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Precision and Stability

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Amico Yasna Pars

Ophthalmology Newsletter

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“Permanence, perseverance and persistence in spite of all obstacles, discouragements and impossibilities: It is this, that in all things distinguishes the strong soul from the weak.”

Thomas Carlyle

PERSISTENCE is an essential factor in the procedure of transmuting DESIRE into its monetary equivalent. The basis of persistence is the POWER OF WILL. THERE IS NO SUBSTITUTE FOR PERSISTENCE! It cannot be supplanted by any other quality!

Those who have cultivated the HABIT of persistence seem to enjoy insurance against failure. No matter how many times they are defeated, they finally arrive up toward the top of the ladder. Sometimes it appears that there is a hidden Guide whose duty is to test us through all sorts of discouraging experiences and stories. The hidden Guide lets no one enjoy great achievement without passing the PERSISTENCE TEST. Those who can't take it, simply do not make the grade.

Those who can “take it” are bountifully rewarded for their PERSISTENCE. They receive, as their compensation, whatever goal they are pursuing. That is not all! They receive something infinitely more important than material compensation--the knowledge that “EVERY FAILURE BRINGS WITH IT THE SEED OF AN EQUIVALENT ADVANTAGE.”

In Amico Yasna Pars, from the starting point, we are always in Pursuit of “take it” phrase knowing that the Equivalent seeds will guide us through our visions, PERFECTION! And the story of “take it” continues for us...



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Tecnis® Symfony

FDA Approves the Tecnis Symfony Intraocular Lenses, the First and Only Extended Depth of Focus Lenses for People with Cataracts.

Discussion

PATIENT CONVERSATIONS

What you need to know to discuss IOL advances with patients.

BY MILIND PANDE, DO, FRCS, FRCOPHTH



Our optimal objective for presbyopia and cataract patients is to provide a full range of focus with the least possible compromise in quality of vision. I customize IOL selection and use a mix-and-match approach to achieve this goal of functional spectacle independence while minimizing compromises in quality of vision.

The process of learning which IOLs work for which patients takes time, and this is especially true for new IOL technologies for which there are not yet extensive clinical data. For instance, I initially implanted the Tecnis Symfony Extended Range of Vision IOL (Abbott Medical Optics; Figure 1) in combination with a multifocal IOL, but I switched to bilateral implantation in many of my refractive lens exchange and cataract surgery patients because I realized that the lens' optics create fewer tradeoffs to the quality of vision than multifocal IOLs.

In the end, it is all about patient satisfaction. The first key to achieving optimal patient satisfaction is proper patient selection; the second is having meaningful conversations about IOL technologies with patients. When patients understand what kind of vision they can expect after surgery, they are more likely to be happy with their results.

A few case examples may help to illustrate these points.

THREE PATIENT TYPES

The ideal candidate. Patient C.W. is a 67-year-old lawyer. He and his wife enjoy weekend trips to the countryside. Other than cataract and high blood pressure, his ocular and systemic histories are unremarkable. After reviewing the patient education materials we provided to him, Patient C.W. expressed an interest in a presbyopia-correcting IOL.

We conducted a baseline panfocal visual acuity assessment, a series of measurements that we do before and after surgery in each eye. I have found that a score of 20/30 or better at all of the panfocal measurement points (Table 1) is consistent with a patient's ability to perform a wide range of tasks with complete spectacle freedom. It also helps me to customize lens choices.

For this patient, I recommended bilateral implantation of the Tecnis Symfony IOL. I like to describe this lens to patients as a *mini-zoom lens*. Just like the zoom on a camera, it provides the same sharp, in-focus image at any point over the range of the zoom. I told Patient C.W. that it would allow him to see clearly without glasses for most of his leisure activities and daily work including use of a smartphone, tablet, and computer, as this was a priority for this profes-

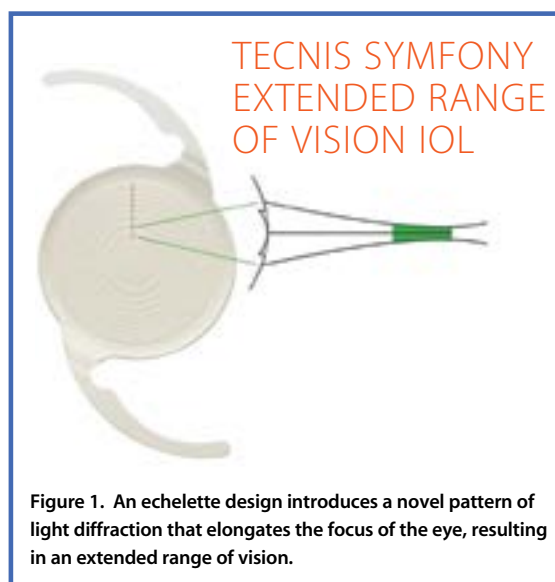


Figure 1. An echelette design introduces a novel pattern of light diffraction that elongates the focus of the eye, resulting in an extended range of vision.

