APACRS EyeWorld DailyNews
Saturday Agra 2014
The official show daily of AIOC 2014 Agra
February 8, 2014

AIOC 2014 Gala Event:
The Bollywood Nights huge success

by Erin L. Boyle EyeWorld Senior Staff Writer

A colorful display of Bollywood dancing capped off the Gala Event at this year's 72nd Annual Conference of AIOS & Diamond Jubilee of IJO, with a large crowd that joined in and enjoyed the festivities.

The Bollywood Nights event at the Gala featured "heart-throbbing dance sequences" and Filmfare Award Winner Playback Singers. The night also featured a laser show and lots of celebrities.

Attendees enjoyed a delicious display of local and regional cuisine at the Gala dinner.

According to the Bollywood

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Impale a lens like Dracula:
Unique aspects of phaco burst mode

by Erin L. Boyle EyeWorld Senior Staff Writer

Using an interesting comparison—that the microburst mode of phaco, which is not often used by ophthalmologists, can be compared to the likes of Count Dracula—**Keiki R. Mehta, MD**, Mumbai, discussed how to use this mode of phacoemulsification with equally interesting results.

After his talk, Dr. Mehta explained:

"Like Count Dracula, who was originally known as Vlad the Impaler, one can impale a lens utilizing a phaco tip," he said. "And once the lens is impaled on it, utilizing the microburst technology, which is available in virtually all phaco machines, you can manage to impale the lens and thereby split it into its component parts with comparative ease."

"It's a brilliant part of a phaco machine, which is something you really should use," he said of the burst mode during his talk.

Presenting about the technology at the "Basics of phaco machines, dynamics, & how recent technology is used" session, Dr. Mehta joined a host of other Indian experts on the topic of phaco machines, including their use and possibilities, led by **Lahane Tatyarao Pundlikrao, MD**, Mumbai. Dr. Mehta's talk was "Burst mode in phaco in supra hard cataracts."

Dr. Mehta talked about how with this technology, once the nuclear tip has become embedded in a

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Keiki R. Mehta, MD

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Greetings from the 4th ACS 2014, Taiwan!

On behalf of all Ophthalmological colleagues and friendly people in Taiwan; we are truly honored to welcome our colleagues from all over the world to Taipei, Taiwan participating in the 4th Biennial Scientific Meeting of the Asia Cornea Society (4th ACS 2104) which will be held from December 11 to 12, 2014.

Taking this wonderful opportunity, we sincerely invite you to attend the meeting and take advantage of this special occasion to renew contacts, exchange ideas and results of the latest development. I believe with your support and participation, we will make this meeting successful and remarkable!

Taipei City is an international class metropolis, and Taiwan is an island of beautiful resources and people. On behalf of local organization team of Taiwan, we express our sincere invitation with greatest hospitality and look forward to welcoming you all in Taipei.

Sincerely yours,

Fung-Rong Hu
President, The 4th Biennial Scientific Meeting of the Asia Cornea Society
President, The Ophthalmological Society of Taiwan

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No cataract too complicated

by Chiles Aedam R. Samaniego EyeWorld Asia-Pacific Senior Staff Writer

Despite advances in phacoemulsification techniques and technologies, complications continue to occur in modern cataract practices. A session yesterday morning tapped into expert opinion demonstrating techniques to handle these difficult and varied cases.

In the case of a patient with cataract and high myopia, **Arup Chakrabarti, MD**, Kerala, was able to perform a routine, uncomplicated cataract surgery. However, implanting the 3-piece hydrophobic IOL, the lens had been folded in reverse—a first for Dr. Chakrabarti—so that the IOL was flipped anteroposteriorly. Yet it wasn't until 4 weeks postop when the patient returned complaining of monocular diplopia with dysphotopsias.

The IOL was grossly displaced superotemporally. The posterior capsule had ruptured. Dr. Chakrabarti decided to reposition the lens.

His technique was simple: injecting copious amounts of dispersive OVD below the cornea to protect the endothelium and above the posterior capsule to prevent the IOL from dropping into the vitreous, he moved the IOL into anterior chamber, flipped the lens, and implanted in the sulcus.

