EMERGING MONOFOCAL INTRAOCULAR LENSES IN EUROPE: POTENTIAL ROLE FOR AVANSEE™ PRESET
Authors:

Kensaku Miyake,
Shozankai Medical Foundation,
Miyake Eye Hospital, Kita-ku, Nagoya, Japan

Emanuel Rosen,
Consultant Ophthalmic Surgeon,
Manchester, UK and Director of ESCRAS

Ichiro Ota,
Shozankai Medical Foundation,
Miyake Eye Hospital, Kita-ku,
Nagoya, Japan

Akira Miyata,
Miyata Eye Clinic, Hiroshima-shi,
Hiroshima, Japan

Hiroyuki Matsushima,
Department of Ophthalmology,
Dokkyo Medical University,
Shimotsuga-gun, Tochigi, Japan

Masahiko Usui,
Tokyo Medical University, Shinjuku-ku,
Tokyo, Japan
Abstract

Intraocular lens (IOL) technology has evolved dramatically during recent years due to the development of injectors that insert a folded IOL into the eye through a small incision. This allows fast, reliable, reproducible and controlled insertion that avoids the need for stitches and reduces the risk of postoperative complications. A number of injectable hydrophobic monofocal IOLs are currently available in Europe. This review compares the characteristics of these IOLs with Avansee – one of the most widely used IOLs in Japan that is due to be launched in Europe in 2014. Studies show that Avansee IOLs inserted using the fully preloaded AvanseePreset injector system are relatively quick and easy to insert with one hand. Once inserted in this way, Avansee IOLs provide high levels of corrected visual acuity, assume a stable position in the eye without exerting zonal stress or transformation of the capsular bag, and fully regain their optical properties after injection. Moreover, Avansee IOLs are associated with a low risk of infection and postoperative complications such as posterior capsule opacification (PCO) and endophthalmitis, and have a low propensity for glistenings over time.

Introduction

Cataracts account for approximately five per cent of blindness in Western Europe and almost 50 per cent of blindness, worldwide. Currently, the only treatment for cataract is surgery. The clouded lens is removed (usually by phacoemulsification) and an IOL is inserted through a small incision into one of three positions; the capsular bag, the sulcus ciliaris, or (less frequently) the anterior chamber in front of the iris. In each case, the IOL replaces the natural lens and acts as a refractive medium for the visual correction of aphakia. IOL implantation is the most frequently performed surgical procedure worldwide. According to industry estimates, nearly 3.6 million IOL implants were performed in Western Europe in 2012, 78 per cent of which were carried out in Germany, France, Italy, Spain and the UK. This number is predicted to rapidly increase as the population continues to age.

IOL technology has evolved dramatically during recent years. The development of foldable IOLs enables the lens to be injected into the eye through a small incision (<2.8mm), thus avoiding the need for stitches and reducing the risk of postoperative complications. After insertion, the optic gently unfolds and the haptic (the flexible support) holds the lens in position, absorbing the omnidirectional shrinking power of the capsular bag. Originally, IOLs were spherical with only one optical function – compensating aphakia. More recent designs include ‘premium’ or ‘enhanced’ IOLs that can improve the quality of vision without the need for glasses and can allow the surgeon to select a lens that suits the individual patient’s lifestyle. For example, aspheric monofocal IOLs can provide a high-quality image for distant vision and enhance contrast perception; toric lenses can correct astigmatism, and multifocal lenses can compensate for presbyopia. However, according to the European Registry of Quality Outcomes for Cataract and Refractive Surgery (EUREQUO), monofocal IOLs are still used in more than 95 per cent of cases.

The quality of the IOL largely depends on the IOL design, material and manufacturing process. Optics made from hydrophobic acrylic are most popular, accounting for 80.8 per cent of implants, followed by hydrophilic acrylic (14.0 per cent) and silicone (3.5 per cent). Ideally, IOLs should have the characteristics outlined in Table 1.

