpose: To evaluate the refractive outcome of adjustment of corneal astigmatism values to incorporate the likely effect of posterior corneal curvature for toric IOL calculation

Methods: 17 consecutive eyes underwent phacoemulsification with toric IOL powers calculated using anterior corneal curvature data adjusted by a nomogram to include the likely effect of posterior corneal curvature and were compared to a consecutive series without adjustment. The effect of posterior corneal curvature is relatively constant and influences the combined anterior and posterior corneal power according to the “rule” of the anterior corneal power. The nomogram is based on previous observation of outcome in eyes receiving toric IOLs calculated on anterior corneal curvature data alone, when analysed by “rule” and suggests a co-efficient of adjustment of 0.75 for WTR eyes and 1.41 for ATR eyes.

Results: Mean absolute error of the power of the refractive astigmatic outcome was reduced by over half from 0.48D (SD 0.43) without adjustment to 0.23 D (SD 0.19) with adjustment by the above method (p<0.05).

Conclusion: To improve outcome prediction a co-efficient of adjustment of 0.75 for WTR eyes and 1.41 for ATR eyes was applied to the corneal astigmatism power value to calculate a more appropriate IOL cylinder power than that calculated by using unadjusted anterior corneal curvature measurements. This lead to a reduction in the mean error of astigmatic power outcome that was both statistically and clinically significant.

Slides are included

59 Marie-José Tassignon

New Insights About Anterior Vitreo-lenticular Interface
60 Helena Cilliers

Cataract surgery outcome in patients with Intra-vitreal Dexamethasone / Ozurdex implant for Retinal Vein Occlusions

Dr Helena Cilliers  Dr Andleeb Zafar  Dr Lubna Razzaq  from Warwick Hospital, South Warwickshire NHS Foundation Trust

Objective: To determine visual outcome following cataract surgery in patients who had treatment with intra-vitreal Dexamethasone / Ozurdex Implant for Retinal Vein Occlusions (RVOs). Whether there is a difference in visual acuity outcome in patients who had Ozurdex, Ranibizumab / Lucentis or Bevacizumab / Avastin at time of surgery.

Method: Retrospective review of patients who required cataract surgery following Ozurdex for RVO’s. Demographic data: Types of RVO’s & information on course of treatment. Findings after cataract surgery are determined by change in visual acuity (VA), change in central macular thickness (CMT) & morbidity from glaucoma & endophthalmitis.

Results: 40 (33.9%) of 98 (83.1%) phakic patients required cataract surgery on average 16.8 (3 – 34) months after first Ozurdex treatment. Patient age ranged from 46 – 87 years; mean of 71.3 years. Male=21; Female=19 CRVO=19; HRVO=3; BRVO=18 (1 had died). 45% had cataract surgery with intra-vitreal injection, 6 (15%) with Ozurdex, 6 (15%) with Lucentis and 6 (15%) with Avastin. Completed cataract surgery outcome data by August 2015 will be discussed in detail including all patients to date.

Conclusion: Intra-vitreal Ozurdex lead to cataract progression in 29.85% in the GENEVA study. Conclusions will be drawn from our data to determine whether cataract surgery significantly improves vision & if additional intra-vitreal treatment at the time of surgery is of benefit.

Financial Interest / Grants: Advisory Board and Travel Grants from Allergan

61 Marie-José Tassignon

YAG Laser Vitreolysis of Vitreous Floaters

62 Andries Stulting

Epstein Memorial Award Lecture

63 Jan Venter

Initial experience with the small incision lenticule extraction (SMILE) to treat myopic refractive error.

JA Venter  Optical Express UK  Port Elizabeth Eye and Laser Institute

Initial experience with the small incision lenticule extraction (SMILE) to treat myopic refractive error.

Purpose: To evaluate initial outcomes of the SMILE procedure in a small cohort of myopic patients.

Methods: A total of 31 eyes of 16 patients were included in this study. Preoperative myopia ranged between -1.50 D to -7.50 D (mean -3.57 ± 1.32 D). The mean cylinder of the study population was -0.60 ± 0.61 D and the mean age was 29.6 ± 7.3 years. Visual acuity and refractive error were recorded postoperatively. Data of the last available visit were used for analysis (mean follow-up 3.5 ± 2.6 months)

Results: The mean postoperative spherical equivalent reduced to 0.10 ± 0.32 D with 96.8% of eyes (30 out of 31) within ± 0.50 D of emmetropia. Of all eyes, 83.9% had postoperative UDVA of 6/6 (0.0 logMAR) or better. Corrected distance visual acuity changed from -0.06 ± 0.05 logMAR to -0.05 ± 0.05 logMAR, with no eye losing 2 or more lines of CDVA. No intraoperative or postoperative complications were recorded in this study.

Conclusion: SMILE is a safe and predictive surgical technique for correction of myopic refractive error.

Financial Interest: None
64  Osama Ibrahim  
Long Term Follow Up of Over 5000 Eyes of SMILE for Myopia

65  Klaus Ditzen  
SMILE-Procedure: Femtosecond laser Correction for Myopia and Astigmatism  
Klaus Ditzen Ophthalmic Department  Bahnhofstr 18  Weinheim, 69469  Germany  
Introduction: Femtosecond laser VISUMAX con cut out from the corneal stroma a Special Cup to correct astigmatism and myopia.  
Material and Methods: With Visumax Femtosecond laser (Carl-Zeiss-Meditec) it is possible to take off a tissue lenticule out of the corneal stroma using the SMILE procedure(Small incision lenticule extraction). After cutting the posterior part of the lenticule the anterior part will be cut. After a peripheral cut of 3 mm there will be solved the lenticule first from the anterior side, second from the posterior side and take off out from the Cornea with a forceps.  
Results: On another Location (Dr Meyer, Cologne, Germany) it will shown all together 400 eyes with correction of myopia 'till -8 D and astigmatism 'till -6 D.  
Conclusion: Good stability, safety and predictability were seen with SMILE (Small incision lenticule extraction).  
Financial Interest: No

