Why Do an Exchange

- Refractive surprise after cataract surgery
- Mal-position or function of an IOL
- Damaged lens or kinked haptic
- Patient dissatisfaction with lens performance
- Uveitis-Glaucoma-Hyphema syndrome (yes we still see it)
- If needed for other anterior segment surgery

Clinical pearls

- In advanced anterior segment surgery being able to do a IOL exchange is a must
- The thought can be scary, but if you have mastered cataract removal with lens implant, you have the skills for implant removal/exchange
- If you think a lens exchange is going to be necessary, do not open posterior capsule (assuming it is not already open)
- Sooner is better, but even months or years after IOL is placed it can be exchanged
- In many cases of ACIOL placement, there is enough residual capsule for posterior lens placement

Financial Disclosure

- Alcon
- Allergan
- AMO
- Bausch and Lomb
- TearScience
- BioTissue
Basic steps-easy as 1,2,3

- Visco-dissect optic and haptics
- Carefully bring lens into anterior chamber
- Remove lens from anterior chamber
- IOL can be cut and removed in pieces
- Can fold IOL and remove in one piece
- Some IOL's can be pulled out of wound without folding (silicone IOL's)
- Place new IOL in bag, AC, sulcus, or suture fixate

Clinical Case

58 Year old man s/p LASIK in 2001
Progressive myopia due to advancing lens changes
Uneventful cataract surgery, but post-op refraction +2.00 and not thrilled

Incorrect Lens Power

- What are the options
- Non Surgical:
  - Glasses or contact lenses
- Surgical:
  - Laser refractive surgery
  - IOL exchange
  - Piggyback IOL

Incorrect Lens Power

- Piggyback IOL
- Second IOL makes up for the lack of power of the first
- Good for +/- 4 diopters of residual refractive error
- Never piggyback two acrylic IOL's due to fibrosis between the IOL's
- Can get chafe from optic, not a good option for small eyes
Incorrect Lens Configuration

• New IOL designs make lens positioning even more important
• Crystalens can dislocate or be in incorrect configuration
• Viscodissection of haptics is essential
• Thick silicone optic can be difficult to cut

Dislocated MFIOl with Dilated Pupil

• Removal of decentered multifocal IOL
• Atonic pupil
• Replace with mono focal IOL
• Repair of pupil after the IOL is exchanged

Sutured IOL XC Prolene for GTX

• Prolene sutured IOL's may dislocate over time
• Complete exchange gives the option of suture replacement on both haptics
• May need to be combined with vitrectomy

*Use of Gortex suture is off label

ACIOl XC with a Bonus

• Elderly patient history of RD and PBK
• Lens dislocated due to long standing PXF
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• Lens dislocated due to long standing PXF
• Difficult to see IOL in OR and ACIOL placed
• Blurred vision next day
• Needs IOL XC

• In some cases ACIOL will need to be removed: UGH, glaucoma, corneal decompensation
• Replacement with PCIOL may be a good option
• PCIOL may need to be fixated to iris or sclera if there is no capsular support
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One in One Out XC

- Lenses that have been “in the bag” for several months to years can be difficult to remove
- Not all lens material needs to be removed
- Haptic amputation with smooth edges is an acceptable option

PPAV IOL Reposition

- Patient with elevated IOP s/p CE/IOL/AV
- Release of aqueous at SL allowed vitreous to come forward
- Vitreous dislocated IOL in superior direction
- Use intracameral kennonog (Triescence)

Thank You