Iris Extirpation, Iris Prosthesis, and Endothelial Keratoplasty:
A New Paradigm for "Doomed" Transplants

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Disclosures

- Alcon: Research
- Beyeonics: Consultant
- Bausch and Lomb: Research
- DORC: Consultant
- Gore: Consultant
- Haag-Streit: Consultant
- Humanoptics: Consultant, Royalties
- Johnson and Johnson Vision: Research
- Plexitome: Research
- VEO Ophthalmics: Royalties

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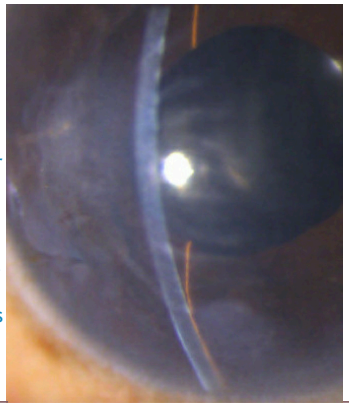
The Problem:

- Iridocorneal adhesions or peripheral anterior synechiae (PAS) are most commonly formed during states of intraocular inflammation including uveitis, glaucoma, and/or surgical or laser surgery in the anterior segment.
- PAS are known contributors to corneal endothelial graft failure, possibly via stimulation of increased T-lymphocyte activity
- Prior studies have found that iridectomy or iris extirpation prior to corneal endothelial transplantation in patients with ICE Syndrome can reduce keratoplasty rejection rates



The Problem:

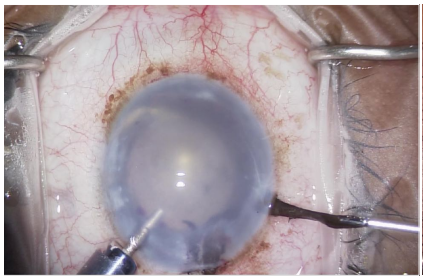
- A bubble placed in an AC with high IK adhesions will likely push the iris forward and cause higher or near total IK adhesions…
- ..Also increases the risk of angle closure glaucoma and resultant sequelae, including graft failure.

Yamagami S, Tsuru T. Increase in orthotopic murine corneal transplantation rejection rate with anterior synechiae. *Invest Ophthalmol Vis Sci*. 1999;40(10):2422-2426.
Chaurasia S, Senthil S, Choudhari N. Outcomes of Descemet stripping endothelial keratoplasty combined with near total iridectomy in iridocorneal endothelial syndrome. *BMJ Case Rep*. 2021;14(2):e240988.

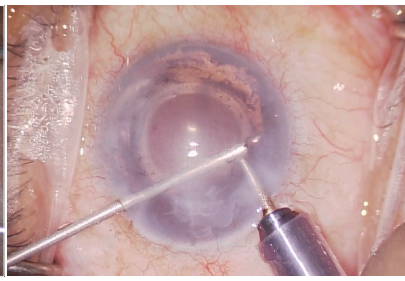
Case Series

- Single surgeon retrospective case series
- Corneal endothelial failure who underwent…
- Combined iris extirpation…
- Custom, flexible, artificial iris implantation…
- Simultaneous (Descemet stripping) automated endothelial keratoplasty

Iris Removal

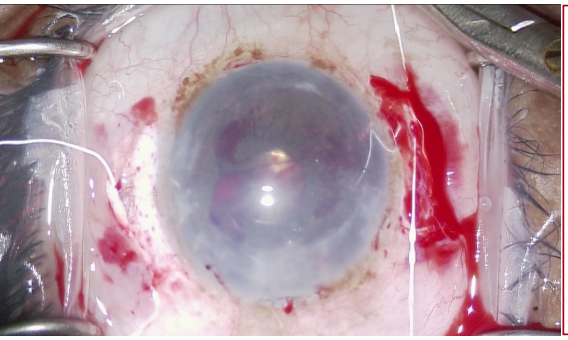


Mechanical Extirpation with 23-g forceps



Vitrector Iris Removal

Iris Prosthesis Placement

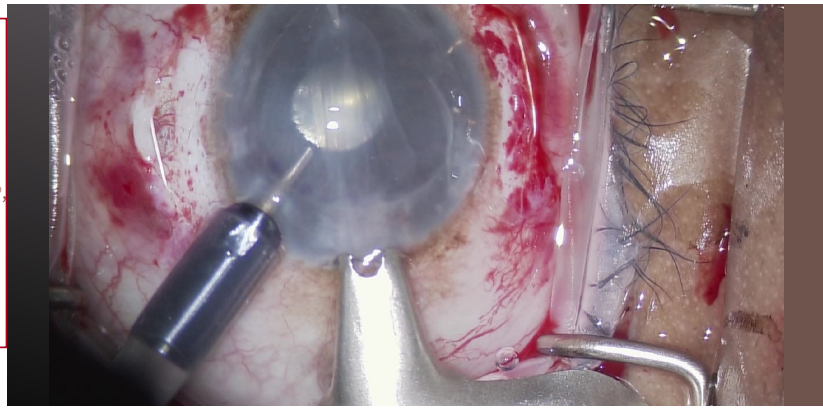


4-point scleral suture fixation of custom, flexible, artificial iris prosthesis

Expanded polytetrafluoroethylene suture (ePTFE, Gore-Tex®, off-label use)

Recreates (at least) relative separation between anterior and posterior segments

Placement of Graft into Recreated, Deep AC



Results:

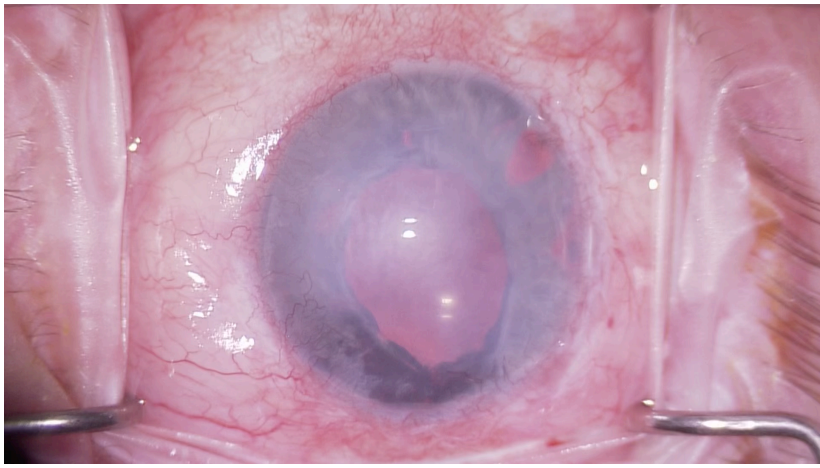
Demographics and Baseline Characteristics	
Gender	4 male, 3 female
Age in years (mean, range)	53, 10-74
Number of Prior Corneal Transplants (mean, range)	2, 0-4
Baseline Visual Acuity (logMAR)	1.45