<table>
<thead>
<tr>
<th>Characteristics of an ideal IOL</th>
<th>Characteristics of an ideal IOL injector system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide high levels of corrected visual acuity (CVA)</td>
<td>Fully preloaded</td>
</tr>
<tr>
<td>Be fully preloaded into an advanced injection system, allowing fast, reliable, reproducible and controlled insertion through a micro-incision</td>
<td>Single-use to avoid the need for cleaning and sterilisation prior to use</td>
</tr>
<tr>
<td>Quickly and fully regain their mechanical and optical properties after injection (even when misaligned)</td>
<td>IOL delivery through the smallest possible incision (generally 2.4 to 2.8mm)</td>
</tr>
<tr>
<td>Assume a stable position after insertion without exerting zonal stress or causing transformation of the capsular bag</td>
<td>Smooth and controlled IOL delivery</td>
</tr>
<tr>
<td>Be associated with a relatively low risk of postoperative complications, such as posterior capsule opacification and endophthalmitis</td>
<td>Lightweight with a plunger-type injector, allowing one-handed IOL delivery</td>
</tr>
<tr>
<td>Have a low propensity for glistening, whitenings and general deterioration over time</td>
<td>Excellent IOL centring within the capsular bag</td>
</tr>
</tbody>
</table>

Table 1: Characteristics of an ideal IOL/IOL injector system
1. Avansee/AvanseePreset

A wide range of aspheric monofocal IOLs are available in Europe, including CT Asphina (Carl Zeiss Meditec), AcrySof IQ (Alcon Laboratories, Inc), KS-3AI (Staar Surgical), Sensar AR40e (Abbott Medical Optics, Inc), AF-I YA-60BB (Hoya Surgical Optics GmbH) and Envista MX60 (Bausch & Lomb, Inc). In Japan, the most popular monofocal IOLs include AcrySof IQ, followed by NX-60 (Eternity; Santen), Sensar AR40e, and Avansee (Kowa Co, Ltd).

Avansee is a posterior chamber monofocal IOL, with modified 3-piece (3P) C-loop haptics made from soft, flexible polyvinylidene fluoride (PVDF) to reduce the risk of breakage during insertion. It is manufactured using a stringently-controlled cast-molding method and carved after polymerisation to provide a square edge. The optic is made from a UV-absorbing, hydrophobic, highly cross-linked, soft acrylic material in yellow (PN6, PN6A, PN6AS, AN6K, AN6MK and AN6KA) or clear (PU6, PU6A, AU6K and AU6KA). After phacoemulsification, the AvanseePreset injector system (PN6, PN6A, PU6 or PU6A) can be used to inject Avansee into the capsular bag through a 2.8 or 3.0mm incision (for sclera-corneal and corneal insertion, respectively) or, if using the small incision AvanseePreset injector system (PN6AS), through a 2.4 to 2.6mm incision. A one-piece (1P) version of Avansee that can be inserted through a smaller 2.2mm incision is currently in development by Kowa Co, Ltd.

Avansee was launched in Japan in 2007.10 The initial 3P spherical models (AN6K, AU6K and AN6MK) were followed by a fully pre-loaded, single-use spherical AvanseePreset injector system (PN6 and PU6) in 2010 and then by aspheric counterparts (AN6KA, AU6KA, AN6MA, PN6A, PU6A and PN6AS) in 2013/2014.11 AvanseePreset is due to be launched in Europe in 2014. The aim of this review is to compare the characteristics of Avansee/AvanseePreset with other commonly-used aspheric monofocal IOLs in order to understand the potential role for AvanseePreset in Europe.

