

SOVABATI DAS GHOSH MEMORIAL VIDEO AWARDS

Date: 17.12.17

Time: 8.30 AM - 9.30 AM

Hall: B

Chairperson: Dr Parag Mukherjee

Co-chairperson: Dr Sugata Nandi Ray

Convener: Dr Rajesh Majumdar Choudhury

Judges: Dr Yajati Ghosh, Dr Chitra Ramamurthy, Dr Sambuddha Ghosh, Dr Naresh Yadav

Moderator: Dr Suchanda Sar

SDG 1

TITLE: Achieving that perfect anterior capsulorrhexis and getting stuck on Zepto... !!

AUTHOR: Dr. Nandini Ray

ABSTRACT: A 66 year old gentleman presented with gradual loss of vision in his left eye. He gave the history of having undergone routine phaco in his right eye in the USA many years ago with a multifocal IOL.

On examination he had a hypermature brunescant cataract in his left eye with a calcified anterior capsule with a vision of PL with accurate PR. There was quiet pseudophakia in his right eye with a diffractive IOL.

It was decided to attempt phaco in his left eye with a multifocal IOL. It was decided to try a ZEPTO capsulorrhexis to reduce risks during Anterior CCC to allow routine phaco with the best possible ELP. Zepto was used to achieve a perfect CCC however the video shows how there was tremendous difficulty in removing the Zepto ring with no release of suction on the anterior capsule. The video shows how release of the Zepto from the anterior capsule was achieved with subsequent complication free phaco eliminating what could have been a subluxation or even a lens drop situation.

SDG 2

TITLE: Shallow Waters

AUTHOR: Dr. Sumitro Saha

ABSTRACT: Maintaining adequate pupillary dilation and anterior chamber depth are important requisite for safe phacoemulsification. This video shows phacoemulsification under topical anaesthesia of an elderly woman with hard brunescant cataract. Nucleus chopping was difficult, pupil constricted, the patient became restless and side ports started leaking. The hurdles were overcome sticking to the basic principles and surgery was completed without complication.

SDG 3

TITLE: Phaco speedbreakers

AUTHOR: Dr. Swati Gupta

ABSTRACT: We all love Speed. This video demonstrates how we aim for speed in our phacoemulsification surgeries. Yet we need to be careful as there might be speedbreakers on our path. The video shows multiple cases starting with a speedy smooth phaco done in a hypermature cataract. This was followed by multiple video clips showing rhexis retrieval with a microrrhexis forceps, case of Acute intraoperative rockhard eye syndrome managed with PPV. Phaco in myopic eye, Phaco in case of mid-dilated pupil with and without iris hooks, IOL stuck in wound. Finally, the video conveys the message that, we should handle every case like we would handle our Ferrari on a Speedbreaker.

SDG 4

TITLE: Different strategies for managing variable zonular weakness in different grades of cataract

AUTHOR: Dr. Sagar Bhargava

ABSTRACT: Managing cataracts in patients with zonular weakness is a challenging scenario. A single approach in dealing with different grades of cataracts may not be desirable as the results may not be favourable. This video describes a series of cases with variable presentation of zonular weakness and different grades of cataract. It tries to highlight a customised approach suitable for a particular type of cataract from soft to grade IV dense cataract.

SDG 5

TITLE: How “safe” is “safe” ???

AUTHOR: Dr. Mrinmoy Das

ABSTRACT: IOL implantation is considered one of the easiest steps in cataract surgery. After phacoemulsification is complete surgeons tend to relax and let their guard down. But truly how “safe” is this “easy” step? That’s the question we wanted to explore. There may be a lot of hiccups during this relatively simple and easy manoeuvre. The wound assisted implantation technique may sometimes cause the IOL to get stuck at the entry point. The single piece hydrophilic acrylic IOL’s have a tendency to be sticky causing the haptics stuck. These IOL’s also tend to get deformed and may result in decentration and we have also noticed a strange phenomenon of plastic like material sticking to the optics in these lenses. The multi piece IOL’s have their own set of problems ranging from broken haptics to flipping of IOL after implantation. This presentation is full of adventures and mishaps and takes an in-depth look into the finer nuances of IOL implantation to make this step more safe and predictable.