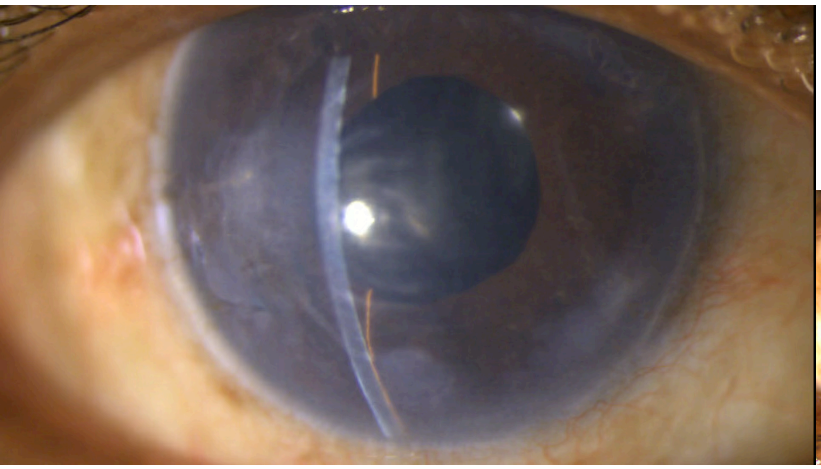
Reason for Initial Corneal Allograft	
Tube Shunt Related Bullous Keratopathy	2
Perforated Infectious Keratitis	2
Fuchs' Endothelial Dystrophy	1
Pseudophakic Bullous Keratopathy	1
Prior Surgical Trauma	1

Results:

Post-Operative Course						
	Baseline Vision (Snellen)	BCVA at POM1 (Snellen)	BCVA at Peak (Snellen)	Re-bubbling	Graft Survival	Other Complications and Surgeries
Eye 1	HM	20/100 +1	20/70	Yes	9 months*	
Eye 2	20/70	20/40	20/30	No	10 months*	
Eye 3	20/100	20/125	20/40	Yes	18 months*	
Eye 4	HM	20/60	20/40	No	2 years	Delayed suprachoroidal hemorrhage requiring drainage with retina surgeon
Eye 5	20/100	LP	20/250	Yes	6 months*	Persistent vitreous hemorrhage requiring pars plana vitrectomy, retinal detachment
Eye 6	20/400	20/80	20/40	Yes	2 years	Lost to follow up, re-presented with biopsy confirmed fibrous downgrowth requiring excision and IOL exchange
Eye 7	CF	20/400	20/125	Yes	18 months*	Retinal detachment requiring pars plana vitrectomy, steroid response requiring tube shunt

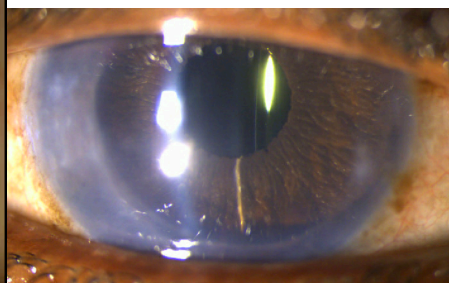
Iris Extirpation, Iris Prosthesis, & AEK – 2 Videos

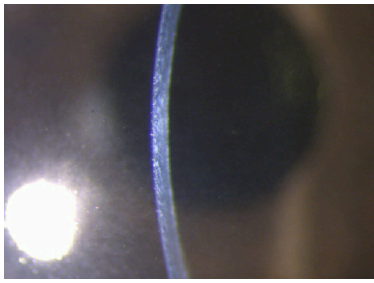




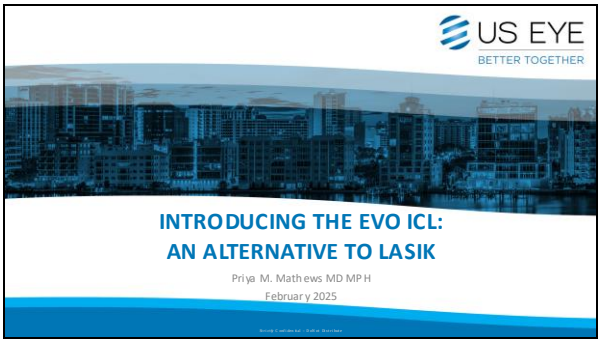
Conclusions

- Combined Iris extirpation, iris prosthesis implantation and endothelial keratoplasty is a viable surgical strategy in eyes with endothelial decompensation and irido-corneal adhesions
- This series represents patients with complex medical and surgical ocular histories, and a wide range of etiologies for initial corneal decompensation