For flipping the lens, Dr. Chakrabarti cautioned that the surgeon should ensure adequate OVD; otherwise, the procedure was as simple as it sounds: ultimately, he said, sometimes you just don't need to overthink things.

Cyres K. Mehta, MD, Mumbai, treated a case of ectopia lentis with what he called the Bag-to-the-Wall technique. The surgeon should begin with a small, centered rhexis since there is a tendency for the tear to extend. In these cases, he cautioned, a laser might not be useful since it could position the rhexis under the iris, and for the technique the rhexis needs to be properly centered and fully exposed.

The bag is then pulled up by the rhexis edge with iris hooks; the surgeon should be careful of letting the edge slip since the rhexis will tend to curl up on itself. The cataract is removed using a chop technique, and the remaining cortex removed using 200 to 300 mm Hg of vacuum. A capsular tension ring is then inserted for support and to restore the shape of the bag.

A prolene suture is inserted through the leading haptic of a 1-piece IOL; using a straight needle, the suture is inserted into the anterior chamber and passed through the fornix. The suture is pulled through as the lens is inserted and the leading haptic pushes the capsular bag against the wall—hence the name—and the suture is locked by passing the needle twice through the conjunctiva.



Attendees learn to manage phaco complications from experts.

Meanwhile, in a case with an opaque cornea, Dr. Mehta demonstrated how the use of a light pipe inserted into the anterior chamber can allow the surgeon to perform cataract surgery without first performing keratoplasty.

The different possibilities for treating subluxated cataracts—among the most common of phaco complications—represent the state of cataract surgery in the face of complications today. **Chitra Ramamurthy, MD**, Bangalore, described the many different approaches she uses to address the problem. Among them are the use of capsule hooks to provide traction as well as good visibility in cases with poor capsular support, and the employment of other devices such as the Cionni ring and iris clip lenses.

These different strategies, provided for by the many available devices for cataract surgery, she said, mean that surgeons can address subluxated lenses—and, indeed, virtually any phaco complication—during either the primary or secondary surgery. **EW**

AIOC continued from page 1

Tourism web site, Bombay was the first Indian city to screen "Cinematography," six short films by Lumiere Brothers. The year was 1896. The first silent feature film was made in India in 1913 and since then, the film making industry here has exploded, finding global mass appeal at the turn of the 21st century.

"Apart from regular screenings at major international film festivals, the overseas market contributes a sizeable chunk to Bollywood's box office collections. Investments made by major global studios such as 20th Century Fox, Sony Pictures, and Warner Bros was confirmation that Bollywood had etched itself on the global psyche," the Bollywood Tourism site said.

In 2003, approximately 30 film



production companies were listed on the National Stock Exchange, showing the true appeal of Bollywood and its continued financial success. **EW**

Impale continued from page 1

hard lens, "the tip does not generate any ultrasound energy, which is a waste," he said. "It just stays within the confines in the lens."

"The big advantage of it is that the cornea, the next day, remains pristine clean," he said.

He said that this mode of phaco could be incredibly useful, even though it remains an unexplored aspect of the phaco machine for many.

"Utilizing this sort of a technology, the microburst, which so often is ignored by most people who tend to simply use pulse and think that pulse phaco is the end-all and be-all of phaco surgery, enables you to do the hardest cataracts with the greatest of ease," Dr. Mehta said.

The fact that this mode is available on nearly all phaco machines makes it useful as a possibility for different scenarios, he said. For instance, he discussed another method using the microburst technology, wherein the surgeon can core out the middle of a hard lens.

The microburst technology can "core out the hard lens utilizing minimum aspiration. Just set it on 80, which is enough to keep the full core available, keep the tip open, and you remove the central core."

"By doing that, you convert the hard lens into a donut — when you split it, there's really nothing left in the middle. If you can remove the middle of a hard lens, a hard lens is a hard lens no more," he said. **EW**

Patient selection important to best outcomes in multifocal IOL cases

by Erin L. Boyle EyeWorld Senior Staff Writer

Proceed with caution in implanting multifocal lenses in patients with perfectionist personalities, because these lenses are not for everyone, said **Mahipal S. Sachdev, MD**, New Delhi.

