PREOPERATIVE DIAGNOSIS: , Cataract, right eye., POSTOPERATIVE DIAGNOSIS:, Cataract, right eye., PROCEDURE:, Phacoemulsification with intraocular lens placement, right eye., ANESTHESIA:, Monitored anesthesia care, ESTIMATED BLOOD LOSS:, None, COMPLICATIONS:, None, SPECIMENS:, None, PROCEDURE IN DETAIL:, The patient had previously been examined in the clinic and was found to have a visually significant cataract in the right eye. The patient had the risks and benefits of surgery discussed. After discussion, the patient decided to proceed and the consent was signed. On the day of surgery, the patient was taken from the holding area to the operating suite by the anesthesiologist and monitors were placed. Following this, the patient was sterilely prepped and draped in the usual fashion. After this, a lid speculum was placed, preservative-free lidocaine drops were placed, and the SuperSharp blade was used to make an anterior chamber paracentesis. Preservative-free lidocaine was instilled into the anterior chamber, and then Viscoat was instilled into the eye., The 3.0 diamond keratome was then used to make a clear corneal temporal incision. Following this, the cystotome was used to make a continuous tear-type capsulotomy. After this, BSS was used to hydrodissect and hydrodelineate the lens. The phacoemulsification unit was used to remove the cataract. The I&A; unit was used to remove the residual cortical material. Following this, Provisc was used to inflate the bag. The lens, a model SA60AT of ABCD diopters, serial #1234, was inserted into the bag and rotated into position using the

Lester pusher., After this, the residual Provisc was removed. Michol was instilled and then the corneal wound was hydrated with BSS, and the wound was found to be watertight. The lid speculum was removed. Acular and Vigamox drops were placed. The patient tolerated the procedure well without complications and will be followed up in the office tomorrow.