

## Commentary: Management of dislocated and subluxated intraocular lens

In present times, cataract surgery has improved to such an extent that complications rarely occur. However, even after successful implantation of the intraocular lens (IOL), we may encounter IOL decentration or dislocation in some patients. The decentration can occur either early or late. Early decentration occurs due to improperly made capsulorrhexis and late decentration is seen following fibrosis of the capsule. Usual causes of decentration are improper fixation of the IOL, psuedoexfoliation, and post YAG capsulotomy. A thorough history and examination must be done before planning the line of management. The condition could be managed by either medical or surgical means.

If the decentration is mild or symptoms occur during dilatation of pupil at night, it can be medically managed by instilling Pilocarpine eye drops. Surgical management of these cases depends on the type of implanted IOL and its location. The decentred IOL can be either rigid or foldable. Rigid and three-piece foldable IOL can be easily placed in the sulcus, but single-piece foldable IOL cannot be placed in the sulcus and needs a different strategy. In case the IOL is dislocated into the vitreous, the services of the vitreoretinal surgeon may be required.

In this issue of the journal, an article "Management of dislocated transscleral fixated lens with one side broken suture" has been published.<sup>[1]</sup> The authors describe tying the same IOL to the sclera with the help of 9-0 polypropylene suture. Its needle can easily go through the eyelet and then be fixed in the already fashioned scleral flap.

With reference to this, we will discuss only the management of anteriorly subluxated or decentred IOL. Herein, the following situations may be seen – the IOL may decenter in the bag, may decenter out of the bag, only half of the lens may be present in the bag, whole of the IOL may be out of the bag, or the haptic of the decentered IOL may be broken.

Several techniques have been developed for repositioning the subluxated IOL. The McCannel suture may be used for transiris fixation of the IOL.<sup>[2]</sup> In the cupid fixation technique,<sup>[3]</sup> the IOL is pierced by a 10-0 or 9-0 polypropylene suture on a straight needle and the IOL is fixed in a previously constructed scleral pocket. Glued IOL is a good technique for scleral fixation.<sup>[4]</sup> The Yamane's technique of fixating a three-piece IOL to the sclera in a sutureless manner by creating flanges is a truly novel technique to refixate the IOL. This transconjunctival flanged haptic technique is independent from scleral flaps, tunnels, sutures, and fibrin glue and has short-learning curve and faster postoperative recovery. A 27- or 30-gauge thin-wall needle is used to engage and exteriorize the haptic can be used.<sup>[5,6]</sup> A broken haptic can be fixed with the capsule by a polypropylene suture so that it does not shift downward.<sup>[7]</sup> The decentred IOL can be placed in the ciliary sulcus if pseudo-phacodonesis is not present. If associated with posterior capsule rupture, the decentred IOL should be brought forward and placed in the sulcus after doing a proper vitrectomy. For IOL exchange, either scleral fixation or iris fixation with iris claw IOL (posterior

fixation on Iris) can be tried depending on the experience of the surgeon.

There are several advantages of repositioning over exchange of the IOL. Here, power calculation is not required and the surgery can be performed in a closed chamber. Therefore, one must try to refixate the same decentred IOL. The exchange of IOL should be the last option as it needs new biometry.

In view of the above discussion, the technique described by the authors<sup>[1]</sup> is definitely a good method and can be easily accomplished by most of the surgeons.

**Kamaljeet Singh**

Regional Institute of Ophthalmology, Moti Lal Nehru Medical College, Allahabad, Uttar Pradesh, India

Correspondence to: Prof. Kamaljeet Singh,  
4A/7 Pannalal Road, Allahabad - 211 002, Uttar Pradesh, India.  
E-mail: kamaljs2@rediffmail.com

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