

# A TITLE EXAMPLE

Just an example of a subtitle that can be a bit longer

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# 1 Introduction

This document aims at demonstrating the capabilities of Quarto's document automation. The document is based on the [Setif](#) template.

## 2 Code blocks using R

### 2.1 Tables

```
mtcars |>  
  knitr::kable()
```

Table 1: mtcars R dataset

	mpg	cyl	disp	hp	drat	wt	qsec	vs	am	gear	carb
Mazda RX4	21.0	6	160.0	110	3.90	2.620	16.46	0	1	4	4
Mazda RX4 Wag	21.0	6	160.0	110	3.90	2.875	17.02	0	1	4	4
Datsun 710	22.8	4	108.0	93	3.85	2.320	18.61	1	1	4	1
Hornet 4 Drive	21.4	6	258.0	110	3.08	3.215	19.44	1	0	3	1
Hornet Sportabout	18.7	8	360.0	175	3.15	3.440	17.02	0	0	3	2
Valiant	18.1	6	225.0	105	2.76	3.460	20.22	1	0	3	1
Duster 360	14.3	8	360.0	245	3.21	3.570	15.84	0	0	3	4
Merc 240D	24.4	4	146.7	62	3.69	3.190	20.00	1	0	4	2
Merc 230	22.8	4	140.8	95	3.92	3.150	22.90	1	0	4	2
Merc 280	19.2	6	167.6	123	3.92	3.440	18.30	1	0	4	4
Merc 280C	17.8	6	167.6	123	3.92	3.440	18.90	1	0	4	4
Merc 450SE	16.4	8	275.8	180	3.07	4.070	17.40	0	0	3	3
Merc 450SL	17.3	8	275.8	180	3.07	3.730	17.60	0	0	3	3
Merc 450SLC	15.2	8	275.8	180	3.07	3.780	18.00	0	0	3	3
Cadillac Fleetwood	10.4	8	472.0	205	2.93	5.250	17.98	0	0	3	4
Lincoln Continental	10.4	8	460.0	215	3.00	5.424	17.82	0	0	3	4
Chrysler Imperial	14.7	8	440.0	230	3.23	5.345	17.42	0	0	3	4
Fiat 128	32.4	4	78.7	66	4.08	2.200	19.47	1	1	4	1
Honda Civic	30.4	4	75.7	52	4.93	1.615	18.52	1	1	4	2
Toyota Corolla	33.9	4	71.1	65	4.22	1.835	19.90	1	1	4	1
Toyota Corona	21.5	4	120.1	97	3.70	2.465	20.01	1	0	3	1
Dodge Challenger	15.5	8	318.0	150	2.76	3.520	16.87	0	0	3	2
AMC Javelin	15.2	8	304.0	150	3.15	3.435	17.30	0	0	3	2
Camaro Z28	13.3	8	350.0	245	3.73	3.840	15.41	0	0	3	4
Pontiac Firebird	19.2	8	400.0	175	3.08	3.845	17.05	0	0	3	2
Fiat X1-9	27.3	4	79.0	66	4.08	1.935	18.90	1	1	4	1
Porsche 914-2	26.0	4	120.3	91	4.43	2.140	16.70	0	1	5	2
Lotus Europa	30.4	4	95.1	113	3.77	1.513	16.90	1	1	5	2
Ford Pantera L	15.8	8	351.0	264	4.22	3.170	14.50	0	1	5	4
Ferrari Dino	19.7	6	145.0	175	3.62	2.770	15.50	0	1	5	6
Maserati Bora	15.0	8	301.0	335	3.54	3.570	14.60	0	1	5	8
Volvo 142E	21.4	4	121.0	109	4.11	2.780	18.60	1	1	4	2

TODO: long tables does not repeat header and the bottom is crushed

```
quakes |>  
  knitr::kable()
```

Table 2: dataset JohnsonJohnson

lat	long	depth	mag	stations
-20.42	181.62	562	4.8	41
-20.62	181.03	650	4.2	15
-26.00	184.10	42	5.4	43
-17.97	181.66	626	4.1	19
-20.42	181.96	649	4.0	11
-19.68	184.31	195	4.0	12
-11.70	166.10	82	4.8	43
-28.11	181.93	194	4.4	15
-28.74	181.74	211	4.7	35
-17.47	179.59	622	4.3	19
-21.44	180.69	583	4.4	13
-12.26	167.00	249	4.6	16
-18.54	182.11	554	4.4	19
-21.00	181.66	600	4.4	10
-20.70	169.92	139	6.1	94
-15.94	184.95	306	4.3	11
-13.64	165.96	50	6.0	83
-17.83	181.50	590	4.5	21
-23.50	179.78	570	4.4	13
-22.63	180.31	598	4.4	18
-20.84	181.16	576	4.5	17
-10.98	166.32	211	4.2	12
-23.30	180.16	512	4.4	18
-30.20	182.00	125	4.7	22
-19.66	180.28	431	5.4	57
-17.94	181.49	537	4.0	15
-14.72	167.51	155	4.6	18
-16.46	180.79	498	5.2	79
-20.97	181.47	582	4.5	25
-19.84	182.37	328	4.4	17
-22.58	179.24	553	4.6	21
-16.32	166.74	50	4.7	30
-15.55	185.05	292	4.8	42
-23.55	180.80	349	4.0	10
-20.00	180.00	0.00	0.0	100

## 2.2 Raw outputs

```
glm <- glm(mpg ~ disp, data = mtcars)
glm
```

```
Call: glm(formula = mpg ~ disp, data = mtcars)
```

```
Coefficients:
```

(Intercept)	disp
29.59985	-0.04122

```
Degrees of Freedom: 31 Total (i.e. Null); 30 Residual
```

```
Null Deviance: 1126
```

```
Residual Deviance: 317.2 AIC: 170.2
```



## 2.3 Plots

```
glm <- lm(mpg ~ disp, data = mtcars)
plot(mpg ~ disp, data = mtcars) # add general linear model dashed line
abline(glm, col = "blue", lty = 2)
```

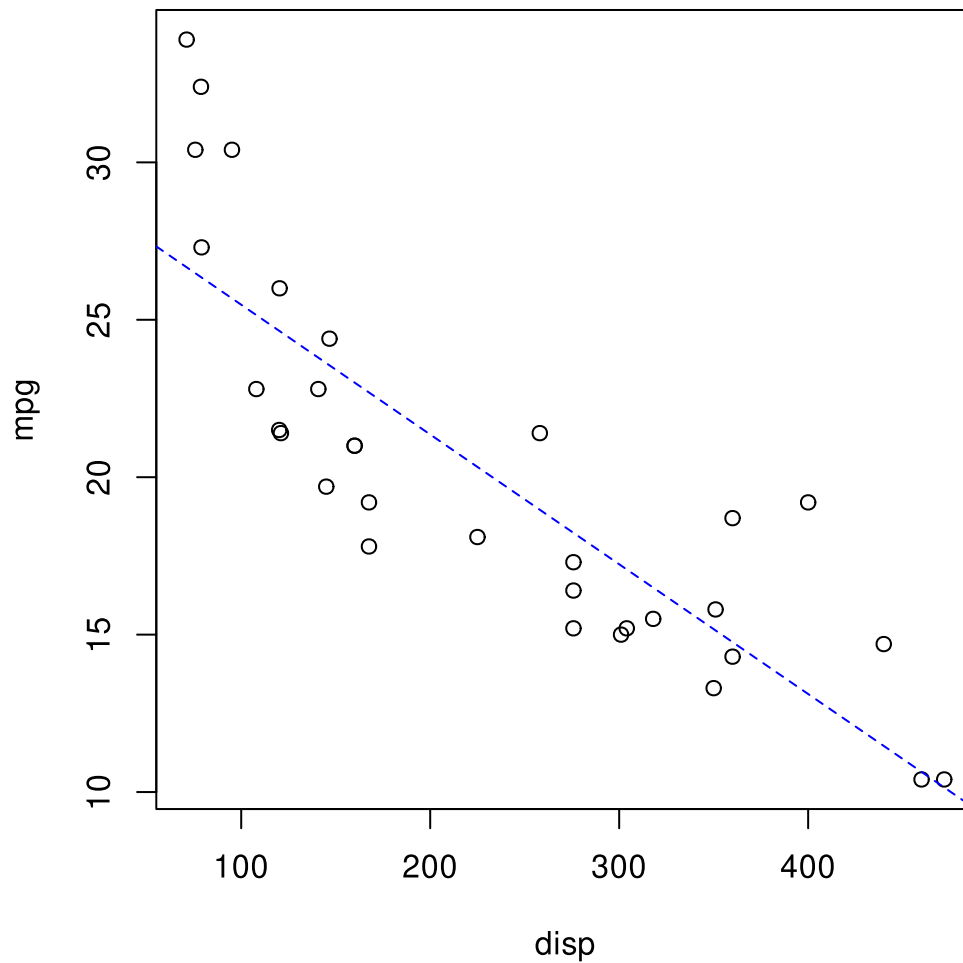


Figure 1: The figure describes the relationship between displacement and miles per gallon based on the mtcars dataset

## 3 Cross ref and refs

### 3.1 Cross references

The code block presented in [Section 2.1](#) uses R to generate a table. The `mtcars` dataset is shown in [Table 1](#).

## 4 Inline code blocks for automatic reporting

Here we can present an example of an inline code block. This is very useful for automatic reporting as we can use variables to include them directly in the text. For instance, the mean mpg of cars is shown 20.090625 (i.e. the previous number was generated using the `mean()` function from the base package).



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# Macular hole surgery: the healing process of outer retinal layers to visual acuity recovery

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## ABSTRACT

**Purpose:** To evaluate optical coherence tomography (OCT) modifications of outer retinal layers as determinants for functional recovery after surgery for idiopathic macular hole (IMH).

**Methods:** This prospective study included 23 eyes of 23 consecutive patients who underwent vitreoretinal surgery for IMH. We excluded patients with other retinal diseases. Baseline and follow-up evaluations at months 3 and 6 included complete ophthalmologic and instrumental evaluations. Functional evaluation was performed by Best Corrected Visual Acuity (BCVA) and Amsler test. Morphologic evaluation was performed by spectral-domain 3D-OCT (Topcon, Tokyo, Japan) for a deep analysis of retinal layers as well as central retinal thickness evaluation. A standard 23-G or 25-G vitreoretinal surgery was performed, completed by posterior hyaloid and inner limiting membrane peeling by means of vital dyes and gas tamponade. Statistical analysis was performed on collected data.

**Results:** The mean BCVA increased significantly from  $0.57 \pm 0.25$  logMAR at baseline to  $0.34 \pm 0.22$  logMAR at month 6. Intraretinal layers modification showed a progressive recomposition of inner segment/outer segment layer in 91% of patients at month 6. Retinal layers recomposition showed a progressive increase in all patients during follow-up from the immediate postoperative control to the last 6-month visit.

**Conclusions:** Optical coherence tomography examination appears useful to investigate visual recovery after macular hole surgery. To ensure postsurgical functional increase, recomposition of all retinal layers, in particular in the outer retina, is mandatory. This process could be slow and not immediately observable during follow-up examinations.

**Keywords:** Idiopathic macular hole, Macular surgery, Optical coherence tomography, Outer retinal layers

## Introduction

Idiopathic macular hole (IMH) is one of the most important vitreoretinal disorders responsible for metamorphopsia and poor central vision in the elderly. Idiopathic macular holes are more common in women and the estimated incidence is reported to be 7.8/100,000 per year (1, 2). Kelly and Wendel first reported the successful closure of IMH with pars

plana vitrectomy and fluid-gas exchange in 1991 (3). Nowadays, improvements in imaging resolution and acquisition of optical coherence tomography (OCT) have made it possible to study inner retinal changes after surgery and to correlate better the morphology with the improvement of visual acuity (VA). It is now possible to identify preoperative predictive factors for functional outcomes following IMH surgery (4).

The aim of our study was to describe the restoration of outer retinal layers from external limiting membrane (ELM), inner segment/outer segment junction (IS-OS), and cone outer segment tips (COST) to retinal pigment epithelium (RPE) after IMH surgery and its relation to visual acuity (VA).

## Methods

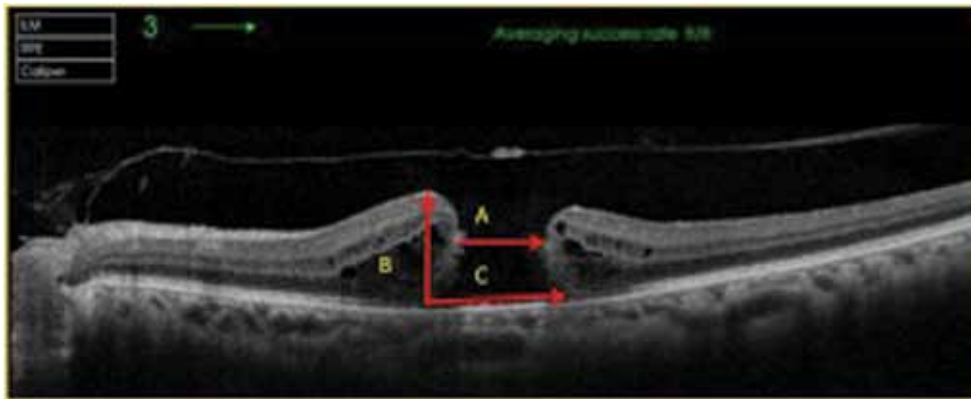
In this prospective study, 23 eyes of 23 patients (8 men and 15 women, mean age at diagnosis 70.17 years [range 62-84]) were recruited consecutively at the Ophthalmology Clinic, Department of Surgical and Morphological Sciences, University of Insubria-Varese, Italy. We selected all patients who

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**Fig. 1** - Baseline evaluation of optical coherence tomography B-scan of idiopathic macular hole. (A) Minimum hole diameter. (B) Height of the hole. (C) Basal diameter.