Qs?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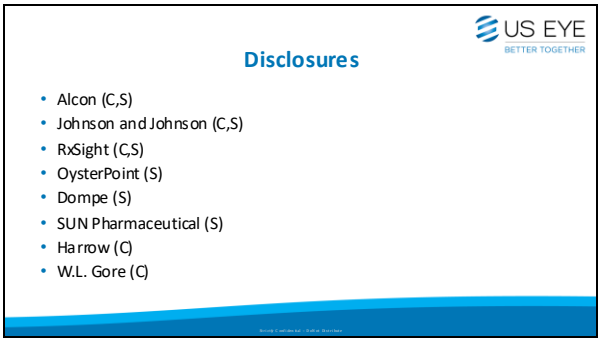
INTRODUCING THE EVO ICL:
AN ALTERNATIVE TO LASIK
Priya M. Mathews MD MPH
February 2025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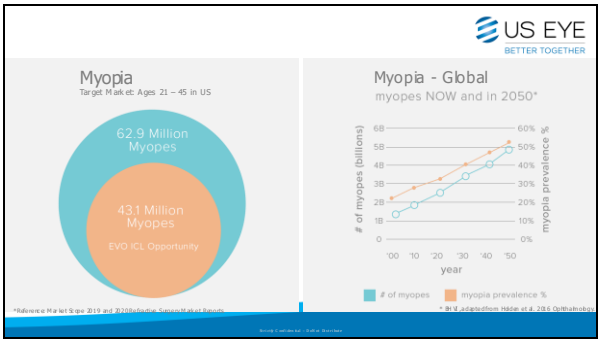
Disclosures
• Alcon (C,S)
• Johnson and Johnson (C,S)
• RxSight (C,S)
• OysterPoint (S)
• Dompe (S)
• SUN Pharmaceutical (S)
• Harrow (C)
• W.L. Gore (C)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Myopia
Target Market: Ages 21 – 45 in US
62.9 Million Myopes
43.1 Million Myopes
EVO ICL Opportunity
Myopia - Global
myopes NOW and in 2050*
# of myopes (billions)
myopia prevalence %
year
# of myopes
myopia prevalence %

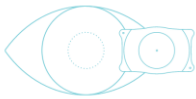
Prevalence of Myopia

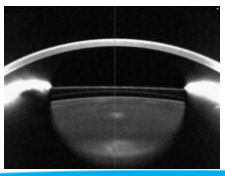
Myopia is projected to affect almost half of the world's population by **2050** — a sevenfold increase

- 5 billion with myopia
- 1 billion with high myopia (>-6D)
- US and Canada increase to 260 million, or close to half of the population, up from 89 million in 2000
- High myopia cases will increase by five times to 66 million

Introduction to the EVO

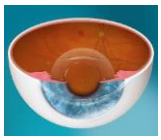
The EVO Visian ICL is a posterior chamber phakic IOL made of biocompatible Collamer implanted in the eye and positioned behind the iris and in front of the natural lens





Introduction to the EVO

- Age: 21 to 45
- Correction or reduction of myopia -3.0 D to -20.0 D with astigmatism correction up to 4.0 D
- Stable Refraction
- Anterior Chamber Depth (ACD) of 3.0 mm or greater
  - From Endothelium to Natural Lens
- Other considerations for those with
  - Thin corneas / corneas at risk for ectasia
  - Dry Eye Risk Factors



The EVO ICL Family of Lenses

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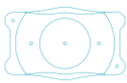
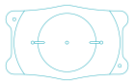
- The addition of the central port to EVO facilitates the flow of aqueous humor through the lens, **eliminating the need for peripheral iridotomies (PIs) prior to implantation.**
- STAAR's Collamer® material has a proven history of over 20 years with **more than 1 million EVO lens implants worldwide**.
- The EVO ICL has a large treatable market and very favorable demographics.



EVO/EVO+Sphere



EVO/EVO+Toric

Benefits of EVO Visian ICL

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A Quick Procedure & Recovery

20-30 minute procedure or less and most people are able to resume daily activities in just a few days with clearer vision.

No Dry Eye Syndrome

By not removing the corneal tissue, the EVO Visian ICL procedure is clinically proven to not cause or worsen dry eye syndrome.[1]

Night Vision

In a clinical study, the EVO Visian ICL provided excellent night vision.[2]

Benefits of EVO Visian ICL

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Biocompatible

EVO is additive lens procedure and works together with the natural parts of your eye to improve your vision.

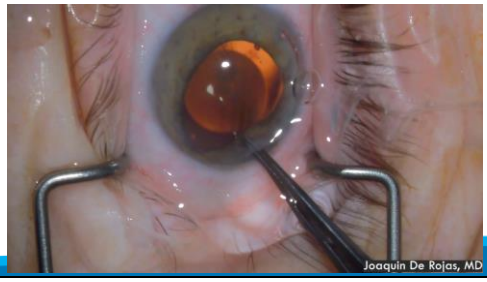
UV Protection

EVO is made of Collamer®, a material shown to be safe in the eye. Collamer provides UV protection and contains collagen, a naturally occurring protein in the body.

Removability

While EVO is designed to be permanently correct your vision, the lens can be removed by a doctor for added peace of mind.

ICL removal is straightforward, such as at time of



EVO ICL Patient Selection Guide: Postoperative Assessment

- RECOMMENDED PATIENT POSTOPERATIVE ASSESSMENT [1]
  - Intraocular pressure should be initially checked 1 – 6 hours postoperatively
  - Postoperative 1 day, 7 day and beyond
  - Visual acuity
  - Intraocular pressure
  - Assess the ICL to crystalline lens vault

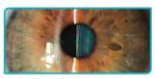
1. Chuck RS, Jacobs DS, Lee JK, Afshari NA, Vitale S, Shen TT, et al. Refractive Errors & Refractive Surgery Preferred Practice Pattern®. Ophthalmology. 2018;125(1):P1-p104.

Measuring the Vault

Although the postoperative vault of EVO is intended to be approximately equal to the central corneal thickness, the optimal vault should be between 50% and 150% of central corneal thickness, this being equivalent to a range of 250 to 900 microns.

- However, in the absence of symptoms, lens vault outside this range may not necessarily require exchange or removal. [1]


NORMAL VAULT


SHALLOW VAULT


HIGH VAULT

1. STAR EVO ICL Directions for Use

EVO/EVO+ ICL FDA Study: Efficacy

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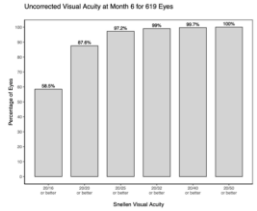

- Mean postoperative UDVA better than 20/20 at all time points

Packer M. United States Multicenter Clinical Trial of a Posterior Chamber Phakic Implantable Lens with a Central Port for Myopia or Myopic Astigmatism. American Society of Cataract and Refractive Surgery Annual Meeting. Washington DC. 24 April 2022.