SDG 6

TITLE: Treading step-by-step into the world of PHACO

AUTHOR: Dr. Sneha Batra

CO-AUTHORS: Dr. Aniket Ginodia, Dr. Ajoy Paul, Dr. Partha Biswas

ABSTRACT: Phacoemulsification has become the surgical process of choice for cataract extraction. Several features of phacoemulsification give it the potential for obtaining better results than obtained by ECCE in the developing world. Shorter rehabilitation time, less astigmatism, and the decreased need for suture removal may result in reduced need for post-operative care. Phacoemulsification can be considered worthwhile if it can be done quickly and safely, and if it has a short learning curve. However, for a young resident/fellow, the initial learning curve is quite steep, and the complication rate and intraoperative costs have been found to be high in the literature. In this video bouquet, we discuss the learning points from selected videos in the first 25 cases of a young surgeon, highlighting the common mistakes, complications and pearls for their management. We hope it will be useful for every budding surgeon and help them in better recognition and management of common complications.

SDG 7

TITLE: Safe Capsulorrhesis in Intumescent Cataract

AUTHOR: Dr. Sugato Paul

ABSTRACT: Capsulorrhesis in hypermature intumescent cataract has the risk of running out and is commonly associated with Argentine flag sign. In this educational video, the steps to prevent it will be discussed.

SDG 8

TITLE: Nightmare in femto OT

AUTHOR: Dr. Aniket Ginodia

CO-AUTHORS: Dr. Sneha Batra, Dr. Partha Biswas, Dr. Ajoy Paul

ABSTRACT: Patient diagnosed Grade 3 cataract in his LE and underwent FLACS.

During I/A, laser capsulotomy margin torn and extended to the equator, but case well managed and foldable IOL placed in the bag. I/A was about to be completed when suddenly the patient felt uncomfortable and without any warning sign the patient vomited. The vomitus entered into the operating field through inner canthus. Paroxysmal vomiting and retching went on for 10 minutes. Thorough wash of cul de sac was done with BSS. Topical antibiotics (Moxifloxacin, Tobramycin) and dexamethasone was given. The patient was discharged after systemic condition was stable. Moxifloxacin, Tobramycin and dexamethasone eye drops for a week in operated eye followed by Prednisolone eye drops. The patient was reviewed twice daily for continuous 7 days and then alternate days for 2 weeks and then monthly for 3 months. On slit lamp examination no anterior chamber reaction seen, vision was 6/6, N6 and patient was doing well.

SDG 9

TITLE: Tamsoma jyotir gamaya: pediatric cataract

AUTHOR: Dr. Anuradha Chandra

CO-AUTHOR: Dr. Asmita Ray

ABSTRACT: The video shows the impact of light in the eyes of one-year old child operated for cataract with IOL implantation.

SDG 10

TITLE: IOLs in distress

AUTHOR: Dr. Tanushree Chakraborty

ABSTRACT: After a routine phaco-emulsification this video shows three cases where there is problem in delivering the IOLs. Case 1: IOL stuck in the injector. Case 2: IOL unfolding in the wound. Case 3: IOL explantation due to cut of trailing haptic because of faulty loading.

SDG 11

TITLE: Management of large iatrogenic zonular dialysis during IOL implantation using capsular tension ring

AUTHOR: Dr. Madhusudhan Mandal

ABSTRACT: Background: Intraoperative zonular dialysis could occur in patients with pre-existing zonular weakness and/or inappropriate manipulation. The aim of this study is to describe a case of large zonular dialysis during IOL implantation and its management using capsular tension ring (CTR). Case presentation: We report a 63 years male presented with diminution of vision in both eyes. Ocular evaluation showed presence of bilateral cataract (NS grade 2). He underwent an uneventful phacoemulsification in right eye while a large zonular dialysis occurred during IOL implantation. CTR was inserted using OVD to stabilise the capsular bag. IOL was repositioned into capsular bag and anterior vitrectomy was performed. Postoperatively the IOL was well centered and BCVA was 6/9. Conclusion: This case report reviews the occurrence of large zonular dialysis even after uneventful phacoemulsification which might be managed with the CTR successfully.