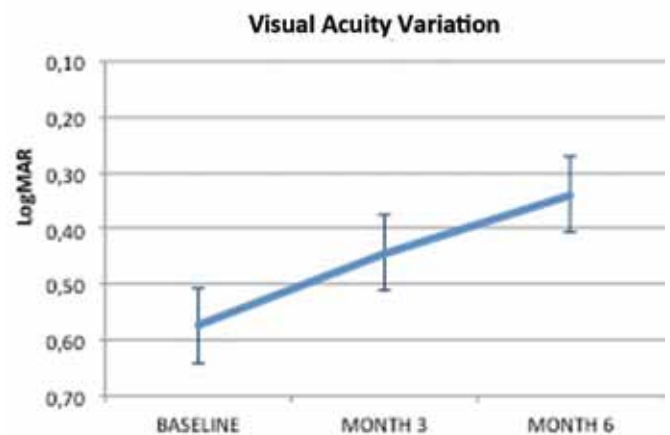
preoperatively complained of reduced VA and metamorphopsia associated with a diagnosis of IMH by funduscopy examination, confirmed by spectral-domain OCT (SD-OCT). Exclusion criteria were any type of previous laser or surgical macular treatments (including intravitreal injections of drugs), ischemic maculopathy, vascular retinopathies, glaucoma, or high myopia (>6 D). All patients signed written informed consent before inclusion in the study, including consent for surgery. This study was conducted in accordance with the tenets of the Declaration of Helsinki.

Patients were examined at baseline and postoperatively at 1, 3, and 6 months of follow-up. The functional examination included Best Corrected Visual Acuity (BCVA) and Amsler grid. Morphologic examination included fundus biomicroscopy and SD-OCT (3D-OCT TOPCON 2000, Tokyo, Japan). Spectral-domain OCT examination was performed preoperatively to evaluate the stage of the IMH according to the International Vitreomacular Traction Study Group Classification (5). Patients were divided into 3 groups: group A (small IMHs), 7 eyes; group B (medium IMHs), 9 eyes; and group C (large IMHs), 7 eyes.

Each OCT B-scan was studied by 2 different expert examiners (S.M.C. and S.D.). Minimum hole diameter (a), height (b), and base (c) value of macular hole were measured. Macular hole index, defined as the ratio of the hole height to the basal hole diameter (b/c), was evaluated (Fig. 1). High-resolution B-scan cross-line protocol allowed to evaluate the presence/absence of IS-OS line and COST line on the fovea and its modifications from baseline to follow-up visits.

All patients underwent 3-port pars plana vitrectomy by 23-G or 25-G sutureless technique (Constellation Vision System, Alcon, Fort Worth, TX, USA) performed by the same surgeon (C.A.). After the induction of posterior vitreous detachment, a complete vitrectomy was performed, completed by triamcinolone vitreal staining (Vitreal S, SOOFT, Rome, Italy) to identify posterior hyaloid macular or papillary adherence. Inner limiting membrane (ILM) was identified and peeled with intraocular forceps from the center macula by means of Brilliant Peel staining (Geuder, Heidelberg, Germany). Light beam was maintained focused in fovea the minimum time needed, reducing the light intensity (6). At the end of the surgery in all patients 20% SF<sub>6</sub> gas (7) was injected and face-down posturing was maintained for 3 days after surgery.

Statistical analysis was performed applying student *t* test and a significance of  $p \leq 0.05$  was considered for compared data.



**Fig. 2** - Visual acuity variation.

## Results

Mean BVCA was  $0.57 \pm 0.25$  logMAR at baseline,  $0.44 \pm 0.22$  logMAR at month 3, and  $0.34 \pm 0.22$  logMAR at month 6 (Fig. 2). All but 1 eye presented a complete closure of macular hole after the surgery, maintained until the end of follow-up.

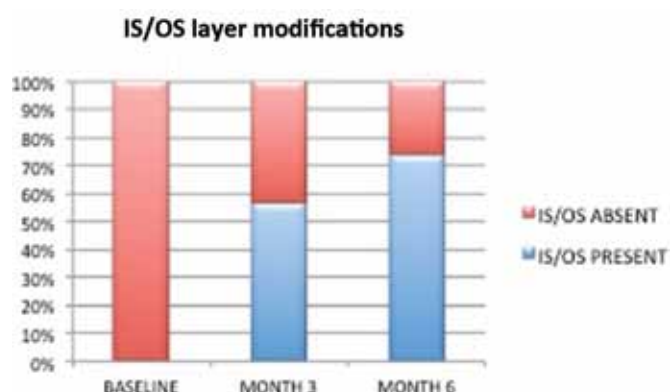
At month 3 and at month 6 follow-up, OCT B-scan showed the recomposition of IS-OS band and COST line in the foveal region. At month 3 after surgery, IS-OS band and COST line integrity were present in 53.5% of patients; at month 6, IS-OS band and COST line recomposition were evident in 73.91% of patients (Fig. 3). In three patients, in the outer retinal layers, we observed the presence of an irregular line with lack of restoration of the IS-OS band and COST line and some hyper-reflective spots corresponding to glial proliferation (Fig. 4).

No significant or substantial differences were reported among different groups, due to the small numbers of cohorts.

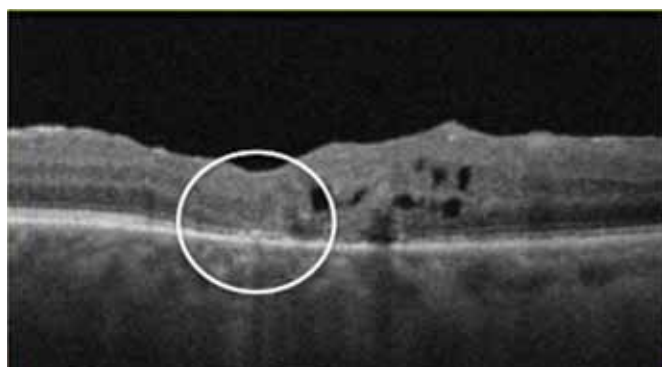
## Discussion

Idiopathic macular hole is an anatomic defect in the fovea characterized by an interruption of all neural retinal layers from the ILM to the RPE. Gass (8, 9) published the first classification of this macular disease in the 1990s. It was a biomicroscopic classification integrated in the following years by OCT classification, following the introduction and the develop-





**Fig. 3** - Recomposition of inner segment/outer segment junction band during follow-up.



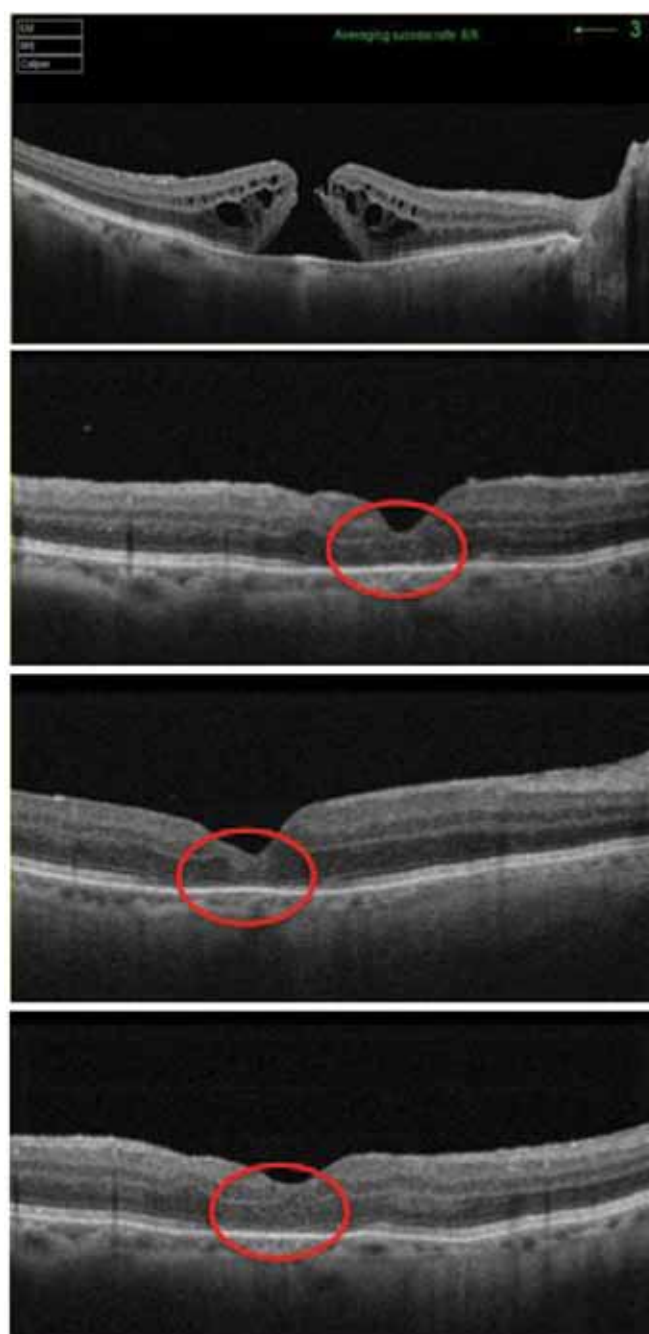
**Fig. 4** - Glial proliferation after macular hole surgery. The inner segment/outer segment junction band and cone outer segment tips line in the foveal region are not visible.

ment of this technology and diagnostic software (10, 11). A panel of experts recently revised and published a new classification based on SD-OCT imaging, based on the experiences of clinical studies for ocriplasmin. They divided IMHs into 3 groups according to the minimum hole diameter measured by OCT: small IMH with an aperture size less than 250  $\mu\text{m}$ , medium IMH with an aperture size between 250 and 400  $\mu\text{m}$ , and large IMH with an aperture size more than 400  $\mu\text{m}$  (5).

At the same time, the recent rapid development of OCT imaging technology has allowed obtaining images with a very high resolution. These features defined and recognized better and complete correspondences between OCT B-scans and histologic retinal layers. In particular, it is possible to study in detail outer retinal layers divided into 4 lines/bands; the presence of all 4 bands is correlated with good VA (12).

The first band seems to originate from the ELM, which is an assembly of junctional complexes between Muller cells and photoreceptors. The second band is often referred to as the IS-OS boundaries of the photoreceptors. The third band has been referred to as COST (13, 14), intermediate line (15), or the Verhoeff membrane (16). The fourth band represents the RPE. Spaide and Curcio (17) suggested that part of the fourth band is contributed by the Bruch membrane and the choriocapillaris.

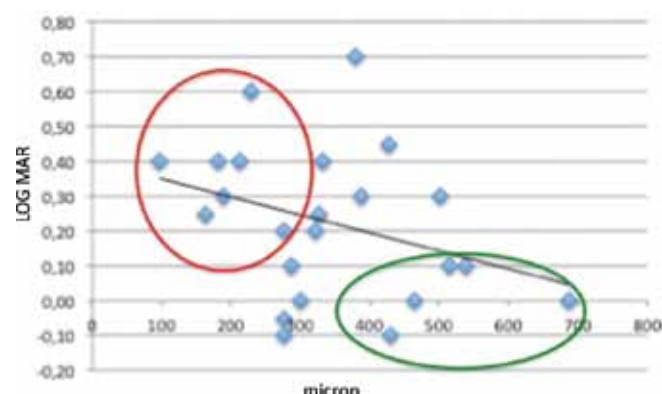
The importance of the integrity of the IS-OS band has been underlined in many clinical studies and its integrity



**Fig. 5** - From above. Recomposition of outer retinal layers during follow-up. The healing process drives a progressive functional recovery.

seems to represent the normal alignment of the photoreceptors, which is essential for normal visual function (18). Several studies also found a correlation in terms of visual improvement to the presence of COST line after treatments for different types of macular diseases. Overall, the presence of all 4 bands is correlated with good VA (19-23).

In our study, we investigated the repair processes of IMH after surgery by means of OCT technology (Fig. 5). The first line appearing at month 1 follow-up is the ELM. The IS-OS



**Fig. 6** - Correlation between best-corrected visual acuity variation and minimum hole diameter of idiopathic macular hole.

band is evident at month 3 in 53.3% of patients, related to a significant improvement in BCVA. This underlines the correlation between restoration and integrity of IS-OS band and VA increase (24-26). The IS-OS band was present at month 6 in 73.91% of patients with a further improvement of the BCVA. The complete restoration of COST line was seen only at month 6 in 5 patients; these patients presented a small IMH at baseline, and they had the best recovery of visual function at month 6 (27, 28).

Moreover, we correlated the variation of BCVA with the minimum diameter of the hole, and showed an inverse correlation between the dimension of macular hole and the final BCVA, underling the importance of a complete outer layer re-composition (Fig. 6).

On the other hand, our study revealed that anatomical closure of IMH did not always correspond with functional success. In 26.09% of patients, during the follow-up, OCT images showed absence of the IS-OS band with a low recovery of BCVA. Optical coherence tomography imaging revealed that the foveal defect was filled with hyperreflective lesions, instead of the re-composition of 4 bands in the outer retina (Fig. 4). These lesions were thought to be glial cell complexes that proliferate in excess as part of the healing process. Some authors suggest that successful restoration of foveal integrity relies on the balance between glial cell proliferation and centripetal reapproximation of the photoreceptors: if the photoreceptors reapproximate appropriately, integrity and proper alignment could be restored. If the glial proliferation process is faster than photoreceptor reapproximation, glial cells fill the foveal defect, and prevent further healing approximation of the photoreceptors. In this case, IS-OS line could not be completely restored (20, 23, 27-30).

This study has some limitations. First, there is a small number of participants, preventing statistical analysis among groups. The second limitation is related to the OCT study of outer retina during follow-up. The presence or the absence of the IS-OS band and the COST line were investigated by a subjective method that could create bias. However, our images were studied by 2 expert readers (S.D. and S.M.C.) and then compared. Automatic software that could recognize each retinal layer is not yet available. Recent SD-OCT instruments recognize ILM and RPE, to measure retinal thickness, ganglion

cell layer, and retinal nerve fiber layer to calculate ganglion cell complex thickness.

In conclusion, SD-OCT allows evaluation of the healing process of foveal defect in IMHs. The restoration of IS-OS band and COST line in the early postsurgical period may reflect structural and functional recovery of the photoreceptors after macular hole surgery. More studies are necessary to define a good correlation with the improvement in VA.

## Disclosures

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Conflict of interest: None of the authors has conflict of interest with this submission.

