PREOPERATIVE DIAGNOSES:,1. Senile nuclear cataract, left eye.,2. Senile cortical cataract, left eye., ,POSTOPERATIVE DIAGNOSES:,1. Senile nuclear cataract, left eye.,2. Senile cortical cataract, left eye., ,PROCEDURES: , Phacoemulsification of cataract, extraocular lens implant in left eye., ,LENS IMPLANT USED:, Alcon, model SN60WF, power of 22.5 diopters., ,PHACOEMULSIFICATION TIME:, 1 minute 41 seconds at 44.4% power., ,INDICATIONS FOR PROCEDURE: , This patient has a visually significant cataract in the affected eye with the best corrected visual acuity under moderate glare conditions worse than 20/40. The patient complains of difficulties with glare in performing activities of daily living.,INFORMED CONSENT:, The risks, benefits and alternatives of the procedure were discussed with the patient in the office prior to scheduling surgery. All questions from the patient were answered after the surgical procedure was explained in detail. The risks of the procedure as explained to the patient include, but are not limited to, pain, infection, bleeding, loss of vision, retinal detachment, need for further surgery, loss of lens nucleus, double vision, etc. Alternative of the procedure is to do nothing or seek a second opinion. Informed consent for this procedure was obtained from the patient.,OPERATIVE TECHNIQUE: , The patient was brought to the holding area. Previously, an intravenous infusion was begun at a keep vein open rate. After adequate sedation by the anesthesia department (under monitored anesthesia care conditions), a peribulbar and retrobulbar block was given around the operative eye. A total of 10 mL mixture with a

70/30 mixture of 2% Xylocaine without epinephrine and 0.75% bupivacaine without epinephrine. An adequate amount of anesthetic was infused around the eye without giving excessive tension to the eye or excessive chemosis to the periorbital area. Manual pressure and a Honan balloon were placed over the eye for approximately 2 minutes after injection and adequate akinesia and anesthesia was noted. Vital sign monitors were detached from the patient. The patient was moved to the operative suite and the same monitors were reattached. The periocular area was cleansed, dried, prepped and draped in the usual sterile manner for ocular surgery. The speculum was set into place and the operative microscope was brought over the eye. The eye was examined. Adequate mydriasis was observed and a visually significant cataract was noted on the visual axis.,A temporal clear corneal incision was begun using a crescent blade with an initial groove incision made partial thickness through the temporal clear cornea. Then a pocket incision was created without entering the anterior chamber of the eye. Two peripheral paracentesis ports were created on each side of the initial incision site. Viscoelastic was used to deepen the anterior chamber of the eye. A 2.65 mm keratome was then used to complete the corneal valve incision. A cystitome was bent and created using a tuberculin syringe needle. It was placed in the anterior chamber of the eye. A continuous curvilinear capsulorrhexis was begun. It was completed using O'Gawa Utrata forceps. A balanced salt solution on the irrigating cannula was placed through the paracentesis port of the eye to affect

hydrodissection and hydrodelineation of the lens nucleus. The lens nucleus was noted to be freely mobile in the bag.,The phacoemulsification tip was placed into the anterior chamber of the eye. The lens nucleus was phacoemulsified and aspirated in a divide-and-conquer technique. All remaining cortical elements were removed from the eye using irrigation and aspiration using a bimanual technique through the paracentesis ports. The posterior capsule remained intact throughout the entire procedure. Provisc was used to deepen the anterior chamber of the eye. A crescent blade was used to expand the internal aspect of the wound. The lens was taken from its container and inspected. No defects were found. The lens power selected was compared with the surgery worksheet from Dr. X's office. The lens was placed in an inserter under Provisc. It was placed through the wound, into the capsular bag and extruded gently from the inserter. It was noted to be adequately centered in the capsular bag using a Sinskey hook. The remaining viscoelastic was removed from the eye with irrigation an aspiration through the paracentesis side ports using a bimanual technique. The eye was noted to be inflated without overinflation. The wounds were tested for leaks, none were found. Five drops dilute Betadine solution was placed over the eye. The eye was irrigated. The speculum was removed. The drapes were removed. The periocular area was cleaned and dried. Maxitrol ophthalmic ointment was placed into the interpalpebral space. A semi-pressure patch and shield was placed over the eye. The patient was taken to the floor in stable and satisfactory

condition, was given detailed written instructions and asked to follow up with Dr. X tomorrow morning in the office.