Introduction

*Cataract Refractive Surgical Practice Highlights™*, which is in its second successful year of publication, focuses on the technologies and strategies most important to cataract surgeons. Each issue of this digital series features interactive content and expert analyses to help surgeons grow their practices and improve surgical skills.

The August issue features comprehensive coverage of the latest cataract refractive tools and technologies from Alcon Laboratories, Inc. Richard Tipperman, MD, demonstrates how the value of effective communication translates into the *value of multifocal IOLs* for patients. Robert H. Osher, MD, takes a no-nonsense approach to *astigmatism correction with toric IOLs*. John P. Berdahl, MD, talks about the importance of *refractive outcomes*, and Richard L. Lindstrom, MD, shows how any cataract surgeon can *incorporate the LenSx® Laser* into the practice with some dedication and the right financial planning.

Click [here](#) for more interactive content from previous issues of *Cataract Refractive Surgical Practice Highlights™*.

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**Expert Analysis**

**Practical communication shows patients the value of multifocal IOLs**

Many technical and surgical aspects of cataract surgery set the stage for successfully implanting multifocal IOLs in patients with presbyopia, but several steps that take place outside of the operating room increase the likelihood of patient satisfaction post-operatively. Pinpointing patients’ visual needs and communicating IOL options and recommendations with a simple, straightforward approach create the best opportunity to reach all potential candidates and ensure that they will choose the right IOL. Patients will ultimately be more willing to pay out of pocket for advanced technology IOLs when they understand the value of having good vision at all distances.

**Patient interest in spectacle independence**

Patients already show a great amount of interest in reduced spectacle dependence. In the 2010 Chase Health Advance Financing Options Survey,¹ patients who had recently undergone cataract surgery were asked, “If you had to pay about $2,000 per eye, would you have taken advantage of a new technology that could have helped reduce your need for glasses?” Ninety-two percent of patients answered “yes,” confirming that the more spectacle independence the surgeon can deliver, the more value the patient gets for the surgery (Figure 1, page 2).

The catch is, surgeons must offer the option of spectacle independence and advanced technology IOLs to all patients, and not all surgeons are doing so. In the Alcon ATIOL Willingness to Pay Study,² patients in Canada and Europe were queried, “Would you be interested in an IOL that could let you see at different distances without...
glasses following cataract surgery?” The average of people who are interested in this technology prior to revealing copay information is approximately 75%, but the average of patients who are offered the technology is only approximately 31% (Figure 2). As a result, physicians fail to reach nearly 50% of potential candidates. Surgeons should remember that it is unfair to rule out a patient ahead of time based on where they live, their appearance, or their perceived needs. Everyone performs far and near tasks each day, so everyone has the potential to benefit from a multifocal IOL.

Before patients were told about the fee associated with gaining access to this technology, interest was quite high. Although interest levels dropped when patients were told about the fee (Figure 3, page 4), this study reveals that there is still a large disconnect between patient demand and what surgeons offer to their patients. The untapped pool of patients interested in multifocal IOLs is high enough that physicians can benefit from providing and suggesting the technology much more than they currently do. However, it is important to clearly explain the risks and benefits of selecting a multifocal IOL.

**Consultations: Choosing the right words**

The patient’s experience in the office impacts his or her IOL selection and, in turn, whether the patient is satisfied with visual results postoperatively. Therefore, it is important for ophthalmologists to present IOL options in a simple, clear manner to ensure that patients understand the benefits and drawbacks of each before making a decision. When discussing options, surgeons should pay close attention to the words used to describe the procedure, the IOLs and the outcomes, while also setting appropriate expectations for postoperative visual results. Although the goal of implanting a multifocal IOL is to provide good vision at all distances, patients may still need glasses for reading and driving at night, and they should be aware of that before opting for a multifocal IOL. However, surgeons
should balance the limitations of multifocal IOLs vs. monofocal IOLs in terms of the improvement in spectacle independence they offer. The phrasing we use is, “Monofocal cataract surgery leaves you completely dependent on glasses. If you do not want that, there is something better.” If the discussion becomes more technical, then the patient loses interest.

