STANFORD
MEDICINE

Byers Eye Institute at Stanford

Stanford Eye Laser Center

Guide to Co-Managed Care

Edward E. Manche, M.D.
Director of Cornea & Refractive Surgery
Stanford University School of Medicine
650.498.7020
eyelaser.stanford.edu

STANFORD EYE LASER CENTER

Guide to Co-Managed Care

2452 Watson Court
Palo Alto, CA 94303

Phone: 650.498.7020
Fax: 650.498.6488

A digital version of this guide is available on our website at eyelaser.stanford.edu

Table of Contents

Purpose of this Guide

Here at the Stanford Eye Laser Center, we hope that by offering your patients the best surgical care, along with your expertise in pre- and post-procedural care, their refractive procedure will be all the more convenient and satisfying.

This co-management training manual has been prepared especially for you and your staff. This should be used as an informative and instructional guide to better maintain the consistency between co-managing facilities. Any new information or co-management materials that are sent to you in the future should be placed in the appropriate sections of this guide.

We sincerely thank you for your referrals and appreciate your confidence in allowing us to share in the care of your patients. If you have any questions or comments, you may call our co-management consultant at (650) 498-7020.

Role of the Co-Managing Doctor

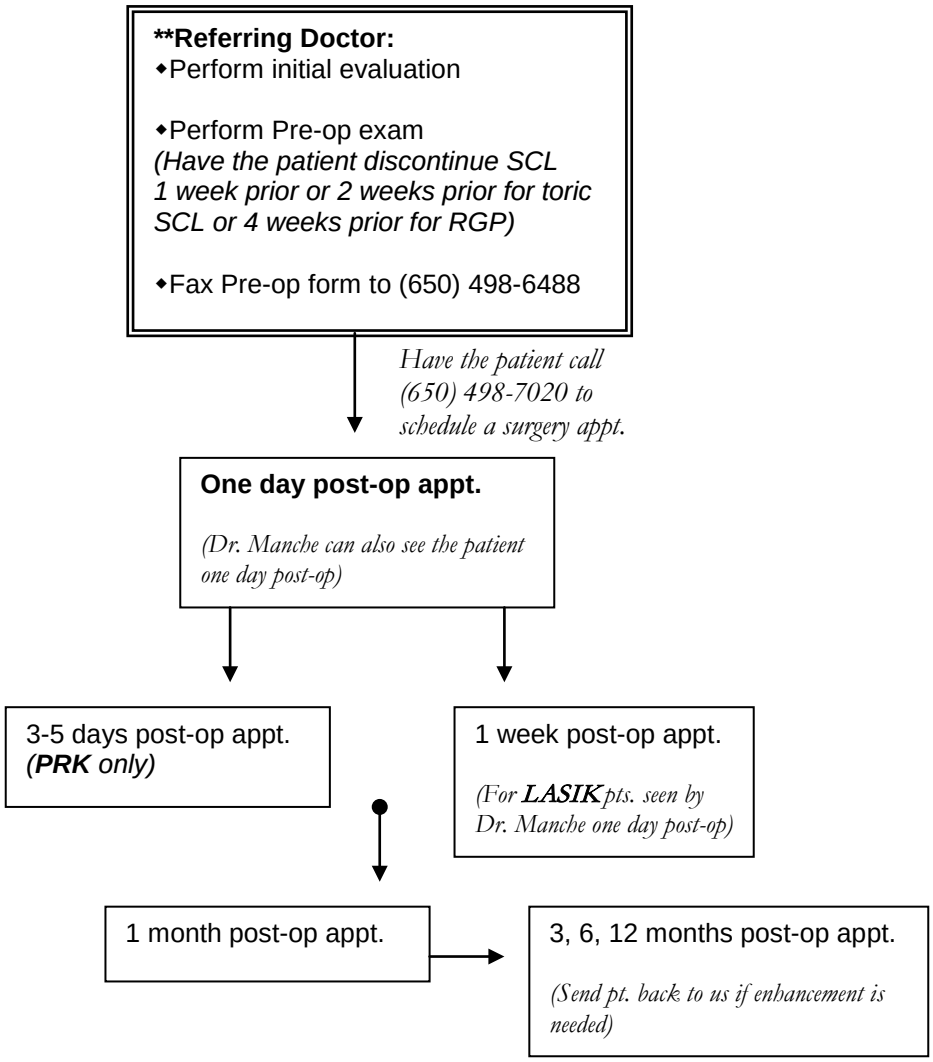
We believe the primary eye care provider has the best knowledge and understanding of the patient's visual needs in terms of motivations for surgery. Refractive surgery candidates should be screened by their family optometrists and be educated to understand that continued primary eye care is necessary after refractive surgery.

