PREOPERATIVE DIAGNOSIS: , Cataract to right eye.,POSTOPERATIVE DIAGNOSIS: , Cataract to right eye.,PROCEDURE PERFORMED: ,Cataract extraction with intraocular lens implant of the right eye, anterior vitrectomy of the right eye.,LENS IMPLANT USED: ,See below.,COMPLICATIONS: , Posterior capsular hole, vitreous prolapse.,ANESTHESIA: ,Topical.,PROCEDURE IN DETAIL: ,The patient was identified in the preoperative holding area before being escorted back to the operating room suite. Hemodynamic monitoring was begun. Time-out was called and the patient eye operated upon and lens implant intended were verbally verified. Three drops of tetracaine were applied to the operative eye. The patient was then prepped and draped in usual sterile fashion for intraocular surgery. A lid speculum was placed. Two paracentesis sites were created approximately 120 degrees apart straddling the temple using a slit knife. The anterior chamber was irrigated with a dilute 0.25% solution of non-preserved lidocaine and filled with Viscoat. The clear corneal temporal incision was fashioned. The anterior chamber was entered by introducing a keratome. The continuous tear capsulorrhexis was performed using the bent needle cystotome and completed with Utrata forceps. The cataractous lens was then hydrodissected and phacoemulsified using a modified phaco-chop technique. Following removal of the last nuclear quadrant, there was noted to be a posterior capsular hole nasally. This area was tamponaded with Healon. The anterior chamber was swept with a cyclodialysis spatula and there was noted to be vitreous

prolapse. An anterior vitrectomy was then performed bimanually until the vitreous was cleared from the anterior chamber area. The sulcus area of the lens was then inflated using Healon and a V9002 16.0 diopter intraocular lens was unfolded and centered in the sulcus area with haptic secured in the sulcus. There was noted to be good support. Miostat was injected into the anterior chamber and viscoelastic agent rinsed out of the eye with Miostat. Gentle bimanual irrigation, aspiration was performed to remove remaining viscoelastic agents anteriorly. The pupil was noted to constrict symmetrically. Wounds were checked with Weck-cels and found to be free of vitreous. BSS was used to re-inflate the anterior chamber to normal depth as confirmed by tactile pressure at about 12. All corneal wounds were then hydrated, checked and found to be watertight and free of vitreous. A single 10-0 nylon suture was placed temporarily as prophylaxis and the knot buried. Lid speculum was removed. TobraDex ointment, light patch and a Soft Shield were applied. The patient was taken to the recovery room, awake and comfortable. We will follow up in the morning for postoperative check. He will not be given Diamox due to his sulfa allergy. The intraoperative course was discussed with both he and his wife.