SDG 12

TITLE: Socket and lid reconstruction after lid sparing orbital exenteration

AUTHOR: Dr. Salil K Mandal

ABSTRACT: This video shows surgical and cosmetic out come and recurrence of the ocular malignancy with spreading tendency after lid sparing orbital exenteration. Effectiveness of

socket and lid reconstruction without removing the periosteum. Orbital exenteration done without removing the periosteum. It helps in accept the split thickness graft over periosteum covering bone orbit and forehead rotational flap for lid reconstruction. Post operatively patient looks better than conventional orbital exenteration. Prosthesis was easy to fit and retain safely due to lid support. All the patients in this series had satisfactory post surgical, cosmetic and functional outcome. Preserving periosteum in the orbit is much effective for split thickness skin graft to accept on host. Lid sparing orbital exenteration without removing periosteum is effective for socket reconstruction by split thickness skin graft. No recurrence in one year follow up

SDG 13

TITLE: Fovea sparing PVD induction in a case of VMT

AUTHOR: Dr Sangeeta Roy

ABSTRACT: Vitreomacular traction(VMT) is a condition in which the vitreous gel has an abnormally strong adhesion to the macula. Over time, the gel tends to pull forward and can cause vessel and retinal distortion causing metamorphopsia and decreased vision. Pars plana vitrectomy with Posterior vitreous detachment(PVD) induction with ILM peeling is done in patients with debilitating symptoms.

It has been seen that PVD induction might lead to macular hole formation in narrow base VMTs'. To prevent macular hole formation a fovea sparing PVD induction is done in this case. The vitreous is stained with triamcinolone and the vitreous attachment at the fovea is segmented from the rest of the posterior vitreous with 25 gauge cutter leaving behind the segmented vitreous strands at the fovea. Then PVD induction and adequate peripheral vitrectomy is done. The ILM is stained with brilliant blue dye and the ILM is peeled along with the segmented vitreous strands attached to the fovea. An isoexpansile concentration of C3F8 gas is used for tamponade. This method prevents traction on the macula thus does not cause macular hole during PVD induction.

SDG 14

TITLE: Code Red in VR Surgeries

AUTHOR: Dr Aniruddha Maiti

CO-AUTHORS: Dr Priyanka Khandelwal, Dr Prosenjit Mondal, Dr Sangeeta Ray, Dr Utsab Pan

ABSTRACT: In this video we are showing different surgical scenarios being faced during various VR surgeries and their solutions and outcome as well as few tips to avoid such situations. It includes all possible complications faced during various VR Surgeries like PVD Induction, ILM peeling in Macular hole surgery or managing dropped lens.

SDG 15

TITLE: Scleral Fixated IOL with lensectomy for dropped cataractous lens

AUTHOR: Dr. Sangeeta Roy

ABSTRACT: A 40 years old male patient presented with sudden onset diminution of vision in the left eye following a blunt trauma. On examination the patient had a BCVA 6/9 and 6/6 in the right eye. On indirect ophthalmoscopy the patient was diagnosed as aphakia with dropped cataractous lens. A pars plana vitrectomy with lensectomy with sutureless SFIOL was planned in the patient. The horizontal axis was marked with toric marker and scleral flaps of size 3mm ×3 mm was raised at the temporal and nasal sides of the cornea. Scleral tunnels were made at the edge of each pockets with the help a 26 gauge needle. A 25 gauge pars plana vitrectomy with lensectomy was done. A multipiece lens was put using the handshake technique. The exteriorized haptics were then tucked inside the tunnels on both the nasal and the temporal sides and the flaps were sutured.