The primary eye care provider has an obligation to the patient to be knowledgeable about the type of treatment the patient will receive upon referral to the refractive surgeon.

The role of the primary eye care provider is:

- To select the appropriate candidates for a refractive procedure.
- To provide information, to educate and counsel patients.
- To perform baseline examinations.
- To monitor patients at specific intervals and to report findings.
- To simulate monovision pre-operatively with the use of contact lenses, where applicable.
- To provide interim glasses or contact lenses, as necessary, during the time between the surgeries on both eyes (i.e., anisometropia).
- To assist presbyopic patients with near vision difficulties.
- To assist the patient with vision difficulties, if any, by correcting the residual refractive error and providing anti-glare coating.
- To look for possible changes in the eye as a result of a refractive procedure.
- To continue to monitor the health of the patient's eye during the aging process, aside from any refractive procedure considerations.

Appointments for the Co-Managed Patient



**FOR YOUR INFORMATION:

A patient may come to the Stanford Eye Laser Center for an initial evaluation and not have heard of co-managing care. We will refer the patient to a co-managing doctor in his or her own area. The patient will complete the initial evaluation at Stanford, then be sent to the suggested doctor for the pre-procedural measurements. Occasionally, we may complete the pre-procedural measurements if the patient has had his or her contact lenses out for the appropriate amount of time. In this case, the patient will need to see you one day after the procedure. If the patient has his/her one day follow-up with Dr. Manche, the patient will need to see you for a 3-5 days post-op follow-up for *PRK* or a 1 week follow-up for *LASIK.*

1 Initial Evaluation Appointment

- Determine if the patient is a good candidate for a refractive procedure.
- Schedule the patient for a complete pre-procedural examination. Have the patient leave out contact lenses for the appropriate amount of time (7 days for soft, 2 weeks for soft toric lenses and 4 weeks for hard or gas permeable lenses).

2 Pre-Procedural Examination

- Do a complete, dilated examination (see pgs. 16-18 for details).
- Discuss co-management with the patient. Collect your usual fee for the pre-procedural measurements. Collecting this fee up front will help insure the patient's commitment to co-management.
- Fax the pre-procedural form to Stanford at (650) 498-6488.

3 Post-Procedural Examination

The patient will see you for the following post-procedural appointments:

- 3-5 day post-procedural appointment (only PRK patients need to be seen for this appointment). The performing surgeon will advise the patient which eye care provider to see.
- 1-week post-procedural appointment. (only LASIK patients seen by Dr. Manche for the one day post-procedural appointment)
- 1-month post-procedural appointment.
- 3-month post-procedural appointment (if the patient is undercorrected after LASIK, it will be determined at this time whether or not to proceed with an enhancement).
- 6-month post procedural appointment (if the patient is undercorrected after PRK, it will be determined at this time whether or not to proceed with an enhancement).

Recommended Ranges for a Refractive Procedure

Diopter Range*	Procedure
MYOPIA CORRECTION	
-0.50 to -12.00	PRK/LASEK
-0.50 to -12.00	LASIK
-5.00 to -20.00	Verisyse or Visian Phakic IOL
ASTIGMATIC CORRECTION	
0.50 (min.) to 6.00 (max.) + or – cyl.	Laser (either PRK or LASIK)
HYPEROPIA CORRECTION	
+1.00 to +6.00 w/ or w/o (+1.00 to +4.00 cyl.)	Hyperopic LASIK
+0.75 to +3.00	Hyperopic CK
+4.00 to +12.00	Investigational Phakic IOL

*Diopter range is based on spherical equivalent.

NOTES ON THE PROCEDURES OFFERED:

Custom Wavefront LASIK is an FDA approved procedure in the U.S. LASIK is a more comfortable procedure post-procedurally and patient experience better vision almost immediately. Custom Wavefront technology tailors a distinct correction for each individual – in fact each treatment is "designed" by the unique characteristics of the individuals' eyes.

Custom Wavefront PRK is a procedure for patients with mild to moderate levels of nearsightedness and farsightedness experience minimal corneal haze after being treated with PRK.

LASEK is a procedure for patients with mild, moderate and high levels of myopia and hyperopia; less pain, faster visual recovery and possibly less haze.