sionally active patient. I did not promise that he would never need glasses. I always ask questions like, "If you have to wear glasses for certain tasks, would you rather it be for reading a novel in bed or for using the computer and shopping?" Most people will choose the former, as Patient C.W. did.

After surgery on his first eye, I asked Patient C.W. how his near vision was. He said it was fine for everything except prolonged reading, as I had anticipated from our panfocal testing results. When it came time for second-eye surgery, I therefore aimed for a micro-monovision target of -0.50 D. This target carries none of the disadvantages of true monovision but provides an extra edge for reading. After this procedure, Patient C.W. was spectacle independent and satisfied with his results.

The noncandidate. Patient L.S. is a 73-year-old woman with age-related macular degeneration (AMD). She would love to be less spectacle dependent, but when she inquired about suitability for "the new lenses" she had heard about, I was not yet comfortable recommending Symfony—I certainly would not implant any other presbyopia-correcting IOL, as all involve compromises in contrast sensitivity that are not acceptable for a patient with limited vision from AMD.

Given what we know about its optics and its quality of vision similar to that of a monofocal lens, I think the

Discussion

COVER FOCUS

TABLE 1. PANFOCAL VISUAL ACUITY MEASUREMENT

Acuity Measure	Distance	Lighting
Distance	6 m	Photopic (330 Lux)
Intermediate	65 cm	Photopic (330 Lux)
Near 1	33–40 cm	Photopic (330 Lux)
Near 2	33–40 cm	Mesopic (100 Lux)

UCVA and distance-corrected visual acuity are tested monocularly and binocularly at each of the specified distances.

Symfony IOL may prove to be a good option in patients with AMD or other significant comorbidities, such as severe glaucoma or uveitis. However, until we have more information about its performance in such eyes, I erred on the side of caution and selected a monofocal IOL for Patient L.S. instead.

The patient who is committed to another option.

Patient D.A. came to me for cataract surgery, ready to have the same lenses his wife got last year. I had put a monofocal toric in her dominant eye and a multifocal toric in her non-dominant, and she was thrilled with the results. Now that it was her husband's turn, he wanted the same lenses but asked whether I could do anything about the glare that had bothered his wife in the early postoperative period. Patient D.A. does a lot more driving than his wife and wondered whether he was likely to experience glare and halos.

When I have to tell patients that they are not good candidates for the IOL their friend or relative got, I use that as an opportunity for patient education. This is a good time to tell them about how we can customize the lens choice to their particular pair of eyes and lifestyle.

I explained to Patient D.A. that we did not need to address astigmatism as we had in his wife's case. I recommended implanting the the Symfony IOL and explained the zoom lens analogy mentioned previously, but I also gave him some reassurance that, compared with multifocal IOLs, the tradeoffs in quality of vision are minimal. Data to date show

that contrast sensitivity and degree of photic phenomena with the Symfony IOL are similar to those of a monofocal lens, which makes it a great choice for someone who wants to avoid the potential for night driving problems.¹⁻³ He was delighted to hear that news. In fact, both spouses left the consultation satisfied that they had gotten the best fit for their eyes and the best lenses available at the time of their respective surgeries.

EASIER CONVERSATIONS

I find that patient conversations are much easier since the introduction of the Symfony lens. The extended range of vision and minimal compromise in quality of vision make it easier to explain the pros and cons of this lens compared with multifocal lenses. I also spend less time explaining the gaps or weaknesses in the range of vision characteristic of multifocal lenses. Most people who are not familiar with optical principles find it difficult to grasp how they could have blurred vision at intermediate distance when they see well at distance and near, as often happens with a multifocal IOL. In those cases, we have to be careful to set expectations correctly to avoid disappointment.

