PREOPERATIVE DIAGNOSIS:, Visually significant nuclear sclerotic cataract, right eye.,POSTOPERATIVE DIAGNOSIS: , Visually significant nuclear sclerotic cataract, right eye.,OPERATIVE PROCEDURES: , Phacoemulsification with posterior chamber intraocular lens implantation, right eye.,ANESTHESIA:, Monitored anesthesia care with retrobulbar block consisting of 2% lidocaine in an equal mixture with 0.75% Marcaine and Amphadase.,INDICATIONS FOR SURGERY:, This patient has been experiencing difficulty with eyesight regarding activities of daily living. There has been a progressive and gradual decline in the visual acuity. The cataract was believed related to her decline in vision. The risks, benefits, and alternatives (including with observation or spectacles) were discussed in detail. The risks as explained included, but are not limited to pain, bleeding, infection, decreased or loss of vision/loss of eye, retinal detachment requiring further surgery, and possible consultation out of town, swelling of the back part of the eye/retina, need for prolonged eye drop use or injections, instability of the lens, and loss of corneal clarity necessitating long-term drop use or further surgery. The possibility of needing intraocular lens exchange or incorrect lens power was discussed. Anesthesia option and risks associated with anesthesia and retrobulbar anesthesia were discussed. It was explained that some or all of these complications might arise at the time of or months to years after surgery. The patient had a good understanding of the risks with the proposed, elective eye surgery. The patient accepted these risks and

elected to proceed with cataract surgery. All questions were answered and informed consent was signed and placed in the chart.,DESCRIPTION OF PROCEDURE: , The patient was identified and the procedure was verified. The pupil was dilated per protocol. The patient was taken to the operating room and placed in the supine position. After intravenous sedation, the retrobulbar block was injected followed by several minutes of digital massage. No signs of orbital tenseness or retrobulbar hemorrhage were present.,The patient was prepped and draped in the usual ophthalmic sterile fashion. An eyelid speculum was used to separate the eyelids. A crescent blade was used to make a clear corneal temporally located incision. A 1-mm Dual-Bevel blade was used to make a paracentesis site. The anterior chamber was filled with viscoelastic (Viscoat). The crescent blade was then used to make an approximate 2-mm long clear corneal tunnel through the temporal incision. A 2.85-mm keratome blade was then used to penetrate into the anterior chamber through the temporal tunneled incision. A 25-gauge pre-bent cystotome used to begin a capsulorrhexis. The capsulorrhexis was completed with the Utrata forceps. A 27-guage needle was used for hydrodissection and three full and complete fluid waves were noted. The lens was able to be freely rotated within the capsular bag. Divide-and-conquer ultrasound was used for phacoemulsification. After four sculpted grooves were made, a bimanual approach with the phacoemulsification tip and Koch spatula was used to separate and crack each grooved segment. Each of the four

nuclear quadrants was phacoemulsified. Aspiration was used to remove all remaining cortex. Viscoelastic was used to re-inflate the capsular bag. An AMO model SI40NB posterior chamber intraocular lens with power *** diopters and serial number *** was injected into the capsular bag. The trailing haptic was placed with the Sinskey hook. The lens was made well centered and stable. Viscoelastic was aspirated. BSS was used to re-inflate the anterior chamber to an adequate estimated intraocular pressure. A Weck-Cel sponge was used to check both incision sites for leaks and none were identified. The incision sites remained well approximated and dry with a well-formed anterior chamber and eccentric posterior chamber intraocular lens. The eyelid speculum was removed and the patient was cleaned free of Betadine. Vigamox and Econopred drops were applied. A soft eye patch followed by a firm eye shield was taped over the operative eye. The patient was then taken to the Postanesthesia Recovery Unit in good condition having tolerated the procedure well.,Discharge instructions regarding activity restrictions, eye drop use, eye shield/patch wearing, and driving restrictions were discussed. All questions were answered. The discharge instructions were also reviewed with the patient by the discharging nurse. The patient was comfortable and was discharged with followup in 24 hours. Complications none.