Preferred practice patterns in aphakia management in adults in India: A survey

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Purpose: To assess different approaches in the management of aphakia in adults in Indian ophthalmologists via an online survey. Methods: A survey-monkey based online questionnaire was fielded to Indian ophthalmologists in accordance with the CHERRIES guidelines. We recorded participants’ demographics, practice settings, and preferred surgical options including the type of intraocular lens (IOL) preferred when encountering a case of aphakia in adults with and without adequate capsular support. Differences between anterior segment (AS) surgeons and vitreoretinal (VR) surgeons as well as differences between surgeons with more or less than 10 years of surgical experience were evaluated using analytic statistics. Results: Of the 481 surgeons who responded to the survey, 369 (77%) were AS surgeons and the remaining 112 (23%) were VR surgeons and represented all regions of India. When encountering posterior capsular rent during cataract surgery, a three-piece IOL in the ciliary sulcus was the most preferred (n = 275, 57%) when there was adequate capsular support, while a retrofitted iris-claw IOL (n = 91, 19%) was the commonest choice in eyes without adequate capsular support. With associated nucleus drop, 85% of surgeons preferred to refer the patient to a VR surgeon and left the eye aphakic. Multivariable logistic regression showed that VR surgeons were more than six times likely to prefer a scleral fixed intraocular lens (SFIOLs) [odds ratio (OR) = 6.5, 95% confidence interval (CI) = 3.4–12.5, P < 0.001] and surgeons with >10 years of experience were also twice more likely to prefer an SFIOL (OR = 2.4, 95% CI = 1.2–4.9, P = 0.02). Conclusion: The choice of IOL in absence of capsular support in adult eyes differs between AS and VR surgeons and is also influenced by the surgeon’s experience.

Key words: Aphakia, posterior capsular rent, retrofitted iris-claw IOL, SFIOL, vitrectomy

The incidence of post-cataract surgery aphakia is <1% but causes a lot of morbidity in patients.1 Management of aphakia has undergone paradigm shifts from anterior chamber intraocular lenses (ACIOLs) of various designs to scleral fixed intraocular lenses (SFIOLs) and more recently, retrofitted iris-claw lenses.2–5 The SFIOL fixation has also seen major shifts from being a predominantly suture-assisted surgery to being sutureless over the past decade.6–9 After the introduction of the sutureless SFIOL by Gabor et al.10 in 2007, the glued intraocular lens (IOL) by Narang et al.11 and the flange fixation by Yamane12 have increased the popularity and adoption of the sutureless SFIOL techniques. With a few other modifications such as the XNIT surgery by Baskaran et al.,13 the introduction of novel IOL designs for sutureless SFIOL fixation such as the one by Madanagopalan et al.,14 management of aphakia has truly come a long way in not only improving the ease of surgery but also improving patient comfort and visual outcomes.

Given the myriad choice of IOLs in the management of aphakia, with many comparative studies showing similar visual outcomes, the choice of IOL depends upon the operating surgeon. Other factors include IOL availability, adequacy of capsular support, coexistent nucleus or cortex drop, white to white diameter, and primary (i.e., at the time of cataract surgery) vs. secondary surgery (after previous surgery).

To the best of our knowledge, surgeon preferences for the management of aphakia in India, in terms of choice of IOL and the factors determining these choices, have not been elucidated to date. In this survey of cataract surgeons across India, we sought to assess preferences in the surgical management of aphakia, especially in the absence of adequate capsular support.

Methods

The study was approved by the Institutional Ethics Committee and the study was carried out as per the tenets of the Declaration of Helsinki. The identity of all participating surgeons was kept anonymous during data collection and analysis. A questionnaire (Annexure I) was used during the

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survey and its administration followed the guidelines from the CHERRIES checklist. The questions were pilot tested by members of the core survey team and questions and/or their options were modified by consensus over an online zoom meeting. The survey was fielded to members of the All-India Ophthalmic Society (AIOS) with valid email ID and phone numbers using emails and WhatsApp messages from March to April 2021. Single responses from participants were ensured by hosting the survey on the survey-monkey platform and tagging responses using the participant’s IP address. Participation was voluntary and was not remunerated. Responses were registered as complete when all the survey questions were answered. The initial part of the questionnaire recorded the type of surgeon (anterior segment (AS) vs. posterior segment), years of surgical experience, region of practice in India (north, east, west, south, and central), type of practice (institutional, private, and combined), area of practice (urban vs. rural), the number of cataract surgeries performed per month, and the number of aphakia patients encountered in practice per month.