2. Avansee is safe and effective for the correction of visual acuity in the majority of aphakic eyes

According to ISO 11979-7:2006(E) Annex B regulations, IOLs must provide a CVA of 0.5 (20/40 vision) or better in at least 88.0 per cent of cases. However, the 1998 EUREQUO survey, which analysed preoperative and intraoperative data from 31 surgical units across 13 European countries (n=2,950), showed a large variation in visual outcome between participating centres, with many units reporting results considerably above and below the averages.12 In this study, a corrected distance visual acuity (CDVA) of 0.5+ in the operated eye was achieved by approximately 84 per cent of patients after six months. The more recent 2013 EUREQUO survey, which analysed data from 368,256 cataract extractions in 15 European countries, suggests that results have improved over recent years.13 Here, 94.4 per cent of all patients achieved a CDVA of 0.5+ after six months, and 85 per cent of eyes achieving a CDVA of 1.0+. No complications related to the use of Avansee were observed and the implanted lenses were deemed to be ‘safe’ in 100 per cent of eyes. A similar study carried out in 70 patients (100 eyes) aged 42+ years attending one of four ophthalmic hospitals in Japan showed that 98 per cent of eyes achieved a CDVA of 0.5+ after one year, with 85 per cent of eyes achieving a CDVA of 1.0+ (data provided by K Miyake, Y Tanifuji, O Nishi, and K Inoue). Posterior capsule opacification (PCO) occurred in two patients six months to one year after surgery. However, corrective surgery was not required because CVAs remained high (1.0 and 0.6). Moreover, data collected between 2007 and March 2014 show that more than half a million units of Avansee/AvanseePreset were supplied to surgeons in Japan, with 22 adverse events (0.0032 per cent) and two serious adverse events (0.0003 per cent) reported (data provided by Kowa Co, Ltd).
Prior to the development of IOL injectors, problems during IOL implantation were relatively common. Placement of rigid or manually-folded lenses into the eye using forceps often led to damaged IOLs, infection, surgically-induced astigmatism and large incisions that often required suturing. The development of IOL injectors has enabled a faster, more controlled, consistent IOL insertion that reduces the risk of error, wastage, infection and postoperative complications (Table 1). In fact, a retrospective 10-year study of all cataract surgeries carried out at an ophthalmology department in the UK showed that, compared with manually-folded lenses (n=412) the relative risk of endophthalmitis was significantly lower (43.8 per cent) with injected lenses (n=10,815; P<0.001). Authors suggest this is primarily due to differences in incision size and lack of contact between the IOL and the ocular surface.

Three major types of injector system are currently available. The first type is the non-preloaded injector (eg, Viscojet [Medicel]) that requires expert skills in lens-loading and cartridge insertion prior to surgery. The second type of device (eg, Skyjet, Blu Mix 2.2 and AcriTec [Zeiss]) is the partially-preloaded system that comes in two sections – the insertion device and an IOL that is already loaded into the cartridge. This type is easier to use than the non-preloaded injector and reduces the risk of IOL misloading, damage and contamination/infection. The third type of device is the single-use, fully-preloaded injector system, such as AvanseePreset, Monarch (AcrySert C; Alcon) and Unfolder Emerald (Tecnis; Abbot Medical Optics). Whereas the first two types of injector system are sometimes reusable, the fully preloaded injectors are disposable, which means they do not require cleaning or sterilisation. Injector systems such as AvanseePreset and AcrySertC also have the benefit of being light and having a syringe-type injector, rather than a screw-type injector, which allows the surgeon to operate with one hand. Moreover, IOL insertion using AvanseePreset can be performed in only three simple steps: one to inject the ophthalmic viscosurgical device (OVD), one to remove the stage and the third to push the plunger. Together, these features eliminate the risk of IOL misloading, reduce the risk of IOL damage, minimise the volume of wastage, increase the reproducibility and speed of the injection process, reduce the risk of contamination/infection, and facilitate IOL manipulation inside the eye. These characteristics are expected to translate into lower failure rates, more operations per hour and improved cost-effectiveness.

A major challenge for injectors is the gliding ability of the cartridge. Friction between the polypropylene cartridge and the IOL can increase the thrust force required to expel the lens from the injector. Excessive pressure may cause the IOL to stick to the cartridge wall resulting in lens damage or crimping and/ or haptic breakage. In addition, cartridge damage or rupture can put unwanted stress on the incision, thereby increasing the risk of postoperative complications. To avoid this, the inside of some injectors (including AvanseePreset) are lubricated to facilitate gliding and reduce thrust force. However, thrust force also depends on the flexibility of the lens and the ratio between the diameter of the injector tip and the folded haptic. Data collected between 2010 (when AvanseePreset was first launched) and March 2014 show that approximately 0.2 million units of AvanseePreset were supplied to surgeons in Japan, with only 122 complaints (0.0624 per cent) about movement abnormalities, including trauma to the optic or haptic, incorrect optic or haptic movement, trapped lens in the nozzle, abnormal resistance force during injection and failure of lens implantation. The reasons underlying these problems are unknown but could relate to user error. To date, no reports of manufacturing errors have been received for AvanseePreset (data provided by Kowa Co, Ltd).