"Any type A, anxious personality may not be the best person to go in for a multifocal lens," he said.

At the "Premium IOLs: Clinical Pearls" session, Dr. Sachdev outlined the use of multifocal lenses for cataract patients. He said that cataract surgery is moving closer and closer toward a standard of obtaining perfection in visual results, and is now targeting emmetropia, which changes the game a bit from the past, when patients expected glasses after cataract surgery.

"Targeting emmetropia essentially means that we are wanting to reduce or eliminate the dependence on glasses, for near, intermediate, and distance," he said.

This change has occurred alongside the profile of the cataract patient changing, he said.

"People remain active much later in life after their retirement. They want to do active things," Dr. Sachdev said. "Also there is an increase in the incidence in the patients in the younger age having cataract, and so therefore the lifestyle is demanding."

These patients are often educated and aware of the new technologies available. They can be economically independent and willing to spend money for these lenses.

But simply because the market is there does not mean that every patient is a good candidate. The technology behind how a multifocal lens works is important to understand because it can dictate who might be a good candidate—and who might not. These lenses show two or more images that are formed at the same moment on the eye. One image is clear while the others blur. The brain ignores the out-of-focus images, only accepting the clear image, Dr. Sachdev explained.

> *"Any type A, anxious personality may not be the best person to go in for a multifocal lens"*

"So this needs some amount of neuroadaptation," he said.

This neuroadaptation process is key to issues in some patients: "There are going to be patients who may not get adapted to this particular thing."

He advised counselling patients about the potential drawbacks of neuroadaptation, being clear about how the lenses work. Examining for pre-existing astigmatism is also important in these cases. EW



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Gonioscopy vital test in glaucoma, physician says

by Erin L. Boyle EyeWorld Senior Staff Writer

Testing is key to proper diagnosis of glaucoma, with gonioscopy, Goldmann applanation tonometry, and full history important, a physician said.

Chandrima Paul, MD, Kolkata, presented on the topic of diagnosis of glaucoma in "What should I do? My patient has an IOP of 24 mm Hg in one eye" in a session called "An Appointment with Glaucoma."

"The take-home message [of my talk] is that when you diagnose glaucoma, you must do a gonioscopy before you put patients on medication," she said after the talk. "Diagnostic tests for glaucoma for IOP should be seen with Goldmann applanation tonometry. Gonioscopy should definitely be done – this examination is mandatory – and finally, the visual field," she said.

These tests are key to confirming diagnosis and determining glaucoma severity, according to Dr. Paul.

"But the main take-home message, for all ophthalmologists, for treating glaucoma patients, is they must do an applanation tonometry with the Goldmann applanation tonometer and gonioscopy to see if the angle is closed or open before you start the patient on any anti-glaucoma medication," she said.

During her talk, Dr. Paul said that certain tests help determine certain information about glaucoma patients – for instance, Goldmann applanation tonometry is now considered the most effective method for testing IOP. OCT can help examine ganglion cell thickness and the retinal nerve fiber layer, while the Heidelberg Retina Tomograph is more related to the disc, she said.

Making sense of IOP fluctuations is very important, research shows, but physicians should remember how studies have also shown that not all ocular hypertension patients progress to glaucoma. If a patient has elevated IOP alone and does not show issues on diagnostic testing, Dr. Paul follows that patient to watch for signs of progression to the disease or worsening of vision. But she is careful about how she approaches the patient about this, she said, because she does not want to scare the patient about the disease, but wants them to instead enjoy their lives without fear of blindness before progression can be confirmed with testing.



Chandrima Paul, MD, emphasizes the value of testing to the diagnosis of glaucoma.

"In that case, I'd just advise the patient to come for an annual examination with a free mind and just to carry on with that," she said.

If the patient showed glaucomatous damage on testing and high pressure, she would establish a glaucoma management pattern that would support the patient, and settle his or her fears by educating them about the disease so they would not be afraid of it, but instead learn how to properly manage it.

"I would support [the patient], I would teach him to use the drops regularly, and I would advise him that glaucoma is not cancer. We can treat the disease," she said. "I would encourage him because when you're always worrying about the future, you forget to live in the present. And that's true for each one of us."