The next parts of the questionnaire were designed to assess surgeon preferences and choice of IOL for managing aphakia in adults under the following headings: planning when the patient is seen in the outpatient setting, aphakia management during primary surgery without nucleus or cortex drop, aphakia management during primary surgery with nucleus or cortex drop, and IOL placement preferences during secondary surgery without adequate capsular support. For management during primary surgery, surgeons were asked about whether they manage the surgery themselves or refer, if managing themselves then do they place an IOL in the same or secondary sitting, how long they prefer to wait for IOL placement of choosing a secondary sitting and the type of IOL they prefer in cases with and without capsular support. Options for IOL types provided were single-piece IOL in sulcus and three-piece IOL in sulcus for eyes with capsular support, and SFIOL, anterior fixed iris-claw, retrofixed iris-claw, iris sutured IOL, and ACIOL for eyes without capsular support. Surgeons were also asked whether performed a peripheral iridectomy while placing a retrofixed iris-claw IOL. If preferring an SFIOL, surgeons were asked if they preferred a sutured or sutureless technique of fixation. If preferring a sutureless technique, the choices provided were glued SFIOL, Gabor Schiatti’s technique (or its modification), or the Yaman technique (or its modification). If preferring a sutured technique, surgeons were asked about the type of suture (9-0 prolene, 10-0 prolene, or Cortex) and the type of SFIOL preferred (SFIOL with eyelets, routine three-piece IOL anchored with haptics, or foldable acrylic IOL with plate haptics (Akreos IOL, Bausch and Lomb, USA). Lastly, surgeons were asked about their preference for managing cases with bilateral aphakia.

Statistical analysis
All categorical variables were expressed as proportions (n, %) and denominators for each question were based on the total responses received for that particular question. Chi-square tests were used to analyze differences between groups. Logistic regression analysis was used to predict the choice of SFIOL in eyes without nucleus drop and no capsular support and covariates included were surgeon type (anterior vs. posterior segment surgeon), surgeon experience, and type of practice (institutional vs. private vs. both).

All data were exported from the survey server into Microsoft Excel and analyzed using STATA 12.1 I/c (Stata Corp, Fort Worth, Texas, USA). All P values < 0.05 were considered statistically significant.

Results
Surgeon characteristics
The survey questionnaires were sent to 10,000 ophthalmologists. A total of 481 (4.8%) surgeons responded to our survey of which 369 (77%) were AS surgeons, whereas the remaining 112 (23%) were vitreoretinal (VR) surgeons. About two-thirds of the participating surgeons had surgical experience of more than 10 years (n = 319, 66%), majority were based in urban areas (n = 413, 86%), and there was good representation from north (n = 78, 16%), south (n = 114, 24%), east (n = 99, 21%), central (n = 42, 9%), and western (n = 142, 29%) Indian regions. Participants were almost equally distributed in terms of institutional (n = 194, 40%) and private practice (n = 184, 38%) while the remaining 103 practitioners were engaged in both institutional and private practice. In terms of surgical cataract volumes, 113 (24%) operated on fewer than 25 cases per month, 138 (28%) did between 25 and 50 surgeries, 107 (22%) did 50 and 100 surgeries, and 74 (15%) did more than 100 surgeries per month while 49 (10%) reported not doing regular cataract surgery.

The majority (n = 375, 78%) preferred phacoemulsification as the primary mode of cataract surgery.

Aphakia planning when seen in outpatient clinics
Most participants saw fewer than 10 aphakia patients per month (n = 430, 89%) and postoperative aphakia was the commonest etiology encountered by participants (n = 351, 73%). Traumatic aphakia (n = 86, 18%) was the second commonest cause reported followed by spontaneous dislocation of IOL (n = 20, 4%). Nearly two-thirds of participants reported managing aphakia themselves when seeing cases in the clinic setting while the rest opted to refer patients to VR surgeons. Placing a three-piece IOL in the ciliary sulcus when available was the commonest choice for surgeons when planning for surgery in the operation department (OPD) [Table 1], whereas an SFIOL was the commonest choice followed by retrofixed iris-claw IOL in the eyes with inadequate capsular support [Table 1].