EVO/EVO+ ICL FDA Study: Predictability and Accuracy

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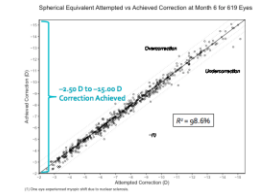

90.5% within ± 0.50 D / 98.9% within ± 1.00 D

EVO/EVO+ ICL FDA Study: Efficacy

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	Eyes (n)	Follow Up	Efficacy Index	UDVA	Accuracy within ± 0.50 D	Accuracy within ± 1.0 D
Published Literature[1]	n = 1,905	Up to 5 years	1.04	-0.02 logMAR	90.8%	98.7%
FDA Clinical Trial	n = 629	6 months	1.06	-0.059 logMAR	90.5%	98.9%

1. Packer M. The implantable Collamer Lens with a central port: review of the literature. Clinical Ophthalmology. 2018:12 2427–2438.
Packer M. United States Multicenter Clinical Trial of a Posterior Chamber Phakic Implantable Lens with a Central Port for Myopia or Myopic Astigmatism. American Society of Cataract and Refractive Surgery Annual Meeting. Washington DC. 24 April 2022.

EVO/EVO+ ICL FDA Study: Stability

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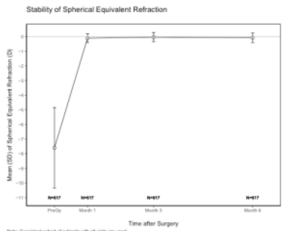

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EVO/EVO+ ICL FDA Study: Safety

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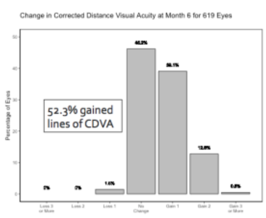

- 98.5% of eyes CDVA at 6 months equal to or better than preoperative CDVA
- All eyes had CDVA 20/32 or better at 1, 3 and 6 months

Packer M. United States Multicenter Clinical Trial of a Posterior Chamber Phakic Implantable Lens with a Central Port for Myopia or Myopic Astigmatism. American Society of Cataract and Refractive Surgery Annual Meeting. Washington DC, 24 April 2022.

EVO/EVO+ ICL FDA Study: Intraocular Pressure

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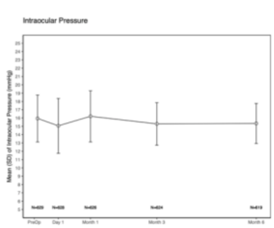

Packer M. United States Multicenter Clinical Trial of a Posterior Chamber Phakic Implantable Lens with a Central Port for Myopia or Myopic Astigmatism. American Society of Cataract and Refractive Surgery Annual Meeting. Washington DC, 24 April 2022.

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EVO/EVO+ ICL FDA Study: Endothelial Cell Density

	Eyes	Follow Up	Endothelial Cell Loss
Published Literature[1]	n = 1,476	14.7 months	2.6%
FDA Clinical Trial	n = 629	6 months	2.3%

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EVO/EVO+ ICL FDA Study: Adverse Events

- Adverse events related to vault occur at very low rates
- **No instances of anterior subcapsular cataract, pupillary block, angle closure glaucoma or pigment dispersion**

	Eyes (n = 629)	Outcome
Angle Narrowing	2 (0.3%)	• No increased IOP • Both lenses exchanged • Both UDVA 20/16
Residual Astigmatism	1 (0.2%)	• Lens repositioned • UDVA 20/16
Halo/Glare	1 (0.2%)	• Lens explanted • CDVA 20/16

Packer M. Initial Safety Multicenter Clinical Trial of a Posterior Chamber Phakic Implantable Lens with a Central Port for Myopia or Myopic Astigmatism. American Society of Cataract and Refractive Surgery Annual Meeting. Washington DC. 2-4 April 2012.

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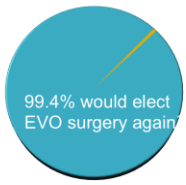
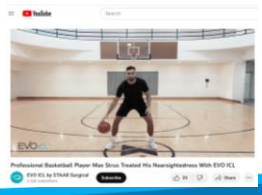
EVO/EVO+ ICL FDA Study

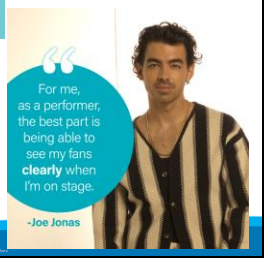
- Maintains physiologic aqueous flow
  - Zero pupillary block
  - Zero anterior subcapsular cataract
- Eliminates need for preoperative peripheral iridotomy
- The results of this clinical trial have definitively demonstrated the safety and effectiveness of EVO/EVO+ Sphere and Toric ICL lenses for the correction of myopia and myopia with astigmatism.

EVO Patient Satisfaction



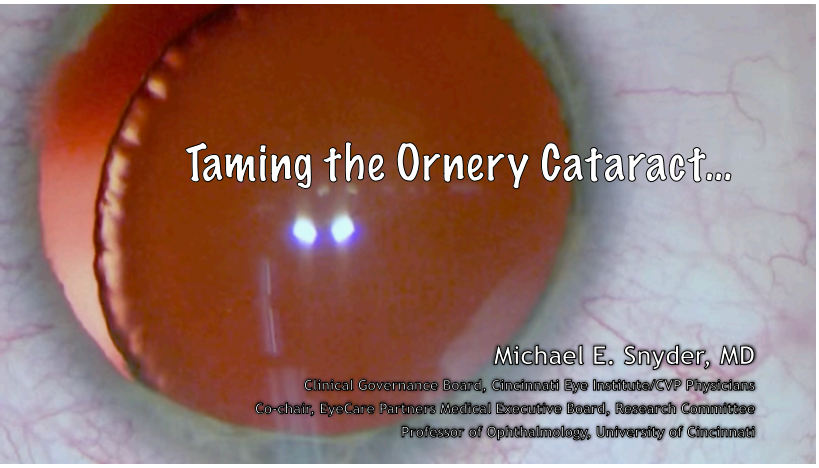
1,542 patients surveyed.
Patient Survey, STAAR Surgical ICL Data Registry, 2018.