Conductive Keratoplasty (CK) is laser-less, non-cutting procedure recently approved by the FDA for the correction of low hyperopia (+1.00 to +3.00 of hyperopia with less than 0.75 diopters of astigmatism).

Verisyse Phakic IOL is a procedure approved by the FDA used to correct high and extreme myopia using an anterior chamber iris claw phakic intraocular lens. (-5.00 to -20.00 of myopia).

Visian ICL is a procedure approved by the FDA used to correct high and extreme myopia using a foldable posterior chamber phakic intraocular lens. (-3.00 to -23.00 of myopia).

IntraLase FS laser uses infrared light to precisely cut tissue by a process known as photodisruption. When used during LASIK, the IntraLase laser replaces the handheld microkeratome blade traditionally used during surgery.

Contraindications for Use: SYSTEMIC

DISEASE	CANDIDATE	F.Y.I.	REASON
AIDS	Depends	Best if patient is on HART therapy and the virus is not detectable in the blood.	Serious infection, if acquired, would be hard to treat – patient could lose vision.
Arthritis – most kinds	Depends	Depends on the severity and how controlled it is.	
Rheumatoid Arthritis	No	Auto-immune disease	Rheumatoid arthritis may cause corneal melting; other types usually are not a problem.
Cancer of the Eye (any type of cancer around the eye or head area, e.g., brain tumor.	No		
Cancer, Leukemia	Depends	Depends on the severity and type of cancer and what kind of medications or treatments the patient is currently taking.	May have healing problems.
Diabetes	Depends – usually yes.	Depends on how controlled it is and what type of diabetes it is.	Patient may have difficulty healing or may have an unstable prescription.
Heart Disease/Conditions (angina, previous heart surgeries)	Yes		May affect the retina or cause degeneration of the retina – may affect the motility of the eye muscles.
Hepatitis	Depends	Depends on type of hepatitis. Type A – ok candidate, Type B or C – depends on whether or not it is active.	Risk of transmission.
Lupus	Depends	This is an autoimmune disease	Can cause corneal surface problems while healing; more susceptible to corneal melting.
Multiple Sclerosis	Depends	Find out what stage the disease is in.	Can cause nystagmus (quivering of the eye); decrease in vision can occur if not controlled; abnormal healing.

Contraindications for Use: CONDITIONS

CONDITION	CANDIDATE	F.Y.I.	REASON
Age factor (min. 18 years old; max depends)	Depends	2 refractions (1 year apart) must be stable – *less than 1 diopter of change.*	A person with unstable vision has a greater risk of being undercorrected.
Keloids	Can have LASIK only	This is a condition, which affects scarring, causing very prominent scars in PRK – depends on the severity.	Problem with corneal healing.
Pregnancy	No	Need to wait at least 3 months after delivery.	Vision very unstable during pregnancy.
Pregnancy/Nursing mothers	Depends	No steroids will be used for corrections less than -3.00 diopters.	Long-tem effects of steroid use in nursing mothers are not well documented.
Unstable Vision	No	More than 0.50 to 0.75 diopter of change within one year warrants unstable vision.	Risk or being undercorrected.

Contraindications for Use: OCULAR DISEASES

DISEASE	CANDIDATE	F.Y.I.	REASON
Cataracts	No	Fogginess/blurring of vision due to the cloudiness of the natural lens inside the eye.	It is better to have a cataract removal, which is a form of refractive surgery.
Keratoconus	No	Surface of cornea is not regular; it is "cone-shaped."	Unstable corneas; having a refractive procedure may worsen the condition.
Lazy Eye (amblyopia)	Depends	A healthy eye with poor vision (even with correction).	May not want to treat the good eye in case of complication.
Macular Degeneration	No	Retinal problem (back of the eye) – need to see a retinal doctor.	Central vision is poor due to the retina, not due to the shape of the cornea.
Retinal Detachment	Depends	When the back layer of the eye has detached.	Needs to see the surgeon.
Retinitis Pigmentosa	Depends on the visual field.	Known as "tunnel vision" (decrease in peripheral vision).	May not want to risk further loss of vision in the eye.
Aphakic Eyes	No	Cataract surgery without implants.	Needs implant(s).