Aphakia management during primary surgery – without nucleus or cortex drop
When encountering posterior capsule rent (PCR) during surgery without nucleus or cortex drop, 390 (81%) participants said that they managed the surgery themselves while 21 (4%) preferred to manage aphakia in a secondary sitting. A separate 20 (4%) preferred to call a VS in the same sitting and another 20 (4%) referred to a VS in a secondary sitting and 30 did not comment. Fig. 1 shows management patterns in the case of PCR with inadequate capsular support. A three-piece IOL in the ciliary sulcus was the preferred IOL of choice when there was adequate capsular support [Table 1] while a retrofixed iris-claw IOL was the commonest choice in eyes without adequate capsular support.

Aphakia management during primary surgery – with nucleus or cortex drop
When encountering PCR during surgery with nucleus or cortex drop, nearly half (n = 202, 42%) preferred to refer the patient to a VR surgeon in a secondary sitting while about a third (n = 132, 27%) called a VR surgeon in the same sitting. In terms of IOL placement in this scenario, a vast majority (85%) preferred to
leave the patient aphakic. The choice of IOL in the few that placed it is shown in Table 1.

Practices for IOL placement during secondary surgery in eyes without capsular support

Most participants who preferred retrofixated iris-claw IOLs (n = 246) performed a peripheral iridotomy (n = 183, 75%) at the time of its placement. The commonest response to a time interval between primary cataract surgery and a secondary IOL placement was 2–6 weeks [Fig. 2]. For those who preferred SFIOL, 125 participants (54%) preferred a sutured IOL while 108 preferred a sutureless SFIOL. In those who went with sutured SFIOL, most preferred to use the polymethyl methacrylate (PMMA) SFIOL with eyelets on the haptics (n = 98/120, 82%), 20 (17%) used a foldable three-piece and 2 (2%) opted for the Akreos plate haptic IOL. Similarly, 10-O prolene suture was used most commonly for fixation (n = 68, 57%) followed by 9-O prolene (n = 44, 37%) and Gortex (n = 8, 7%). In those choosing sutureless SFIOL, the glued IOL was the most preferred (n = 42, 40%) followed closely by the Yamane technique (n = 37, 35%) and the Gabor technique (n = 26, 25%). In patients with bilateral aphakia already using spectacles or contact lenses, 212 (44%) participants offered a secondary IOL while 77 (16%) were advised to continue aphakic glasses and 125 (26%) would give the option of contact lenses for visual rehabilitation, and 67 (14%) did not comment.

Comparison in practice patterns for aphakia management between anterior and posterior segment surgeons

Table 2 shows a comparison of practice patterns between AS and VR surgeons. There were more AS surgeons with > 20 years of surgical experience. Only about half of the AS surgeons preferred to manage cases of aphakia when seeing them in the OPD compared to nearly all VR surgeons. In aphakia without...
adequate capsular support, AS surgeons preferred to use retrofixated iris-claw IOLs most commonly (50%) as opposed to VR surgeons who preferred SFIOL (65%) [Table 2]. Another difference was that while opting for an SFIOL, more than half of the AS surgeons preferred sutured SFIOLs, whereas more VR surgeons opted for the sutureless techniques. While doing sutureless SFIOL, AS surgeons opted for the glued IOL most frequently (49%) while VR surgeons chose the Yamane technique (40%) [Fig. 3], though these differences were not statistically significant [Table 2].

Comparison in practice patterns for aphakia management with respect to surgeon experience
Participants with experience <10 years were most commonly in institutional practice while more experienced surgeons were in private practice [Table 3]. A significantly higher proportion of younger surgeons preferred the retrofixated iris-claw IOL when encountering aphakia without adequate capsular support while senior surgeons preferred the SFIOL and retrofixated iris-claw almost equally [Table 3]. Similarly, if doing sutureless SFIOL, younger surgeons preferred the