In general, hydrophilic acrylic lenses require a lower injection force than hydrophobic acrylic lenses but forces vary within each IOL class according to the IOL and injector characteristics. In one study, a force of 14 to 19N was required for injection of hydrophilic IOLs (Finevision [Physiol. S.A.], Ioflex [Mediphacos Ltd.], and AcriTec 366D IOL [Carl Zeiss Meditec AG]) compared with 23 to 29N for most hydrophobic IOLs (Sensar AR40e, iSert 251 [Hoya], Envista MX60) and up to 71N with resultant cartridge damage for the hydrophobic AF-1 YA-60BB. Authors suggest this is primarily due to differences in incision size and lack of contact between the IOL and the ocular surface.

In this study, all IOLs were preloaded into the same type of injector (Acjucci 2.2-1P [Medicel AG]), which suggests the differences in injection force were due to IOL characteristics, rather than injector design. Results from a prospective observational study in which routine phacoemulsification was followed by AcrySof SN6CWS implantation using the supplied preloaded injector (n=85) showed that correct IOL delivery was achieved in only 45 per cent of eyes, whereas 55 per cent of eyes required additional rotational manipulation of the IOL. Other problems included trapped trailing haptics, haptic-optic adhesion, overriding of the plunger over the optic and trauma to the optic edge. In this study, risks were similar irrespective of IOL power and the experience of the operating surgeon. These results can be explained by a further study in which the maximum forces required to expel AcrySof SN6CWS from the supplied preloaded injector and NX-60 from the non-preloaded MX-60 injector into phacoemulsified porcine eyes (n=5 to 6 per IOL) were significantly higher than those required by KS-Xs (Staar Japan) and AvanseePreset. Authors suggest that the low IOL delivery force required by the KS-Xs and AvanseePreset injectors have the potential to lessen hand stress, facilitate injector manoeuvring and improve IOL insertion accuracy, thereby reducing the risk of surgical complications such as those experienced with AcrySof SN6CWS.

Figure 1: The thrust force required to expel an IOL from its supplied preloaded injector into phacoemulsified porcine eyes varies between IOLs.
4. Avansee regains its biomechanical and optical properties after injection

4.1 Biomechanical properties: shape recovery after injection

The compressive forces applied to the IOL during injection can potentially lead to IOL damage and loss of optical performance after implantation due to lens deformation.2 Whereas hydrophilic IOLs have a relatively high degree of elasticity and good shape memory, some (but not all) hydrophobic IOLs fail to fully regain their initial shape after injection.9 This can lead to impaired visual performance and postoperative complications such as PCO. IOLs with higher water content often have lower glass transition temperature (Tg; the temperature at which a material passes from its rigid glassy state into its soft, flexible state). This means they are less likely to be damaged during folding and injection, and are more likely to quickly and fully regain their shape after implantation. A study comparing the biomechanical properties of 11 benchmark IOLs showed that pre-equilibrated IOLs (eg, iPure, Podeye, Finevision, AcniTec 366D and Ioflex) had a higher water content, lower Tg, and less residual deformation after compression than the dry-packaged IOLs (AcrySof SN60WF, Tecnis ZCB00, Sensar AR40e, AF-1 YA-60BB, and iSert 251).9 Another study showed that, among the six dry-packaged hydrophobic IOLs examined, water content was highest for Avansee AU6 (≤2.0 per cent), followed by Sensar AR40e (≤0.7 per cent), AcrySof MA60BM and SA60AT (≤0.3 per cent), AF-1 VA-60BB [Hoya] (≤0.16 per cent) and Nex-Acri N4-18B (≤0.1 per cent). Tg were 15.0, 13.0, 18.5, 12.0 and 3.6°C. Although biomechanical studies are required to compare the time and extent of shape regain after compression for Avansee versus other IOLs, Avansee’s high water content and relatively low Tg suggests that its flexibility will be at least as good as that observed for other dry-packaged IOLs.

4.2 Optical properties: axial displacement and tilt

The alignment of an IOL within the eye largely depends on the pressure applied to the capsular bag by the IOL haptic. Too much pressure can change the shape of the capsular bag from a circle to an ellipse, leading to misalignment (decentring and tilt) of the IOL along the optic axis. For some IOLs, this can lead to reduced vision quality.8 Data from the Miyake Eye Hospital in Japan show that, once inserted, Avansee does not cause zonal stress or transformation of the capsular bag and that the soft haptics are unlikely to damage the eye (Figure 2; data provided by I Ota). Moreover, IOL stability was shown to increase as the angle of contact between the loop and the lens capsule gets larger and,
compared with other lenses, the angle of contact for Avansee is relatively large (75.8° vs 59.6° for AcrySof IQ, 64.6° for Tecnis, 81.1° for AF-I FY-60AD and 97.47° for Eternity X-70). Together, these results suggest that Avansee may be more stable than other IOLs and less prone to misalignment.