In my practice, we initiate consultations with a lifestyle questionnaire, which encourages patients to think about their visual needs. We carefully consider the phrasing of each question. Our questionnaire asks: 1) After cataract surgery, if you could, would you like to perform distance activities like driving, watching television and playing sports without glasses? 2) If you could, would you like to perform reading tasks such as desk work, computer work, puzzles and games without glasses? 3) Would you like to have both? In our experience, patients overwhelmingly believe that having the ability to perform near, intermediate and distance activities without glasses is the best option, and IOLs such as the AcrySof® IQ ReSTOR®+3.0 D IOL (Alcon Laboratories, Inc.) deliver good vision at all distances.

The language surgeons use when describing the IOL options and the procedures is also important. When multifocal IOLs were first introduced, they were known as “premium IOLs.” The word “premium” implied that the purchase was unnecessary. When the IOL is described as an advanced technology or a high-definition IOL, then patients can see the value in the purchase. Similarly, if surgeons call monofocal cataract surgery a “standard” or “common” operation, then patients will automatically want to choose that option because they think it is what most people choose. Referring to the procedure as “basic” cataract surgery instead sets the appropriate frame of reference for patients and implies that they do not gain all-around improved vision beyond distance vision only.

**Recommend the right IOL**

Making an IOL recommendation is a key step in ensuring that the patient will choose the IOL that is best for his or her lifestyle. Ophthalmologists should phrase the recommendations and risks simply, such as, “In my experience, patients are extremely happy with multifocal IOLs. In the rare cases when patients are not completely satisfied, it is fixable.” I also use the Eyemaginations* videos for presbyopia-correcting IOLs to give patients an overview of the complications that they should consider.

If an ophthalmologist is uncomfortable making a recommendation, he or she can say, “After looking at your eyes, you do not have astigmatism. You are otherwise healthy and, if you do not want to rely on glasses as often, I would say that the AcrySof® IQ ReSTOR® IOL is the best option for you.” If the technology is not appropriate for a patient, surgeons should tell them, “This IOL exists, but in your case I would not recommend it because....” If patients have healthy

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eyes, an absence of significant high-order aberrations, and they do not have large pupils, then I would consider them candidates for this technology.

**Conclusion**

The patients who we treat today are more demanding than ever before, and they generally do not tolerate higher levels of refractive error. Patients desire an IOL that reduces spectacle dependence and provides clear vision at all distances. However, ophthalmologists can only tap into this pool of candidates only if they offer the multifocal IOLs that address patients’ demanding visual needs. Surgeons must set realistic expectations for outcomes and explain the risks and benefits of multifocal IOLs in such a way that patients understand their value. In our practice, we have taken these essential steps and have found that patients are more willing to pay out of pocket for an IOL that provides the best chance for spectacle independence for everyday tasks, over an IOL that provides only improved distance vision.

*Dr. Tipperman is a refractive and cataract specialist with Ophthalmic Partners of Pennsylvania in Bala Cynwyd, PA and with Wills Eye Institute in Philadelphia, PA.*

**References**

Surgical Pearls for Implanting Toric IOLs

- Hang your procedure plan and topography on the microscope in the operating room so that it is visible at all times.
- Know exactly where your target meridian is and mark it precisely using ink, a Wet-Field Osher ThermoDot* marker or the technique of your choice.
- Rotate the IOL a few degrees shy of the target meridian since it is easier to adjust by a clockwise rotation.
- Maintain a large pupil to facilitate visualization of the dots on the IOL periphery.
- Always hydrate before removing OVD so the anterior chamber will not shallow and the lens will not rotate.

Also explain that an AK, which is less expensive, is not as accurate as correcting astigmatism with a toric IOL. In my practice, 51% of my cataract surgery candidates opt for astigmatism correction. Of those patients, 27% choose toric IOLs, and the rest choose AKs.

Diagnostics and Preoperative Planning

Accurate diagnostics and preoperative planning are required for performing successful astigmatism correction during cataract surgery. Measurements such as manual K readings, automated keratometry (IOLMaster* and LENSTAR*), corneal topography and wavefront aberrometry provide a good picture of a patient’s astigmatism. I recommend that surgeons obtain at least two types of measurements to accurately determine the patient’s amount of cylinder. Consistency is also key—having the same technician obtain a specific type of measurement, such as K readings, improves reliability. Topography is necessary to differentiate regular from irregular astigmatism.