## References

1. Jackson TL, Donachie PH, Sparrow JM, Johnston RL. United Kingdom National Ophthalmology Database study of vitreoretinal surgery: report 2, macular hole. *Ophthalmology*. 2013;120(3): 629-634.
2. McCannel CA, Ensminger JL, Diehl NN, Hodge DN. Population-based incidence of macular holes. *Ophthalmology*. 2009;116(7): 1366-1369.
3. Kelly NE, Wendel RT. Vitreous surgery for idiopathic macular holes. Results of a pilot study. *Arch Ophthalmol*. 1991;109(5):654-659.
4. Kusuha S, Negi A. Predicting visual outcome following surgery for idiopathic macular holes. *Ophthalmologica*. 2014;231(3): 125-132.
5. Duker JS, Kaiser PK, Binder S, et al. The International Vitreomacular Traction Study Group classification of vitreomacular adhesion, traction, and macular hole. *Ophthalmology*. 2013;120(12): 2611-2619.
6. Azzolini C, Brancato R, Venturi G, Bandello F, Pece A, Santoro P. Updating on intraoperative light-induced retinal injury. *Int Ophthalmol*. 1994-1995;18(5):269-276.
7. Donati S, Caprani SM, Airaghi G et al. Vitreous substitutes: the present and the future. *Biomed Res Int*. 2014;2014:351804.
8. Gass JD. Idiopathic senile macular hole. Its early stages and pathogenesis. *Arch Ophthalmol*. 1988;106(5):629-639.
9. Gass JD. Reappraisal of biomicroscopic classification of stages of development of a macular hole. *Am J Ophthalmol*. 1995; 119(6):752-759.
10. Azzolini C, Patelli F, Brancato R. Correlation between optical coherence tomography data and biomicroscopic interpretation of idiopathic macular hole. *Am J Ophthalmol*. 2001;132(3): 348-355.
11. Azzolini C, Sansoni G, Donati S, et al. Clinical analysis of macular edema with new software for SD-OCT imaging. *Eur J Ophthalmol*. 2013;23(6):899-904.
12. Wong IY, Lu LP, Koizumi H, Lai WW. The inner segment/outer segment junction: what have we learnt so far? *Curr Opin Ophthalmol*. 2012;23(3):210-218.
13. Srinivasan VJ, Monson BK, Wojtkowski M, et al. Characterization of outer retinal morphology with high-speed, ultrahigh-resolution optical coherence tomography. *Invest Ophthalmol Vis Sci*. 2008;49(4):1571-1579.
14. Rii T, Itoh Y, Inoue M, Hirakata A. Foveal cone outer segment tips line and disruption artifacts in spectral-domain optical coherence tomographic images of normal eyes. *Am J Ophthalmol*. 2012;153(3):524-529.e1.
15. Oishi A, Hata M, Shimozone M, Mandai M, Nishida A, Kurimoto Y. The significance of external limiting membrane status for visual acuity in age-related macular degeneration. *Am J Ophthalmol*. 2010;150(1):27-32.e1.

16. Lai WW, Leung GY, Chan CW, Yeung IY, Wong D. Simultaneous spectral domain OCT and fundus autofluorescence imaging of the macula and microperimetric correspondence after successful repair of rhegmatogenous retinal detachment. *Br J Ophthalmol*. 2010;94(3):311-318.
17. Spaide RF, Curcio CA. Anatomical correlates to the bands seen in the outer retina by optical coherence tomography: literature review and model. *Retina*. 2011;31(8):1609-1619.
18. Villate N, Lee JE, Venkatraman A, Smiddy WE. Photoreceptor layer features in eyes with closed macular holes: optical coherence tomography findings and correlation with visual outcomes. *Am J Ophthalmol*. 2005;139(2):280-289.
19. Donati S, Caprani SM, Francesco Semeraro, et al. Morphological and Functional Retinal Assessment in Epiretinal Membrane Surgery. *Semin Ophthalmol*. 2016 Aug;10:1-8 [Epub ahead of print].
20. Ko TH, Fujimoto JG, Duker JS, et al. Comparison of ultrahigh- and standard-resolution optical coherence tomography for imaging macular hole pathology and repair. *Ophthalmology*. 2004;111(11):2033-2043.
21. Baba T, Yamamoto S, Arai M, et al. Correlation of visual recovery and presence of photoreceptor inner/outer segment junction in optical coherence images after successful macular hole repair. *Retina*. 2008;28(3):453-458.
22. Bottoni F, De Angelis S, Luccarelli S, Cigada M, Staurenghi G. The dynamic healing process of idiopathic macular holes after surgical repair: a spectral-domain optical coherence tomography study. *Invest Ophthalmol Vis Sci*. 2011;52(7):4439-4446.
23. Itoh Y, Inoue M, Rii T, Hiraoka T, Hirakata A. Significant correlation between visual acuity and recovery of foveal cone microstructures after macular hole surgery. *Am J Ophthalmol*. 2012;153(1):111-9.e1.
24. Chang LK, Koizumi H, Spaide RF. Disruption of the photoreceptor inner segment-outer segment junction in eyes with macular holes. *Retina*. 2008;28(7):969-975.
25. Inoue M, Watanabe Y, Arakawa A, Sato S, Kobayashi S, Kadonosono K. Spectral-domain optical coherence tomography images of inner/outer segment junctions and macular hole surgery outcomes. *Graefes Arch Clin Exp Ophthalmol*. 2009;247(3):325-330.
26. Liu P, Sun Y, Dong C, et al. A new method to predict anatomical outcome after idiopathic macular hole surgery. *Graefes Arch Clin Exp Ophthalmol*. 2016;254(4):683-688.
27. Wakabayashi T, Fujiwara M, Sakaguchi H, Kusaka S, Oshima Y. Foveal microstructure and visual acuity in surgically closed macular holes: spectral-domain optical coherence tomographic analysis. *Ophthalmology*. 2010;117(9):1815-1824.
28. Hasebe H, Matsuoka N, Terashima H, Sasaki R, Ueda E, Fukuchi T. Restoration of the Ellipsoid Zone and Visual Prognosis at 1 Year after Surgical Macular Hole Closure. *J Ophthalmol* 2016; 2016:1769794.
29. Oh J, Smiddy WE, Flynn HW Jr, Gregori G, Lujan B. Photoreceptor inner/outer segment defect imaging by spectral domain OCT and visual prognosis after macular hole surgery. *Invest Ophthalmol Vis Sci*. 2010;51(3):1651-1658.
30. Kawashima Y, Uji A, Ooto S, Hangai M, Hosoda Y, Yoshimura N. Association Between Insufficient Photoreceptor Layer Plugging and Postoperative Visual Outcome in the Surgically Closed Macular Hole. *Am J Ophthalmol*. 2015;160(5):982-989.e1.

# INTRAOPERATIVE AND POSTOPERATIVE COMPLICATIONS IN PHACOVITRECTOMY FOR EPIRETINAL MEMBRANE AND MACULAR HOLE

## A Clinical Audit of 1000 Consecutive Eyes

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**Purpose:** The aim of this study was to report the intraoperative and postoperative complications of phacovitrectomy for epiretinal membrane (ERM) and macular hole (MH).

**Methods:** This was a retrospective audit of 1,052 phacovitrectomy operations (410 for ERM and 642 for MH) by the same surgical team between 1998 and 2017. Outcome measures included rates of intraoperative anterior segment and posterior segment complications such as posterior capsule rupture and retinal breaks. A subgroup analysis of 189 procedures in which postoperative complications were rigorously recorded was also undertaken.

**Results:** The rate of posterior capsule rupture was 2.2%, with no difference between ERM and MH (1.7 vs. 2.5%;  $P = 0.40$ ). Iatrogenic retinal tears were more common in MH than in ERM surgery (15.6 vs. 6.8%;  $P < 0.001$ ). The chance of one or more anterior segment or posterior segment intraoperative complications occurring (excluding iatrogenic retinal breaks) was not associated with: indication for surgery, grade of surgeon, gauge of surgery, surgical machine, diabetic status, patient sex, or patient age. Subgroup analysis showed postoperative events as follows: posterior capsular opacification 10.6% (20/189), posterior synechiae 4.2% (8/189), uveitis 2.1% (4/189), angle closure glaucoma 1.6% (3/189), and rhegmatogenous retinal detachment 1.1% (2/189).

**Conclusion:** Phacovitrectomy seems to be safe in phakic patients with ERM or MH, performed either by fellows or consultants. It avoids the requirement for repeat surgery and is more cost and resource efficient.

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Vitrectomy may be combined with cataract surgery (phacovitrectomy) in the management of phakic eyes with macular hole (MH) or epiretinal membrane (ERM).<sup>1</sup> Even with minimal preexisting cataract, phacovitrectomy may be preferred to vitrectomy alone to preempt the progression of postvitrectomy cataract and provide quicker overall visual recovery from a single procedure.<sup>2</sup>

Although phacovitrectomy is more time and resource efficient than vitrectomy followed by sequential cataract surgery, there have been concerns that it may be associated with a higher risk of intraoperative and perioperative complications.<sup>1</sup> The effect of longer

surgical time and the interaction of posterior segment manipulation and tamponade on anterior segment structures are issues that have been previously raised.<sup>1</sup> Specifically, posterior synechiae formation, small myopic refractive shift, and posterior capsule opacification (PCO) have been reported.<sup>3–5</sup> Whether vitreoretinal (VR) surgeons are as adept at anterior segment surgery compared with high-volume cataract surgeons is another potential debate. However, combined surgery negates the requirement for postvitrectomy cataract surgery which has its own challenges, including an increased risk of posterior capsular rupture and zonular dehiscence.<sup>6</sup> There are also economic

considerations, with phacovitrectomy being up to 20% more cost-efficient than 2-step surgery.<sup>7</sup>

Overall, the published evidence to date suggests that phacovitrectomy is safe in the management of MH and ERM.<sup>8</sup> The literature, however, is confined to small uncontrolled studies on phacovitrectomy and to small comparative case series on phacovitrectomy versus sequential cataract surgery.<sup>4,9,10</sup> There are no large, published series on phacovitrectomy outcomes, which would help to inform the discussion and future decision making.

The aim of this study was to report our institution's experience in more than 1,000 consecutive phacovitrectomy operations performed by the same group of VR surgeons (consultants and fellows) for MH and ERM with emphasis on intraoperative complication rates and with a subgroup analysis on postoperative complications.

## Methods

This retrospective, consecutive case series was conducted in accordance with the principles of the Declaration of Helsinki. Ethical approval was obtained by an institutional review board. All VR operations, including phacovitrectomies, performed at our institution since October 1998 under the care of 3 consultant VR surgeons (T.H.W., D.A.H.L., and R.S.W.) have been prospectively recorded on an electronic patient record (EPR) system (Vitreor; AxSys Technologies, Glasgow, United Kingdom). Mandatory data-entry fields for each operation include: laterality of affected eye, indication for surgery, surgical procedure undertaken, and intraoperative complications. The EPR can also record postoperative data including postoperative complications but these data fields are not mandatory.

### Main Cohort

An anonymized search was performed for all phacovitrectomy operations undertaken at our institution for MH or ERM between October 1998 and June 2017. The primary outcome was the incidence of intraoperative complications. The rates of specific anterior segment and posterior segment complications were compared by chi-square analysis between: ERMs and MHs; consultants and fellows; 20-G and small-

gauge (23-G or 25-G) surgery; and use of the Accurus machine (Alcon Laboratories, Fort Worth, TX) versus the Constellation machine (Alcon Laboratories). Multivariate logistic regression was performed to determine risk factors associated with having one or more anterior segment or posterior segment intraoperative complications, respectively, among the following: indication for surgery (ERM vs. MH), patient age, diabetic status, grade of surgeon (fellow vs. consultant), trocar gauge, and phacovitrectomy machine (Accurus vs. Constellation). For reporting purposes, posterior capsule rupture (PCR) in our study was defined as either 1) a tear of the posterior capsule with or without vitreous loss or 2) vitreous loss with an intact posterior capsule, for example due to zonular rupture, in keeping with the definitions used in large, landmark reports on cataract surgery complications.<sup>11,12</sup> Statistical testing was performed using SPSS version 20 with  $P < 0.05$  considered statistically significant.

### Postoperative Subgroup

A subgroup of consecutive cases performed by a single consultant (THW) over a 3-year period was identified (the "Post-op" subgroup) where postoperative data including postoperative complications were rigorously recorded. A secondary outcome of the study was to determine for this subgroup the incidence of the following postoperative events: PCO, raised intraocular pressure, uveitis, posterior synechiae (PS), vitreous hemorrhage, retinal detachment, and endophthalmitis.

### Surgical Procedure

Cataract surgery was performed by phacoemulsification before vitrectomy as a planned procedure in all cases. Anterior and posterior segment surgeries were performed with the same machine. Before January 2010, the Accurus was used and thereafter the Constellation. Machine settings such as infusion pressure, cut rate, and vacuum varied based on individual surgeon preferences. Capsulorhexis was performed manually in all cases using a needle or forceps.

## Results

There were 1,052 phacovitrectomies performed on 991 patients during the study period for either MH ( $n = 642$ ) or ERM ( $n = 410$ ). This represented the majority (81%) of all phakic eyes treated for ERM or MH at our institution over the study period and especially in the last 5 years of that period (91%). Demographics

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and operative details are outlined in Table 1. Fellows performed more surgery than consultants but the proportion of fellow cases was similar for both MH and ERM (58 vs. 57% respectively). Patients undergoing MH were statistically younger than those undergoing ERM, but this discrepancy did not seem to be clinically relevant (69.0 vs. 70.4 years,  $P = 0.007$ ). Compared with ERM cases, MH cases were more likely to be female (71 vs. 50%,  $P < 0.001$ ), involve gas tamponade (99 vs. 12%,  $P < 0.001$ ), use 20-G trocars (47 vs. 35%,  $P < 0.001$ ), and use the Accurus machine (39 vs. 29%,  $P = 0.001$ ). The discrepancy in gauge and instrumentation between ERMs and MHs is a reflection of our institution's changing case-mix over time. Proportionately more MH procedures were performed early in the study period when 20-G trocars and the Accurus machine were standard.

Intraoperative complications are shown in Table 2 with comparisons by: surgical indication (ERM vs. hole), grade of surgeon (consultant vs. fellow), gauge of surgery (20-G vs. small-gauge) and machine (Accurus vs. Constellation). The PCR rate was 2.2% overall in the series. The rate of PCR and the rates of other specific anterior segment complications were not statistically different across any of the comparator groups, with the exception of the rate of AC tears, which were higher for fellows (1.6%) than consultants (0.0%,  $P < 0.01$ ). Regarding posterior segment complications, the only statistically relevant difference across groups occurred in the rates of retinal tears, which were more common in MH (vs. ERM), 20-G

surgery (vs. small-gauge surgery), and use of the Accurus machine (vs. Constellation). Post hoc testing confirmed that these three factors in addition to diabetes were statistically correlated with retinal tears ( $P < 0.001$ ) on multivariate regression, whereas patient age, sex, and surgeon grade were not significant ( $P > 0.05$ ).

Multivariate logistic regression found the chance of having one or more anterior segment complications during phacovitrectomy was not associated ( $P > 0.05$ ) with any of the following: indication of surgery (ERM vs. MH), grade of surgeon (fellow vs. consultant), gauge of surgery (20-G vs. smaller gauge), machine (Accurus vs. Constellation), diabetic status of patient, patient sex, or patient age. Likewise, the chance of having one or more posterior segment intraoperative complications (excluding iatrogenic retinal tears) was not correlated with any of these aforementioned variables.

