Welcome to the 37th ESCRS in Paris, the city of haute couture and haute cuisine! We kindly invite you to our booth no. D145 (pavilion 7.2) to explore “high fashion” ophthalmic innovations and “high standard cooking” recipes for best practices in ophthalmic surgery. Paris is destined to be the host for anything new and classy. Throughout the history, it has always been a perfect place for science, art and entertainment – a combination that attributes to ophthalmology as well as to our booth activities.

According to our headnote “powered by challenge”, we are proud whenever we meet a challenge. And products that are truly innovative deserve to bear our honoring headnote “created by challenge”.

The development of our DMEK RAPID corneal donor transportation system was a challenge that we mastered in cooperation with the German Society for Tissue Transplantation (DGTF) and Prof. Peter Szurman (Sulzbach, Germany). It is a promising innovation in DMEK surgery, because, for the first time, it safely brings a pre-loaded transplant in a ready-to-use cartridge into the OR. Outsourcing the preparation of Descemet membranes to cornea banks has the potential to further standardize the overall DMEK procedure and increase efficiency. Read more about the first CE-marked DMEK transportation system on page 2.

On page 3, Dr. Shady Suffo (UKdS, Germany) and his team from UKdS Homburg, Germany, demonstrate how a newly developed corneal marker supports perfect double running cross-stitch sutures in PK with neutral postoperative astigmatism.

In June this year, Prof. Spitzer (Hamburg, Germany) presented his key findings on low impact of F4H4 on endothelial cells at the Geuder FLORetina symposium on innovative vitreoretinal liquids. His results affirm that the application of this highly effective wash out solution is safer than using other SFAs (page 4).

A comparative test shows that the flow rate of silicone oil injection can be up to three times higher when employing our new polyimide tip cannulas (page 4).

We are happy to announce that Geuder became an exclusive partner of FSSB (Germany) for distributing premium quality suture materials by ONATEC® to the ophthalmic market (page 5).

On the same page, you can learn about some general factors that influence sharpness, supported by test results of a comparison between a 2.4 NanoEdge phaco slit knife and an equal knife of a famous competitor.

Dr. Shin Yamane’s intrascleral IOL fixation with our double-needle stabilizer became so popular that we are providing two pages of valuable FAQs to answer all the questions we were asked since introducing the instrument in 2018 (page 6 & 7). We highly recommend Prof. David Chang’s compendium on advanced IOL fixation techniques, not only because he has dedicated several chapters to the “Yamane technique” (page 8).

Finally, we compiled some suggestions for the few hours of leisure time, that you will hopefully have during the ESCRS 2019 in Paris.

We are looking forward, to talk to you about all things ophthalmology (and other topics) at our booth in Paris!
With DMEK RAPID (Revolutionary Advanced Preloadable Injection Device) Geuder – in co-operation with the DFGF (German Society for Tissue Transplantation) and Prof. Peter Szurman – sets a milestone in the history of keratoplasty. In May 2019, the innovative system for transportation of pre-prepared Descemet lamellas obtained CE-certification and is now officially launched at ECRS.

THE CLINICAL SITUATION
One of the big challenges in DMEK surgery is to prepare the fragile, only 10 to 30 μm thin, Descemet lamella without causing any damage or tears, which would inevitably lead to loss of the urgent-ly needed endothelial cells. Present preparation procedures are putting surgeons under considerable burden. The patient is already waiting and lying in the operating theatre. Right before the transplantation surgery the surgeon has to prepare the DMEK lamella from the corneoscleral disk on his own, stain and load it into the glass cartridge. The success of this preparation does not only depend on the surgeon’s skills and practice. Moreover, factors like age, nicotine consumption, pre-existing pathologies such as diabetes, previous surgery or corneal injuries and other pre-existing conditions of the donor may influence the duration and success of the preparation enormously – quite apart from the stress to perform well in time. There is a persistent risk of damaging the precious transplant or making it unusable by inadvertence or any other lapse. In case preparation of the graft ends undesirable, the patient will have to be dismissed and admitted again on another day and a valuable and expensive donor cornea would be lost.