When developing a surgical plan for implanting a toric IOL, I review the diagnostic measurements and consider surgically induced cylinder. If a patient has with-the-rule astigmatism, then I may err slightly less than against-the-rule cylinder. I also try to correct as much of the cylinder as possible. For instance, to correct an average cylinder amount of 1.4 D, I would overcorrect and implant a T4 toric IOL that corrects 1.5 D, resulting in an absolute value of 0.1 D. I would not put in a T3 that corrects only 1.0 D, resulting in 0.4 D of cylinder.

Some measurements are unnecessary for toric IOL implantation. Refractive cylinder, for example, is irrelevant for patients with cataracts. Also, unless a patient has a significant amount of cylinder such as 3 D to 4 D, I normally disregard spectacle prescription.

Pearls for Accurate Alignment

To ensure accurate IOL alignment, I take a slit-lamp photo with a high-resolution camera and use corresponding software to locate the target meridian. In addition, I use an imaging system from

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SensoMotoric Instruments (SMI)* to capture an image of the patient’s eye before dilation to confirm exactly where the toric IOL aligns on the target meridian in surgery. As an extra step, a nurse makes a reference mark with ink at 6 o’clock, but I rarely rely on the ink mark unless all else fails. More recently, I have been using a Wet-Field Osher ThermoDot* marker, which is a small dot cautery that patients do not feel, and that will remain visible throughout the course of the procedure.

**Conclusion**

A surgeon’s goal is usually to achieve an emmetropic result. Correcting astigmatism at the time of cataract surgery will increase patient satisfaction and allow patients to see more clearly without glasses than ever before. In my experience, the toric IOL is an accurate and effective solution for astigmatism correction and will soon become the new standard of care for cataract patients with astigmatism. 

Dr. Osher is professor of ophthalmology at the College of Medicine of the University of Cincinnati and Medical Director Emeritus of Cincinnati Eye Institute in Ohio.

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**Q&A**

**Importance of refractive outcomes in cataract surgery**

Many surgeons have experienced refractive surprises postoperatively that may have led to enhancement procedures, or have dealt with patients who are unsatisfied with their visual results. Patients are increasingly demanding of greater spectacle independence, so it becomes more important that ophthalmologists invest the time and energy necessary to consistently achieving target refraction after cataract surgery.

Sioux Falls ophthalmologist John P. Berdahl, MD, specializes in laser refractive cataract surgery with the LenSx® Laser (Alcon Laboratories, Inc.). Here, he shares his expertise about the importance of good refractive outcomes, and the tips and tools needed to achieve this goal for every patient with cataracts.

**Are your patients more or less demanding of exceptional refractive outcomes than they were 5 to 10 years ago?**

**John P. Berdahl, MD:** I have noticed an increased demand for better refractive outcomes. Fortunately, in my practice, patient expectations are in line with the visual results that we can deliver. Patient expectations have increased over the years because educated patients are aware that ophthalmologists now have access to technology that can meet or exceed their refractive goals.

**How have your refractive outcomes improved with the femtosecond laser?**

**Berdahl:** Surgeons must remove as many variables as possible during cataract surgery to improve refractive outcomes. Therefore, I prefer performing cataract surgery using the LenSx® Laser because it brings

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precision and reproducibility to the procedure. Using the LenSx® Laser, I can input exact incision sizes and customize the size and location of every capsulorhexis, which some studies suggest helps predict effective lens position (ELP) within the capsular bag.1,2 [AU QUERY: Please provide references.] I perform approximately 25% to 30% of my cases on the laser, and my outcomes are better because it helps to reduce refractive surprises postoperatively.

“I also use the ORA* intraoperative wavefront aberrometry system in conjunction with the LenSx® Laser to help refine my diagnostics.”

— John P. Berdahl, Md

What other pearls do you have for accurately determining ELP?

Berdahl: Although traditionally surgeons have found it difficult to determine ELP, advances in technology have made this step easier for surgeons. For example, I use the LENSTAR® optical biometer to measure lens thickness and anterior chamber depth to more accurately predict ELP. I also use the ORA* intraoperative wavefront aberrometry system in conjunction with the LenSx® Laser to help refine my diagnostics, measurements and thus, my refractive outcomes.

How has your surgical experience changed with the SoftFit™ Patient Interface (PI; Alcon Laboratories, Inc.)?