Thank You!!

priya.mathews@useye.com



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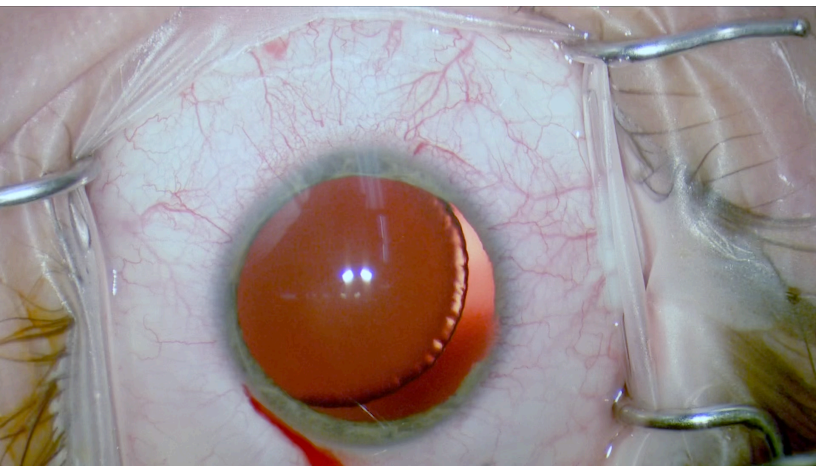
- Humanoptics: Consultant, Royalties
- Johnson and Johnson Vision: Research
- Plexitome: Research
- VEO Ophthalmics: Board member, Royalties (TKP)

There are lots of way to skin a cat(aract)...

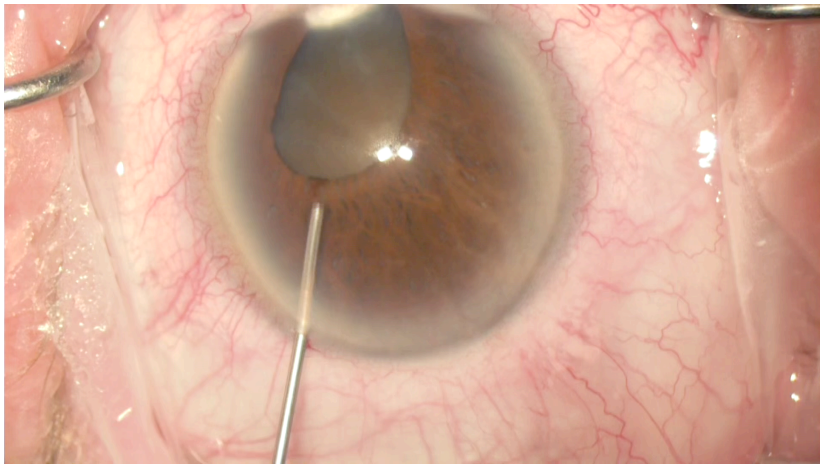
Zonulopathy with Sector Iris Defect



Tips:

- Vitrectomy first, and please use the pars plana!
- Capsule Hooks for Larger Zonular Dialysis
- MCTR with Needless Suture Retrieval
- PC tears require simultaneous engagement of the capsule and movement of the I/A handpiece. If you only aspirate when stationary, a tear will not occur.

Traumatic “CataROCK” with Corectopia

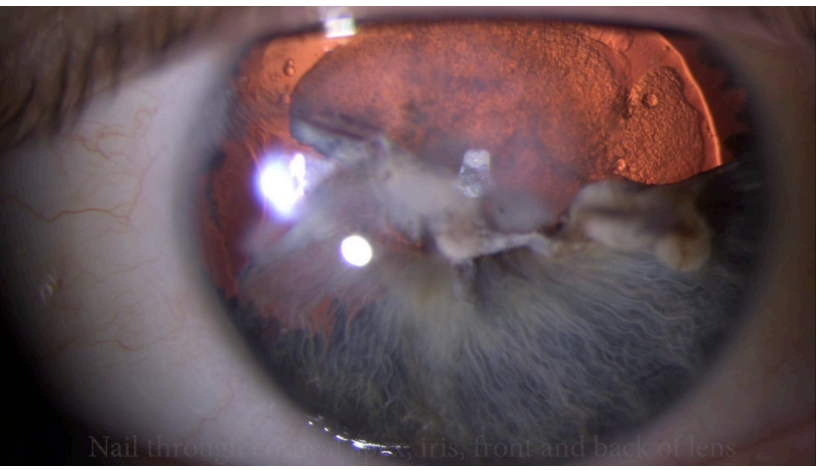


Traumatic “CataROCK” with Corectopia Tips:

- Dispersive OVD for very dense lenses *with repeated replenishment*
- Horizontal chop minimizes energy, zone friendly, and permits working in center safe zone
- Pull pieces central rather than going the periphery

Traumatic “CataROCK” with Corectopia Tips (2):

- Subincision US contact can damage iris, even through sleeve.
- For latter dense fragments, place IOL before removal as “shield.”
- Can stuff nuclear fragments into (metal tip) I/A.
- The vitrector is an excellent tool to sculpt a pupil.
- A new pupil does not have to include the old pupil.



Tips:

- Microscissors can be very helpful for fibrotic capsules for both CCC and PCCC.
- Dry aspiration is an excellent technique in soft material/young patients.
  - 27G cannula, 3cc syringe half-filled with BSS.
- Even with an axial scar, one can preserve the native cornea with decent results.

Take Homes:

- PPV for Anterior Vitrectomy
- Dry Aspiration
- Capsule Shield
- MCTR/Bag Preservation
- Repair or Replace the Iris

Thanks!

Incorporating Practice-Wide Protocols for Light Adjustable Lens (including comanaged care)

Joaquin De Rojas, MD
Assistant Medical Director
Director of Refractive Surgery
Center for Sight- Sarasota FL

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A US EYE COMPANY

Why We Adopted the Light Adjustable Lens in 2023

- Reduce LASIK/PRK enhancement rate
- Give patients an option for to customize their vision to their lifestyle
- Give patient an option for premium surgery with no reduction in contrast or increased glare and halos (relative to a monofocal IOL)[1]
- Give patients with unique vision challenges the option the option for premium surgery
- Give undecided patients the ability to "try out" and "tweak" their vision after surgery

1. RxSight P160055: FDA Summary of Safety and Effectiveness Data

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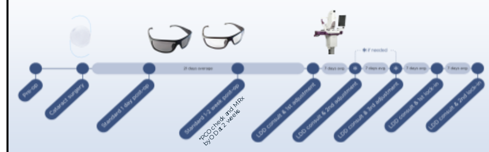
Practice Implementation