There were 189 phacovitrectomy cases in the "Post-op" subgroup. The demographic data were comparable with the wider study, with a mean age of 68 years, a female preponderance (56%), 61% having surgery for MH, 47% using 20-G trocars, and 60% having surgery using the Constellation. The intraoperative complications were also similar to the wider study with a PC rupture rate of 2.1%. Follow-up ranged from 6 weeks to 14 years with a median of 0.47 years. Postoperative events in descending order of frequency were as follows: PCO (10.6%,  $n = 20$ ); raised intraocular pressure (5.8%,  $n = 11$ ), posterior synechiae

Table 1. Demographics and Surgical Details of Phacovitrectomy Cases

	ERM	MH	All	$P^*$
n	410	642	1,052	—
Mean age (years)	70.4	69.0	69.5	0.007†
Sex	49.6% female	71.2% female	62.8% female	<0.001‡
Diabetes	Yes: 63 (15.4%) No: 347 (84.6%)	Yes: 73 (11.4%) No: 569 (88.6%)	Yes: 136 (12.9%) No: 916 (87.1%)	0.06‡
Grade of surgeon	Cons: 176 (42.9%) Fellow: 234 (57.1%)	Cons: 267 (41.6%) Fellow: 375 (58.4%)	Cons: 443 (42.1%) Fellow: 609 (57.9%)	0.67‡
Machine	Accurus: 117 (28.5%) Constell: 293 (71.5%)	Accurus: 247 (38.5%) Constell: 395 (61.5%)	Accurus: 364 (34.6%) Constell: 688 (65.4%)	0.001‡
Gauge of surgery	25-G: 51 (12.4%) 23-G: 217 (52.9%) 20-G: 142 (34.6%)	25-G: 55 (8.6%) 23-G: 285 (44.4%) 20-G: 302 (47.0%)	25-G: 106 (10.1%) 23-G: 502 (47.7%) 20-G: 444 (42.2%)	<0.001‡
Gas tamponade	Yes: 48 (11.7%) SF <sub>6</sub> : 31 (7.6%) C <sub>2</sub> F <sub>6</sub> : 11 (2.7%) C <sub>3</sub> F <sub>8</sub> : 6 (1.5%) No: 362 (88.3%)	Yes: 637 (99.2%) SF <sub>6</sub> : 53 (8.3%) C <sub>2</sub> F <sub>6</sub> : 205 (31.9%) C <sub>3</sub> F <sub>8</sub> : 379 (59.0%) No: 5 (0.8%)	Yes: 685 (65.1%) SF <sub>6</sub> : 84 (8.0%) C <sub>2</sub> F <sub>6</sub> : 216 (20.5%) C <sub>3</sub> F <sub>8</sub> : 385 (36.6%) No: 367 (34.9%)	<0.001‡
Laser and/or cryotherapy	Yes: 116 (28%)	Yes: 209 (33%)	Yes: 325 (31%)	0.145‡

\*Epiretinal membrane versus macular hole.

†Student's *t*-test two-tailed.

‡Chi-square test two-tailed.

Cons, consultant; Constell, Constellation machine; G, gauge.

Table 2. Intraoperative Complications in Phacovitrectomy With Breakdown by Surgical Indication, Surgeon Grade, Trocar Gauge, and Machine

Intraoperative Complication	Total (n = 1,052)	ERM (n = 410)	MH (n = 642)	<i>P</i> <sup>*</sup>	Fellow (n = 609)	Consult (n = 443)	<i>P</i> <sup>†</sup>	20g (n = 444)	23g and 25g (n = 608)	<i>P</i> <sup>‡</sup>	Accurus (n = 364)	Constell (n = 688)	<i>P</i> <sup>§</sup>
Anterior Segment													
One or more AS complications	46 (4.4%)	16 (3.9%)	30 (4.7%)	0.55	27 (4.4%)	19 (4.3%)	0.91	23 (5.2%)	23 (3.8%)	0.27	19 (5.2%)	27 (3.9%)	0.33
PCR and/or vitreous loss	23 (2.2%)	7 (1.7%)	16 (2.5%)	0.40	10 (1.6%)	13 (2.9%)	0.16	10 (2.3%)	13 (2.1%)	0.90	9 (2.5%)	14 (2.0%)	0.64
AC tear¶	10 (1.0%)	4 (1.0%)	6 (0.9%)	0.94	10 (1.6%)	0 (0.0%)	0.007	4 (0.9%)	6 (1.0%)	0.89	3 (0.8%)	7 (1.0%)	0.76
Iris trauma/prolapse	6 (0.6%)	2 (0.5%)	4 (0.6%)	0.77	3 (0.5%)	3 (0.7%)	0.70	4 (0.9%)	2 (0.3%)	0.22	3 (0.8%)	3 (0.4%)	0.43
Zonular dialysis	6 (0.6%)	2 (0.5%)	4 (0.6%)	0.77	6 (1.0%)	0 (0.0%)	0.05	3 (0.7%)	3 (0.5%)	0.70	2 (0.5%)	4 (0.6%)	0.95
Lens exchange/other IOL problems	5 (0.5%)	3 (0.7%)	2 (0.3%)	0.33	1 (0.2%)	4 (0.9%)	0.17	3 (0.7%)	2 (0.3%)	0.42	3 (0.8%)	2 (0.3%)	0.23
Dropped lens	0 (0.0%)	0 (0.0%)	0 (0.0%)	—	0 (0.0%)	0 (0.0%)	—	0 (0.0%)	0 (0.0%)	—	0 (0.0%)	0 (0.0%)	—
Other	0 (0.0%)	0 (0.0%)	0 (0.0%)	—	0 (0.0%)	0 (0.0%)	—	0 (0.0%)	0 (0.0%)	—	0 (0.0%)	0 (0.0%)	—
Posterior segment													
Retinal tears	128 (12.2%)	28 (6.8%)	100 (15.6%)	<0.001	81 (13.3%)	47 (10.6%)	0.19	77 (17.3%)	51 (8.4%)	<0.001	64 (17.6%)	64 (9.3%)	<0.001
Vitreous Hg	2 (0.2%)	1 (0.2%)	1 (0.2%)	0.99	0 (0.0%)	2 (0.5%)	0.18	1 (0.2%)	1 (0.2%)	0.82	0 (0.0%)	2 (0.3%)	0.30
Subretinal Hg	2 (0.2%)	1 (0.2%)	1 (0.2%)	0.99	1 (0.2%)	1 (0.2%)	0.99	1 (0.2%)	1 (0.2%)	0.82	1 (0.3%)	1 (0.1%)	0.65
Choroidal or suprachoroidal Hg	7 (0.7%)	2 (0.5%)	5 (0.8%)	0.71	3 (0.5%)	4 (0.9%)	0.46	2 (0.5%)	5 (0.8%)	0.46	2 (0.5%)	5 (0.7%)	0.74

\*Chi-square two-tail tested for epiretinal membrane versus macular hole.

†Chi-square two-tailed test for fellow versus consultant grade surgeon.

‡Chi-square 2-tailed test for 20-gauge surgery versus small-gauge (23- or 25- gauge) surgery.

§Chi-square two-tailed test for Accurus machine versus Constellation machine.

¶Anterior capsule tear refers to either run-out of the anterior capsule during capsulorhexis or tears to a normal capsulorhexis occurring during the remainder of phacoemulsification surgery.

AC, anterior capsule; AS, anterior segment; Constell, constellation; Consult, consultant surgeon; G, gauge; IOL, intraocular lens; Hg, hemorrhage; PC, posterior capsule.

Table 3. Anterior Segment Complications Compared With the Cataract-Only Literature

Intraoperative Complications	This Study (n = 1,052)	RCONOD <sup>11</sup> (n = 180,114)	NCD <sup>15</sup> (n = 55,567)
One or more complications (AS or SCH)	4.9%	4.2%	4.6%
PCR and/or vitreous loss	2.2%	2.0%	1.9%
Other	1.0%	0.7%	1.1%
Iris trauma/prolapse	0.6%	0.5%	0.6%
Zonular dialysis	0.6%	0.5%	0.5%
Epithelial abrasion	0.0%	0.3%	0.2%
Endothelial damage/Descemet's tear	0.0%	0.2%	0.3%
Nuclear/epinuclear fragment into vitreous	0.0%	0.2%	0.2%
Corneal edema	0.0%	0.1%	0.1%
Lens exchange/other IOL problems	0.5%	0.1%	0.1%
Phaco burn/wound problems	0.0%	<0.1%	0.2%
Hyphema	0.0%	<0.1%	<0.1%
Choroidal/suprachoroidal hemorrhage	0.7%	<0.1%	<0.1%

AS, anterior segment; IOL, intraocular lens; NCD, National Cataract Dataset; PC, posterior capsule; RCONOD, Royal College of Ophthalmologist's National Ophthalmology Database; SCH, suprachoroidal hemorrhage.

(4.2%, n = 8), uveitis (2.1%, n = 4), ocular surface disease (2.1%, n = 4), angle closure glaucoma (ACG, 1.6%, n = 3), persistent CMO (1.6%, n = 3), retinal detachment (1.1%, n = 2), early gas dissipation (1.1%, n = 2), vitreous hemorrhage (0.5%, n = 1), toxic anterior segment syndrome (0.5%, n = 1), refractive surprise (0.5%, n = 1), and endophthalmitis (0.0%, n = 0). Of the 8 patients who developed PS, none had intraoperative complications, all had gas tamponade and 6 (75%) occurred with 20-G surgery. Eight percent (6/88) of 20-G cases developed PS versus 2% (2/101) for small-gauge ( $P = 0.10$ ).

Overall, there were 3 cases of ACG in the postoperative subgroup. One case occurred in the early postoperative period, whereas the other 2 presented as delayed events at 6 months and 3 years. All 3 cases involved gas tamponade (2 with C<sub>3</sub>F<sub>8</sub> and 1 with C<sub>2</sub>F<sub>6</sub>) and none were associated with any intraoperative complications. Two ACG cases were successfully treated using peripheral iridotomy and medical therapy, while 1 required glaucoma drainage surgery.

### Discussion

We performed a large, retrospective audit on the safety of phacovitrectomy surgery. Anterior segment intraoperative complications in our series were comparable with rates reported in recent cataract-only series. Posterior capsule rupture is widely regarded as an indicator of the quality of cataract surgery and, in our series, measured 2.2%.<sup>11–14</sup> In 2 large, multicentre studies on cataract surgery using EPR data from the

United Kingdom, PCR rates were 1.92% (from the National Cataract Dataset) and 1.95% (from the Royal College of Ophthalmologists' National Ophthalmology Database, RCONOD) in 55,567 and 180,114 cataract operations, respectively.<sup>11,12,15</sup> In addition to PCR, the rates of other anterior segment complications in our phacovitrectomy series were similar to results from the aforementioned EPR-based cataract reports, as shown in Table 3.

Suprachoroidal hemorrhage after cataract surgery occurred in 0.05% and 0.07% of cases in the RCONOD<sup>11</sup> and National Cataract Dataset series,<sup>15</sup> respectively. The rate in our phacovitrectomy series was considerably greater at 0.7%. However, allowance must be made for the additional risk with pars plana vitrectomy. We have previously published on suprachoroidal hemorrhage after pars plana vitrectomy alone, with incidences of 1.0 and 0.6% for 20-G and 23-G surgery, respectively.<sup>16</sup> This indicates that compared with sequential surgery, the risk of suprachoroidal hemorrhage in our phacovitrectomy series was acceptable.

Analysis of intraoperative complications (Table 2) revealed that retinal tears were more common with: MH (vs. ERM), 20-G (vs. small-gauge) surgery, and Accurus (vs. Constellation) machinery. The association of retinal tears with MH over ERM has been reported elsewhere<sup>17</sup> and most likely reflects the discrepancy in PVD status between the two conditions, with a greater proportion of MHs requiring PVD induction. The association of tears with larger trocar gauge<sup>16–19</sup> and with lower cut-rate machines<sup>20</sup> is again



consistent with previous reports on vitrectomy-only surgery—and is consistent with the widely acknowledged effect these instrumentation factors have on intraoperative vitreous traction. Because of limitations in our data collection, specific machine settings such as vacuum and cut rates were not faithfully recorded for each case; so, we could not explore the independent contribution of these factors in our study.

Although larger trocar gauge and older, lower cut-rate machinery were correlated with retinal tears, it was interesting that these instrumentation factors were not correlated with an increased risk of one or more (nonretinal tear) posterior segment complications. This may reflect a lack of statistical power in our study, given that hemorrhagic posterior segment complications (e.g., suprachoroidal hemorrhage) occur at such low rates in phacovitrectomy. However, our findings may be considered consistent with a previous report on vitrectomy-only surgery, where no overall statistical difference in suprachoroidal hemorrhage rates was found between 20-G and 23-G surgery.<sup>16</sup>

Regarding postoperative complications, PCO requiring YAG capsulotomy was the most common event with an incidence of 10.6%. This rate compares favorably with previous reports of PCO in vitrectomized eyes where incidence has varied between 10% and 51%.<sup>6,21–26</sup> Vitrectomy before or combined with cataract surgery is a recognized risk of PCO.<sup>25,26</sup> Our relatively low rate may be attributable to our standard IOL, which was a hydrophobic acrylic lens (AcrySof SA60AT; Alcon) known to have a low propensity for PCO after cataract-only surgery.<sup>27</sup> All eyes in our postoperative subgroup were operated by a single surgeon who aimed to leave the posterior capsule intact (surgeon preference). Some surgeons in our unit perform prophylactic posterior capsulotomy with the vitrectomy cutter to prevent PCO.<sup>28</sup>

Our subgroup retinal detachment rate was 1.1%, which is consistent with RCONOD data of 1.0% and 2.4% for PPV in ERM and MH, respectively.<sup>29,30</sup> The incidence of PS formation was 4.2% in our subgroup, which is comparable with a previous report by Oh et al<sup>31</sup> (6.1%) on 23-G phacovitrectomy. Posterior synechiae seems to be less common with small-gauge phacovitrectomy than traditional 20-G surgery, where rates in some series have been as high as 19% to 34%.<sup>32</sup> This trend was evident in our own results; although PS occurred in 6.8% (6/88) of 20-G cases in the postoperative subgroup, it occurred in only 2% (2/101) of small-gauge (23-G and 25-G) cases ( $P = 0.10$ ).