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**Table 1:** Choice of IOL based on whether following PCR, there is nucleus/cortex drop and whether there is adequate capsular support

|                     | Aphakia in OPD | Aphakia in OR, No Nucleus Drop | Aphakia in OR with Nucleus Drop |
|---------------------|----------------|-------------------------------|---------------------------------|
|                     | Capsular support present | Capsular support absent | Capsular support present | Capsular support absent | Capsular support present | Capsular support absent |
| Three-piece IOL in the sulcus | 201 (42%) | - | 275 (57%) | - | 60 (12%) | - |
| SFIOL               | 6 (1%)          | 155 (32%) | 2 (<1%) | 73 (15%) | 1 (<1%) | 43 (9%) |
| Retro-fixated iris-claw | 7 (1%) | 109 (23%) | 6 (1%) | 91 (19%) | - | 24 (5%) |
| Single-piece IOL in the sulcus | 41 (9%) | - | 50 (10%) | - | 7 (1%) | - |
| Single-piece IOL in bag | 46 (10%) | - | 41 (8.5%) | - | 5 (1%) | - |
| ACIOL               | 4 (<1%) | 33 (7%) | 5 (1%) | 36 (7%) | - | 1 (<1%) |
| Anterior iris claw | 3 (<1%) | 9 (2%) | 1 (<1%) | 5 (1%) | - | - |
| Don't put IOL or refer | 173 (36%) | 175 (36%) | 101 (21%) | 205 (43%) | 408 (85%) | 413 (86%) |

**Table 2:** Comparison of practice settings and patterns in the management of aphakia between AS surgeons vs. VR surgeons

| Variable                                      | AS surgeon (n=369) | VR surgeon (n=112) | P   |
|-----------------------------------------------|--------------------|--------------------|-----|
| Years of practice: <5 years                   | 47 (13%)           | 19 (17%)           | 0.012 |
| 5-10 years                                    | 72 (19%)           | 23 (21%)           |     |
| 10-20 years                                   | 110 (30%)          | 45 (40%)           |     |
| >20 years                                     | 140 (38%)          | 24 (22%)           |     |
| Type of practice                              |                     |                    |     |
| Institutional                                  | 157 (43%)          | 37 (33%)           | 0.17 |
| Private                                       | 137 (37%)          | 47 (42%)           |     |
| Both                                          | 73 (20%)           | 28 (25%)           |     |
| % Urban practice                              | 312                | 101                |     |
| Prefer phacoemulsification for cataract surgery | 285 (78%)          | 90 (86%)           | 0.05 |
| No. of aphakia seen per month (<10)           | 338 (94%)          | 92 (84%)           | 0.006 |
| Commonest causes of aphakia seen in practice  |                     |                    |     |
| Postoperative                                 | 276 (77%)          | 75 (68%)           | 0.02 |
| Spontaneous IOL dislocation                   | 10 (3%)            | 10 (9%)            |     |
| Spontaneous lens dislocation                  | 4 (1%)             | 3 (3%)             |     |
| Traumatic aphakia                             | 64 (18%)           | 22 (20%)           |     |

**Response to aphakia management**

| I plan and manage cases myself                | 210 (58%)          | 97 (89%)           | <0.001 |
| Choice of IOL with aphakia and capsular support with no nucleus drop: 3-piece IOL in the sulcus | 68% | 75% | 0.24 |
| Choice of IOL with aphakia and no capsular support with no nucleus drop: SFIOL | 34% | 65% | <0.001 |
| Retro-fixated iris-claw IOL                  | 50% | 30% |     |
| PI done for iris-claw                        | 80% | 55% | 0.001 |
| If doing SFIOL, then most preferred technique | 60% (Sutured) | 57% (Sutureless) | <0.001 |
| If doing sutureless SFIOL, then the most preferred technique | 49% (Glued IOL) | 40% (Yamane) | 0.12 |
Yamane technique while older surgeons preferred the glued IOL.

A multivariable logistic regression analysis with the type of surgeon, surgeon experience, and type of practice (institutional vs. private) found that VR surgeons were more than six times likely to prefer an SFIOL (OR = 6.5, 95% CI = 3.4–12.5, \( P < 0.001 \)) compared to AS surgeons. In the same model, surgeons with >10 years of experience were more than twice likely to prefer an SFIOL (OR = 2.4, 95% CI = 1.2–4.9, \( P = 0.02 \)). Institutional practitioners did not differ from private practitioners in terms of the type of IOL and for most other parameters (data not shown).