This situation has now changed tremendously, with the availability of a preloaded DMEK-lamella. Just like cataract surgeries, where more and more pre-loaded IOIs are common, the Descemet lamella can now be ordered from a cornea bank in a pre-loaded cartridge. By skipping the challenging preparation, a DMEK surgery can be planned more reliably just like a routine cataract surgery[1].

SUCCESSFUL COOPERATION WITH DFGF AND PROF. PETER SZURMAN
Making the Descemet Membrane Endothelial Keratoplasty more predictable, easier, safer and faster by outsourcing the preparation and validation where it can be performed most efficiently – at the cornea bank – was the goal of this collaboration. With the implementation of DMEK RAPID, the first CE-certified DMEK preloading-system, it is possible to order pre-loaded (and pre-stained) transplants directly from the cornea bank – the same way as it has become a gold standard in cataract surgery. There is justifiable hope that the implementation of DMEK RAPID with standardized, validated and most importantly centralised (cornea bank only) preparation will not only accelerate the DMEK surgery procedure but furthermore increase efficiency by decreasing the number of potentially failed preparations and non- utilisable corneas.

DMEK RAPID IN DETAIL
The transportation system DMEK RAPID consists of the clinically proven Geuder DMEK glass cartridge, two permeable closure caps, a transportation holder for cartridge, tube and optional cell culture flask.

THE CLINICAL BENEFITS AT A GLANCE:
- More predictable, easier, safer and faster DMEK surgery
- Outsourcing of preparation and validation of the graft
- Emphasizing and focusing on implantation surgery

THE BENEFITS OF DMEK RAPID IN A NUTSHELL:
- Complex and risky preparation of donor lamella is no longer required in the OR
- Cornea bank supplies pre-prepared graft to surgeon in a safe transportation and ready-to-use application system
- DMEK surgery starts with implantation of a ready-to-inject Descemet lamella
- Cornea bank proves quality of transplant and validates sufficient endothelial cell density
- Time saving and standardization of DMEK surgery procedure is evident

With DMEK RAPID more pre-loaded IOLs are common, the Descemet lamella is no longer required in the OR. Just like cataract surgeries, where more and more pre-loaded IOIs are common, the Descemet lamella can now be ordered from a cornea bank in a pre-loaded cartridge. By skipping the challenging preparation, a DMEK surgery can be planned more reliably just like a routine cataract surgery[1].
PK WITH VISION PRESERVATION

CORNEAL SUTURE MARKER FOR DEFINING THE SUTURE PATH OF A RUNNING CROSS STITCH PROCEDURE BY HOFFMANN IN PK.

The penetrating keratoplasty (PK) where, in a so-called open sky procedure, all layers of the cornea are being replaced by donor tissue, is one of the oldest transplantations in medical history but yet requires particular surgical skills.

WHY?
The challenge in performing a penetrating keratoplasty is to place the sutures for donor cornea fixation in a way that no postoperative iatrogenic astigmatism is induced, preventing persistent vision deterioration.

One option, which proved itself throughout the history of corneal transplantation, is to fixate the cornea transplant through a running cross stitch suture – the double running crossed diagonal suture by Hoffmann with 2 x 8 bites.

As the name suggests, the challenges of this suture technique lie in the precision required to exact the desired results are not always achieved.

SOLUTION:
Dr. Shady Suffo, leading assistant medical director of the ophthalmic clinic at the university hospital of Saarland (Homburg, Germany), took on this challenge and developed the Homburg Cornea Suture Marker, which he and Geuder AG made ready for serial production. The innovative, reusable instrument enables even unexperienced surgeons to place a perfect cross stitch suture as part of a penetrating keratoplasty and thereby minimize most of the vision relevant disadvantages of a PK.

HOW?
By means of the Homburg suture marker, the markings as well as the suture path can be marked in several steps and be placed entirely independent of the visual estimate of the surgeon. The precise marking of the needle entry and exit points guarantees a reproducible and homogenous suture path, resulting in a consistent running cross stitch suture. Thanks to this, the surgeon can provide safety to his patients and usually achieves reliable and best possible results, which can be reached after a penetrating keratoplasty.