Contraindications for Use: OCULAR DISEASES

DISEASE	CANDIDATE	F.Y.I.	REASON
Genital Herpes or Cold Sores	Yes	These kinds of herpes cannot spread to the eye after treatment.	
Herpes Simplex in the Eye	No		Herpes virus can be re-activated by a refractive procedure.
Herpes Zoster	Usually No	Related to chickenpox; if herpes is active, a refractive procedure should not be performed.	Can cause corneal scarring.
Nystagmus	Depends	The surgeon would have to decide.	The eye needs to be stable during the procedure.
Stroke(s)	Depends		Eye problems could lead to paralysis of the eye.

What Refractive Surgery Can and Cannot Do

CAN	CANNOT
• Refractive surgery can decrease the patient's dependence on glasses or contacts and, in some cases, eliminate the need for them. • If patients wear contacts comfortably prior to surgery, they will probably be comfortable with contacts after surgery (if needed at all). • 95% of refractive patients can drive during the daytime without glasses or contacts after having a refractive procedure. • Refractive surgery can provide functional vision for most activities. • Refractive surgery can provide a more natural vision compared to spectacles. • Refractive surgery could eliminate the barrier to pursue a particular occupation (e.g., fireman, policeman, etc.) • PRK and LASIK provide long-term stability due to the fact that these procedures do not weaken the structural integrity of the cornea.	• Refractive surgery cannot correct or prevent presbyopia. • Amblyopic people cannot achieve better vision than their best corrected vision. • Refractive surgery cannot prevent the natural progression of refractive error. • Unlike corrective lenses, which can provide a precise refraction, the results of refractive surgery cannot be guaranteed. • Myopic degeneration or other retinal pathology cannot be corrected with refractive surgery. • Glasses or contact lenses may still be occasionally needed after refractive surgery, particularly in low light or nighttime situations.

Patient Selection

INTRODUCTION TO SELECTION

Because optometrists have patients they have followed for years, they can provide better insight to a patient's personality traits and qualifications as a candidate for a refractive procedure.

Patients are most likely to be satisfied with the results of refractive surgery if they have specific objectives in mind. A specific objective creates an end point that marks the success of the procedure for the patient.

Patients who have a goal of getting away from glasses/contacts altogether may not be satisfied until perfection is achieved or until vision is equivalent to their best corrected vision. Therefore, all patients must carefully be educated as to the limitations of a refractive procedure so that their expectations are reasonable.

MOTIVATION

Reasons for considering a refractive procedure are:

- Physiological
- Occupational
- Recreational
- Cosmetic

By carefully selecting and counseling a refractive candidate for treatment, you will be able to offer predictability with little or no complications and meet the patient's expectations.

SELECTION

Questions that will assist you in selecting the best candidates for a refractive procedure include:

- Does the patient have realistic, well-defined goals and expectations?
- Is the patient willing to accept some risk that their objective might not be achieved?
- Is the patient able to understand the concept of the risk/benefit ratio?
- Is the patient a stable, mature individual?

EXPECTATION

Identifying and shaping a patient's expectations are the critical success factors. The role of refractive treatment for any particular patient should be to make the patient less dependent on spectacles or contact lenses. The patient should be made aware that he or she may need some element of spectacle correction after the procedure. Additionally, patients must be counseled concerning the implications of future presbyopia.

CONCLUSIONS

With careful evaluation in terms of ocular health, refractive status and motivation, it is possible to offer an excellent outcome with refractive treatment. Only with careful counseling can we select those whose expectations are realistic and for whom the selected procedure is the best choice for their vision correction.

Patient Counseling

Once the patient is well informed about the benefits and limitations of a refractive procedure, the following should be discussed:

- Clinical findings and their eye condition.
- The various refractive procedure options based on their refractive error.
- Recommendation of the suitable procedure for the patient.
- The treatment procedure.
- The risks and complications (see pgs. 13-14 for details).
- The post-treatment pain and medications to be used.
- The temporary anisometropia (for unilateral procedures) and its optical management.
- The time involved for visual recovery for the recommended procedure (i.e., discuss temporary hyperopic shift for the first 2-3 months after PRK treatment).
- The possible difficulties with night driving.
- The possible need for glasses or contact lenses post-treatment.
- A thorough explanation of presbyopia.
- The future communication that will take place between you and the surgeon.

Risks and Complications

20/20 VISION

Although most patients have a 66-94% chance of being corrected to 20/20, it cannot be guaranteed. The success of a refractive procedure mainly depends on the patient's expectations. Based on the results from other refractive patients with similar vision, the surgeon may give the patient a general idea of the expected outcome.

