Modern ECCE, Phaco to & fro

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My Golden rules

- **Patient selection.**
- **Decision(s).**
- **Visualization (operative).**
- **Where to start?**
- **When to consult? & who?**
- **When to convert? & how?**

I. Patient Selection

History

- Age; (extreme)
  Infant: uveitis
  Old: eye and/or systemic co-morbidity, zonular instability
- Occupation; VIPs, trouble maker
- Recommended
- personality

I. Patient Selection

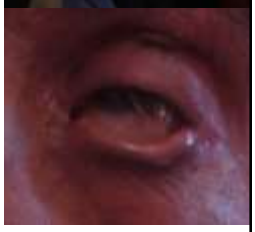
- Systemic disease; dyspnea
- Social history; post operative care and hygiene
- Drugs;
  - Anticoagulant **(recent, INR)**
  - Prostate, stop or not?
    Female??? Urinary dysfunction, renal stone

Examination

- General examination;
  Kyphosis (special bed),
  tremor (head fixation).

- Supra-orbital ridge, sunken globe.
  (Temporal approach)

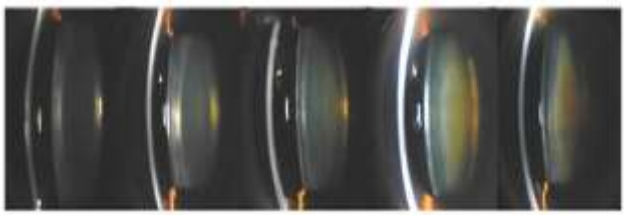
- Lid mal-position



- Ocular surface inflammation Vs **infection**

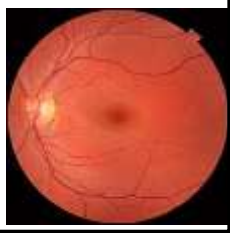
- Cornea; dystrophies, opacities
  Prognosis vs visualization

- Before dilatation;
  Rubeosis,
  Pupil reaction,
  Angle,
  Iris itself.



- AC depth

- Density of cataract, optic disc



- Detailed dilated fundus examination
  (Eg, AION, RP, CNV, Scar, Hole, DR, etc)

I. Patient Selection

- To avoid what make surgery is more difficult
- And what make the prognosis guarded

II. DECISION(s)

- To do or not?
- Anesthesia?
- Phaco or ECCE?
- Power of phaco?
- Power, Type of IOL?

II. DECISION

- Decision taken at the clinic with slit-lamp help rather than OR.
- If any doubt, be safe (easy way is the best).
- Respect the anatomy.
- Respect other eye whatever the circumstances.
- Respect general condition.
- **Is it better for the patient or the surgeon?**

II. DECISION

- **Types of Anesthesia;**

1. GA,
2. Retro-bulbar,
3. Peri-bulbar & Sub-Tenon,
4. Topical +/- intra-cameral.

N.B. According to ASCRS, 60% TOPICAL

III. Visualization

- **Surgeon sitting**

1. Back support
2. Hand support
3. Neck extended
4. Feet and foot pedal

- **Microscopic sitting**

1. Reset
2. High magnification
3. Iris pattern

III. Visualization

- **Patient sitting(Red reflex)**

1. Head support
2. Comfort
3. Head and/or hand fixation

- **Corneal corrugation** (ant. Vs post. Lip of tunnel)
- **Eye wandering**

IV. Where to start?

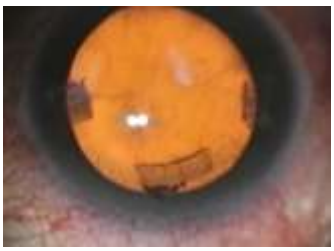
Retrograde is better

- Aspiration of VES
- I & A of lens matter
- 2nd quadrant (in the center)
- Avoid the last, avoid the 1st
- IOL implantation
- Hydration
- The groove
- Rhexis, always try.
- A-Z

IV. How to start?

- **Tunnel and site ports;**
  - Site; posterior with myopia
  - Dimensions; short with myopia

Video pass through



IV. How to start?

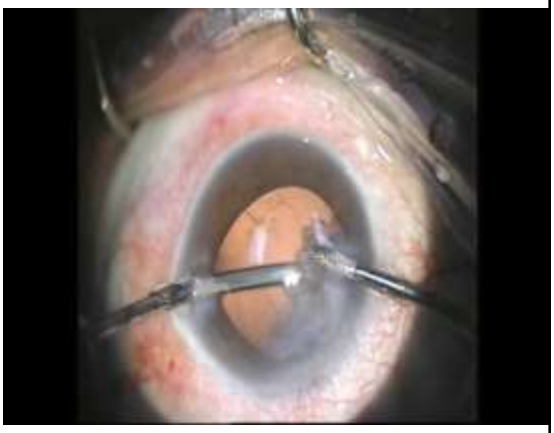
- **Capsulorhexis;** RRCS
  - Always try it even before phaco shift
  - Needle bent
  - start at center to desired diameter
  - 3 clock hours

IV. How to start?

- **Phaco technique:**
  - Start with divide and conquer
  - Groove depth
  - Groove length
  - Shift to stop and chop (optional)
  - Shift to quick chopping (optional)
  - Master all technique
  - Take it to the center

IV. How to start?

- **I & A;**
  - Introduction
  - Engagement
  - Stripping
  - Aspiration

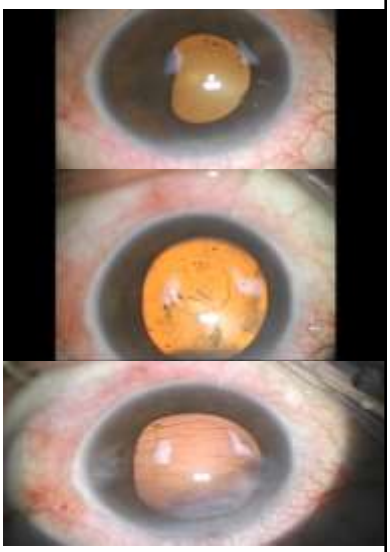


IV. How to start?

- Keep instruments floating within the site ports
- Keep The AC formed
- Keep calm
- Keep your patient calm
- Keep fluiability of the steps
- Keep Visualization

V. When to consult? Ask for HELP

- Tunnel
- Capsulorhexis
- Phaco
- I & A
- IOL implantation
- Hydration



VI. When to convert? & How?

- Tunnel
- Capsulorhexis
- Phacoemulsification
- PCR

VI. When to convert? & How?

- Keep calm and form the AC
- Separate new well coapted section rather than enlarged tunnel
- Release capsulotomy
- Vitrectomy if needed after suturing and not from the tunnel

ECCE

- Clear corneal incision

ECCE

- Post-SST Modern ECCE

Conclusion

- ECCE is very impotant surgical station, but not the last
- Phaco-shift step is mandatory
- Even with best hand, ECCE still has a place in cataract surgery
- think twice, is Phaco better for surgeon or for patient?
- Each man walks in a different way, let us hope that all the ways will lead us to the bagal IOL (ROME).

THANK YOU