

# Amar Agarwal, MS, FRCS, FRCOphth

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## Why did you choose to become an ophthalmologist?

My parents, Drs. J. Agarwal and T. Agarwal, were ophthalmologists and founded Dr. Agarwal's Eye Hospital in Chennai, India, in 1957. When I was 10 years old, they taught me to suture onion leaves. I was mesmerized by my parents' surgical skills, and ever since then, I wanted to become an ophthalmologist.

## What are the unique features of your hospital?

The hospital is built in the shape of an eye. In other words, it is an eye in concrete. The pupil is the entrance, the lens is the reception area, and a ramp depicts the optic nerve. My parents designed and built this eye-shaped hospital, and it has been featured in "Ripley's Believe It or Not." In 2006, we decided to expand the group. We currently have 60 hospitals, seven of which are located outside India, with more than 200 eye doctors and about 2,500 employees. We perform all phaco cases with an air pump that has gas-forced infusion to prevent surge. This was started by my sister, Sunita Agarwal.

## What has your experience with the glued IOL technique revealed about its advantages?

Intrascleral haptic fixation was first performed by Gabor Scharioth, MD, from Germany, who is not only an excellent surgeon but also a great human being. We started creating scleral flaps and using tissue glue to seal the flaps and the IOL haptics. The advantage of using a glued IOL can be understood through the analogy of a camera lens. Imagine a dislocated camera lens that is fixed to the camera body with sutures or clips. The photographs will be of poor quality because the lens moves. If the lens is glued to the camera's body, the lens will not move, and the picture quality will be very good. We demonstrated this using a high-speed camera that takes 250 frames per second with the help of Dr. Abhay R. Vasavada, FRCS, from India.

There is no pseudophakodonesis with a glued IOL; it does not move like a sutured IOL. When gluing an IOL, it is essential to externalize enough of the haptic to tuck and glue. It is also important not to use an ophthalmic viscosurgical device alone to form the chamber. Adding fluid infusion through an anterior chamber maintainer or trocar cannula is preferable.

I performed the glued IOL technique on my 85-year-old mother-in-law, who is aphakic in both eyes and has endothelial cell counts of 1,400 cells/mm<sup>2</sup>. Her visual acuity is now 20/20. If I had made a mistake during surgery, my wife would have cut me into so many small pieces that I would not have been able to reply to these five questions.

## What advice can you offer regarding how to be an effective presenter at clinical meetings?

The key is to always speak from the heart and talk only about what you do. It is also effective to show surgical videos, as one video is worth a thousand words. Listen to other exceptional speakers such as David F. Chang, MD; Richard Packard, MD, FRCS, FRCOphth; H. Burkhard Dick, MD, PhD; Robert Osher, MD; and Brian C. Little, MA, DO, FRCS, FRCOphth, and try to emulate them.

## How has the experience of traveling throughout the world benefited you as a physician and an individual?

The experience has been terrific. I have met so many people all around the world. By interacting with fellow ophthalmologists from various parts of the world, I have learned a lot and improved my surgical skills. I have also made many friends on every continent. The love I have received from all the people with whom I have come in contact is what I will take with me when the Almighty calls me. ■

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