TITLE OF OPERATION: ,1. Secondary scleral suture fixated posterior chamber intraocular lens implant with penetrating keratoplasty.,2. A concurrent vitrectomy and endolaser was performed by the vitreoretinal team.,INDICATION FOR SURGERY: ,The patient is a 62-year-old white male who underwent cataract surgery in 09/06. This was complicated by posterior capsule rupture. An intraocular lens implant was not attempted. He developed corneal edema and a preretinal hemorrhage. He is aware of the risks, benefits, and alternatives of the surgery and now wishes to proceed with secondary scleral suture fixated posterior chamber intraocular lens implant in the left eye, vitrectomy, endolaser, and penetrating keratoplasty.,PREOP DIAGNOSIS: ,1. Preretinal hemorrhage.,2. Diabetic retinopathy.,3. Aphakia.,4. Corneal edema.,POSTOP DIAGNOSIS: ,1. Preretinal hemorrhage.,2. Diabetic retinopathy.,3. Aphakia.,4. Corneal edema.,ANESTHESIA: , General.,SPECIMEN: ,1. Donor corneal swab sent to Microbiology.,2. Donor corneal scar rim sent to Eye Pathology.,3. The patient's cornea sent to Eye Pathology.,PROS DEV IMPLANT: ,ABC Laboratories 16.0 diopter posterior chamber intraocular lens, serial number 123456.,NARRATIVE: , Informed consent was obtained, and all questions were answered. The patient was brought to the preoperative holding area, where the operative left eye was marked. He was brought to the operating room and placed in the supine position. EKG leads were placed. General anesthesia was induced. The left ocular surface and periorbital skin were disinfected and draped in the standard

fashion for eye surgery after a shield and tape were placed over the unoperated right eye. A lid speculum was placed. The posterior segment infusion was placed by the vitreoretinal service. Peritomy was performed at the 3 and 9 o'clock limbal positions. A large Flieringa ring was then sutured to the conjunctival surface using 8-0 silk sutures tied in an interrupted fashion. The cornea was then measured and was found to accommodate a 7.5-mm trephine. The center of the cornea was marked. The keratoprosthesis was identified.,A 7.5-mm trephine blade was then used to incise the anterior corneal surface. This was done after a paracentesis was placed at the 1 o'clock position and viscoelastic was used to dissect peripheral anterior synechiae. Once the synechiae were freed, the above-mentioned trephination of the anterior cornea was performed. Corneoscleral scissors were then used to excise completely the central cornea. The keratoprosthesis was placed in position and was sutured with six interrupted 8-0 silk sutures. This was done without difficulty. At this point, the case was turned over to the vitreoretinal team, which will dictate under a separate note. At the conclusion of the vitreoretinal procedure, the patient was brought under the care of the cornea service. The 9-0 Prolene sutures double armed were then placed on each lens haptic loop. The keratoprosthesis was removed. Prior to this removal, scleral flaps were made, partial thickness at the 3 o'clock and 9 o'clock positions underneath the peritomies. Wet-field cautery also was performed to achieve hemostasis. The leading hepatic sutures were then passed through the

bed of the scleral flap. These were drawn out of the eye and then used to draw the trailing hepatic into the posterior segment of the eye followed by the optic. The trailing hepatic was then placed into the posterior segment of the eye as well. The trailing haptic sutures were then placed through the opposite scleral flap bed and were withdrawn. These were tied securely into position with the IOL nicely centered. At this point, the donor cornea punched at 8.25 mm was then brought into the field. This was secured with four cardinal sutures. The corneal button was then sutured in place using a 16-bite 10-0 nylon running suture. The knot was secured and buried after adequate tension was adjusted. The corneal graft was watertight. Attention was then turned back to the IOL sutures, which were locked into position. The ends were trimmed. The flaps were secured with single 10-0 nylon sutures to the apex, and the knots were buried. At this point, the case was then turned back over to the vitreoretinal service for further completion of the retinal procedure. The patient tolerated the corneal portions of the surgery well and was turned over to the retina service in good condition, having tolerated the procedure well. No complications were noted. The attending surgeon, Dr. X, performed the entire procedure. No complications of the procedure were noted. The intraocular lens was selected from preoperative calculations. No qualified resident was available to assist.