Berdahl: Our practice acquired the SoftFit™ PI, a soft, hydrogel insert, in early 2013, and it has added several more advantages to the LenSx® Laser. For example, it eliminates fogging so patients have a better view of the fixation light, ensuring proper docking. The interface also speeds the femtosecond treatment phase to just under 2 minutes (Video), minimizes corneal distortion, decreases IOP and requires 66% less energy for lens fragmentation versus previous interfaces. In my opinion, however, the greatest advantage of the SoftFit™ PI is that I am able to achieve free-floating capsulotomies in more than 99% of cases, which better facilitates removal of lens material.

Why do you think improved refractive outcomes that the LenSx® Laser provides are important for your overall business model?

Berdahl: In addition to standard cataract technology and procedures fully covered by Medicare and other insurers, patients can partially pay out of pocket for premium technologies and procedures under Medicare, such as advanced technology IOLs and laser refractive cataract surgery. This allows ophthalmologists to have a market-based portion of the practice dedicated to meeting patients’ high expectations for refractive outcomes. I have found that many of my patients are willing to pay out of pocket for the enhanced refractive outcomes that the LenSx® Laser can provide, and this has helped my practice to succeed.
How will enhanced refractive outcomes continue to play a role in cataract surgery?

Berdahl: It is interesting how one technology causes improvements to other technologies, just as phacoemulsification led to foldable IOLs implanted through small incisions. Laser refractive cataract surgery has only been available for approximately two years, and yet it complements new diagnostic devices and advanced technology IOL designs to better control refractive error. As technologies continue to feed off one another, this synergy will help ophthalmologists to provide increasingly better refractive outcomes for patients with cataracts.

Dr. Berdahl is a specialist in advanced cataract, corneal and glaucoma surgery at Vance Thompson Vision in Sioux Falls, SD.

References
1. [AU QUERY: Please provide references.]
2. [AU QUERY: Please provide references.]

FinAncIAL considerATions

Keys to running a successful LRCS practice: Making the numbers work

Incorporating laser refractive cataract procedures into an ophthalmology practice can be a successful venture, both financially and in terms of patient satisfaction. Surgeons who want to start performing laser vision correction for patients with cataracts should make a commitment to the technology, undergo necessary training and create a business plan for the transition.

They may consider adding technologies or tools to their practice that may improve refractive outcomes. For example, the LenSx® Laser (Alcon Laboratories, Inc.) can improve both spherical and refractive outcomes and reduce the number of enhancements required postoperatively.¹ The financial considerations associated with purchasing a new device may make some surgeons hesitant to make the transition. In an audience poll conducted at the Hawaiian Eye 2013 meeting for comprehensive ophthalmologists, 81% of respondents cited cost as the number one concern in offering femtosecond laser technology to patients with cataracts² (Figure, page 16). With proper financial planning, however, surgeons can offer laser refractive cataract procedures while still remaining financially viable.

The LenSx® Laser costs approximately $500,000 to $600,000, plus an additional fee that ranges from $300 to $400 per procedure. To make a successful investment in this technology, surgeons must offset the cost by increasing four variables: number of procedures, revenue per procedure, conversion rates and number of satisfied patients.

Number of procedures

To make this work financially, surgeons must perform a minimum of 1,000 cataract surgeries per year, with 300 to 400 of those
being premium-channel procedures. High-volume surgeons who match these numbers can consider purchasing the technology either through a loan or by collaborating with other surgeons to create enough volume for the shared access model. However, small-volume surgeons can also make it work by using hospitals or shared access facilities. In this model, each surgeon pays a per-procedure fee to access the technology.

Sightpath* is one company that provides mobile excimer lasers and is starting to mobilize femtosecond lasers for cataract surgery. Companies like Sightpath deliver the equipment along with a skilled technician to operate it, which makes the surgeon feel more comfortable and is a great option for surgeons new to the technology.

**Revenue per procedure**

Many surgeons also adjust their fees as they add new technology to the practice. In my practice, a manual procedure with a microkeratome costs approximately $1,600 per eye. Once we acquired the laser, we increased the cost of surgery to $2,000 per eye, regardless of whether we use the femtosecond laser.