The Symfony Extended Range of Vision IOL is not perfect, but it requires far fewer visual compromises, and, thus, there is much less to explain. My results to date show that patients have seamless continuous vision from distance to intermediate plus functional near vision. The fact that some patients do not achieve good enough near vision for prolonged reading or fine print is easily addressed with a micro-monovision target of less than -0.75 D in the second eye. ■



AT A GLANCE

- A visual acuity of 20/30 or better at all of the panfocal measurement points is consistent with a patient's ability to perform a wide range of tasks with complete spectacle freedom.
- The extended range of vision and minimal compromise in quality of vision of the Symfony IOL make it easier to explain its pros and cons when compared with multifocal IOLs.

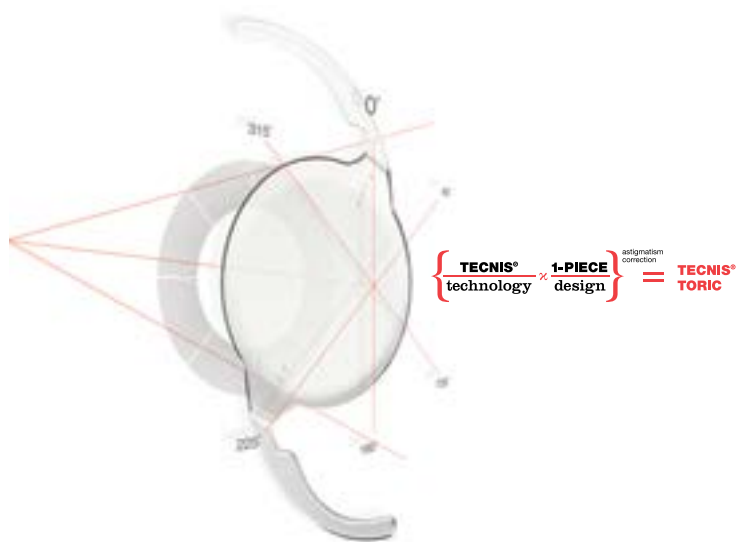
1. Data on file, Abbott Medical Optics. 2014CT0002 - Symfony Harmony EMEA Trial
2. Data on file, Abbott Medical Optics. 166, Extended Range of Vision IOL 3-Month Study Results (NZ).
3. Weeber HA, Piers PA. Theoretical performance of intraocular lenses correcting both spherical and chromatic aberration. *J Refract Surg.* 2012;28(1):48-52.

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Tecnis[®] Toric

THE LEGACY YOU LEAVE IS THE LIFE YOUR PATIENTS LIVE.



The toric IOL is available in ten cylinder powers (1, 1.50, 2.25, 3, 3.75, 4.5, 5.25, 6, 7, and 8 D at the IOL plane) that are recommended to correct between 1 and 5.48 D of corneal astigmatism. It is based on the time-tested platform of the hydrophobic acrylic, monofocal aspheric Tecnis 1-piece IOL (ZCB00) that offers material and design benefits that are especially well-suited for toric IOL technology. Clinical trial outcomes for the Tecnis Toric IOL show excellent clinical performance in terms of intraocular stability, refractive correction, and functional outcomes, and it is a surgeon-friendly lens that is easy to insert and align.

Discussion

Toric IOL expands options for pre-existing astigmatism

May 15, 2013

By Cheryl Guttman Krader

Reviewed by Kerry Assil, MD, and Farrell C. "Toby" Tyson, II, MD

"I consider toric IOL implantation the best modality for providing excellent uncorrected distance vision in patients with more than 1 to 1.5 D of astigmatism," said Farrell C. "Toby" Tyson, II, MD, private practice, Cape Coral Eye Center, Cape Coral, FL, and an investigator in the premarketing, North American Tecnis Toric IOL clinical trial.

"With the Tecnis Toric IOL, surgeons now have a valuable new option to help them achieve this goal."

"The [IOL] offers a cluster of desirable features that together enable surgeons to provide superior vision for patients with pre-existing corneal astigmatism," said Kerry Assil, MD, who is in private practice, Assil Eye Institute, Los Angeles. In a symposium held during the annual meeting of the American Society of Cataract and Refractive Surgery in San Francisco, he was the first U.S. surgeon to implant the lens following its FDA approval.

The North American clinical trial evaluating the safety and effectiveness of the IOL had two arms. In a randomized,

double-masked arm, 197 eyes received the Tecnis Toric ZCT150 (1.5 D cylinder correction at the IOL plane) or the one-piece, aspheric monofocal Tecnis IOL (model ZB00). The second arm of the trial had an open-label design, included 72 eyes, and evaluated the other three cylinder powers (models ZCT225, ZCT300, and ZCT400).