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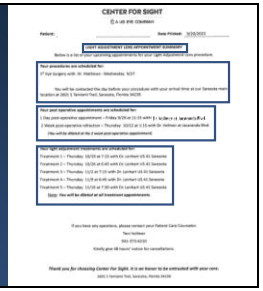
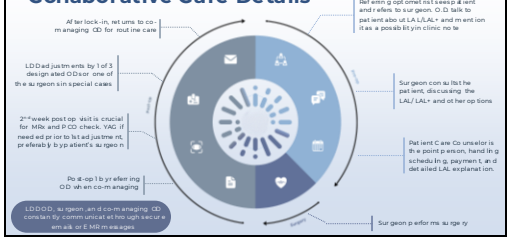
The Light Adjustable Lens At Our Practice

The Light Adjustable Lens in Our Practice

Providing a "white-glove" experience



Collaborative Care Details



Current Communication Strategy

The co-managing OD communicates with the surgeon if PCO noted prior to adjustments

The LDD OD communicates with the surgeon if PCO is noted and VAG is needed during adjustment day

LDD OD communicate with co-managing OD or MD if there is worsening dry eye, concern for CME or an unhappy patient.

It's always okay to pause adjustments, regroup, or "phone a friend" (surgeon)

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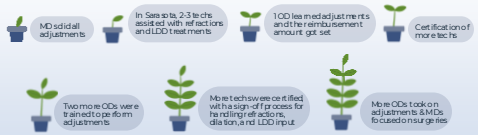
Collaborative care has evolved over time...



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Closing comments: tips for success

- Excellent communication is paramount
  - Between doctors: Co-managing OD, OD performing light tx, surgeon
  - Patient care counselor
  - Patient
- ODs empowered to consult with patient and help determine refractive targets
- Watch out for PCO and and DED throughout light adjustments!
- MDs should learn and do everything themselves first, then delegate some care
- Once delegation stage is reached, written up protocols and guidelines are helpful
- Teamwork; Incentives should be aligned among doctors to deliver the best possible care for patients

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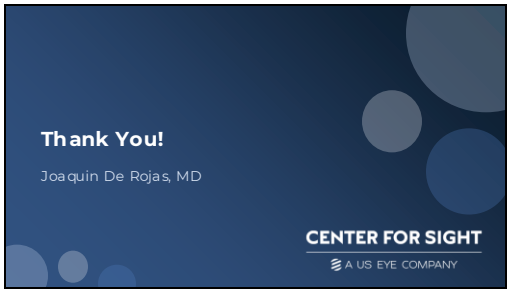
Thank You!
Joaquin De Rojas, MD
CENTER FOR SIGHT
A US EYE COMPANY

Cataract Surgery in Nanophthalmos:
What's the Big Deal about Small Eyes

Michael E. Snyder, MD
Board of Governors, CVP
Co-Chair, EyeCare Partners Medical Executive Board Research Committee
Professor of Ophthalmology, University of Cincinnati

Disclosures

- DORC: Consultant
- Gore: Consultant
- Haag-Streit: Consultant
- Humanoptics: Consultant, Royalties
- Johnson and Johnson Vision: Research
- Plexitome: Research
- VEO Ophthalmics: Board member, Royalties (TKP)

Nanophthalmos:
What's the Big Deal About Small Eyes?

- Difficult IOL calculations
- Limited IOL power availabilities
- "Tight quarters" for AC surgical maneuvers
- "Posterior pressure" during surgery
- Zonulopathies
- High risks for ciliary effusions or malignant glaucoma

In the Clinic...

Nanophthalmos and IOL Power Calculations

- Cooke 6/8
- Hill-RBF?
- Barrett Universal II?
- Olsen II?
- Holladay?
- HofferQ

Nanophthalmos and IOL Power Calculations

- Cooke 6/8
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- Olsen II?
- Holladay?
- HofferQ

In the OR...

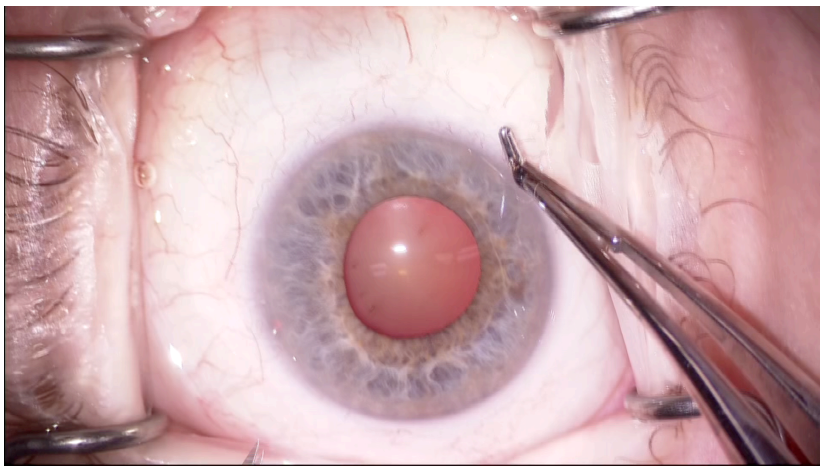
Pre-emptive Maneuvers

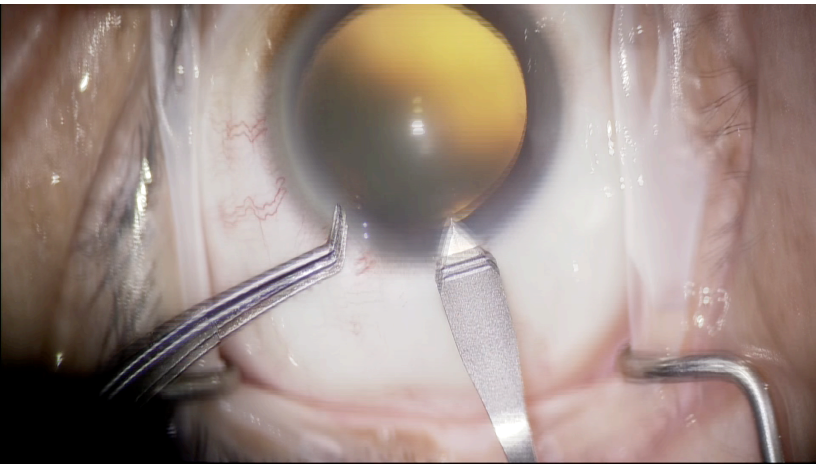
- Reverse Trendelenburg
  - Reduces orbital congestion
  - Reduces periorbital venous pressure

Pre-emptive Maneuvers

- General Anesthesia
  - Smooth muscle relaxation reduces orbital congestion and periorbital venous pressure
  - Paralytics reduce rectus muscle action/posterior pressure

In the Eye...