Posterior synechiae formation is very uncommon after routine cataract surgery. Its occurrence after phacovitrectomy may be attributed to the effect of

tamponade agents on the iris-capsular-bag diaphragm. All eight cases of PS in our series involved gas tamponade. Gas and oil tamponade have been linked with PS formation after phacovitrectomy in previous reports.<sup>31</sup> A proinflammatory effect from combined surgery may also play a role in PS formation, with prolonged surgical time associated with PS in some series.<sup>31</sup> Two of eight cases of PS in our series occurred in the context of active uveitis.

The incidence of uveitis in our series (2.1%) was higher than one would anticipate after routine cataract surgery, where the incidence from large series has been reported as low as 0.24%.<sup>33</sup> Rates of uveitis after vitrectomy alone for macular disease are not well documented. It was our standard practice to prescribe either dexamethasone 0.1% or prednisolone acetate 1% drops QDS for 4 weeks for combined cases, which was the same protocol we used in cataract-only cases. Our practice in this regard is consistent with a recent survey of VR surgeons, which found that the majority use the same anti-inflammatory protocol for phacovitrectomy as for cataract-only cases, despite these surgeons reporting that phacovitrectomy is more inflammatory than cataract surgery alone.<sup>34</sup> This paradox suggests the need for further research to standardize best practice. Our study lends support to the rationale for increasing the frequency of steroid drops and/or using adjuvant anti-inflammatory drops for combined cases to counteract these inflammatory tendencies.

In 3 cases in our series (1.5%), ACG developed. All 3 cases had uncomplicated surgery with gas tamponade. A similar incidence of ACG (1.82%) was reported by Raj et al<sup>35</sup> in their series of 493 phacovitrectomies, although all their ACG cases occurred with oil rather than gas. After routine cataract surgery, ACG is exceedingly rare. In vitrectomy-only cases, an early intraocular pressure spike with a shallow anterior chamber can occur due to gas overfill, ciliary body rotation, or gas trapped behind the iris in the posterior chamber.<sup>36</sup> However, late ACG is rarely reported in these cases. Our findings suggest that patients counseled for combined surgery should be warned of this additional risk. The fact that 2 of 3 ACG cases presented more than 6 months after phacovitrectomy highlights the importance of advising patients, even those who have had uncomplicated surgery, of the importance of annual intraocular pressure monitoring.

We did not assess refractive outcomes in this study but have previously reported a small myopic shift (approximately  $-0.3D$ ) in phacovitrectomy for macular disease compared with routine cataract surgery.<sup>37</sup> This is consistent with several other reports.<sup>38,39</sup>

Significantly, we observed the same magnitude myopic shift with sequential cataract surgery after previous vitrectomy as with combined phacovitrectomy,<sup>37</sup> suggesting that factors related to vitrectomy (or a history of vitrectomy) are likely to explain myopic shift rather than factors inherent to combined surgery as such. The size of myopic shift in combined surgery in both our own experience and in much of the literature<sup>37–39</sup> has been small in absolute terms and can be mitigated by optimizing biometric constants.

Aside from MH and ERM, combined phacovitrectomy may be useful in other VR pathologies such as diabetic retinopathy, retinal detachments, or trauma, particularly when there is significant lens opacification obscuring fundal views.<sup>1,40</sup> We did not extract data for these patients because of the varying baseline characteristics and prognostic outcomes of this heterogeneous group. In eyes requiring surgery for diabetic retinopathy, it has been our practice to limit combined surgery to cataracts that impair the operative view because vitrectomy has been shown to induce less cataract in diabetic vitrectomy.<sup>41</sup> In addition, we prefer to avoid prolonging intraocular surgery in diabetic patients in whom retinal surgery is likely to be more complex in the first place.

The main limitation of our study was its retrospective design. The integrity of EPR data entered in the time-pressured clinical environment may be compromised by inaccuracies and omissions. There is also a well-documented tendency for surgeons to under-record their complications.<sup>42</sup> For these reasons, we chose to compare the complication rates in our series against studies that have faced similar constraints: where data has been extracted retrospectively from EPR platforms.

Our results provide important evidence for the safety profile of phacovitrectomy surgery when undertaken by VR consultants and fellows. Anterior segment intraoperative complications were similar to published rates encountered with cataract surgery alone, whereas posterior segment complications were similar to those encountered with vitrectomy alone. Vitreoretinal surgeons at our institution frequently perform cataract surgery, whereas this may not be the case in all units. This variability could influence the decision on whether to perform combined surgery. The decision should also take account of patient factors, especially age. Patients aged 50 years and younger are less likely to develop postvitrectomy cataract.<sup>43</sup> They are also more likely to have clear lenses and residual accommodative function so that lens extraction is best avoided. An informed discussion on the risks and benefits of combined surgery is essential in all cases, including the risks of refractive

errors and postoperative inflammation. In our subgroup analysis, postoperative safety was acceptable, although the rates of uveitis and ACG seemed higher than would be encountered after cataract surgery alone. Further research is required on ways to minimize these events postoperatively. Preemptive anti-inflammatory treatment and regular postoperative monitoring are recommended. As instrumentation improves, these complications are likely to become rarer and this trend was observed in our own series. It is our unit's standard practice to perform phacovitrectomy in most phakic patients with ERM or MH even where cataract is mild. Phacovitrectomy avoids the additive risks associated with repeat surgery and is more time, cost, and resource efficient.<sup>7</sup>

**Key words:** epiretinal membrane, macular hole, phacovitrectomy, complications, safety, postoperative, intraoperative.

## References

1. Steel DHW. Phacovitrectomy: expanding indications. *J Cataract Refract Surg* 2007;33:933–936.
2. Muselier A, Dugas B, Burelle X, et al. Macular hole surgery and cataract extraction: combined vs consecutive surgery. *Am J Ophthalmol* 2010;150:387–391.
3. Manvikar SR, Allen D, Steel DHW. Optical biometry in combined phacovitrectomy. *J Cataract Refract Surg* 2009;35:64–69.
4. Kim YK, Woo SJ, Hyon JY, et al. Refractive outcomes of combined phacovitrectomy and delayed cataract surgery in retinal detachment. *Can J Ophthalmol* 2015;50:360–366.
5. Pinarci EY, Bayar SA, Sizmaz S, et al. Anterior segment complications after phacovitrectomy in diabetic and nondiabetic patients. *Eur J Ophthalmol* 2013;23:223–229.
6. Szijarto Z, Haszonits B, Biró Z, Kovacs B. Phacoemulsification on previously vitrectomized eyes: results of a 10-year-period. *Eur J Ophthalmol* 2007;17:601–604.
7. Seider MI, Michael Lahey J, Fellenbaum PS. Cost of phacovitrectomy versus vitrectomy and sequential phacoemulsification. *Retina* 2014;34:1112–1115.
8. Rogers S, Madhusudhana KC, Kang HK, et al. Combined phacovitrectomy for macular hole: long-term results. *Ophthalmic Surg Lasers Imaging* 2007;38:452–456.
9. Wu Z, Zhang J, Chen Y, et al. Efficacy of phacovitrectomy combined with internal limiting membrane peeling for macular diseases. *Eye Sci* 2012;27:25–29.
10. Jalil A, Steeples L, Subramani S, et al. Microincision cataract surgery combined with vitrectomy: a case series. *Eye (Lond)* 2014;28:386–389.
11. Day AC, Donachie PHJ, Sparrow JM, Johnston RL. The Royal College of Ophthalmologists' National Ophthalmology Database study of cataract surgery: report 1, visual outcomes and complications. *Eye (Lond)* 2015;29:552–560.
12. Narendran N, Jaycock P, Johnston RL, et al. The Cataract National Dataset electronic multicentre audit of 55,567 operations: antiplatelet and anticoagulant medications. *Eye (Lond)* 2009;23:10–16.
13. Desai P. The National Cataract Surgery Survey: II. Clinical outcomes. *Eye (Lond)* 1993;7:489–494.

14. Desai P, Minassian DC, Reidy A. National Cataract Surgery Survey 1997–1998: a report of the results of the clinical outcomes. *Br J Ophthalmol* 1999;83:1336–1340.
15. Jaycock P, Johnston R, Taylor H, et al. The Cataract National Dataset electronic multi-centre audit of 55,567 operations: updating benchmark standards of care in the United Kingdom and internationally. *Eye (Lond)* 2009;23:38–49.
16. Neffendorf JE, Gupta B, Williamson TH. Intraoperative complications of patients undergoing small-gauge and 20-gauge vitrectomy: a database study of 4,274 procedures. *Eur J Ophthalmol* 2017;27:226–230.
17. Gosse E, Newsom R, Lochhead J. The incidence and distribution of iatrogenic retinal tears in 20-gauge and 23-gauge vitrectomy. *Eye (Lond)* 2012;26:140–143.
18. Nakano T, Uemura A, Sakamoto T. Incidence of iatrogenic peripheral retinal breaks in 23-gauge vitrectomy for macular diseases. *Retina* 2011;31:1997–2001.
19. Ramkissoon YD, Aslam SA, Shah SP, et al. Risk of iatrogenic peripheral retinal breaks in 20-g pars plana vitrectomy. *Ophthalmology* 2010;117:1825–1830.
20. Rizzo S, Genovesi-Ebert F, Belting C. Comparative study between a standard 25-gauge vitrectomy system and a new ultrahigh-speed 25-gauge system with duty cycle control in the treatment of various vitreoretinal diseases. *Retina* 2011;31:2007–2013.
21. Chang MA, Parides MK, Chang S, Braunstein RE. Outcome of phacoemulsification after pars plana vitrectomy. *Ophthalmology* 2002;109:948–954.
22. Pinter SM, Sugar A. Phacoemulsification in eyes with past pars plana vitrectomy: case-control study. *J Cataract Refract Surg* 1999;25:556–561.
23. Ling R, Simcock P, McCoombes J, Shaw S. Presbyopic phacovitrectomy. *Br J Ophthalmol* 2003;87:1333–1335.
24. Mochizuki Y, Kubota T, Hata Y, et al. Surgical results of combined pars plana vitrectomy, phacoemulsification, and intraocular lens implantation. *Eur J Ophthalmol* 2006;16:279–286.
25. Toda J, Kato S, Oshika T, Sugita G. Posterior capsule opacification after combined cataract surgery and vitrectomy. *J Cataract Refract Surg* 2007;33:104–107.
26. Roh JH, Sohn HJ, Lee DY, et al. Comparison of posterior capsular opacification between a combined procedure and a sequential procedure of pars plana vitrectomy and cataract surgery. *Ophthalmologica* 2010;224:42–46.
27. Mian SI, Fahim K, Marcovitch A, et al. Nd:YAG capsulotomy rates after use of the AcrySof acrylic three piece and one piece intraocular lenses. *Br J Ophthalmol* 2005;89:1453–1457.
28. Alexander P, Luff AJ. Primary surgical posterior capsulotomy during phacovitrectomy. *Eye (Lond)* 2015;29:590.
29. Jackson TL, Donachie PHJ, Sparrow JM, Johnston RL. United Kingdom National Ophthalmology database study of vitreoretinal surgery: report 2, macular hole. *Ophthalmology* 2013;120:629–634.
30. Jackson TL, Donachie PHJ, Williamson TH, et al. The Royal College of Ophthalmologists' National Ophthalmology database study of vitreoretinal surgery: report 4, epiretinal membrane. *Retina* 2015;35:1615–1621.
31. Oh JH, Na J, Kim SW, et al. Risk factors for posterior synechiae of the iris after 23-gauge phacovitrectomy. *Int J Ophthalmol* 2014;7:843–849.
32. Kim SW, Oh J, Song JS, et al. Risk factors of iris posterior synechia formation after phacovitrectomy with three-piece acrylic IOL or single-piece acrylic IOL. *Ophthalmologica* 2009;223:222–227.
33. Abbouda A, Tortorella P, Restivo L, et al. Follow-up study of over three years of patients with uveitis after cataract phacoemulsification: outcomes and complications. *Semin Ophthalmol* 2015;31:1–10.
34. Aptel F, Colin C, Kaderli S, et al. Management of postoperative inflammation after cataract and complex ocular surgeries: a systematic review and Delphi survey. *Br J Ophthalmol* 2017;101:1–10.
35. Raj P, Kumar K, Chandnani N, et al. Secondary angle-closure glaucoma due to posterior synechiae of Iris following combined phacoemulsification and 23-gauge transconjunctival vitrectomy. *Semin Ophthalmol* 2017;32:537–542.
36. Chin EK, Almeida DRP, Strohbehn AL, et al. Elevated intraocular pressure following pars plana vitrectomy due to trapped gas in the posterior chamber. *Retin Cases Brief Rep* 2016;10:334–337.
37. Fajgenbaum MAP, Robins J, Williamson TH. Refractive outcomes using the lenstar optical low coherence reflectometry biometer in phacovitrectomy for epiretinal membranes and macular holes. *Open J Ophthalmol* 2017;7:216–224.
38. Falkner-Radler CI, Benesch T, Binder S. Accuracy of preoperative biometry in vitrectomy combined with cataract surgery for patients with epiretinal membranes and macular holes. Results of a prospective controlled clinical trial. *J Cataract Refract Surg* 2008;34:1754–1760.
39. Kim M, Kim HE, Lee DH, et al. Intraocular lens power estimation in combined phacoemulsification and pars plana vitrectomy in eyes with epiretinal membranes: a case-control study. *Yonsei Med J* 2015;56:805.
40. Chaudhry NA, Cohen KA, Flynn HW, Murray TG. Combined pars plana vitrectomy and lens management in complex vitreoretinal disease. *Semin Ophthalmol* 2003;18:132–141.
41. Jackson TL, Johnston RL, Donachie PHJ, et al. The Royal College of Ophthalmologists' National Ophthalmology database study of vitreoretinal surgery: report 6, diabetic vitrectomy. *JAMA Ophthalmol* 2016;134:79–85.
42. Cooper MA, Ibrahim A, Lyu H, Makary MA. Underreporting of robotic surgery complications. *J Healthc Qual* 2015;37:133–138.
43. Kataria AS, Thompson JT. Cataract formation and progression in patients less than 50 years of age after vitrectomy. *Ophthalmol Retin* 2017;1:149–153.

# Visual outcomes and subjective experience after bilateral implantation of a new diffractive trifocal intraocular lens

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**PURPOSE:** To assess clinical outcomes and subjective experience after bilateral implantation of a diffractive trifocal intraocular lens (IOL).