UNDER/OVER CORRECTION

There is always the possibility of undercorrecting or overcorrecting a patient. If undercorrected, a patient will have to wait three months after LASIK and six months after PRK before having an enhancement. It is unusual that a patient is overcorrected (less than 2%). However, if overcorrected, a patient will become farsighted and will need reading glasses immediately.

GLASSES/CONTACTS AFTER SURGERY

If a patient has never had a problem being *fitted* for contact lenses, then he or she should be able to wear contacts again if **needed**. If a patient's vision is not corrected to at least 20/40 or better, then correction will still be needed for distance vision.

PRESBYOPIA

If a patient has reading glasses before refractive procedure, he or she will still need them after the procedure (unless the patient can tolerate monovision). Monovision will delay the need for reading glasses. However, if a person is going to read find print or read for long periods of time, reading glasses will probably be required. If a patient is approaching 40-42 years of age and has noticed a decrease in reading vision, he or she will most likely be dependent upon reading glasses immediately following a refractive procedure.

LOSS OF VISION

No surgeon at the Stanford Eye Laser Center has had a patient who experienced complete loss of vision as a result of refractive surgery. However, an acquired infection following a refractive procedure could result in loss of vision if not treated immediately. Chances of acquiring an infection are about 1:1000 for PRK and 1:1500 for LASIK, but we inform every candidate of this minute possibility nonetheless. The patient will be taking antibiotic eyedrops and given a list of post-procedureal instructions to follow after treatment.

FLUCTUATION OF VISION

Following a refractive procedure, a patient's vision will fluctuate. The length of time a patient's vision will fluctuate depends on three things: 1) the pre-operative level myopia (higher levels fluctuate more significantly) 2) which procedure the patient has and 3) how quickly a patient heals. PRK patients' vision will be blurry and/or fuzzy for about 4-12 weeks while their vision gradually clears. LASIK patients *usually*

experience good, clear vision almost immediately. On the other hand, some LASIK patients can experience fuzziness post-procedurally but notice gradual clearing with each passing day.

GLARE AND HALOS

Following a refractive procedure, patients may experience seeing glare or halos around lights at night. Many contact lens wearers are familiar with these nighttime images, even before having refractive procedure. In most cases, this side effect will diminish with time, sometimes taking from three weeks to three months to completely disappear. Wearing a mild prescription for nighttime driving can minimize permanent glare or halos (more likely to appear in patients with higher degrees of myopia).

LOSS OF BEST CORRECTED VISION

If a patient needs glasses or contacts following a refractive procedure, the vision with correction (glasses or contacts) may not be as sharp as it was before the procedure. Loss of best-corrected vision is only noticeable when wearing correction (if needed). For people with less than -7.00 diopters of sphere, the chance of losing best corrected vision is less than 2%. The risk becomes greater as the degree of myopia or hyperopia increases. Loss of best-corrected vision can be permanent and may not be correctable with glasses or contact lenses. This is a risk with any refractive procedure.

CORNEAL HAZE

Corneal haze is a side effect only for PRK treatment. It is a reaction to healing and therefore affects all post-procedural PRK patients. Most patients do not notice corneal haze because of the trace amount on the cornea's surface. Corneal haze usually takes one month to disappear and appears as fuzziness and/or blurriness to the patient. There is less than a 2% chance that a person will have residual haze lasting longer than one year following PRK. Within this small percentage, there is an 80% chance that the haze can be removed with laser and a 20% chance that it could be permanent.

LONG TERM

Both PRK and LASIK procedures are expected to be permanent because they do not weaken the structural integrity of the cornea. Therefore, patients should not experience any regression over the long term.

ADDED RISKS WITH THE LASIK PROCEDURE

- Epithelial ingrowth
- Wrinkling of the flap
- Dislodgement of the flap

Although rare, these complications can occur but they are almost always correctable by the surgeon.

Pre-Procedural Examination

Prior to the patient's procedure, he or she must have a dilated examination. The information on the following page is required for a complete pre-procedural examination. **After completing the patient's exam, please fax the necessary forms to (650) 498-6488.** A dilated exam is usually performed on both eyes at the time of this pre-procedural exam. However, some patients may prefer to have one eye dilated at a time.

We commonly treat both eyes at the same time, both for the PRK and LASIK procedure. Patients tend to favor simultaneous treatment in both eyes because they miss less work, they don't have as many follow-up visits, and they do not have to suffer the anisometropia of having a single eye corrected. Nevertheless, we leave this decision up to the patient.