The effect of IOL misalignment on vision quality varies between IOLs. Most aspheric IOLs, including Tecnis and AcrySof SN60WF, are designed to induce negative spherical aberration (SA) in order to fully or partially compensate for the positive SA present in the aging cornea.20,21 Although this can improve contrast sensitivity, common levels of IOL decentration can reduce the overall visual performance of these lenses. In contrast, the misalignment of IOLs that retain the SA of the eye, such as Avansee and Akreos (Bausch & Lomb, Inc.), has little effect on visual performance.22-25 In fact, a study carried out in a model eye with an average centring error for IOLs in normal human eyes showed that coma aberration (determined by wavefront aberration analysis) was approximately proportional to the degree of centring error or tilt and that retinal images (determined by Landolt ring simulation) deteriorated accordingly (Figure 3).23 In this study, four 3P acrylic IOLs (one spheric and three aspheric IOLs with SA -0.27μm, -0.17μm and -0.04μm) were inserted into IOL holders without misalignment, with a shift of 0.5mm, or with a tilt of 5.0 degrees. Compared to IOLs without misalignment, defocused modulation transfer function (MTF) and defocused point spread function (PSF) significantly deteriorated for IOLs with a decentring effect or tilt and a greater degree of SA corrective power; whereas the IOL with same asphericity as Avansee (SA -0.04μm) was largely unaffected. These data suggest that the depth of focus was large and the influence of IOL shift or tilt on the retinal image was slight in IOLs that retain, or minimally correct, the SA of the eye.

5. The rate of postoperative complications varies between IOLs

According to the EURREQUO study (n=523,921), the most common complications within 60 days of IOL implantation in Europe are postoperative PCO that disturbs vision (mean incidence 0.21 per cent), endophthalmitis (0.036 per cent), persistent corneal oedema (0.15 per cent), uveits requiring medication (0.35 per cent) and uncontrolled elevated intraocular pressure (0.06 per cent).4

5A. Avansee is associated with a low rate of PCO

PCO is caused by hyperplasia and cellular migration of lens epithelial cells (LECs) from the anterior capsule to the posterior capsule following IOL implantation, leading to a thickening (Soemmerring’s ring formation), opacification and clouding of the posterior lens capsule (often called a secondary cataract).26

Although treatment with neodymium-ytrrium-aluminium-garnet (Nd:YAG) laser capsulotomy is effective, treatment is expensive and carries a risk of retinal detachment, macular oedema and intraocular pressure elevation. PCO should therefore be avoided whenever possible.

The risk of PCO varies according to IOL material, manufacturing process and design.27-30 A recent meta-analysis of data from nine randomised clinical trials in 861 eyes showed that hydrophobic IOLs were associated with significantly lower PCO rates than hydrophilic IOLs with a similar platform (P=0.0002 and P=0.0001 after one and two years, respectively).29 Authors suggest this is because hydrophobic surfaces promote proliferation and migration of LECs from the equatorial area to the visual region,31 whereas hydrophobic IOLs block the migration of LECs via tight adherence to the collagen membrane,32 tight apposition of

---

**Figure 4:** Electron microscopy shows that molded lenses, such as AcrySof (Alcon) and Avansee AN6K (Kowa Co, Ltd), tend to have a squarer edge than lathe-cut lenses (data provided by Kowa Co, Ltd).
The transparency of IOL optics can deteriorate after implantation due to glistenings (small bright spots) and/or whitenings (scattering, sub-surface nano glistening [SSNG]). Both events are due to the formation of small, fluid-filled vacuoles in the optic material. Glistenings are caused by vacuoles 1 to 20μm in diameter across the entire IOL optic, whereas whitenings are due to ~100nm vacuoles that scatter light at the sub-surface of the optic. In general, IOLs such as Sensar AR40 (AMO) and Acryfold UY60BBR (Hoya) that have lathe-cut optics made from a stable, uniform and highly cross-linked polymer are less likely to allow water to gather in the micro void of the material and are therefore less susceptible to glistenings and whitenings than IOLs with cast-molded optics, such as AcrySof MA60AC (Alcon) and Avansee. However, incubation of five dry-packaged hydrophobic IOLs and two wet-packaged IOLs with hydrophilic properties (X-60 [Santen] and H60M [Storz]) over a range of temperatures showed that the change in water saturation was inversely proportional to the density of cross-linkages in the optic polymer (data provided by H Matsushima).