**SETTING:** Midland Eye Institute, Solihull, United Kingdom.

**DESIGN:** Cohort study.

**METHODS:** Patients had bilateral implantation of Finevision trifocal IOLs. Uncorrected distance visual acuity, corrected distance visual acuity (CDVA), and manifest refraction were measured 2 months postoperatively. Defocus curves were assessed under photopic and mesopic conditions over a range of +1.50 to -4.00 diopters (D) in 0.50 D steps. Contrast sensitivity function was assessed under photopic conditions. Halometry was used to measure the angular size of monocular and binocular photopic scotomas arising from a glare source. Patient satisfaction with uncorrected near vision was assessed using the Near Activity Visual Questionnaire (NAVQ).

**RESULTS:** The mean monocular CDVA was  $0.08 \log\text{MAR} \pm 0.08$  (SD) and the mean binocular CDVA,  $0.06 \pm 0.08 \log\text{MAR}$ . Defocus curve testing showed an extended range of clear vision from +1.00 to -2.50 D defocus, with a significant difference in acuity between photopic conditions and mesopic conditions at -1.50 D defocus only. Photopic contrast sensitivity was significantly better binocularly than monocularly at all spatial frequencies. Halometry showed a glare scotoma of a mean size similar to that in previous studies of multifocal and accommodating IOLs; there were no subjective complaints of dysphotopsia. The mean NAVQ Rasch score for satisfaction with near vision was  $15.9 \pm 10.7$  logits.

**CONCLUSIONS:** The trifocal IOL implanted binocularly produced good distance visual acuity and near and intermediate visual function. Patients were very satisfied with their uncorrected near vision.

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Multifocal intraocular lenses (IOLs) are becoming more widely used as patients increasingly seek spectacle independence after cataract surgery.<sup>1,2</sup> The optical principles of multifocal IOLs include diffractive, zonal refractive, and aspheric designs, and the design may have a significant impact on postoperative visual outcomes. Diffractive IOLs are based on the Huygens-Fresnel principle, in which concentric rings on the optic surface typically generate 2 foci (distance and near), with a proportion of incident light lost at higher orders of diffraction.<sup>3</sup> Numerous studies<sup>4–6</sup> have found that diffractive IOLs can provide good distance and near visual acuity, despite the loss of some energy.

However, patients may still be dependent on spectacles for intermediate vision after implantation of bifocal diffractive IOLs.<sup>6–8</sup>

A combination of 2 diffractive profiles can provide 3 foci for an IOL. Gatinel et al.<sup>9</sup> describe a trifocal IOL design featuring a diffractive pattern on the anterior optic surface consisting of alternating diffractive steps of different heights. The 2 specific diffractive patterns result in foci for distance vision, intermediate vision (+1.75 diopter [D] addition [add]), and near vision (+3.50 D add). The Finevision IOL (Physiol) uses this trifocal design; the IOL received Conformité Européenne status in February 2010. It has an apodized

optic with decreasing step height from the center to the periphery, resulting in variable distribution of light energy to far, intermediate, and near vision with changing pupil diameters.<sup>A</sup> The proportion of incident light directed to far vision is greater than for near or intermediate vision at all pupil diameters and rises with pupil size to increase distance-vision dominance.

There are little published data on the *in vivo* clinical outcomes with trifocal IOL designs. Vokresenskaya et al.<sup>10</sup> describe the initial results of implantation of the MIOL-Record trifocal IOL (Reper NN) in 36 eyes (28 patients). They found the IOL gave good distance, intermediate, and near acuity; however, there were frequent subjective reports of halos (25%), glare (16.7%), and nighttime difficulties (22.3%). Dysphopia is commonly associated with multifocal IOLs; it occurs as a consequence of simultaneous multiple image formation, with a tendency to become less problematic over time as neuroadaptation progresses.<sup>10-12</sup> Furthermore, a recent French study<sup>13</sup> of the preliminary postoperative outcomes in 10 patients who had implantation of the Finevision diffractive trifocal IOL reported good binocular outcomes.

The purpose of the present study was to evaluate visual and subjective outcomes with the Finevision trifocal IOL. The study is 1 of very few to date regarding the use of trifocal IOLs and to our knowledge represents the largest cohort evaluated with the Finevision IOL. Given the association between multifocal IOLs and photic phenomena and previously published data indicating that visual performance may be improved with bilateral rather than unilateral implantation of multifocal IOLs,<sup>2,14,15</sup> all patients in our study had bilateral implantation of the trifocal IOL and per the protocol, the size of the glare area was determined using a simple halometry technique.<sup>B</sup>

## PATIENTS AND METHODS

This prospective interventional study included patients having routine cataract surgery and implantation of the Finevision trifocal IOL between July 2011 and October 2011. All study procedures were performed at Midland Eye Institute, United Kingdom, and the local ethics committee approved the investigation. The research adhered to the Declaration of Helsinki. After receiving an explanation of the nature and possible consequences of the study, all patients provided informed consent.

Patients with bilateral visually significant cataract scheduled for routine phacoemulsification cataract surgery and IOL implantation were enrolled in the study. Exclusion criteria included ocular disease other than cataract and previous ocular surgery or inflammation.

### Intraocular Lens

The Finevision is a single-piece aspheric diffractive trifocal IOL composed of 25% hydrophilic acrylic material (Figure 1). The overall IOL diameter is 10.75 mm and the optic, 6.15 mm. The IOL is available in powers from +10.00 to +30.00 D in 0.50 D steps. The intermediate-vision and near-vision add powers are +1.75 D and +3.50 D, respectively.<sup>A</sup> The optic has a combination of 2 diffractive structures on the anterior surface with asymmetric light distribution between the 3 resultant useful foci; for a 20.0 D IOL and a 3.0 mm pupil diameter, the light-energy distribution to distance, near, and intermediate vision is 42%, 29%, and 15%, respectively.<sup>9</sup> Approximately 14% of light energy is lost at higher orders of diffraction with this IOL compared with 18% with IOLs of a typical bifocal refractive design.<sup>3</sup> The apodized optic increases the proportion of light directed to far vision with pupil size.

### Surgical Technique

All patients had cataract surgery under topical anesthesia performed by the same experienced surgeon (S.S.). A



**Figure 1.** The trifocal diffractive IOL (image provided by manufacturer).

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standard sutureless microincision phacoemulsification technique was used. The IOL was implanted in the capsular bag with a single-use injection system (Microset, Physiol). Postoperatively, topical therapy included a combination of antibiotic and steroidal agents. Second-eye surgery took place within 6 weeks of the initial operation.

## Postoperative Assessment

In addition to routine postoperative checks, patients were evaluated 2 months after second-eye surgery. At this visit, the manifest refraction and logMAR uncorrected (UDVA) and corrected (CDVA) distance visual acuities were recorded. Binocular defocus curve testing was performed under photopic (85 candelas [ $\text{cd}$ ]/ $\text{m}^2$ ) and mesopic (5  $\text{cd}/\text{m}^2$ ) conditions from +1.50 to -4.00 D of defocus in 0.50 D steps with randomization of test chart letters using Thomson Test Chart XPert (Thomson Software Solutions) and defocus levels. Defocus lenses were inserted into a trial frame, accounting for the manifest distance refractive error, and magnification effects were accounted for in the analysis. Contrast sensitivity was measured monocularly and binocularly under photopic conditions at spatial frequencies of 3, 6, 12, and 18 cycles per degree using the CSV-1000 contrast test (Vector Vision).

Halometry was used to measure the size of the glare area for each patient monocularly and binocularly under mesopic (5  $\text{cd}/\text{m}^2$ ) conditions. A bright light-emitting diode (LED) (color temperature 3200 K) mounted at the end of a black telescopic arm was positioned in the center of a flat-screen monitor. Purpose-designed software allowed a letter (equivalent to 0.3 logMAR) to be moved along 45-degree meridians from the edge of the screen toward the glare source on a black background. The letter presented changed randomly as it moved toward the glare source; the patient was asked to identify each letter, and the eccentricity of the closest location to the LED at which the patient could correctly identify the letter was recorded. The procedure was repeated for each of the 8 meridians (in random order), allowing determination of the size of the photopic scotoma associated with the trifocal IOL.

To assess subjective satisfaction with near vision function, patients completed a validated 10-item questionnaire (Near Activity Visual Questionnaire [NAVQ]).<sup>16</sup> The NAVQ is designed to evaluate presbyopic corrections and requires patients to indicate their level of difficulty in performing common near-vision and intermediate-vision tasks without the use of reading spectacles (0 = no difficulty; 3 = extreme difficulty) and to rate overall satisfaction with near vision (0 = completely satisfied; 4 = completely unsatisfied). The summated score from the main body of 10 questions is adjusted to a Rasch score (from 0 to 100 logits) using a conversion table; 0 indicates no difficulty at all with any near tasks and 100 indicates extreme difficulty with all near activities.

## RESULTS

This study evaluated 30 eyes of 15 patients. The mean age of the 8 men and 7 women was 69.8 years  $\pm$  10.0 (SD) (range 52 to 86 years). All patients had uneventful cataract surgery in both eyes. The IOLs were well centered in all eyes, and no pupil distortion or iris trauma occurred.

**Table 1.** Monocular and binocular logMAR distance visual acuities 2 months postoperatively.

		Number (%)	
Acuity	Mean $\pm$ SD	20/40 or Better	20/25 or Better
Monocular			
UDVA	0.19 $\pm$ 0.09	24* (80)	6* (20)
CDVA	0.08 $\pm$ 0.08	30* (100)	21* (70)
Binocular			
CDVA	0.06 $\pm$ 0.08	15 <sup>†</sup> (100)	13 <sup>†</sup> (87)

CDVA = best-corrected distance visual acuity; UDVA = uncorrected distance visual acuity

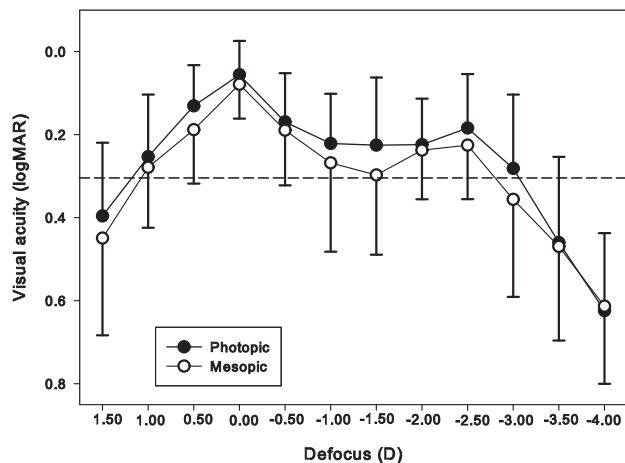
\*Eyes

<sup>†</sup>Patients

Table 1 shows the mean monocular and binocular distance visual acuities and the distance vision efficacy. The mean monocular refractive correction was 0.27  $\pm$  0.36 D sphere (range -0.25 to +1.00 D) and -0.48  $\pm$  0.45 D cylinder (range 0.00 to -1.50 D). Figure 2 shows the binocular mean defocus curves under photopic and mesopic conditions. Under both lighting conditions, the optimum visual acuity results were obtained at 0.00 D defocus (equivalent to distance-vision viewing), with a second peak at -2.50 D (equivalent to near viewing at 40 cm). No distinct peak in the intermediate zone was present for either lighting level, although the range of clear vision (0.3 logMAR or better) extended from +1.00 to -2.50 D of defocus, with no sharp drop in acuity in the intermediate zone under the photopic condition. Although in general the mean visual acuities were better under the photopic testing condition, the differences between lighting conditions were not significant except at -1.50 D defocus ( $P = .008$ ), corresponding to an intermediate viewing distance.

Figure 3 shows the monocular and binocular distance contrast sensitivity (log10) under photopic conditions. Binocular contrast sensitivity values were significantly better than monocular values at all spatial frequencies tested ( $P < .05$ ). No significant differences in contrast sensitivity values between right eyes and left eyes were found at any spatial frequency ( $P > .05$ ).

Postoperatively, no patient reported adverse photic phenomena. Figure 4 shows the halometry results; the magnitude of the mean monocular and binocular photopic scotomas measured under mesopic conditions is shown. The mean photopic scotomas were generally uniform in shape, extending binocularly between 0.69  $\pm$  0.24 degrees and 1.03  $\pm$  0.20 degrees for all 8 meridians.

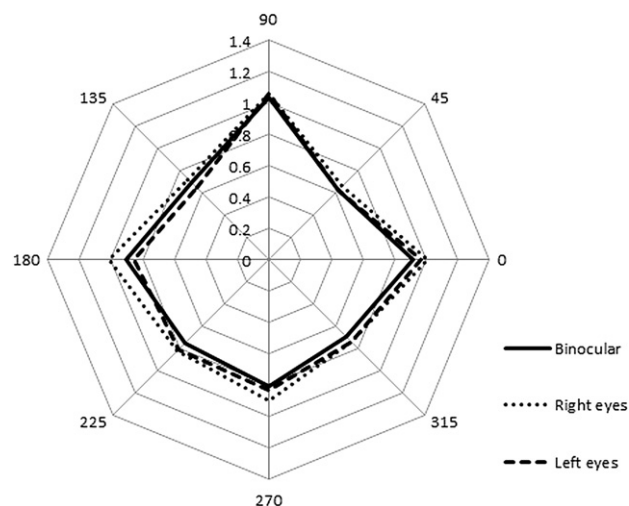


**Figure 2.** Binocular mean defocus curves under photopic conditions and mesopic conditions. Error bars represent  $\pm 1$  SD. The dotted reference line at 0.3 logMAR equates to the European driving standard.

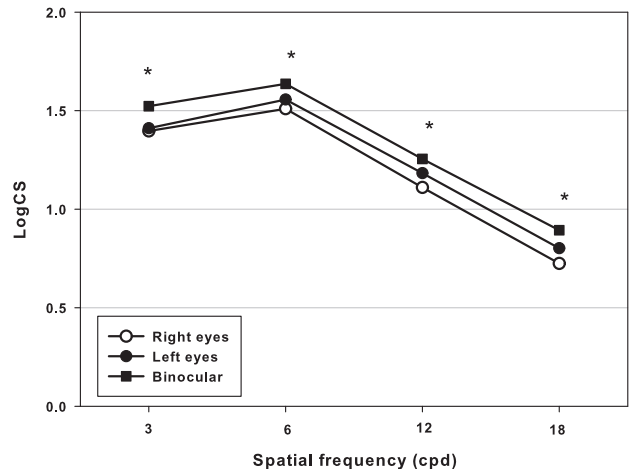
The NAVQ scores for subjective satisfaction with near vision were high, with a mean Rasch score of  $15.9 \pm 10.7$  logits (0 = completely satisfied; 100 = completely unsatisfied) (range 0 to 33.3). The mean overall satisfaction score with near vision (0 = completely satisfied; 4 = completely unsatisfied) was 0.7 (range 0 to 2).