Pre-Procedural Measurements

PSYCHOLOGICAL HISTORY

A summary of motivations and expectations would be very helpful in acquainting us with the patient. Thus, we could reach a final determination as to whether we can satisfactorily address the patient's objectives.

MEDICAL HISTORY

- Allergies, including drug allergies
- Medication: systemic and ocular
- Systemic diseases, i.e., diabetes, hepatitis, etc. (see pg. 6). Collagen Vascular Disease such as Lupus (SLE) and Rheumatoid Arthritis are contraindications for PRK and LASIK. Epithelial healing is likely to be very slow and the possibility of corneal ulcers exists. Herpes Zoster and Herpes Simplex necessitate precaution since cases of herpes reactivation have been reported after use of the excimer laser.
- Pregnancy is a contraindication.

OCULAR HISTORY

- A complete ocular history, including any history of amblyopia, ocular injury, ocular surgery, retinal detachment or herpetic keratitis is particularly valuable.
- Stability of refraction: The patient must be at least 18 years of age and two refractions (one year apart) must be stable (less than one diopter of change).
- Contact lens history: The patient needs to be instructed to leave soft contact lenses out for a minimum of one week, soft toric contact lenses out for two weeks and hard contact lenses (including gas permeable lenses) out for a minimum of four weeks prior to the pre-procedural exam to ensure that there is no corneal distortion. If any distortion is noted, it will be necessary to leave the lenses out for a longer period of time until the refraction and sequential topographies are stabilized and confirmed.

UNCORRECTED VISUAL ACUITY

It is important to document uncorrected vision pre-procedurally, especially in cases of mild myopia where a patient may be a borderline candidate. As you know, a patient with -1.00D of myopia may read 20/40 to 20/400 uncorrected. The level of visual disability pre-procedurally thereby becomes an important aspect as to whether the patient is actually a good candidate.

BEST SPECTACLE CORRECTED VISUAL ACUITY

More importantly, BSCVA must be documented in order to assess for any loss of best-corrected visual acuity post-procedurally. BSCVA includes the 20/15 line as well; however, you should encourage the patient to read as many lines as possible. Many myopic patients, especially those who are severely myopic, may not be able to read 20/10 to 20/15 pre-procedurally and should not expect to achieve this level of visual acuity post-procedurally.

REFRACTION

A thorough refraction is essential in providing a basis to calculate surgical parameters. Refractions for refractive surgery differ from refractions for glasses or contacts in the following ways:

- *Fogging technique* should be utilized to minimize the myopic sphere as much as possible to achieve best-corrected vision.
- The cylinder, however, should be maximized. As much cylinder as the patient will accept without reducing best corrected visual acuity should be dialed in. Minimum sphere and maximum cylinder increases the odds of achieving emmetropia.
- *Monocular refraction* only is needed.
- Binocular balancing is not necessary. Patients who cannot be refracted to 20/20 or better need closer evaluation. If the cornea, lens, macula and optic nerve appear normal, a rigid contact lens over-refraction can be performed to rule our irregular astigmatism. If this yields better results, a search for keratoconus or contact lens-induced corneal warpage is undertaken. This is best determined with computed topographical corneal analysis.
- Cycloplegic refraction is necessary to ensure that a significant accommodative component (accommodative spasm or pseudomyopia) is not evident. Cyclopentalate 1% should be used for all patients under age 30. Tropicamide 1% should be used for all patients 30 years of age and older.

KERATOMETRY

There is no correlation between pre-procedural central keratometric power and the effect of refractive surgery. Patients with extreme refractive values outside the normal range of 39-48 diopters should be regarded with suspicion. Steep corneas should alert you to search for other signs of keratoconus. Similarly, irregular keratometry mires and contact lens wearers with somewhat flatter corneas may suggest contact lens warpage.

OCULAR DOMINANCE

Ocular dominance must be determined, especially if monovision is desired. There are many other methods of determining the dominant.

CORNEAL TOPOGRAPHY

Corneal topography is performed to show the curvature and any irregularities on the surface of the cornea, such as corneal warpage or keratoconus. We will perform the topography at our center if you do not have a topography system.