66  Moones Abdalla  
SMILE for Hyperopic and Mixed Astigmatism

67  Frik Potgieter  
SMILE for Myopia and Myopic Astigmatism

68  Osama Ibrahim  
SMILE Beyond Myopia and Myopic Astigmatism

69  Moones Abdalla  
SMILE Technique: Pearls and Pitfalls
Courses

Course 1: Basic Phaco-emulsification
- Phaco-emulsification in the 21st Century. An overview of the procedure of phaco-emulsification, preparations and selections of patients as a novice surgeon, surgical steps and management of routine phaco cataract surgery in the learning phase of this procedure.
- Phacodynamics. A discussion of the fluidics and ultrasonics of phaco-emulsification technology, and ways to improve efficiency and speed in phaco cataract surgery.

70 Stephen Beaty

Course 2: Pediatric Cataract Surgery
- Infant and pediatric cataract surgery videos of each step and instruction / tips.
- Discussion of the newest Infant Aphakia Treatment Study results and impact on pediatric cataract surgery care.
- Managing the anomalous pediatric lens (sublimed lens management, removal, and videos of IOL in settings lacking capsular support. This includes the Artisan IOL surgery in children.

Tips and guideline sharing for managing the pediatric aphakic or pseudophakic patient in the office.

71 Erick Bothun

72 Marie-José Tassignon

73 Abhay Vasavada

74 Faruk Örge

75 Jacobus Pauw
Course 3: DALK
Purpose: To standardize a rather new and "unpredictable" surgical technique and make it affordable to the average corneal surgeon.

76 Massimo Busin
- Deep trephination for standardized DALK: How to substantially shorten your learning curve.
- The small "big-bubble" technique for DALK.

77 Mark Terry
- DALK: A standard technique that improves operating time and avoids complications.
- DALK: Intra operative OCT insights.

Slides are included

Course 4: MIGS for the Comprehensive Cataract Surgeon
The Clinical Pearls and Pitfalls of combining Minimally Invasive Glaucoma Surgery (MIGS) with cataract surgery will be discussed and illustrated. The practicalities of introducing MIGS techniques such as i-Stent, Trabectome or Canal Expander to your armamentarium as a comprehensive cataract surgeon will be discussed, with specific reference to IOP results, indications, contra-indications, surgical techniques and tips, prevention and management of complications and choice of procedures.

78 James Hays
Slides are included

79 Petrus Gous

80 Mark Packer
Slides are included

81 Jacobus Pauw

82 Marissa Willemse
Course 5: Endothelial Keratoplasty

Purpose: To standardize a rather new and “unpredictable” surgical technique and make it affordable to the average corneal surgeon.

83 Massimo Busin
- DSAEK for Challenging cases.
- Endothelial Keratoplasty: Which technique today?
- Pull-through technique for standardized DMEK graft delivery.

84 Mark Terry
- A Standardized DMEK Technique with a short learning curve to improve results and minimize complications.
- DSAEK: Complications and how to avoid them.
- DMEK: How to decide when to re-bubble and when not to re-bubble.

Slides are included

Course 6: Management of Posterior Capsule Rupture

Posterior capsule rupture (PCR) is one complication every cataract surgeon will encounter. However, it is crucial that the situation is managed effectively in order to achieve 2 goals –

a) preventing further enlargement of the PCR along with vitreous management, and
b) being able to implant an intraocular lens (IOL) in the capsular bag.

This course will highlight and discuss through actual cases, different scenarios where PCR occurs and how the surgeon should effectively manage the situation in order to ensure consistent outcomes. It will also discuss the role of pars plana vitrectomy versus limbal vitrectomy for the cataract surgeon. Using the pars plana approach will make sure that we do not exert additional traction on the vitreous from top, as well as will prevent enlargement of the PCR as we are pulling the vitreous down instead of pulling it up. It will also show, in a stepwise manner, how the anterior segment surgeon can easily perform anterior vitrectomy through the pars plana approach, without the need for any special instrumentation or a retinal surgeon.

85 Abhay Vasavada

Course 7: Management of Difficult Cataracts & Challenging Situations

This course shall attempt to identify the challenges arising during emulsification of difficult cataracts in adverse environments and discuss surgical strategies to deal with them successfully. It will highlight appropriate surgical options for a reproducible and optimum outcome whenever the surgeon encounters difficult situations. Situations such as posterior polar cataracts, malpositioned IOLs and subluxated lenses will be discussed. At the end, the attendee will be able to choose the most appropriate surgical strategy to effectively manage complicated cataract cases.

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Course 8: Highlights from the Physician CEO™ Program: “Designs for Practice Growth.”

CEOs lead, they do not manage. Leadership is about strategy, values and purpose. Medical practices hold patient benefit as core value. It is time for physicians to recapture leadership in medicine - it is time for the Physician CEO™. www.Physician-CEO.com

The Physician CEO™ program is offered at the Kellogg School of Management at Northwestern University outside of Chicago, which is a globally top-ranked business school for executive education. The program is offered on an annual basis to physicians and is focused specifically to impact practice growth.

Dr. Kezirian will present highlights from the Physician CEO™ program. The premise underlying the program is that physicians can and must provide the leadership for effective medical systems, and the program gives physicians the tools they need to do so. Topics include: Finance, Leadership, Marketing, Negotiations, Operations and Strategy.

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    Slides are included