## DISCUSSION

Multifocal IOLs are becoming more widely used as patients having cataract surgery or lens exchange have increasing functional expectations and a desire



**Figure 4.** Size of monocular and binocular photopic scotomas measured using halometry under mesopic conditions. The y-axis represents the extent of scotoma from the glare source (degrees). The radial axis represents the visual-field meridian (degrees).



**Figure 3.** Monocular and binocular contrast sensitivity functions under photopic conditions. The asterisks represent a statistically significant difference between monocular values and binocular values (cpd = cycles per degree).

for postoperative spectacle independence.<sup>17-19</sup> Current diffractive multifocal IOLs typically provide good vision at distance and near<sup>1,19,20</sup> but have the disadvantages of a bifocal design, which can lead to difficulties with intermediate vision<sup>9,A</sup> (eg, during computer use) and is associated with frequent reports of dysphotopsia.<sup>5,21</sup> The current study evaluated the postoperative visual outcomes and patient satisfaction with the Finevision IOL, a new diffractive trifocal IOL design.<sup>9</sup>

To our knowledge, this is 1 of only 2 studies to report the clinical outcomes in a cohort that had binocular implantation of diffractive trifocal IOLs. The mean monocular UDVA ( $0.19 \pm 0.09$ ) and CDVA ( $0.08 \pm 0.08$ ) results are similar to the values reported by Voskresenskaya et al.<sup>10</sup> (0.13 and 0.07, respectively; converted from decimal values) with predominantly monocular implantation of the MIOL-Record IOL. Furthermore, our visual acuity outcomes are comparable to those achieved with several bifocal-design diffractive IOLs.<sup>1,5,20</sup> However, both our mean binocular UDVA and CDVA are lower than those reported by Lesieur<sup>13</sup> with the same IOL (mean  $0.00 \pm 0.01$  and  $0.00 \pm 0.00$ , respectively); it is likely that this difference is due to the older population in the present study ( $69.8 \pm 10.0$  years compared with  $59.3 \pm 4.1$  years). The optical performance of the human eye is known to decline with age,<sup>22</sup> with a resultant reduction in visual acuity for elderly phakic and pseudophakic individuals.<sup>23,24</sup>

The mean and range of postoperative refractive cylinders in the present study ( $-0.48 \pm 0.45$  D and 0 to  $-1.50$  D, respectively) closely agree with results in several studies that assessed the clinical outcomes

with IOLs having diffractive profiles.<sup>2,5,20</sup> In a study by Fernández-Vega et al.,<sup>2</sup> the mean postoperative refractive cylinder was  $-0.51 \pm 0.78$  D with the Acri.Tec 447D IOL. Alió et al.<sup>5</sup> found a mean of  $-0.46 \pm 0.46$  D (range 0 to  $-1.50$  D) with the Acri.Lisa 366D IOL. In the future, toric trifocal IOL designs, rather than limbal or corneal relaxing incisions, could provide a predictable solution for patients with significant preoperative corneal astigmatism rather than excluding patients with significant astigmatism.

Binocular defocus curve testing indicated an extended range of clear vision rather than distinct peaks corresponding to the 1.75 D and 3.50 D adds. The mean visual acuity was 0.3 logMAR or better from  $+1.00$  to  $-2.50$  D defocus under both photopic and mesopic conditions, with no apparent peak in visual acuity in the intermediate zone. Such a finding may be expected given the asymmetric light distribution of the Finevision IOL, in which a relatively small proportion of light is available for intermediate vision compared with the proportion available for distance and near (eg, 42%, 29%, and 15% directed to distance, near, and intermediate foci, respectively, for a 3.0 mm pupil<sup>9</sup>). As pupil size increases, a greater proportion of light is directed to the distance focus due to the apodized optic so that for a 5.0 mm pupil, only approximately 5% of light is available for intermediate vision. The reduced light available for intermediate vision with larger pupil sizes is likely to be the cause of the significantly poorer visual acuity under mesopic conditions than under photopic conditions at  $-1.50$  D defocus. There were no significant differences in visual acuity between mesopic conditions and photopic conditions at any of the other defocus levels tested.

In this study, binocular contrast sensitivity values were significantly higher than monocular values at all spatial frequencies. The well-known effect of binocular summation explains the difference between monocular and binocular results and is in agreement with previous reports of diffractive IOL outcomes in which several authors advised binocular implantation to optimize contrast sensitivity.<sup>2,15,25</sup> Multifocal IOLs have been reported to cause up to a 50% reduction in contrast sensitivity<sup>26</sup>; however, our monocular contrast sensitivity values were within the normal range for older adults obtained with the CSV-1000 and described by Pomerance and Evans<sup>27</sup>. However, they were slightly below their mean values; this could be partly due to the older cohort in the present study (mean  $69.8 \pm 10.0$  years versus  $63.9 \pm 12.2$  years) and normal age-related retinal and neural changes.<sup>28,29</sup>

Photic phenomena frequently associated with multifocal IOLs, including glare, halos, and positive dysphotopsia, can affect the quality of life<sup>30</sup> and are approximately 3.5 times more common with multifocal IOLs than with monofocal IOLs.<sup>31</sup> In the present study, no patient reported photic phenomena, suggesting that the design of the Finevision IOL, with increasing far vision dominance as pupil size increases, may be effective in minimizing halos and glare perception. However, our cohort size was limited to 15; a larger scale study would be required to gain a full insight into the frequency of adverse photic phenomena with the Finevision IOL. The mean size of the photopic scotomas (monocular extent from glare source ranged from  $0.6 \pm 0.3$  degrees to  $1.1 \pm 0.2$  degrees) in the present study compares favorably with previous measures using the same technique in patients with a multifocal and an accommodating IOL design.<sup>C</sup> Subjective satisfaction with uncorrected near vision measured with the NAVQ questionnaire was high in the present study (mean  $15.9 \pm 10.7$  logits). The NAVQ test<sup>16</sup> is designed to allow a more standardized comparison of presbyopia-correction strategies by questioning patients about their ability to perform common near tasks, such as reading mail and seeing the display on a computer without an additional near-vision correction. Rasch-scaled scores may range from 0 (no difficulty at all with near vision) to 100 (extreme difficulty with all near tasks), and the mean value obtained with the Finevision trifocal IOL showed a higher level of patient satisfaction with near vision than reported by Buckhurst et al.<sup>16</sup> for other multifocal IOLs (mean  $18.9 \pm 13.2$  logits) and accommodating IOLs (mean  $34.2 \pm 12.1$  logits). The NAVQ includes questions related to intermediate and distance visual function (eg, using a computer and performing hobbies such as gardening or playing cards); the improved score with the Finevision IOL compared with other presbyopia-correcting IOLs may be due in part to the improved intermediate visual ability provided by the 1.75 D intermediate add power.

In conclusion, the Finevision trifocal IOL provided a good standard of distance vision acuity and intermediate and near visual function, as shown by defocus curve testing. The increasing far-vision dominance of the IOL as pupil size increases may be effective in reducing the photic phenomena frequently associated with multifocal IOLs. Near-vision satisfaction in this cohort of patients with bilateral implantation was high, which along with the clinical measures, suggests that the Finevision IOL is an effective method of providing good distance, near, and intermediate visual ability.



### WHAT WAS KNOWN

- Bifocal diffractive IOLs can provide good uncorrected distance and near acuities; however, intermediate vision may be poorer.
- Multifocal IOLs are also associated with frequent reports of dysphotopsia.

### WHAT THIS PAPER ADDS

- Bilateral implantation of the new trifocal diffractive IOL can provide an extended range of clear vision, with high levels of patient satisfaction relating to uncorrected near vision and no reports of dysphotopsia in this cohort.

### REFERENCES

- Zhang F, Sugar A, Jacobsen G, Collins M. Visual function and spectacle independence after cataract surgery: bilateral diffractive multifocal intraocular lenses versus monovision pseudophakia. *J Cataract Refract Surg* 2011; 37:853–858
- Fernández-Vega L, Alfonso JF, Baamonde MB, Montés-Micó R. Symmetric bilateral implantation of a distance-dominant diffractive bifocal intraocular lens. *J Cataract Refract Surg* 2007; 33:1913–1917
- Davison JA, Simpson MJ. History and development of the apodized diffractive intraocular lens. *J Cataract Refract Surg* 2006; 32:849–858
- Alfonso JF, Fernández-Vega L, Baamonde MB, Montés-Micó R. Correlation of pupil size with visual acuity and contrast sensitivity after implantation of an apodized diffractive intraocular lens. *J Cataract Refract Surg* 2007; 33:430–438
- Alió JL, Elkady B, Ortiz D, Bernabeu G. Clinical outcomes and intraocular optical quality of a diffractive multifocal intraocular lens with asymmetrical light distribution. *J Cataract Refract Surg* 2008; 34:942–948
- Blaylock JF, Si Z, Vickers C. Visual and refractive status at different focal distances after implantation of the ReSTOR multifocal intraocular lens. *J Cataract Refract Surg* 2006; 32:1464–1473
- Pepose JS, Qazi MA, Davies J, Doane JF, Loden JC, Sivalingham V, Mahmoud AM. Visual performance of patients with bilateral vs combination Crystalens, ReZoom, and ReSTOR intraocular lens implants. *Am J Ophthalmol* 2007; 144:347–357
- Hütz WW, Eckhardt H, Röhrig B, Grolmus R. Intermediate vision and reading speed with Array, Tecnis, and ReSTOR intraocular lenses. *J Refract Surg* 2008; 24:251–256
- Gatinel D, Pagnoulle C, Houbrechts Y, Gobin L. Design and qualification of a diffractive trifocal optical profile for intraocular lenses. *J Cataract Refract Surg* 2011; 37:2060–2067
- Voskresenskaya A, Pozdeyeva N, Pashtae N, Batkov Y, Treushnikov V, Cherednik V. Initial results of trifocal diffractive IOL implantation. *Graefes Arch Clin Exp Ophthalmol* 2010; 248:1299–1306
- Dick HB, Krummenauer F, Schwenn O, Krist R, Pfeiffer N. Objective and subjective evaluation of photic phenomena after monofocal and multifocal intraocular lens implantation. *Ophthalmology* 1999; 106:1878–1886
- Pieh S, Lackner B, Hanselmayer G, Zöhrer R, Sticker M, Weghaupt H, Fercher AF, Skorpik C. Halo size under distance and near conditions in refractive multifocal intraocular lenses. *Br J Ophthalmol* 2001; 85:816–821. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1724058/pdf/v085p00816.pdf>. Accessed October 9, 2012
- Lesieur G. Résultats après implantation d'un implant trifocal diffractif [Outcomes after implantation of a trifocal diffractive IOL]. *J Fr Ophtalmol* 2012; 35:338–342
- Montés-Micó R, España E, Bueno I, Charman WN, Menezo JL. Visual performance with multifocal intraocular lenses; mesopic contrast sensitivity under distance and near conditions. *Ophthalmology* 2004; 111:85–96
- Jacobi FK, Kammann J, Jacobi KW, Großkopf U, Walden K. Bilateral implantation of asymmetrical diffractive multifocal intraocular lenses. *Arch Ophthalmol* 1999; 117:17–23. Available at: <http://archophth.jamanetwork.com/data/Journals/OPHTH/9851/ecs80070.pdf>. Accessed October 9, 2012
- Buckhurst PJ, Wolffsohn JS, Gupta N, Naroo SA, Davies LN, Shah S. Development of a questionnaire to assess the relative subjective benefits of presbyopia correction. *J Cataract Refract Surg* 2012; 38:74–79
- Hawker MJ, Madge SN, Baddeley PA, Perry SR. Refractive expectations of patients having cataract surgery. *J Cataract Refract Surg* 2005; 31:1970–1975
- Pager CK. Expectations and outcomes in cataract surgery; a prospective test of 2 models of satisfaction. *Arch Ophthalmol* 2004; 122:1788–1792. Available at: <http://archophth.jamanetwork.com/data/Journals/OPHTH/9933/ECS30234.pdf>. Accessed October 9, 2012
- Muñoz G, Albarrán-Diego C, Ferrer-Blasco T, Sakla HF, García-Lázaro S. Visual function after bilateral implantation of a new zonal refractive aspheric multifocal intraocular lens. *J Cataract Refract Surg* 2011; 37:2043–2052
- Alió JL, Plaza-Puche AB, Piñero DP, Amparo F, Jiménez R, Rodríguez-Prats JL, Javaloy J, Pongo V. Optical analysis, reading performance, and quality-of-life evaluation after implantation of a diffractive multifocal intraocular lens. *J Cataract Refract Surg* 2011; 37:27–37
- Alfonso JF, Puchades C, Fernández-Vega L, Montés-Micó R, Valcárcel B, Ferrer-Blasco T. Visual acuity comparison of 2 models of bifocal aspheric intraocular lenses. *J Cataract Refract Surg* 2009; 35:672–676
- Guirao A, González C, Redondo M, Geraghty E, Norrby S, Artal P. Average optical performance of the human eye as a function of age in a normal population. *Invest Ophthalmol Vis Sci* 1999; 40:203–213. Available at: <http://www.iovs.org/cgi/reprint/40/1/203.pdf>. Accessed October 9, 2012
- Westcott MC, Tuft SJ, Minassian DC. Effect of age on visual outcome following cataract extraction. *Br J Ophthalmol* 2000; 84:1380–1382. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1723326/pdf/v084p01380.pdf>. Accessed October 9, 2012
- Desai P, Minassian DC, Reidy A. National cataract surgery survey 1997–8: a report of the results of the clinical outcomes. *Br J Ophthalmol* 1999; 83:1336–1340. Available at: <http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1722910&blobtype=pdf>. Accessed October 9, 2012
- Schmidinger G, Simader C, Dejacó-Ruhswurm I, Skorpik C, Pieh S. Contrast sensitivity function in eyes with diffractive bifocal intraocular lenses. *J Cataract Refract Surg* 2005; 31:2076–2083
- Pieh S, Weghaupt H, Skorpik C. Contrast sensitivity and glare disability with diffractive and refractive multifocal intraocular lenses. *J Cataract Refract Surg* 1998; 24:659–662
- Pomerance GN, Evans DW. Test-retest reliability of the CSV-1000 contrast test and its relationship to glaucoma therapy. *Invest Ophthalmol Vis Sci* 1994; 35:3357–3361. Available at: <http://www.iovs.org/cgi/reprint/35/9/3357>. Accessed October 9, 2012

28. Elliott DB. Contrast sensitivity decline with ageing: a neural or optical phenomenon? *Ophthalmic Physiol Opt* 1987; 7:415–419
29. Spear PD. Neural bases of visual deficits during aging. *Vision Res* 1993; 33:2589–2609
30. Javitt JC, Steinert RF. Cataract extraction with multifocal intraocular lens implantation; a multinational clinical trial evaluating clinical, functional, and quality-of-life outcomes. *Ophthalmology* 2000; 107:2040–2048
31. Leyland M, Zinicola E. Multifocal versus monofocal intraocular lenses in cataract surgery; a systematic review. *Ophthalmology* 2003; 110:1789–1798

#### OTHER CITED MATERIAL

- A. PhysiOL. Finevision product brochure, 2012. Available at: [http://international.physiol.be/\\_boutique/Multifocal-IOL/39739-FineVision.html](http://international.physiol.be/_boutique/Multifocal-IOL/39739-FineVision.html). Accessed October 9, 2012
- B. Buckhurst PJ, Wolffsohn JS, Shah S, Naroo S, Davies LN. Evaluation of dysphotopsia with multifocal intraocular lenses.