SLIT LAMP EXAMINATION

- *Lids/lashes*: Make sure eyelids close properly.
- *Cornea*: Note any previous scars/opacities, especially those opacities that may be herpatic in origin. The excimer laser could reactivate herpes virus. Scars could interfere with keratometry incisions. Look for early signs of keratoconus such as Fleischers ring, striae lines, apical thinning and scarring. Hereditary dystrophies or endothelial changes should also be noted.
- *Anterior chamber*: A quiet anterior chamber is expected.
- *Iris*: Note pigment dispersion and iris transillumination defect characteristics of pigmentary dispersion syndrome, which could contribute to future elevations of IOP.
- *Lens*: Any progressive lenticular opacity may cause a change in refraction (e.g., increase in myopia from nuclear sclerotic cataract), thus any refractive procedure is contraindicated. It is noteworthy that most types of refractive error can be corrected with an IOL at the time of cataract surgery. Note any subluxation of the lens that might induce astigmatism.

RETINAL EVALUATION

A dilated fundus examination is necessary to thoroughly evaluate any evidence of retinal pathology, such as macular disease or peripheral retinal pathology (i.e., lattice degeneration, white without pressure, holes, tears, or detachments). The patient must understand that the risk of detachment does not decrease simply because the dependence on glasses decreases. Annual examinations are still required and must be emphasized.

Post-Procedural Measurements

Follow-up care is three to five days (after PRK only), one month, three months, and six months after each eye. However, you may feel it necessary to see a patient more often than these suggested intervals. If so, all visits should still be included in your co-management fee.

Your co-management fee does not include the cost of spectacles or contact lenses.

After completing the post-procedural examination, please fax the form to (650) 498-6488.

The performing surgeon (Dr. Manche) will review the examination and contact you by either phone or fax.

Post-Procedural Medications/Comments

LASIK

Interval	Medication	Comments
1 day	**Vigamox or Zymar**: 1 drop, 4 times per day for 4 days starting the day after surgery. **EconoPred or Pred Forte**: 1 drop, 4 times per day for 7 days starting the day after surgery. **Artificial Tears**: As needed starting the day after surgery.	
1 month	**Artificial Tears:** As needed starting the day after surgery.	
3 months	**Artificial Tears:** As needed starting the day after surgery.	
6 months	**Artificial Tears:** As needed starting the day after surgery.	

PRK

Interval	Medication	Comments
3 days	**Vigamox or Zymar**: 1 drop, 4 times per day starting the day of surgery for 3-5 days. **Flarex**: 1 drop, 4 times per day starting the day of surgery and taper for 1 month. **Artificial Tears**: As needed starting the day after surgery.	On post-procedural day 3 or 5 (if epithelium is healed), the bandage contact lens is removed and the patient should continue to use the Vigamox or Zymar but discontinue the next day. If the epithelium is not healed, keep the bandage contact lens in place and continue with the same drops and follow daily until epithelization is complete.
1 month	**Artificial Tears:** As needed.	
3 months	**Artificial Tears:** As needed.	
6 months	**Artificial Tears:** As needed.	

Required Post-Procedural Tests

Post-Procedural Tests	3-5 days	1 month	3 months	6 months	1 year
Uncorrected VA	✓	✓	✓	✓	✓
Manifest refraction		✓	✓	✓	✓
Biomicroscopy	✓	✓	✓	✓	✓
IOP		✓			
Cycloplegic refraction (only if enhancement is needed)				✓	
Dilated fundus exam					✓

The 3-5 day Post-Procedural Visit

Expected Findings	PRK	LASIK
Symptoms	Symptoms range from mild foreign body sensation to moderate FBS, lid edema, tearing, photophobia, and eye soreness which may last for up to a week.	Symptoms range from no discomfort to mild foreign body sensation, burning, watering, redness, lid edema, or tenderness around the eye for a week.
Visual Acuity	Wide range but typically better than 20/200.	Wide range but typically much better than 20/50.
Manifest Refraction	N/A	N/A
Biomicroscopy	90% of patients will have complete re-epithelialization on post-op day three. It is very common to see superficial punctuate staining, especially in the center of the cornea. Despite this punctuate staining, the bandage contact lens can be taken out. However, if there is an area of the epithelial defect, then the bandage contact lens should be kept in place until complete re-epithelialization occurs. The patient should be sent back to the performing surgeon if any infiltrate is seen.	Mild superficial punctuate staining is not uncommon. In cases of epithelial ingrowth, slipped flap, or any infiltrate, the patient must be sent back to the center right away.
Medications/Treatment	If the epithelium is healed, the bandage contact lens is removed and Vigamox or Zymar is discontinued. If the epithelium is not healed, keep the bandage contact lens in place and continue with the same drops until complete epithelialization. Use Flarex QID x 1 month. Use lubricating eyedrops as needed.	Discontinue Vigamox or Zymar on post-op day 4 and Econpred or Pred Forte on post-op day 7. Use lubricating eyedrops as needed.

