

# SAY ANYTHING

## WHAT IS THE BIGGEST LESSON YOU HAVE LEARNED DURING A COMPLICATED CATARACT PROCEDURE?



**JESSE RICHMAN, MD**

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“ I’ve learned over the years that it is important to keep yourself calm during a complicated surgery. Often, when a complication occurs, or when you sense one may, your heart rate increases, and it’s easy to make the situation worse. Take a few breaths and slow down. If I suspect a capsule problem, I’ll ask for an additional OVD to be opened before I’m even certain there is a real issue so that no one has to scramble for it should one occur. If a challenging surgery develops a true complication, I don’t rush the surgery in order to simply finish. I take my time and try to fix everything as well as possible. Lastly, I revert to basic surgical principles such as paying attention to fluidics, making sure instruments are neutral through the incisions and not distorting them, and placing a suture through a large incision to stabilize the chamber to make sure vitreous cannot easily move anteriorly—when retina surgeons perform a vitrectomy, they work in a closed chamber, and we should too.”



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“ Sometimes, cataract surgery becomes complicated by severe zonular weakness, such as in patients with advanced pseudoexfoliation or prior ocular trauma. In these situations, it is sometimes not possible to successfully place an IOL in the capsular bag. It can be tempting to try and place a sulcus IOL, but when there is a large zonular dialysis (especially inferiorly), a sulcus IOL can migrate through the zonular defect and become decentered. It can also be tempting to place an anterior chamber IOL (ACIOL) in these situations to provide vision rehabilitation for patients with a single surgical procedure. I want to explain why I believe this is not the best approach for most patients.

In these situations, my recommendation is to complete the cataract removal safely, let any nuclear pieces go if they have migrated into the vitreous cavity, perform an anterior vitrectomy if indicated, and leave the patient aphakic. (Come back to fight another day, so to speak.) Patients are often best served by taking a conservative approach—and that may mean leaving them aphakic for a little while, letting their corneal edema clear, and then returning to the OR to place an IOL in a more controlled setting. I have seen numerous patients on referral who had IOLs placed in the bag, sulcus, or anterior chamber, only to have postoperative subluxation of the IOL or other complications that then required additional surgery to fix. These surgeries are often made more difficult by having to remove malpositioned hardware placed at the time of the initial surgery (frequently an ACIOL). The incision needed to place (and remove) an ACIOL is large, which can induce significant irregular astigmatism in addition to other issues with ACIOLs, such as pseudophakic bullous keratopathy, ocular hypertension, and cystoid macular edema, among others.



**ONLINE SURVEY RESPONDER**

“ Getting well prepared before surgery is the most important part, and taking over early from a junior surgeon who is underperforming is never a bad decision.”

My preferred technique is to leave the patient aphakic initially and then return to the OR 2 to 3 weeks later, once their corneal edema has cleared. This may require anterior segment surgeons to work alongside a posterior segment surgeon who can perform a thorough pars plana vitrectomy. When there is inadequate capsular support for an IOL in the bag, I like to place a scleral-fixated IOL using the Yamane technique. This typically requires the use of a special-order IOL (my IOL of choice is a CT Lucia 602 [Carl Zeiss Meditec]), but until that IOL arrives, the patient can be fitted with an aphakic soft contact lens for temporary vision improvement. In the end, patients can see exceedingly well with an IOL that is unlikely to result in late dislocation or corneal edema.” ■