**Discussion**

This study presents data on various preferences for management of aphakia from all parts of India with a good mix of institutional vs. private practitioners and a good distribution over years of surgical practice, hence possibly representing practice patterns across India. AS surgeons managed cases of aphakia with no nucleus drop about half the time and resorted to iris-claw IOL more frequently in the same sitting. As opposed to this, VR surgeons preferred an SFIOL more often in all scenarios. While choosing an SFIOL, AS surgeons preferred the sutured SFIOL while VR surgeons chose sutureless IOL more frequently. Additionally, VR surgeons and surgeons with more experience chose SFIOL more often.

In aphakic eyes without adequate capsular support, AS surgeons were comfortable in managing cases with no nucleus drop about half the time and preferred assistance from a VR surgeon at other times. Also, they showed a trend toward using retro pupillary iris-claw IOL more frequently at the time of the primary surgery. Interestingly, when they saw patients in OPD, they chose SFIOL more frequently, showing that iris-claw is perceived to be an easier and quicker option at the time of encountering aphakia during primary cataract surgery. As opposed to this, VR surgeons preferred an SFIOL much more often and in all scenarios. Previous studies comparing iris-claw vs. SFIOL have shown delayed visual recovery in the iris-claw group compared to SFIOL.\(^{[14–16]}\) Additionally, the long-term data on retro pupillary iris-claw IOLs is scant,\(^{[15]}\) and its influence on pupil dynamics has not been studied. The commonest complication with iris-claw IOLs is D-shaped disfigurement of the pupil,\(^{[14,16]}\) localized iris atrophy, and poor mydriasis making future VR procedures difficult, likely prompting VR surgeons to avoid this approach.

While choosing an SFIOL, AS surgeons preferred the sutured SFIOL while VR surgeons chose sutureless IOL more frequently. A previous robust study showed equivalent results with sutured vs. sutureless SFIOL,\(^{[3]}\) hence surgeon preference may not influence visual outcomes much. However, there may be a fear of IOL drop while performing sutureless SFIOLs due to the inherent maneuvers involved. This fear is also demonstrated when doing sutureless SFIOL where AS surgeons preferred glued IOL more often for security compared to the Yamane technique by VR surgeons.

Lastly, VR surgeons and surgeons with more experience choose SFIOL more often. There could be several reasons to explain this trend. It is possible that this group had more exposure to the SFIOL technique during training, or this shows changing trends with time in view of retrofixated IOLs becoming recently available with ease of fixation making them...
preferable in recent times. It is also possible that retro pupillary iris-claw IOLs don’t do well in the long term with pigment dispersion, secondary glaucoma, persistent uveitis, and poor mydriasis, and hence experienced surgeons’ resort to SFIOL more, though these were not inquired in the survey.

The limitations of this study are possible under-representation of rural practitioners. To the best of our knowledge, this is the first survey showing the preferences of Indian surgeons in the management of aphakia to the best of our knowledge. However, surveys with a larger sample are required to confirm or refute the preferences of surgeons in managing aphakia in the Indian context.

**Conclusion**

In conclusion, this survey showed current trends in the management of aphakia among Indian ophthalmologists. Retro pupillary iris-claw IOLs are preferred increasingly by AS surgeons especially in the primary cataract setting without adequate capsular support, whereas VR surgeons and more experienced AS surgeons preferred SFIOL in this scenario. A similar survey may be repeated periodically to document changing trends in the surgical management of aphakia in the future, and results from this survey can be used as a benchmark for future comparisons.

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**Conflicts of interest**

There are no conflicts of interest.

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ANNEXURE 1

Aphakia Management: An online survey

QUESTIONNAIRE TO ANALYZE THE PREFERRED MODE OF MANAGEMENT IN APHAKIA

Management of aphakia poses many challenges for ophthalmologists and involves many different approaches. This online survey attempts to identify the most preferred techniques in the management of aphakia by Indian ophthalmologists.

There are a few multiple-choice questions divided into six parts which should take about 5 min to complete. Your participation is completely voluntary and anonymous. You can take the survey only once.