IOVS 2011; 52:E-Abstract 6185. Available at: <http://abstracts.iovs.org/cgi/content/abstract/52/6/6185?sid=cd47d4aa-3a70-407c-8326-0b320217ea88>. Accessed October 9, 2012

- C. Berrow EJ, Shah S, Wolffsohn JS, Sheppard AL, Bhatt U, Bhogal G, Buckhurst P. Binocular visual outcome of combining a segmented multifocal with an 'accommodating' intraocular lens. IOVS 2012; 53:E-Abstract 1367



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# Intra-ocular diathermy forceps

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## ABSTRACT.

**Purpose:** The purpose of this study was to develop intra-ocular diathermy forceps and test them on perfused porcine cadaver eyes.

**Methods:** We designed two types of 23-gauge intra-ocular bipolar diathermy forceps by modifying commercially available membrane peeling forceps. In the first type, the emitting electrode is connected to one-half of the core and the return electrode to the other half, with one jaw of the forceps attached to each half. In the second type, the emitting electrode is attached to the core and both jaws of the forceps, and the return electrode to the surrounding tube. We compared the new diathermy forceps to conventional intra-ocular diathermy, on perfused porcine cadaver eyes. First-order retinal artery and vein closure was confirmed both by a perfusion study and by histology of the treated vessels.

**Results:** Type 1 diathermy forceps closed retinal arteries and veins more successfully (five of five and five of five successful treatments, respectively) than Type 2 diathermy forceps (five of five and four of five, respectively) and conventional diathermy (three of five and four of five, respectively). Less energy was used with Type 1 compared to Type 2 and conventional for artery closure ( $1.5 \pm 0.0$  versus  $4.6 \pm 3.3$  versus  $2.1 \pm 0.8$  joules, respectively) and vein closure ( $1.5 \pm 0.0$  versus  $5.4 \pm 4.6$  versus  $2.4 \pm 0.8$  joules, respectively). Histology of the treated vessels confirmed the perfusion study results.

**Conclusion:** We designed two types of a new multifunctional intra-ocular instrument with the ability to peel membranes and to grasp, compress and coagulate retinal blood vessels. Both types pose operational advantages compared to current conventional intra-ocular diathermy.

**Key words:** coagulation – intra-ocular diathermy forceps – perfusion – porcine eye model – retinal blood vessels – retinal hemangioblastoma

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## Introduction

Intra-ocular diathermy was pioneered in the 1970s (Parel et al. 1974). Monopolar diathermy coagulated blood vessels, but caused collateral

retinal damage. Bipolar diathermy had narrower coagulation boundaries (Tate et al. 1975; Parel et al. 1983). There have been no advances in intra-ocular diathermy design since the 1980s, in contrast to laparoscopic

surgery, where bipolar diathermy forceps are routinely used since the 1990s (Entezari et al. 2007).

Current bipolar intra-ocular diathermy probes have multiple weaknesses, which become evident during attempted closure of hemangioblastoma feeder vessels (van Overdam et al. 2017). The conventional diathermy probe is point-shaped. The surgeon must push on the blood vessel with the probe to close it and then coagulate it. High energy levels are needed to coagulate the distal vessel wall, leading to collateral damage. Secondly, the tip of the diathermy probe blocks the surgeon's view of the blood vessel and coagulation reaction, unless the surgeon removes the probe from the treated area. Thirdly, in case of iatrogenic bleeding, there is unavoidable delay between the removal of the instrument involved in the bleeding episode and the introduction of the diathermy probe into the eye. This makes bleeding more difficult to control.

Therefore, we designed a new intra-ocular instrument combining the ability to apply mechanical compression from opposite sides, a diathermy function and a membrane peeling function, which addresses these weaknesses.

## Materials and Methods

Two types of bipolar diathermy forceps were developed by modifying available single-use 23-gauge peeling forceps (Vitrex, the Netherlands; Bausch & Lomb, US). In Type 1, the emitting electrode is connected to one-half of the core and the return electrode to the other half, with one jaw of the forceps attached to each half of the core. In

Type 2, the emitting electrode is attached to the core and both jaws of the forceps and the return electrode to the surrounding tube. Both types retain membrane peeling function.

The diathermy forceps were tested *ex vivo* on perfused porcine cadaver eyes. The eyes were harvested at a local abattoir immediately after killing the animal and transported in heparinized saline (50 units/ml), in melting ice. The time between eye harvesting and preparation was less than 6 hr.

The ophthalmic artery was cannulated with a 23-gauge cannula. The retinal vessels were accessed via an open-sky approach. The vitreous was segmented with No 05-0740 scissors (Lawton, Germany) and was removed, as much as possible, from the retinal surface, with cotton buds. The eyes were filled with perfluorodecalin (DORC, Netherlands). A blood

column was present in the retinal vessels at the end of the process.

We powered the diathermy instruments with a bipolar coagulator (450 kHz) (Aesculap, Germany), delivering power in 0.1 watt steps. The surgeon adjusted energy duration by foot pedal. A starting power of 1.5 watt was chosen based on published recommendations (Parel et al. 1983).

Fifteen porcine eyes were used, five with Type 1, five with Type 2 and five with a conventional disposable 23-gauge bipolar diathermy (Kirwan Surgical Products, US). We treated a first-order branch of the superior or inferior retinal artery and vein, by either compressing the vessel lumen from both sides with the diathermy forceps or by pushing from above with conventional diathermy, until we saw complete disruption of the blood column, caused by coagulation. We

confirmed the results of the coagulation treatment by perfusing the eyes with 100 ml heparinized (50 IU/ml) succinylated gelatin 4% (B.Braun, Germany) with 30 mg of fluorescein added to it, at 0.1 ml/min, using a microprocessor-controlled dispensing pump (ALT, US).

The eyes underwent standard formalin fixation and paraffin embedding prior to histological examination.

## Results

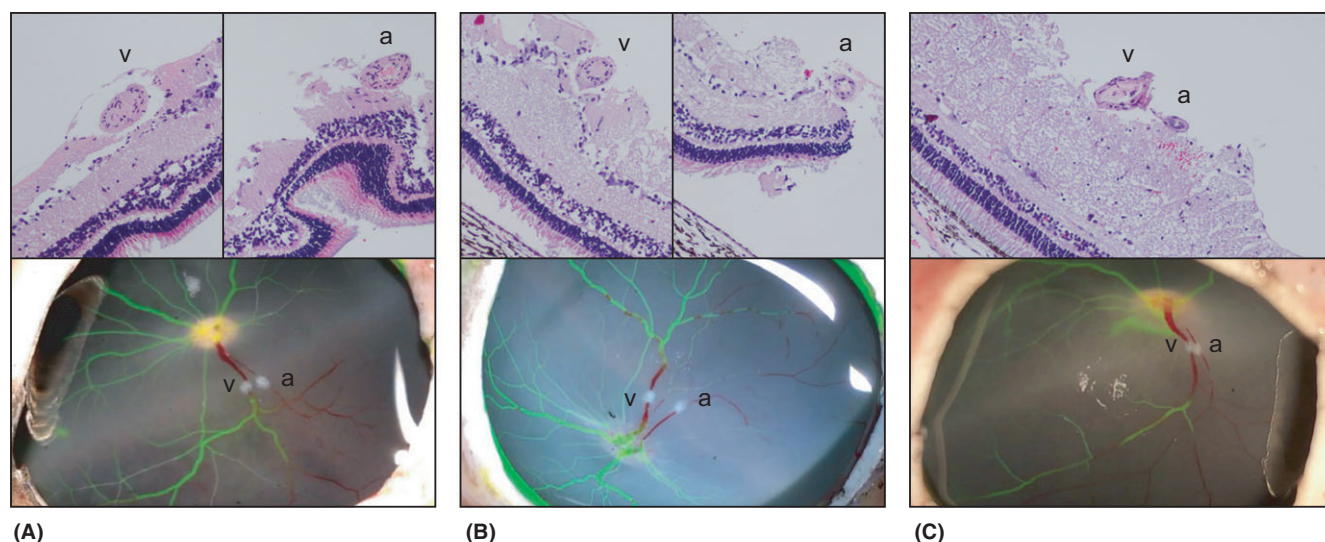
The results of the perfusion study and the energy required to close retinal arteries and veins with conventional, Type 1 and Type 2 diathermy forceps, are given in Table 1.

Two coagulation applications were needed with conventional diathermy in two of five eyes (arteries) and three of five eyes (veins) because the study

**Table 1.** *Ex vivo* performance of the diathermy forceps compared to conventional diathermy.

Diathermy Type	Eyes (n)	Closure rate		Energy (joules ± SD)		Time (seconds ± SD)	
		Artery	Vein	Artery	Vein	Artery	Vein
Conventional diathermy probe	5	3/5	4/5	2.1 ± 0.8	2.4 ± 0.8	1.4 ± 0.5	1.6 ± 0.5
Type 1 diathermy forceps	5	5/5	5/5	1.5 ± 0.0	1.5 ± 0.0	1.0 ± 0.0	1.0 ± 0.0
Type 2 diathermy forceps	5	5/5	4/5	4.6 ± 3.3	5.4 ± 4.6	1.2 ± 0.8	1.4 ± 1.1

SD = standard deviation.



**Fig. 1.** Fundus photographs and histology slides of coagulated porcine retinal blood vessels. Histology slides (above) and fundus photographs (below) of porcine retinal arteries (labelled a) and veins (labelled v) coagulated with conventional diathermy (panel A), Type 1 diathermy forceps (panel B) and Type 2 diathermy forceps (panel C). In the fundal photographs, the blood columns in the artery and vein have been interrupted by coagulation. The coagulated site and the blood vessel downstream from it show no flow during perfusion of the ophthalmic artery with fluorescein-stained fluid. The histology slides (magnification 100x; haematoxylin and eosin stain) show coagulated and closed retinal blood vessels following application of diathermy. Retinal detachment is a common artefact because of preparation of the eye for the perfusion study and/or tissue processing for histological examination.



investigator did not see sufficient coagulation reaction after the first application.

For Type 2 forceps, the starting power was increased to 4.0 watt because there was no diathermy effect with lower power in the first two eyes. More vitreous was removed from the retinal surface in the remaining three eyes, which reduced the power needed to close the vessels. Use of Type 2 diathermy forceps can be seen in the Video Clip S1.

Histology of the treated vessels confirmed the results of the perfusion study. Both types of forceps closed retinal arteries and veins more effectively than conventional diathermy. Fundus photographs and histology slides of coagulated porcine retinal blood vessels, coagulated with conventional, Type 1 and Type 2 diathermy forceps, are shown in Figure 1.

## Comment

This is the first report on two types of a new intra-ocular bipolar diathermy instrument, since the publication by Parel et al. (1983) on the conventional bipolar diathermy probe. Both types, in an *ex vivo* proof-of-concept study, grasp, compress and coagulate retinal blood vessels more effectively than conventional diathermy.

Our design successfully addresses weaknesses of conventional diathermy. Firstly, the blood vessel can be compressed between the jaws of the forceps and be coagulated using lower energy. Secondly, the design ensures visualization of the target blood vessel during the entire coagulation process so the minimum energy necessary is used. The *ex vivo* nature of the model allows for energy requirement comparison between the diathermy forceps and conventional diathermy. The comparison favours the diathermy forceps. Thirdly, the diathermy forceps can be

used as regular micro-forceps, with diathermy continuously available for tissues that are being manipulated and at risk of sudden bleeding.

The presence of vitreous close to blood vessels increased the energy requirements for coagulation when using Type 2 forceps. This may be because the space between the emitting and return electrodes (the jaws and the tube of the forceps) can be occupied by vitreous, which interferes, due to its higher impedance than water, with the electric current. In contrast, in Type 1 forceps, the emitting and return electrodes are connected to the jaws of the forceps with the target blood vessel, but no vitreous, directly between them.

We have designed a new intra-ocular instrument combining the ability to apply mechanical compression on opposite walls of a blood vessel, with a bipolar diathermy and membrane peeling function. This enables the surgeon to have, in effect, multiple instruments, including more effective diathermy, in one hand, meaning that there is no delay between onset of bleeding and coagulation. This will facilitate intra-ocular vascular control.

## References

- Entezari K, Hoffmann P, Goris M, Peltier A & van Velthoven R (2007): A review of currently available vessel sealing systems. *Minim Invasive Ther Allied Technol* **16**: 52–57.
- van Overdam KA, Missotten T, Kilic E & Spielberg LH (2017): Early surgical treatment of retinal hemangioblastomas. *Acta Ophthalmol* **95**: 97–102.
- Parel JM, Machemer R & Aumayr W (1974): A new concept for vitreous surgery. 4. Improvements in instrumentation and illumination. *Am J Ophthalmol* **77**: 6–12.
- Parel JM, Machemer R, O'Grady GE, Crock GW & Nose I (1983): Intraocular diathermy coagulation. *Graefes Arch Clin Exp Ophthalmol* **221**: 31–34.

Tate GW JR, Hutton WL, Vaiser A & Snyder WB (1975): A coaxial electrode for intraocular diathermy. *Am J Ophthalmol* **79**: 691–693.

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## Supporting Information

Additional Supporting Information may be found in the online version of this article:

**Video Clip S1.** Use of the diathermy forceps on a porcine retinal vein and artery. Subsequent perfusion of the ophthalmic artery with fluorescein-stained infusate shows that the coagulated sites and the blood vessels, downstream from those sites, show no flow.