RESULT:
Until today, surgeons had to rely on their visual estimate for marking a running cross stitch suture by Hoffmann in penetrating keratoplasty. The doctor’s practical experience and skills play a defining role in contributing to the result of the surgery.

With the Homburg Corneal Marker, the precise location of the needle entry and exit points for both running sutures is ensured, while securing that they cross at the interface. Because of this, the tension of both sutures will become identical 360° along the interface, providing a regular fixation of the transplant and leading to a faster visual rehabilitation.

THE TECHNIQUE – EXPLAINED STEP BY STEP

1. Provisional fixation of the donor cornea

2. Marking the first running suture (red dots)
   For marking the needle entry and exit points of the first running suture, align the arc of the instrument with the trephined edge of the recipient cornea (inner limitation of the interface). Align the visual marks M1 and M2 with the cardinal suture, so that M2 sits at the overlapping transplantation edge (outer limitation of the interface).

3. Repeating the markings (red dots)
   Repeat the type of marking eight times along each cardinal suture.

4. Positioning the first running suture (red lines)
   Perform the first running suture along the red dots in a star-shaped pattern. The dots at the edge of the recipient cornea constitute the suture entry points. The dots at the recipient limbus constitute the suture exit points. The dashed lines indicate suture passage below the cornea, whereas continuous lines indicate suture passage above the cornea.

5. Marking the second running suture (green dots)
   For marking the needle entry and exit points of the second running suture, align the arc of the instrument with the trephined edge of the recipient cornea. Align the left end of the arc (A) with the entry point of the first running suture, and align M2 with the first running suture at the interface. Repeat this type of marking eight times along the first running suture.

6. Positioning the second running suture (green lines)
   Perform the second running suture along the green dots in a star-shaped pattern, as well. The dots at the edge of the recipient cornea constitute the suture entry points. The dots at the recipient limbus constitute the suture exit points. The dots at the recipient limbus constitute the suture exit points.

7. Removing the cardinal sutures
   Remove the cardinal sutures after the double running suture is placed.

8. Result
   The result is a neat and evenly double running suture by Hoffmann, crossing each other at the interface.
the major determining factor according to the Hagen-Poiseulle law. Further the material is known to be chemically inert and therefore resistant against solvents and oils. In combination with its rigidity properties, PI is the ideal material for viscous fluid injection (VFI) and extraction (VFE).

Our new VFI / VFE cannulas are available in 20G, 23G, 25G and 27G and can be inserted into all suitable trocar systems of the same size. The cannulas can be attached to any syringe, extension tubing or injection system with a Luer lock connector.

Silicone oil is an important and useful tool in vitreoretinal surgery. It is mainly used after pars plana vitrectomy (PPV) as a long term tamponade. But there are also complications linked to its application such as sticky oil, emulsification or droplets sticking to the retina or the IOL. Silicone oil remnants are also considered to be a cause for secondary glaucoma. Therefore it is important to remove silicone oil remnants as completely as possible.

One tool for removing silicone oil remnants is F4H5 (Perfluorobutylpentane), a semi-fluorinated alkane with unique amphiphilic properties. Because of its very short molecule chains, F4H5 mixes with silicone oil easily, thus reducing its viscosity and facilitating the removal in a short wash out procedure. It can even solvate sticky oil which is known to be very difficult to remove.

As other semi-fluorinated alkanes (SFAs) showed significant negative effects such as inflammation or retinal degeneration there were also concerns that F4H5 might have negative impacts on corneal endothelial cells.

Prof. Martin Spitzer (Hamburg, Germany) and his team investigated this assumption. Their results were published in the study “Effects of Perfluorobutylpentane (F4H5) on Corneal Endothelial Cells” in March 2019.