“Once we acquired the laser, we increased the cost of surgery to $2,000 per eye, regardless of whether we use the femtosecond laser.”
— Richard I. Lindstrom, MD

**Conversion rates**

Surgeons who want to invest in a femtosecond laser should be operating at a 30% conversion rate. At our practice, we present advanced technology IOLs and laser cataract refractive surgery as a package. That increases the value and proposition and, subsequently, the conversion rate to advanced technology IOLs. Sometimes the reverse effect occurs when surgeons who acquire femtosecond lasers experience an increase in the conversion rate to multifocal and toric IOLs. We offer patients the option of toric IOLs to reduce astigmatism and improve functional distance vision or multifocal IOLs to improve both near and distance vision. Included in that package is access to laser cataract surgery. Therefore, patients not only get the benefit of a toric or multifocal IOL, but also upgrade from manual to laser-assisted cataract surgery.

**Satisfied patients**

Surgeons who currently have the LenSx® Laser tend to be early adopters of new, innovative technology. Patients tend to like the

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idea of a precision laser, and news spreads by word of mouth to not only other patients but also doctors in the community who may refer patients to optometrists and ophthalmologists who have the most advanced technology. That may attract an increased volume of patients to the practice and contribute to overall practice growth.

Making the leap

Surgeons who want to start performing laser refractive cataract procedures may consider investing in a femtosecond laser. Both high- and low-volume surgeons can access the technology and use it successfully with the right planning and preparation. Much of the decision to acquire new technology comes down to personality type and whether the surgeon is an early adopter. Fortune tends to favor early adopters of new technologies that stand the test of time, and I believe the femtosecond laser will become a standard part of cataract surgery in the future.

Dr. Lindstrom is founder and attending surgeon of Minnesota Eye Consultants and Adjunct Professor Emeritus at the University of Minnesota Department of Ophthalmology in Minneapolis, MN.

References
1. AcrySof® IQ ReSTOR® IOL Directions for Use. Fort Worth, TX: Alcon Laboratories, Inc.

AcrySof® IQ ReSTOR® Intraocular Lenses — Important Safety Information

CAUTION: Federal (USA) law restricts this device to the sale by or on the order of a physician.

INDICATIONS: The AcrySof® IQ ReSTOR® Posterior Chamber Intraocular Lens (IOL) is intended for primary implantation for the visual correction of aphakia secondary to removal of a cataractous lens in adult patients with and without presbyopia, who desire near, intermediate and distance vision with increased spectacle independence. The lens is intended to be placed in the capsular bag.

WARNING/PRECAUTION: Careful preoperative evaluation and sound clinical judgment should be used by the surgeon to decide the risk/benefit ratio before implanting a lens in a patient with any of the conditions described in the Directions for Use labeling. Physicians should target emmetropia, and ensure that IOL centration is achieved. Care should be taken to remove viscoelastic from the eye at the close of surgery.

Some patients may experience visual disturbances and/or discomfort due to multifocality, especially under dim light conditions. Clinical studies with the AcrySof® ReSTOR® lens indicated that posterior capsule opacification (PCO), when present, developed earlier into clinically significant PCO. Prior to surgery, physicians should provide prospective patients with a copy of the Patient Information Brochure available from Alcon for this product informing them of possible risks and benefits associated with the AcrySof® IQ ReSTOR® IOLs.

Studies have shown that color vision discrimination is not adversely affected in individuals with the AcrySof® Natural IOL and normal color vision. The effect on vision of the AcrySof® Natural IOL in subjects with hereditary color vision defects and acquired color vision defects secondary to ocular disease (e.g., glaucoma, diabetic retinopathy, chronic uveitis, and other retinal or optic nerve diseases) has not been studied. Do not resterilize; do not store over 45°C; use only sterile irrigating solutions such as BSS® or BSS PLUS® Sterile Intraocular Irrigating Solutions.

ATTENTION: Reference the Directions for Use labeling for a complete listing of indications, warnings and precautions.
AcrySof® IQ Toric Intraocular Lenses — Important Safety Information CAUTION:

Federal (USA) law restricts this device to the sale by or on the order of a physician.

INDICATIONS: The AcrySof® IQ Toric posterior chamber intraocular lenses are intended for primary implantation in the capsular bag of the eye for visual correction of aphakia and pre-existing corneal astigmatism secondary to removal of a cataractous lens in adult patients with or without presbyopia, who desire improved uncorrected distance vision, reduction of residual refractive cylinder and increased spectacle independence for distance vision.