Rotational stability

IOL rotational stability was assessed by software analysis of high-resolution digital slit lamp photographs taken at serial visits from 1 day to 6 months postoperatively. Of 174 eyes with the Tecnis Toric IOL implanted, 148 had photographic data at all follow-up visits. Between day 1 and 6 months, mean absolute axis change was $<3^\circ$. The axis changed by $\leq 5^\circ$ between 1 and 3 months in 93% of eyes and between 3 and 6 months in 94% of eyes.

"The new American National Standards Institute criterion for rotational stability of a toric IOL requires that at least 90% of eyes have no more than a 5° axis change between consecutive visits at least 3

months apart," Dr. Tyson said. "These data show the Tecnis Toric IOL exceeds this tough standard."

Dr. Tyson and Dr. Assil attribute the rotational stability of the Tecnis Toric IOL to its long overall diameter, 13 mm, and proprietary offset, forward-mounted, rigid haptics design (Tri-Fix).

"The optic sits posteriorly and with the haptics, creates three points of fixation with the capsular bag that makes undesired secondary rotation unlikely," Dr. Assil said.

Other clinical trial results showed mean reduction in cylinder was significantly greater in eyes with the toric IOL implanted than in the controls receiving the ZB00; overall, residual refractive cylinder was <1 D in 94% of Tecnis Toric IOL eyes and <0.50 D in 72% of the eyes.

The refractive difference favoring the toric IOL group over controls translated into significantly better uncorrected distance visual acuity (UDVA) for the toric IOL eyes and a higher rate of spectacle indepen-

dence for distance. In the randomized study arm at 6 months, mean monocular UDVA was logMAR 0.10 (Snellen 20/25) in the toric IOL eyes compared to logMAR 0.16 (Snellen 20/29) in the controls. The results with toric IOL implantation were similar in the open label arm in which mean logMAR UDVA at 6 months was logMAR 0.11 (Snellen 20/26). The proportion of eyes achieving 20/20 or better UDVA was 44% for the toric IOL group and 24% for the controls; rates for 20/40 or better UDVA were 97% and 87%, respectively. Visual acuity outcomes

Both Dr. Tyson and Dr. Assil noted that even if eyes have some minor residual sphere and cylinder, the Tecnis Toric IOL still provides good acuity. They attribute that performance to several factors. "Eyes achieve crisper vision with better correction of spherical aberration (SA) and particularly eyes that already have reduced contrast acuity secondary to some retinal pathology," Dr. Tyson said.

"Since the Tecnis aspheric technology fully compensates for population average SA of +0.27 μm , it is likely to come close to the 'sweet spot' of zero SA in more eyes. With its greater SA compensation, the Tecnis Toric IOL is also preferred in eyes with a history of myopic LASIK that tend to have higher-than-average positive corneal SA." Visual quality in eyes with the Tecnis Toric IOL implanted is also enhanced by the lens material, Dr. Assil said.

"The Tecnis hydrophobic acrylic polymer has very low chromatic aberration, is clear without any tint, and starts out and remains glistening-free," he said. "It is a superb optical material providing excellent contrast acuity and clarity that helps to forgive slight residual refractive errors." Considering the clinical trial outcomes, Dr. Assil said that the Tecnis Toric IOL calculator seems to be providing precise results. It is also intuitively simple to use and allows surgeons to aim for slight under- or overcorrection of cylinder if they desire,

he said.

The implant also has very favorable handling characteristics. It delivers smoothly through a 2.2- to 2.4-mm incision. Once in the eye, it can be dialed into the desired position before the haptics engage the capsular equator.

"With this material, the haptics don't stick to the optic, and the lens can be easily rotated clockwise or counterclockwise, thus allowing me to fine-tune the lens position by as little as 5° based on intraoperative aberrometry," Dr. Tyson said.

Kerry Assil, MD

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Dr. Assil and Dr. Tyson are consultants to Abbott Medical Optics.