Nanophthalmos Tips

- General anesthesia *with paralysis*
- Reverse Trendelenburg
- Intravenous mannitol
- CTR
- Irido-hyaloidio-zonulotomy
- Healon5

Nanophthalmos Tips

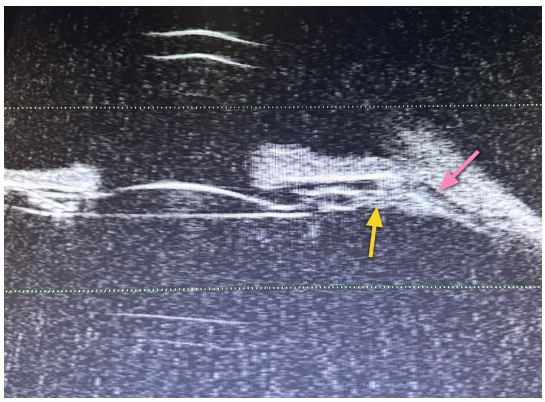
- General anesthesia *with paralysis*
- Reverse Trendelenburg
- Intravenous mannitol
- CTR
- *Irido-hyaloidio-zonulotomy*

Nanophthalmos Tips

- General anesthesia *with paralysis*
- Reverse Trendelenburg
- Intravenous mannitol
- CTR
- *Irido-hyaloidio-zonulotomy: What about case 2?*

"Malignant Glaucoma"
vs.
Aqueous Misdirection
vs.
Choroidal expansion…

Effectiveness of IHZ?



Nanophthalmos Tips

- General anesthesia *with paralysis*
- Reverse Trendelenburg
- Intravenous mannitol
- CTR
- Irido-hyaloidio-zonulotomy
- *Scleral windows?*

Nanophthalmos Controversy

- Scleral windows?

  Rajendrababu S1, Babu N1, Sinha S1, Balakrishnan V1, Vardhan A1, Puthuran GV1, Ramulu PY. Randomized Controlled Trial Comparing Outcomes of Cataract Surgery in Nanophthalmos With and Without Prophylactic Sclerostomy. Am J Ophthalmol. 2017 Nov;183:125-133.

- 60 eyes. 38.7% vs. 17.2% uveal effusions.

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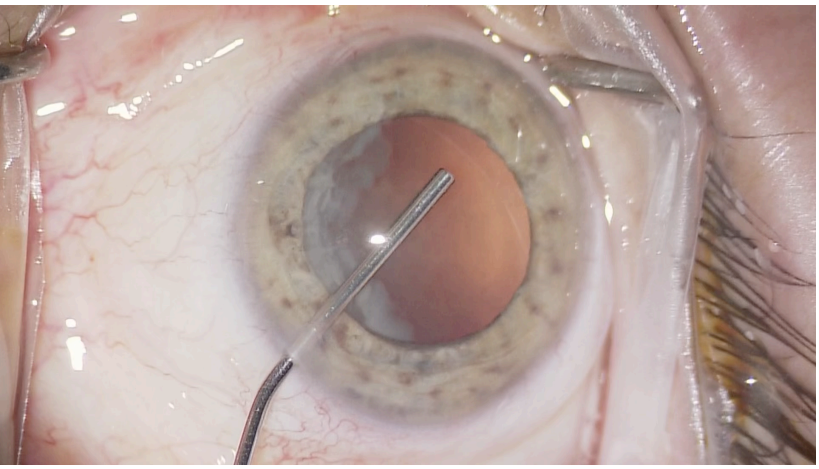
- 60 eyes. 38.7% vs. 17.2% uveal effusions.
- Nothing is a "free pass…"



Late Ciliary Effusions

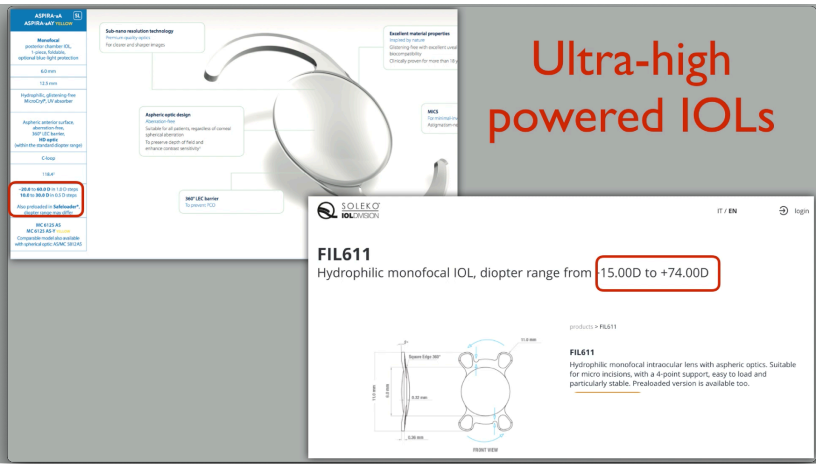
- Even with a scleral window, the ostium may close over over time (think bleb failure).
- If patient develops more than trivial *myopic shift* months or years out, it is likely a ciliary effusion.
- Diagnosis is presumed, but UBM is confirmatory.
- Retreatment with intermediate-term or long-term atropine cycloplegia may be needed. Some folks only take a drop a week …

Nanophthalmos Tip

- General anesthesia *with paralysis*
- Reverse Trendelenburg
- Intravenous mannitol
- CTR
- Irido-hyaloidio-zonulotomy
- Scleral windows!
- Atropine

Special IOLs

- Highest available in the US is 40D



What Documents Are Needed for CUDE?