1. TYPE OF SURGEON?
   ANTERIOR SEGMENT SURGEON
   VITREORETINAL SURGEON
   BOTH
   Other (please specify) ________________

2. EXPERIENCE IN THE FIELD?
   LESS THAN 5 YEARS
   5–10 YEARS
   10–20 YEARS
   MORE THAN 20 YEARS

3. PLACE OF PRACTICE IN INDIA?
   NORTH
   SOUTH
   EAST
   WEST
   CENTRAL

4. TYPE OF PRACTICE?
   INSTITUTIONAL
   PRIVATE
   BOTH

5. AREA OF PRACTICE?
   URBAN
   RURAL

6. NUMBER OF CATARACT SURGERIES PERFORMED PER MONTH?
   LESS THAN 25
   25–50
   50–100
   MORE THAN 100
   NOT DOING REGULAR CATARACT SURGERIES

7. PREFERRED METHOD OF CATARACT SURGERY?
   PHACOEMULSIFICATION
   SMALL INCISION CATARACT SURGERY

8. NUMBER OF PATIENTS WITH APHAKIA SEEN IN OPD IN 1 MONTH?
   LESS THAN 10
   10–25
   25–50
   MORE THAN 50

9. MOST COMMON CAUSE OF APHAKIA OBSERVED IN OPD CASES?
   TRAUMATIC DISLOCATION
   POSTOPERATIVE
   SPONTANEOUS DISLOCATION OF CRUSTALLINE LENS
   SPONTANEOUS DISLOCATION OF IOL
   Other (please specify) ________________

10. IN A SCENARIO OF A PATIENT PRESENTING WITH APHAKIA IN OPD
    PLAN THE MANAGEMENT MYSELF
    REFER TO A VITREORETINAL SURGEON
11. WHEN YOU SEE A PATIENT WITH APHAKIA IN OPD, WITH ADEQUATE CAPSULAR SUPPORT, YOUR PREFERRED INTRAOCULAR LENS (IOL) OF CHOICE IS
SINGLE-PIECE IOL IN BAG
SINGLE-PIECE IN SULCUS
3-PIECE IOL IN SULCUS
SCLERAL FIXATED IOL.
ANTERIOLY FIXATED IRIS CLAW
RETROFIXATED IRIS CLAW
ANTERIOR CHAMBER IOL
Other (please specify) ____________________________

12. WHEN YOU SEE A PATIENT WITH APHAKIA IN OPD, WITH INADEQUATE CAPSULAR SUPPORT, YOUR PREFERRED INTRAOCULAR LENS (IOL) OF CHOICE IS
SCLERAL FIXATED IOL
IRIS SUTURED IOL
ANTERIOLY FIXATED IRIS CLAW
RETROFIXATED IRIS CLAW
ANTERIOR CHAMBER IOL
Other (please specify) ____________________________

13. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) ON TABLE, ACCESS TO VITREORETINAL EQUIPMENT?
Yes
No

14. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) WITHOUT NUCLEUS/CORTEX DROP ON TABLE WITH ADEQUATE CAPSULAR SUPPORT, WHAT WOULD BE YOUR NEXT STEP OF MANAGEMENT?
PLAN THE MANAGEMENT MYSELF IN THE SAME SITTING
PLAN MANAGEMENT MYSELF AT A LATER DATE
CALL A VITREORETINAL SURGEON IN THE SAME SETUP IN FOR MANAGEMENT IN THE SAME SITTING
REFER TO A VITREORETINAL SURGEON FOR MANAGEMENT ON A LATER DATE

15. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) WITHOUT NUCLEUS/CORTEX DROP ON TABLE, WITH ADEQUATE CAPSULAR SUPPORT, WHAT WOULD BE YOUR PREFERRED IOL OF CHOICE
SINGLE-PIECE IOL IN BAG
SINGLE-PIECE IOL IN SULCUS
3-PIECE IOL IN SULCUS
SCLERAL FIXATED IOL

16. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) ON TABLE WITHOUT NUCLEUS/CORTEX DROP; IF CAPSULE SUPPORT IS INSUFFICIENT/INADEQUATE, WHAT WOULD BE YOUR NEXT STEP OF MANAGEMENT?
PLAN THE MANAGEMENT MYSELF IN THE SAME SITTING
PLAN MANAGEMENT MYSELF AT A LATER DATE
CALL A VITREORETINAL SURGEON IN THE SAME SETUP IN FOR MANAGEMENT IN THE SAME SITTING
REFER TO A VITREORETINAL SURGEON FOR MANAGEMENT ON A LATER DATE.

17. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) ON TABLE WITHOUT NUCLEUS/CORTEX DROP; IF CAPSULE SUPPORT IS INSUFFICIENT/INADEQUATE, WHAT WOULD BE YOUR PREFERRED INTRAOCULAR LENS (IOL) OF CHOICE
SCLERAL FIXATED IOL
ANTERIOLY FIXATED IRIS-CLAW
RETROFIXATED IRIS-CLAW
ANTERIOR CHAMBER IOL
Other (please specify) ____________________________

18. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) WITH NUCLEUS/CORTEX DROP ON TABLE
PLAN THE MANAGEMENT MYSELF IN THE SAME SITTING
PLAN MANAGEMENT MYSELF AT A LATER DATE
CALL A VITREORETINAL SURGEON IN THE SAME SETUP FOR MANAGEMENT IN THE SAME SITTING
REFER TO A VITREORETINAL SURGEON FOR MANAGEMENT AT A LATER DATE.

19. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) ON TABLE WITH NUCLEUS/CORTEX DROP; IF CAPSULE SUPPORT IS ADEQUATE, YOUR PREFERRED INTRAOCULAR LENS (IOL) IS
SINGLE-PIECE IOL IN BAG
SINGLE-PIECE IOL IN SULCUS
THREE-PIECE IN SULCUS
20. IN AN EVENT OF POSTERIOR CAPSULE RENT (PCR) ON TABLE WITH NUCLEUS/CORTEX DROP; IF CAPSULE SUPPORT IS INADEQUATE, YOUR PREFERRED INTRAOCULAR LENS (IOL) IS
- SCLERAL FIXATED IOL
- ANTERIORLY FIXATED IRIS-CLAW
- RETROFIXATED IRIS-CLAW
- ANTERIOR CHAMBER IOL
- Other (please specify)

21. IN THE CASE OF IRIS-CLAW IOL DO YOU PERFORM PERIPHERAL IRIDECTOMY?
- Yes
- No
- I DON’T DO IRIS-CLAW

22. WHEN DO YOU PLAN SECONDARY IOL IMPLANTATION?
- <2 WEEKS
- 2–6 WEEKS
- 6 WEEKS TO 3 MONTHS
- 3 MONTHS TO 6 MONTHS
- Other (please specify)

23. IN THE CASE OF SFIOL, WHICH METHOD DO YOU PREFER?
- SUTURELESS SFIOL
- SUTURED SFIOL
- I DON’T DO SFIOL

24. IN THE CASE OF SUTURELESS SFIOL, WHICH METHOD DO YOU PREFER?
- GLUED SFIOL
- GABOR-SCHARIOTT’S TECHNIQUE
- YAMANE’S SFIOL

25. IF SFIOL IS PLANNED, WHAT IS PREFERRED?
- COMPLETE VITRECTOMY – PARS PLANA APPROACH
- ANTERIOR VITRECTOMY – PARS PLANA APPROACH
- ANTERIOR VITRECTOMY THROUGH LIMBAL APPROACH

26. IN THE CASE OF SUTURED SFIOL, WHICH SUTURE DO YOU PREFER FOR ANCHORING THE IOL?
- 9-0 PROLENE
- 10-0 PROLENE
- GORTEX SUTURED SFIOL

27. IN THE CASE OF SUTURED SFIOL, WHICH TYPE OF IOL DO YOU PREFER?
- SINGLE-PIECE SFIOL (PMMA) WITH EYELETS IN THE HAPTICS
- ROUTINE 3-PIECE IOL ANCHORED WITH HAPTICS
- FOLDABLE ACRYLIC IOL WITH MODIFIED PLATE HAPTICS SUCH AS ACREOS IOL
- Other (please specify)

28. IN A PATIENT WITH UNILATERAL APHAKIA, ALREADY USING CONTACT LENSES AND COMFORTABLE WITH IT
- COUNSEL TO CONTINUE USING CONTACT LENSES
- PLAN SECONDARY IOL

29. IN A WORKING-AGE GROUP YOUNG PATIENTS WITH BILATERAL APHAKIA AND COMFORTABLE USING APHAKIC GLASSES
- ADVISE TO CONTINUE APHAKIC GLASSES
- GIVE OPTION OF CONTACT LENSES
- PLAN SECONDARY IOL

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