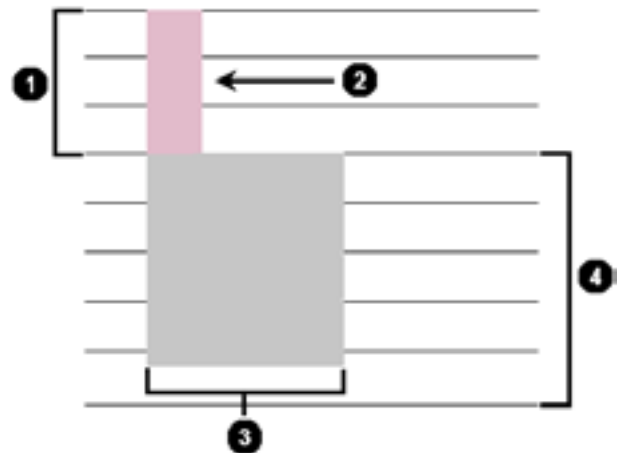


WHITESTAR Signature® PRO

WHITESTAR ICE Technology (Pulse Shaping)

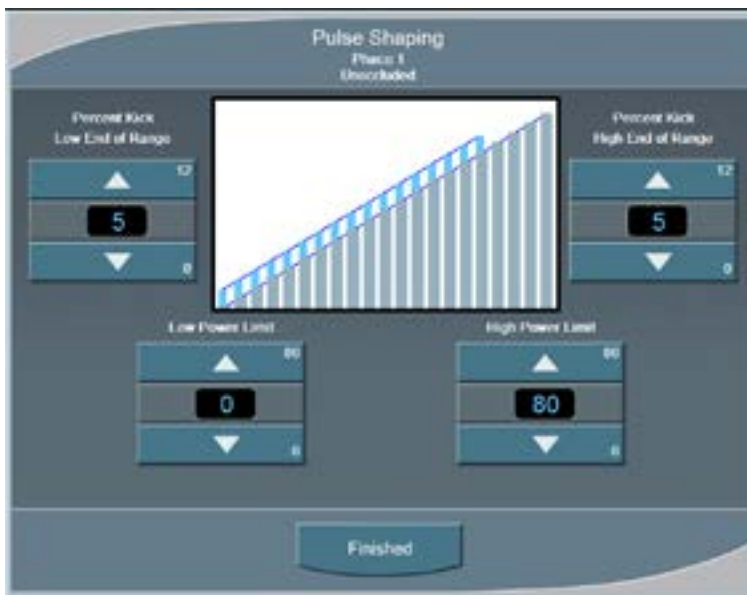
The WHITESTAR ICE Technology was the next micro-pulse advance in phacoemulsification technology, which combined modulated ultrasonic power (pulse shaping) with vacuum control through the application of the Chamber Stabilization Environment (CASE). This pulse shaping technology modifies the standard square wave pulse, by increasing the amplitude of the first millisecond of the on time “kick”, and then setting the remaining part of the on time to the standard power setting. This is repeated for each on time period, resulting in increased control and efficiency in phacoemulsification.

WHITESTAR ICE Technology Pulse Shaping



1. Kick Amplitude
3. Burst Width

2. 1 Millisecond Kick
4. Phaco Power Level



There are four settings for WHITESTAR ICE Pulse Shaping:

- Low Power Limit
- High Power Limit
- Percent Kick Low End of Range
- Percent Kick High End of Range

The Low Power Limit and High Power Limit settings define the range of the applied pulse shaping. When the applied phaco power is outside these limits, there is no pulse shaping. The Percent Kick settings determine the amplitude, or amount of the applied phaco power “kick” in the first millisecond of phaco power, either in the low end or the high end of the power range. As the phaco power increases from the Low Power Limit to the High Power Limit, the percentage of kick interpo-

lates for the power ranges in between the two limits.

As an example, if you establish small a kick setting for the low end of the range and establish a large kick setting for the high end of the range, the kick percentage gradually increases as the phaco power increases. When the percent kick at the low end is the same as the high end, then the kick remains constant throughout the low to high range.

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* in combination with UNO Colorline MACH2 vitreous cutters

Surgical Instruments



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surgery just easy for you.

- Maximum cleanliness: The easy to connect cleaning adapter enables cleaning of tips separated from the handle for an excellent care of health.

Upcomming Events

8 – 11 September 2016

16th Euretina Congress

Copenhagen, Denmark

10 - 14 September 2016

The XXXIV Congress of the European Society of Cataract and Refractive Surgeons (ESCRS)

Copenhagen, Denmark

21-23 September 2016

7th European Ophthalmology Conference

Amsterdam, Netherlands

25-29 September 2016

The XXII Biennial Meeting of the International Society for Eye Research

Tokyo, Japan



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