At the end of the session during the discussion period, **Sood Devindra, MD**, New Delhi, who led the session, asked Dr. Paul "what would you follow as a bare-minimum work-up for your glaucoma patients?"

She replied, "Basically, for any glaucoma patients, you need to take a good history. Because family history is important. A drug history is important. Following that if you go for more tests, I would definitely recommend Goldmann's tomography reading, followed by OCT, gonioscopy, a disc examination, and a field."

Other physicians also presented on the topic including **Prateep Vyas, MD**, Indore, who followed Dr. Paul's talk. He discussed "Is this optic disc glaucomatous? What next."

"Disc examination is very critical in diagnosis and follow-up of glaucoma," he said. "Careful examination of the disc is of paramount importance."

He said that normal discs might not look similar, creating the possibility for differing diagnosis. He showed an image of an optic disc and said that physicians might diagnosis the same case differently, and for good reason: not all abnormal discs are glaucoma, but some might think they are.

"Correlating visual field changes are important in diagnosis," he said, as well as quantification of visual defect.

He said that difficult discs are not uncommon, and it can be difficult to determine whether a patient is glaucomatous or not for even the most experienced physician. EW

Femto lasers: Ophthalmic surgery's multi-tool

In an ongoing phase 4 prospective study, **Mike Holzer, MD**, Heidelberg, and his colleagues are comparing femtosecond laser cataract surgery—specifically using the VICTUS femtosecond laser platform (Bausch + Lomb, Rochester, NY/Technolas Perfect Vision, Munich, Germany)—with conventional manual cataract surgery.

Currently, their data shows no significant difference between the two procedures in terms of visual acuity, IOP, flare, effective lens position, and average phaco time. However, in terms of effective phaco time, they have thus far noted a greater than 50% reduction using the femtosecond laser.

At the moment, said Dr. Holzer, the main advantage of femtosecond laser machines is that they offer the potential to be ophthalmic surgery's multi-tool: one platform has the potential for use in a wide range of applications. The VICTUS in particular currently has U.S. Food and Drug Administration approval for flap creation, capsulotomy, and arcuate incisions. Femtosecond lasers also have the potential to be used for a number of other procedures including various techniques for presbyopic correction, corneal tunnel ring preparation, various penetrating and lamellar keratoplasty procedures.

Dr. Holzer is attending the meeting as a guest speaker. EW

Techniques: Paddle chopping the femto cataract

by Chiles Aedam R. Samaniego EyeWorld Asia-Pacific Senior Staff Writer

"We all think that managing the femtofragmented nucleus is easy," said **Ronald Yeoh, MD**, Singapore. "It should be easy, but the crucial point is that the nuclear division done by the laser is actually not complete."

The reason being, he said, that all femto platforms leave 500 microns of the nucleus uncut to avoid rupturing the capsule.

Complete separation of the fragments is a crucial part of the procedure, so surgeons need to modify their technique.

Dr. Yeoh considered two options: first, creating a groove and pushing the fragments aside. But then, he said, "Why have you bought a million-dollar femtolaser machine if you're still going to do phaco?"



Ronald Yeoh, MD

The second option is to do a variant of the direct chop, impaling the nucleus along the line of the groove and using a direct chop to separate it. However, when Dr. Yeoh used this technique, he felt "quite uncomfortable," "clumsy," and "really looked amateurish."

"I really felt uncomfortable and I thought there must be a better way," he said.

The answer lay somewhere in the past.

About 20 years ago, said Dr. Yeoh, **Takayuki Akahoshi, MD**, Tokyo, introduced the prechop technique. The technique, however, did not catch on: though it worked very well in Dr. Akahoshi's hands, the average surgeon could not replicate his results.

The scenario changes with the use of the femtosecond laser: You can insert the original ring chopper created by Dr. Akahoshi into the groove created by the laser.

However, Dr. Yeoh identified two problems with using Dr. Akahoshi's original ring chopper: first, his original choppers were designed when incisions were much larger than they are now; using them today can stretch the incision.

Second, the ring design could sometimes retain lens fragments from previous procedures.

