

PREOPERATIVE DIAGNOSIS:, Cataract, nuclear sclerotic, right eye.,POSTOPERATIVE DIAGNOSIS:, Cataract, nuclear sclerotic, right eye.,OPERATIVE PROCEDURES: , Phacoemulsification with intraocular lens implantation, right eye.,ANESTHESIA: , Topical tetracaine, intracameral lidocaine, monitored anesthesia care.,IOL: , AMO Model SI40 NB, power \*\*\* diopters.,INDICATIONS FOR SURGERY: , This patient has been experiencing difficulty with eyesight regarding activities in their daily life. There has been a progressive and gradual decline in the visual acuity. By examination, this was found to be related to cataracts. The risks, benefits, and alternatives (including observation or spectacles) were discussed in detail. The patient accepted these risks and elected to proceed with cataract surgery. All questions were answered and informed consent was obtained.,Questions were answered in personal conference with the patient to ensure that the patient had a good grasp of the operative goals, risks, and alternatives involved as well as the postoperative instructions. A preoperative surgical history and physical examination was done to ensure that the patient was in optimal general health for cataract surgery. To minimize and decrease the chance of bacterial infection, the patient was started on a course of antibiotic drops for two days prior to surgery.,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 a comfortable supine position. The operative table was placed in Trendelenburg head-up tilt

to decrease orbital congestion and posterior vitreous pressure. The patient was prepped and draped in the usual ophthalmic sterile fashion. The lids and periorbital area were prepped with full-strength Betadine solution with care taken to concentrate on sterilizing the eyelid margins. The conjunctival cul-de-sac was also prepped in dilute Betadine solution. The fornices were also prepped. The drape was done meticulously to ensure complete eyelash inclusion. An eyelid speculum was placed to separate the eyelids. A paracentesis site was made. Intracameral preservative-free lidocaine was injected. Amvisc Plus was then used to stabilize the anterior chamber. A 3-mm diamond blade was then used to carefully construct a clear corneal incision in the temporal location. A 25-gauge pre-bent cystotome was used to begin a capsulorrhexis. The capsular flap was removed. A 27-gauge blunt cannula was used for hydrodissection. The lens was able to be freely rotated within the capsular bag. Divide-and-conquer technique 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 remaining cortex with the I/A handpiece. Viscoelastic was used to re-inflate the capsular bag. The intraocular lens was injected into the capsular bag. The lens was then dialed into position. The lens was well-centered and stable. Viscoelastic was aspirated. BSS was used to re-inflate the anterior chamber to an adequate estimated intraocular

pressure along with stromal hydration. 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 well-centered intraocular lens. The eyelid speculum was removed and the patient was cleaned free of Betadine. Zymar and Pred Forte drops were applied. 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.