In order to investigate effects of F4H5 on corneal endothelial cells Prof. Spitzer used a porcine corneal endothelial organ culture model. This model employs a special dissection technique (“split corneal buttons”) that reduces endothelial cell loss caused by stromal swelling during longer cultivation periods. These “split corneal buttons” were placed in pure F4H5 for 15, 30, 60 and 120 minutes and after incubation irrigated in balanced salt solution (BSS) to remove F4H5 remnants. After further cultivation the corneal buttons were compared to those of the control group (which were only incubated in BSS without any other substances) and endothelial cell density (ECD) was quantified after different incubation periods (15, 30, 60 and 120 min) on day 1, 8 and 15 of cultivation. A decline of endothelial cell density and morphological changes were assessed as indirect markers for possible cell toxicity.

The group with an incubation time of 120 minutes showed a significantly higher reduction of ECD compared to the control group. After 15, 30 and 60 minutes no significant reductions were observed, however, morphological changes occurred after 60 minutes of incubation.

These results verify that F4H5 does not show significant short-term-effects, such as ECD decline or morphological changes when left in contact with the corneal endothelium up to 30 minutes. Nevertheless, Prof. Spitzer recommends thorough removal of F4H5 after wash out procedure, but he and other surgeons experienced that wash out procedures with F4H5 are very simple and fast. Therefore exposure times of the corneal endothelium to F4H5 can usually be kept below 30 minutes and should not cause any limitations in clinical application of this wash-out solution.

They are made of polyimide (PI) because of its excellent mechanical properties which allow to build cannulas with very thin walls but high flexural strength and modulus. With such thin walls, the inner diameter is enlarged, resulting in drastically increased flow rates, as the inner diameter is the major determining factor according to the Hagen-Poiseulle law. Further the material is known to be chemically inert and therefore resistant against solvents and oils. In combination with its rigidity properties, PI is the ideal material for viscous fluid injection (VFI) and extraction (VFE).

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Geuder's new polyimide tip cannulas are designed for the injection and extraction of highly viscous fluids such as 1,000 – 5,000 cs silicone oil.

Silicon oil injection / extraction with new polyimide tip cannulas

Flow rate of silicone oil injection up to 3 times higher

Silicone oil injection (and even extraction). The double amount of oil can be injected in the same time (per minute), hence surgeons can benefit from saving time during silicone oil injection (and even extraction).

Compared to conventional metal tip cannulas, flow rate of silicone oils is significantly higher when using the new polyimide (PI) cannulas. For these flow rate tests, several silicone oils from Fluoron were used. The results are showing that in average the double amount of oil can be injected in the same time (per minute), hence surgeons can benefit from saving time during silicone oil injection (and even extraction).
It is not only the edge of a blade that has an impact on sharpness. There are more factors that influence sharpness as well. The shape of the blade (edge and grind) plays a major role, but also the sectility of the tissue influences the effectiveness of a cut. The Intraocular pressure (IOP) and the applied angle of incision play a role, too.

PHYSICS AND GEOMETRY

The edge of the blade determines the cutting ability of a knife, whereas the grind (Fig. 1) determines the ability to penetrate tissue. So a blade is facing resistance from three directions: the edge from medial and grind from lateral left and right (Fig. 2).

Advancing a blade creates 3 vector components: (A) thrust component that creates the incision (C) thrust component that enlarges the incision (B) pull-through component that improves the efficiency of the blade (Fig. 3).[1]

SECTILITY OF TISSUE

The sectility of tissue depends on the tendency of the fibers to be severed rather than displaced by an advancing blade. Tissue that is very mobile tends to shift ahead of the blade without being cut through (Fig. 4).

INTROOCULAR PRESSURE

As the tension of the tissue is increased by high IOP, a low IOP may result in lower sectility (Fig. 5).

PENETRATION FORCE COMPARISON OF 2.4MM DOUBLE BEVEL PHACO SLIT KNIVES

Due to a sophisticated bevel shape and unique chemical etching process under constant in-process sharpness inspections the Geuder NanoEdge Phaco Slit Knife beats the common competitor knife in a laboratory penetration test. With NanoEdge, less force is required to achieve the same blade advancement, proving that the NanoEdge knife is sharper.

When Sharpness Matters!

