Grappling with the pros and cons of IOL complication options, and seeking a surgical solution to a genetic problem.

BY MICHAEL A. KLUFAS, MD

Scleral Fixation of Dislocated Acrylic IOL

Video submitted by Mitul Mehta, MD, MS
Mitul Mehta, MD, MS, presents a case report of a dislocated one-piece acrylic intraocular lens (IOL) and capsular bag complex, which is rescued and fixated to the sclera. Depending on practice patterns, often the vitreoretinal surgeon is best suited for IOL rescue or exchange, particularly if the lens is dislocated into the posterior segment. Thanks to innovative colleagues, myriad surgical approaches are available: IOL rescue with fixation to the sclera or iris, IOL explantation with scleral- or iris-fixated lens, or placement of an anterior chamber IOL (ACIOL).1 Outside of the United States, the availability of the Artisan Aphakia iris-fixated IOL (Ophtec), often called the iris-claw lens, presents retina surgeons with yet another option.

Some surgeons theorize that, when there are many methods to address a problem, it means that no method is perfect. In many IOL complication cases, the surgeon may question whether to perform a tried-and-true procedure such as ACIOL placement or a more innovative technique. Melamud and colleagues evaluated vitrectomy with ACIOL or scleral-fixated lens placement in 57 eyes and found that final visual acuity and complication rates were similar between the two groups, and that epiretinal membrane formation was higher in the ACIOL group. The authors concluded that both techniques are equally

WHAT IS YOUR PREFERRED SECONDARY IOL TECHNIQUE?

View Dr. Mehta’s video on Eyetube and tell us about your preferred secondary IOL technique the comments box.
Anterior Capsular Phimosis in Myotonic Dystrophy

Video submitted by Michael A. Klufas, MD

I present a video of a reported complication after cataract extraction in a patient with myotonic dystrophy. A 15-year-old female presented with progressively decreased vision 3 months after cataract surgery and was found to have dense capsular opacification over the IOL. The membrane was not amenable to Nd:YAG laser capsulotomy, and a surgical membranectomy was indicated. The membrane was incised with a microvitreo-

retinal blade, opened with curved 25-gauge scissors, and then removed with the vitreous cutter.

Myotonic dystrophy is an autosomal dominant disorder derived from expansion of CTG repeated in the untranslated region of the protein kinase gene DMPK on chromosome 19q. Patients with myotonic dystrophy have an increased risk of secondary anterior and posterior capsular opacification and intraocular fibrosis. The disorder has been associated with many ocular abnormalities including cataract, hypotony, miosis, retinal lesions, and oculomotor weakness. The trauma of cataract surgery may trigger lens epithelial cells to undergo fibroblastic and proliferative reaction to produce collagen, resulting in capsular opacification. DMPK has been found to be expressed in lens epithelial cells of myotonic dystrophy patients, suggesting that the defect in the protein kinase is somehow involved in this proliferation after cataract surgery. Others hypothesize that ciliary body atrophy in myotonic dystrophy may result in unopposed centripetal force at the capsular margin and progressive phimosis.