Dr. Yeoh thus redesigned the instrument by slimming it down and filling in that hole, creating what he calls the "paddle prechopper." Surgeons can insert the paddle prechop-

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Femto cataract: Marching ahead

by Chiles Aedam R. Samaniego EyeWorld Asia-Pacific Senior Staff Writer

Despite criticism from skeptics, femtosecond lasers for cataract surgery continue to tantalize experts with the promise of a paradigm shift akin to the introduction of phacoemulsification in the age of ECCE. A session held yesterday examined the knowledge gathered by some of the most fervent femto believers from experience with the technology over the last 2 years.



Attendees listening to the session.

7 Ps

The advantages of femtosecond laser-assisted cataract surgery, believes **Mathew Kurian, MD**, Bangalore, can be summed up into "7 Ps": Precision, Pristine cuts, Predictability of Phacofragmentation, Phacodonesis, Patient comfort, and Pan cataract—the last highlighting the efficacy of femtosecond lasers in addressing virtually any kind of cataract.

Dr. Kurian uses the LenSx (Alcon, Fort Worth, Texas) with the new Soft Fit patient interface, which reduces corneal molding and lowers the increase in IOP on docking to 16 mmHg.

"Pan cataract"

The experience of **Kasu Prasad Reddy, MD**, Hyderabad, reinforces Dr. Kurian's last P. Dr. Reddy is the first ophthalmic surgeon in India to perform femtoseond laser-assisted cataract surgery—he's since performed over 1,520 cases, with, "by the Grace of God," as he likes to put it, not one complication, not a single nucleus dropped. His list of procedures includes a wide variety of challenging cases, some of which some surgeons might balk at with conventional phacoemulsification.

These cases include posterior polar cataracts in cases in which an accommodative lens—in which a perfectly centered and sized capsulotomy is crucial; calcified cataracts; white intumescent cataracts; traumatic cataracts; cases post retinal detachment; and cataracts with an implantable collamer lens.

He has even used the femtosecond laser to perform a case that required both an anterior and posterior capsulotomy.

Dr. Reddy uses the VICTUS femtosecond laser platform (Bausch + Lomb, Rochester, NY/Technolas Perfect Vision, Munich, Germany).

"Constant updating"

In the 2 years since the procedure was introduced, the technology has undergone "constant updating." Currently, said **C.M. Wavikar, MD**, Thane, developers are looking into integrating the therapeutic and diagnostic aspects of the platform, with the Alcon Refractive Cataract Suite attempting to integrate the laser platform with diagnostic instruments such as OCT imaging (already integrated into the VICTUS, which has real-time OCT imaging).

Other developments he said ophthalmic surgeons require from the technology include nomograms for femtosecond laser arcuate incisions, more comprehensive sets of cut patterns for the different platforms, the ability to perform lenticular extraction procedures and corneal pockets (currently limited to the VisuMax femtosecond laser platform from Carl Zeiss Meditec, Jena, Germany).

In the future, said Dr. Wavikar, surgeons will be able to use femtosecond lasers even with opaque corneas, for vitreous adhesions, lentotomy, the creation of multifocal corneas and/or lenses, corneal crosslinking, intracorneal device implantation, and a wide range of other applications.

Reception

And yet, despite all this potential, the initial response to femtosecond laser-assisted cataract surgery was "lukewarm," said Sanjay Chaudhary, MD, New Delhi.

Improvement in patient awareness and education has since improved the reception of the technology, but initially the aggressive publicity of enthusiastic users who "went overboard" to tout the technology's initially unestablished capabilities reinforced by the mismatch between those promises and the actual results led to much skepticism.

In addition, he said, the cost was "badly placed," particularly in India—femtosecond laser-assisted cataract surgery packages were initially priced at three times the cost of conventional cataract surgery, an additional expense disproportionate to the actual value added to the conventional procedure. In certain international markets where the technology's initial reception was less skeptical, Dr. Chaudhary said the femto procedure was only marked up 0.2x the price of conventional.

Add to this what Dr. Chaudhary considered the Indian mindset, which seemed to find the cost of femtosecond laser-assisted cataract surgery appropriate for a procedure such as cardiac surgery—but not for cataracts.