What makes a knife sharp?

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Advancing a blade creates 3 vector components: (A) thrust component that creates the incision (C) thrust component that enlarges the incision (B) pull-through component that improves the efficiency of the blade (Fig. 3).[1]
WHAT IS THE BEST IOL TO USE?
3-piece IOLs with haptics made out of PVDF. This haptics material is very malleable and resistant, allows for better flange formation and can better prevent erosion through the conjunctiva. Dr. Shin Yamane mainly uses X-70 (Santen, Japan) because it has a large optic, helping to avoid iris capture.

Other IOLs reported to have been successfully implanted:
- ZA9003 (J&J Vision)
- MA60MA (Alcon)
- CT LUCIA 602 (ZEISS)
- SENSAR AR40e (J&J)

CAN I USE A STANDARD 30G NEEDLE FOR THE YAMANE ISHF TECHNIQUE?
No. The lumen of standard 30G needles is too narrow to dock the haptics of any 3-piece IOL. The ultra thin wall (UTW) 30G needles provide the most secure tunnel for the haptics of 3-piece IOLs. It is recommended that the inner diameter of the needle to be used must be 0.18 mm or greater (fig. 1 & 2).

CAN I USE A STANDARD 27G NEEDLE?
Yes. The lumen of standard 27G needles is adequate for docking, however the external diameter is significantly wider than the haptic and this may increase the likelihood of postoperative hypotony and IOL slippage, if the flanged haptic slides through the needle track back into the eye.

The technique was initially developed using 27G needles.

WHO SELLS THE 30G UTW NEEDLES?
Yamane developed the technique while using 30G thin wall TSK needles, item 3012/UTW. These can be obtained with:
- TSK Tochigi Seiko, Japan
- Delasco, USA
- TSK Laboratory, Europe

The UTW 30G needle (left) allows for proper fitting of haptics, while the standard 30G needle (right) does not allow haptics to advance beyond the beveled section (fig. 3).

CAN I EXTERNALIZE THE HAPTICS SEQUENTIALLY, INSTEAD OF SIMULTANEOUSLY?
Yes. The technique originally calls for the needles to be externalized simultaneously. An alternative is to externalize the leading haptic first, prior to docking and externalizing the trailing haptic. It must be kept in mind that pulling out the leading haptic with the 30G needle first, will rotate the IOL in an anticlockwise direction. As a result it becomes more difficult to insert the tip of the trailing haptic into the second 30G needle.

WHY IS THE SURFACE OF THE RING REFLECTIVE?
To prevent IOL from tilting, the fixation ring is to be kept parallel to the iris plane. The light of the microscope will reflect on the ring surface as a visual aid for inclination of the instrument. Therefore the reflection on the instrument needs to be the strongest, after confirming that the reflection on the cornea is in the center (fig. 4).
Cauterization of the haptics is to be performed by using a low temperature cautery device. The haptic should be dry in order to avoid a twisted flange and must not touch the cautery to evade adhesion. Moreover the cautery should only come close to the haptic, never in touch.

Some recommended low temperature battery cauteries are:

- Bovie Medical
- Kinhan Surgical Products
- Beaver-Visitec International

**WHAT IS CONSIDERED OPTIMAL IN TERMS OF FLANGE SHAPE?**

An optimal flange is that of a mushroom-like shape with a diameter of approximately double the diameter of the haptic (fig. 5). This shape provides maximum hold in the scleral tunnel and minimum leak to the subconjunctival space.

**HOW MUCH OF THE HAPTIC SHOULD BE INTRODUCED INTO THE 30G / 27G NEEDLE CAVITY?**

The haptic is advanced about 2 mm into the needle in the case of 30G UTW needles. For 27G needles, the haptic will have to advance about 3 mm to be able to create better points of fixation inside the needle.

**WHAT IS THE APPROPRIATE TIP TO BENT LENGTH FOR THE NEEDLES?**

7 mm

If the 30G UTW needle (27G alternative) is bent 7 mm from the tip it will stop when the needle has advanced 3 mm into and through the sclera (fig. 7). This applies if the needle is used in combination with our instrument.