6. Glistenings have not been observed with Avansee

PCO cases requiring Nd:YAG treatment after two years was significantly lower in patients receiving Avansee or AcrySof than in those receiving the rounder-edged Hoya YA-60BBR IOL (P<0.0001 for both comparisons) (Table 2) (data provided by K Miyake). Together, these results suggest that a hydrophobic, square-edged IOL, such as Avansee and AcrySof SN60WF, should be used whenever possible to reduce the risk of PCO.

5B. Endophthalmitis

Acute endophthalmitis is one of the most serious complications of cataract surgery and often results in severe visual impairment, blindness and even death. In most cases, postoperative endophthalmitis is caused by pathogens that are transferred into the eye from the ocular surface during surgery. Compared to manually-folded IOLs, IOL insertion using injectors significantly decreases the incidence of endophthalmitis by limiting the contact between the IOL and the conjunctival flora. Differences in endophthalmitis rates appear to exist between IOL injection systems. Of the 22 adverse events reported for Avansee between its launch in 2007 and March 2014, two were due to endophthalmitis (data provided by Kowa Co, Ltd). However, both cases were observed with IOLs that were inserted without the AvanseePreset system and neither case was due to a manufacturing error.

### Table 2: The proportion of PCO cases requiring Nd:YAG treatment after two years for benchmark IOLs (data provided by K Miyake)

<table>
<thead>
<tr>
<th>Company</th>
<th>Model Description</th>
<th>Number of cases</th>
<th>Number of cases requiring Nd:YAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kowa</td>
<td>AvanseePreset AN6K, AN6K, AN6M, and AN6MK</td>
<td>2,206</td>
<td>38 (1.7%)*</td>
</tr>
<tr>
<td>Alcon</td>
<td>AcrySof SA60AT, SN60AT, SN60WF</td>
<td>1,604</td>
<td>39 (2.4%)*</td>
</tr>
</tbody>
</table>
| Hoya    | YA-60BBR | 1,052 | 76 (7.2%)

*P<0.0001 versus Hoya

### Figure 5: The change in water uptake over a range of temperatures varies between IOLs (data provided by A Miyata)

### Figure 6: In IOLs with the same degree of water uptake, the likelihood of glistenings is inversely proportional to the density of cross-linkages in the optic polymer (data provided by H Matsushima)
Conclusions

The development of preloaded injectors that insert a folded IOL into the eye through a small incision has led to significant improvements in the speed, reliability, reproducibility, safety and cost-effectiveness of cataract operations. Ideally, IOLs should provide high levels of CVA. They should also be fully preloaded into a single-use advanced injection system, assume a stable position after injection without exerting zonal stress or causing transformation of the capsular bag, and quickly and fully regain their optical properties after injection. Moreover, they should be associated with a relatively low risk of infection and postoperative complications, and have a low propensity for glistening and general deterioration over time.

Studies to date show that Avansee – currently one of the most widely used IOLs in Japan and soon to be launched in Europe – fulfills each of these requirements. Moreover, Avansee has demonstrated a low incidence of adverse events since its launch in Japan (the second largest IOL market in the world) in 2007. Together, these data suggest that AvanseePreset will be useful for the treatment of aphakia during cataract surgery in Europe.

Acknowledgements:

This review was funded by Kowa Pharmaceutical Europe. Authors would like to thank Yasuhiro Tanifuji (Tanifuji Eye Clinic, Monoka-shi, Iwate, Japan), Okifumi Nishi (Nishi Eye Hospital, Osaka-shi, Osaka, Japan), Takashi Fujikado (Department of Applied Visual Science, Osaka University Graduate School of Medicine, Suita-shi, Osaka, Japan) and Yoshihiro Tokuda (Inoue Eye Hospital, Chiyoda-ku, Tokyo, Japan) for its kind provision of data, and GK Pharmacomm for its editorial support.
Reference List


(39) Tetz M, Werner L. Edge profiles of currently available intraocular lenses and recent improvements. European Ophthalmic Review 2009;374-76.