- A Letter from the treating physician:
  - Why is a CUDE needed?
  - Why are alternative therapies unsatisfactory?
  - What is the risk?
- A detailed description of the device (Brochure, IFU, publications, etc.)
- An independent assessment from an uninvolved physician
- A draft informed consent for the use of the non-FDA approved device
- Clearance from the Institution/ASC
- Letter of Authorization (LOA) from the device manufacturer

Need IRB Approval…

- The IRB will also require:
  - A Single Site Submission
  - Curriculum Vitae
  - Good Clinical Practice Certificates of Research Staff
- The FDA will require Concurrence of the IRB chair

The Physician's Responsibilities

- Ensure that pt understands that the suggested device is not FDA approved
- Evaluate the potential risks and benefits with the patient
- Oversee the device use and pt care
- Provide a letter to both the FDA and IRB within 45 days
  - Success or failure of procedure
  - Any issues with the use of the device
  - A summery of the patient's outcome
- Documentation for return of any unused devices (must be sent back to manufacturer)
- Closeout with IRB

Thanks/Qs?

The Latest in LASIK & PRK (and beyond)

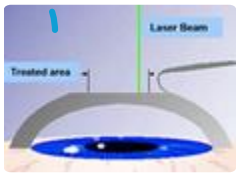
Joaquin De Rojas, MD
Director of Refractive Surgery
Cataract, LASIK & Corneal Surgeon
Center For Sight / US Eye

All-Laser LASIK and PRK

- Enhanced wavefront-optimized ablations
- State-of-the-art topography-guided ablations
- Addresses irregular astigmatism and higher order aberrations

- Advanced eye tracking and iris registration
  - 1050 Hz, 2.5 ms latency
  - Accounts for effects of cyclotorsion

Outcomes of Wavefront Optimized ablations



- 20/15 vision is common, especially in younger patients
- Lower higher order aberrations such as coma compared to older devices
- Less incidence of halos and dysphotopsias
- FDA approved for up to -12.00 of myopia, +6.00 of hyperopia, 6.00 of mixed astigmatism
- We limit LASIK treatments to corneas thicker than 500 microns that have no signs of early ectasia

TOPOGRAPHY-GUIDED ABLATIONS (THE FUTURE IS NOW!)

Topography-guided ablations: RESULTS

With Phorcides software:

100% of patients ending up with 20/15 or better OU, and 100% achieving 20/20 or better in each eye.[1,2]

- Topo-guided is useful if there is irregular astigmatism

1. Rush SW, Pickett CJ, Wilson BI, Rush RB. Topography-Guided LASIK: A Prospective Study Evaluating Patient-Reported Outcomes. Clin Ophthalmol. 2023 Sep 25;17:2815-2824.
2. Stulting RD, Lobanoff M, Mann PM2nd, Wexler S, Stonecipher K, Potvin R. Clinical and refractive outcomes after topography-guided refractive surgery planned using Phorcides surgery planning software. J Cataract Refract Surg. 2022 Sep 1;48(9):1010-1015.

A LASER VISION CORRECTION CASE?

40 yo F presents for LASIK eval. "I want to be glasses free!"

PMH/POH: soft contact lens wearer

Social Hx: Very active lifestyle: snowboarding, snowmobiling, hiking, and constant vacations!

	OD	OS
VAsc	CF at 6 feet	CF at 6 feet
MR	-6.25-1.00 x017 → 20/20-2	-6.75-0.50 x152 → 20/20
L/L/L	1-2+ MGD	1-2+ MGD
C/S	LG: 0 temporal / 1+ nasal	LG: 1+ temporal / 2+ nasal
Cornea	3-4+ PEE	3-4+ PEE
Lens	clear	clear
Everything else	wnl	wnl

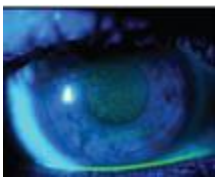
ANA+ (1:320) →

PRK CANCELLED THE DAY BEFORE! →

RHEUMATOLOGY CONSULT →

DX OF INFLAMMATORY ARTHRITIS MADE →

MOBIC PO STARTED



PROCEED WITH LASIK OR PRK?

VS.

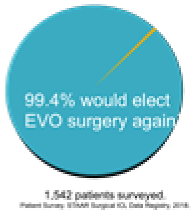
SOMETHING ELSE

EVO/EVO+ ICL FDA Study:

- **2022** US FDA Approval
- Maintains physiologic aqueous flow
  - Zero pupillary block
  - Zero anterior subcapsular cataract
- Eliminates preoperative peripheral iridotomy
- The results of this clinical trial have definitively demonstrated the safety and effectiveness of EVO/EVO+ Sphere and Toric ICL lenses for the correction of myopia and myopia with astigmatism.[1,2,3]

1. Igarashi A, Kamiya K, Shimizu K, Komatsu M. Visual Performance after implantable Collamer lens implantation and wavefront-guided laser in situ keratomileusis for high myopia. Am J Opthalmol. 2009.
2. Martinez-Plazs E, Lopez-Miguel A, Lopez-De La Rosa A, et al. Effect of the EVO+ Visian Phakic Implantable Collamer Lens on Visual Performance and Quality of Vision and Life, Am J Ophthalmol 2021;226:117–125.
3. Ganesh S, Brar S, Pawar A. Matched population comparison of visual outcomes and patient satisfaction between 3 modalities for the correction of low to moderate myopic astigmatism. Clin Ophthalmol. 2017 Jul 3;11:1253-1263.

EVO Patient Satisfaction



Results of the EVO ICL at CFS: Our first 3 Patients

	PREOP BCVA		POSTOP UNCORRECTED VA	
			OD	OS
Patient 1	OD -10.00-3.75 x 173 = 20/25 OS -10.25-3.25 x 170 = 20/25	→	20/15	20/15
Patient 2	OD -9.00-1.25 x 075 = 20/20 OS -9.25-1.00 x 085 = 20/20	→	20/15	20/20
Patient 3	OD -10.75-1.25 x 037 = 20/20 OS -12.25 sph = 20/25	→	20/20	20/15

BACK TO OUR INFLAMMATORY ARTHRITIS PATIENT

- **Decision:** EVO ICL OU (same day surgery for both eyes). ***Target***: -0.50 OD / plano OS (dominant)

PreOp BCVA	-6.25-1.00 x017 → 20/20-2	-6.75-0.50 x152 → 20/20
PostOp DAY 1 **UCVA**	20/30 , J1+	20/20, J1

- **Outcome:** The patient is THRILLED! Dry eye has improved!