**WHAT IS THE APPROPRIATE LENGTH OF THE HAPTIC TO “CAUTERIZE”?**

0.5 to 1 mm

Post-operative OCT measurements have shown that 1.0 mm of the haptic is necessary to make a flange diameter of 0.3 mm (14), which is the size required to fit the scleral tunnel created by the 30G needle. If 27G needles are used, the flange diameter needs to be 0.4 mm or greater.

**WHAT IOL HAPTIC MATERIAL IS MORE SUITABLE FOR THE TECHNIQUE?**

PVDF haptics

Most 3-piece IOLs have thin haptics that are prone to bending and breaking while manipulation. The double-needle technique requires an IOL that can withstand significant manipulation. Polyvinylidene fluoride (PVDF) haptics are very malleable and resistant, create a much better flange than PMMA haptics and can prevent erosion through the conjunctiva. PMMA haptics are not discarded but it must be taken into consideration that its material makes the intrascleral manipulation of the trailing haptics more difficult. Additionally, the haptics may be more susceptible to breakage or bending.

**WHAT IS THE OPTIMAL SCLERAL TUNNEL LENGTH?**

2 mm

“Too short a scleral tunnel may result in IOL dislocation, and too long a tunnel may lead to intraoperative distortion of the cornea. A too small angle of the 30G needle can also lead to this.”

**THE RING HAS AN UNIVERSAL INNER DIAMETER, HOW DO I ACCOMMODATE FOR DIFFERENT CORNEA SIZES?**

The two dents on the inner edge of the ring are in line with the two insertion point visual marks. Use these to place reference marks and to align the ring inside diameter with the corneal limbus (figs. 8 & 9).

**WHAT TYPE OF INTRAOCULAR FORCEPS ARE SUITABLE TO MANIPULATE THE IOL HAPTICS?**

Intracocular chamber forceps such as G-32997 are suitable for manipulation of the haptics and its insertion into the needle cavity (fig. 10). Prior to the implantation of the secondary IOL a previous lens needs to be removed, the same forceps is used for both procedures.

**WHERE DOES THE FLANGE NEED TO BE PLACED?**

The flange needs to be placed under the conjunctiva and back into the scleral tunnel. Leaving the flange in between conjunctiva and sclera could provoke erosion.

**WHAT TO DO WHEN HAVING ISSUES PLACING THE FLANGE BACK INTO THE SCLERAL TUNNEL?**

“Too small a flange harbours the risk of IOL dislocation (during wound healing). Too large a flange is difficult to be pushed into the scleral tunnel. If so, you should enlarge the entry site of the tunnel using the 30G needle (fig. 11).”

**HOW TO PREVENT AIR BUBBLES FROM ENTERING WITH VIEW FOR NEEDLE INSERTION DURING HAPTIC FIXATION?**

Fill syringes with a small amount of BSS and make sure to irrigate the needle before the scleral pass.

**ANY SUGGESTIONS TO AVOID HAPTIC-NEEDLE FIT COMPLICATIONS?**

Before the procedure, it is recommended to verify that the IOL haptic fits into the thin wall 30G needle to avoid previously reported problems of the haptics not fitting into the lumen of the needle. This is not the case when using 27G needles, but it must be kept in mind that the IOL haptic and needle lumen relation changes. As the haptic is easier to be inserted into the needle, it will also be easier for the haptic to slip out, so it is recommendable to insert the haptic at least 3 mm into the needle.

**TECHNIQUE ON VIDEO**

Flanged IOL fixation with intraoperative adjustment of refractive error

**DOWNLOAD:**

PDF brochure of the Yamane Double-Needle Stabilizer

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**NEWSLETTER ESCRS 2019  WWW.GEUDER.COM**
IOL FIXATION COMPENDIUM

BOOK RECOMMENDATION: ADVANCED IOL-FIXATION-TECHNIQUES
BY DAVID F. CHANG

Anomalous or deficient capsule anatomi- cally can pose numerous challenges even for expe- rienced ophthalmic surgeons and lead to IOL complications. Dozens of different approaches to implantation of IOLS with impaired capsu- lar support have been developed but so far no compendium has been written that includes the most important surgical strategies.