Enthusiasts have also struggled with the technology's "selling punch line": initially, said Dr. Chaudhary, those wishing to promote the technology went for labeling femtosecond laser-assisted cataract surgery a "bladeless" procedure, but the branding did not work the way it did for "bladeless" femtosecond laser LASIK.

More acceptable, he said, was highlighting the procedure's safety and—though not unanimously supported by current data—better visual outcomes. Post cataract surgery emmetropia rates, for instance, are now approaching those of LASIK.

In any case, the acceptance of the procedure has certainly improved 2 years later. Dr. Chaudhary said that there were three times more femtosecond laser-assisted cataract surgery procedures performed in 2013 than in 2012, and the numbers continue to rise, with some experts projecting a five-fold increase from 2013 to 2014. **EW**

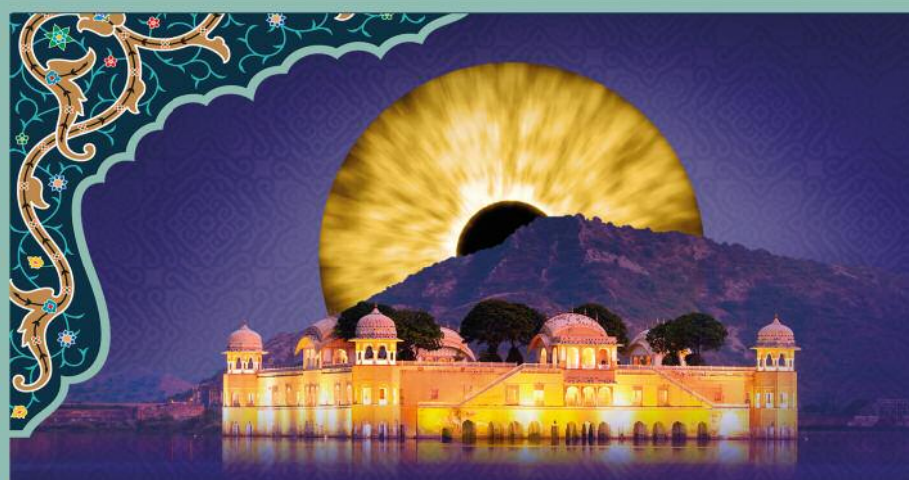
Techniques-continued from page 6

per into the grooves created by the femtosecond laser to split it into quadrants.

His new chopper, he said, makes it "much, much easier and safer to remove the nuclear quadrants and not make us look like idiots trying to remove these partially divided quadrants."

Dr. Yeoh introduced the paddle prechopper to audiences at yesterday's "Curbside Consultation" session. Chaired by **D. Ramamurthy, MD**, Coimbatore, the session was formatted as an interactive panel discussion designed "to drive home as many take-home messages to the delegates," said Dr. Ramamurthy.

From year to year, he added, "Curbside Consultation" has been one of the AIOS Annual Conference's most successful sessions. **EW**



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Dear Friends & Colleagues

After the overwhelming success of the 26th APACRS in Singapore in July 2013, the APACRS is moving on to the second most populous country in the world, India. As we have seen in recent cataract and refractive surgery meetings, there have been many significant contributions to the scientific literature and film festivals from the Indian subcontinent. It is timely therefore that we return to India for the first time in 17 years.

We have deliberately chosen the city of Jaipur, the capital of Rajasthan as the venue for the meeting. Jaipur is at the heart of the "golden triangle" in Indian tourism, the other two points of the triangle being Delhi and Agra where the unmissable Taj Mahal is located. The meeting will be held in the wonderfully designed Fairmont Jaipur which is reminiscent of an old Indian fort. It is near the famous Amber Fort and nature reserves. We have chosen 13-16 November 2014 as the date of the meeting as the weather is at its finest then, warm in the day and cool in the night.

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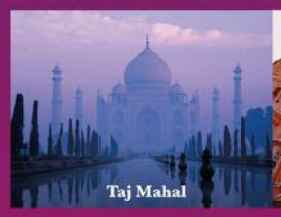
Must See in and around Jaipur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