WARNING/PRECAUTION: Careful preoperative evaluation and sound clinical judgment should be used by the surgeon to decide the risk/benefit ratio before implanting a lens in a patient with any of the conditions described in the Directions for Use labeling. Toric IOLs should not be implanted if the posterior capsule is ruptured, if the zonules are damaged, or if a primary posterior capsulotomy is planned. Rotation can reduce astigmatic correction; if necessary lens repositioning should occur as early as possible prior to lens encapsulation. All viscoelastics should be removed from both the anterior and posterior sides of the lens; residual viscoelastics may allow the lens to rotate.

Optical theory suggests that high astigmatic patients (i.e. > 2.5 D) may experience spatial distortions. Possible toric IOL related factors may include residual cylindrical error or axis misalignments. Prior to surgery, physicians should provide prospective patients with a copy of the Patient Information Brochure available from Alcon for this product informing them of possible risks and benefits associated with the AcrySof® IQ Toric Cylinder Power IOLs.

Studies have shown that color vision discrimination is not adversely affected in individuals with the AcrySof® Natural IOL and normal color vision. The effect on vision of the AcrySof® Natural IOL in subjects with hereditary color vision defects and acquired color vision defects secondary to ocular disease (e.g., glaucoma, diabetic retinopathy, chronic uveitis, and other retinal or optic nerve diseases) has not been studied. Do not resterilize; do not store over 45° C; use only sterile irrigating solutions such as BSS® or BSS PLUS® Sterile Intraocular Irrigating Solutions.

ATTENTION: Reference the Directions for Use labeling for a complete listing of indications, warnings and precautions.

The LenSx® Laser — Important Safety Information

CAUTION: United States Federal Law restricts this device to sale and use by or on the order of a physician or licensed eye care practitioner.

INDICATION: The LenSx® Laser is indicated for use in patients undergoing cataract surgery for removal of the crystalline lens. Intended uses in cataract surgery include anterior capsulotomy, phacoemulsification, and the creation of single plane and multiplane arc cuts/incisions in the cornea, each of which may be performed either individually or consecutively during the same procedure.

RESTRICTIONS:
• Patients must be able to lie flat and motionless in a supine position.
• Patient must be able to understand and give an informed consent.
• Patients must be able to tolerate local or topical anesthesia.
• Patients with elevated IOP should use topical steroids only under close medical supervision.

CONTRAINDICATIONS:
• Corneal disease that precludes planaplanation of the cornea or transmission of laser light at 1030 nm wavelength
• Descemetoclele with impeding corneal rupture
• Presence of blood or other material in the anterior chamber
• Poorly dilating pupil, such that the iris is not peripheral to the intended diameter for the capsulotomy
• Conditions which would cause inadequate clearance between the intended capsulotomy depth and the endothelium (applicable to capsulotomy only)
• Previous corneal incisions that might provide a potential space into which the gas produced by the procedure can escape
• Corneal thickness requirements that are beyond the range of the system
• Corneal opacity that would interfere with the laser beam
• Hypotony or the presence of a corneal implant
• Residual, recurrent, active ocular or eyelid disease, including any corneal abnormality (for example, recurrent corneal erosion, severe basement membrane disease)
• History of lens or zonular instability
• Any contraindication to cataract or keratoplasty
• This device is not intended for use in pediatric surgery.

WARNINGS: The LenSx® Laser System should only be operated by a physician trained in its use.

The LenSx® Laser delivery system employs one sterile disposable LenSx® Laser Patient Interface consisting of an applanation lens and suction ring. The Patient Interface is intended for single use only. The disposables used in conjunction with ALCON® instrument products constitute a complete surgical system. Use of disposables other than those manufactured by Alcon may affect system performance and create potential hazards.
The physician should base patient selection criteria on professional experience, published literature, and educational courses. Adult patients should be scheduled to undergo cataract extraction.

**PRECAUTIONS:**
- Do not use cell phones or pagers of any kind in the same room as the LenSx® Laser.
- Discard used Patient Interfaces as medical waste.

**AEs/COMPLICATIONS:**
- Capsulotomy, phacofragmentation, or cut or incision decentration
- Incomplete or interrupted capsulotomy, fragmentation, or corneal incision procedure
- Capsular tear
- Corneal abrasion or defect
- Pain
- Infection
- Bleeding
- Damage to intraocular structures
- Anterior chamber fluid leakage, anterior chamber collapse
- Elevated pressure to the eye

**ATTENTION:** Refer to the LenSx® Laser Operator’s Manual for a complete listing of indications, warnings and precautions.