In the book “Advanced IOL Fixation Techniques: Strategies for Compromised or Missing Capsular Support”, which has been released in April 2019, no other than David F. Chang dedicated various chapters to the “Yamane technique” and our double-needle stabilizer.

584 pages of comprehensive work with more than 1,100 graphics and images plus 150 video links are structured in three main parts:

• Part 1 contains techniques for capsule positioning for zonulopathy or posterior capsular rupture
• Part 2 presents options for fixation if the capsule is missing: anterior chamber IOLs, iris-claw IOLs, iris and transcleral joint fixation with use of the Yamane double-needle stabilizer or the IOL “adhesive technologies”
• Part 3 covers different topics such as anterior vitrectomy, calculation of the IOL power for non-capsular IOLs and pupilloplasty with gliding knots and sutures.

THE BEAUTIFUL CITY OF PARIS WITH ITS ART, CULTURE AND FOOD IS ALWAYS WORTH A TRIP!

The triangle between Blvd. Raspail – Rue de Sèvres – Blvd. Saint-Germain, which is a part of the district Saint-Germain-des-Prés and located in the 6th arrondissement of Paris, already finds its origin in the roman coloniza- tion of the left shore of the Seine. This part of the town - known as the science and culture district – is one of the best hidden secrets in Paris, unspoiled from tourists (as far as possible in Paris). The Eiffel Tower and the Jardin du Luxembourg are just a short walk away and also one of the most precious and oldest churches in town – the abbey Saint-Germain-des-Prés – can be found here. However, what’s special about this district, are the countless little boutiques, bars and restaurants, which are located within this triangle.

Next to the chocolate factory “La Maison du Choco- lat” at the Rue de Sèvres, big names like Hermès and Longines can be found.

Everyone who devotes to the assiduous Blvd. Ras- pail, will discover the hoary Hotel Lutetia and across from it a little park, which invites to rest and relax.

The park borders to “Le Bon Marché” – a shopping paradise in which you can spend several hours if you want to – and at “Le Babylou” you can find the best Chocolate-Tartes in town.

PLACE DES VOSGES & LE MARAIS

Don’t miss to visit the warmly recommended Place des Vosges, which is the oldest one in Paris. It was built between 1898 and 1900 in which the Musée d’Orsay is located, the Cité de l’Architecture et du Patrimoine, which is a museum of ar- chitecture and monumental sculptures, housed in the Palais de Chaillot or the Paris Museum of Modern Art, which is near to the Champs-Elysees.

PARIS TIPS

Explore the shops along Rue des Francs Bourgeois and around Paris.

La Petite Auberge

As a meatlover you can get satisfied in the 15th arrondissement at 13 rue Hameau. The menu is simple nonetheless you get served excellent food such as steak, crispy hand-cut deep-fried potatoes or a slice of homemade fruit tart. All this for a favourable price.

Fills up early, so booking is advised.

Phone: +33 1 45 32 75 71

FOOD & DRINKS NEARBY THE ESCRS CONGRESS

750g La Table

The restaurant got originated by Jean-Baptiste Duqueune who first created a website of food and wine pairings. The name “750g” is a reference to the weight of the contents of a bottle of wine.

The two-room bistro’s décor is simple, souvenirs from a trip to New Zealand for the World Cup, red leather banquettes and the handwritten menu adorn the bistros room.

Not only the Lonely Planet guide book but also the New York Times food critic recommends this inconspicuous looking bistro.

Hearty portions of beef, pork or veal accompanied by homemade French fries.

Le Gran Pan

The one and only shop in the district – close to the Ile de France/Notre Dame, a must-visit in Paris. With its unremarkable wooden door, the bar at 14 Rue Haute in Le Marais is easy to miss, but if you once made it inside, you will experience an intimate atmosphere, wooden stools, deep green velvet and flattering lightning as well as cocktails with fresh seasonal ingredients.