The 1 Month Post-Procedural Visit

Expected Findings	PRK	LASIK
Symptoms	Some patients experience no symptoms, others experience glare and halos (especially at night). Occasional foreign body sensation is commonly reported.	Occasional foreign body sensation is sometimes reported.
Visual Acuity	Greater than 20/40.	20/40 – 20/20
Manifest Refraction	Slightly hyperopic (avg. 1 D). Low amount of astigmatism is not uncommon.	Varies but is close to emmetropia. Low amount of astigmatism is not uncommon.
Biomicroscopy	Corneal clarity ranges from clear, trace, to mild haze. Arcuate haze in only some areas of the cornea is normal.	Flap interface will barely be seen. Flap should be aligned and no wrinkling should be seen (refer to "Managing Complications" section)
IOP	Should be close to the baseline pre-procedural pressure. It is not necessary to check the IOP if steroid is not being used.	N/A
Medications/Treatment	If less than or equal to -3.50, decrease Flarex from QID to BID x 1 month. Lubricating eyedrops as needed. If IOP is less than 4-5mm Hg from the baseline when steroid is used, then contact us for steroid management. If manifest refraction is greater than the expected hyperopic shift, then contact us for steroid management. If corneal haze is more than mild, it is not necessary to adjust the steroid. It is always safer to retreat than to increase steroid. Schedule PRK for the second eye if all findings are normal.	Use lubricating eyedrops as needed.

The 3 Month Post-Procedural Visit

Expected Findings	PRK	LASIK
Symptoms	None to mild glare and halos.	None.
Uncorrected Visual Acuity	20/40 – 20/20	20/40 – 20/20
Best Corrected Visual Acuity	20/20 or better.	20/20 or better.
Manifest Refraction	Close to emmetropia. Low amount of astigmatism is not uncommon.	Close to emmetropia. Low amount of astigmatism is not uncommon.
Biomicroscopy	Corneal clarity ranges from clear, trace, to mild haze. Arcuate haze in only some areas of the cornea is normal. Overall haze might be more than what was noted in the 1-month follow-up visit.	Quiet interface, cap aligned.
IOP	N/A	N/A
Medications/Treatment	Use lubricating eyedrops as needed. Glasses can be prescribed for night driving or reading if needed.	Enhancement or retreatment indicated in cases of myopic regression or undercorrection.

The 6 Month Post-Procedural Visit

Expected Findings	PRK	LASIK
Symptoms	None.	None.
Uncorrected Visual Acuity	20/30 – 20/20	20/30 – 20/20
Best Corrected Visual Acuity	20/20 or better.	20/20 or better.
Manifest Refraction	Close to emmetropia. Low amount of astigmatism is not uncommon.	Close to emmetropia. Low amount of astigmatism is not uncommon.
Biomicroscopy	Corneal clarity ranges from clear, trace, to mild haze.	Quiet interface, cap aligned.
IOP	N/A	N/A
Cycloplegic Refraction	Only necessary if retreatment is indicated.	N/A
Medications/Treatment	None. Enhancement or retreatment is indicated in cases of myopic regression, undercorrection or if moderate to severe corneal haze exists.	None. Enhancement or retreatment is indicated in cases of myopic regression, undercorrection.

Managing Complications

EPITHELIAL DEFECT

If you are seeing the PRK patient on post-op day 3, the epithelium should be healed in more than 95% of patients. It is not uncommon to notice some superficial punctuate staining even on post-op day 3. However, if there is no geographic epithelial defect, then the bandage contact lens can be removed. Sometimes the newly grown epithelium might slough off because it is still poorly attached. The patient may call or come back to the office complaining of pain and irritation. If there is an area of epithelial defect greater than 0.5 mm, place a new bandage contact lens on the eye, start the antibiotic QID again, and see the patient every day until the epithelium has healed completely.

CORNEAL INFILTRATE

If you note a corneal infiltrate at any of the follow-up visits, the patient needs to return to the surgeon immediately for treatment and management.

OVERCORRECTION

It is normal to be overcorrected by approximately 1 diopter in the first 1-3 months after PRK. If the patient complains of difficulty in reading while waiting to have the procedure for the second eye, it might be helpful to provide temporary spectacle correction to assist the patient. It is important to reassure the patient that vision should gradually get better, but avoid making any promises. However, if the manifest refraction at the 1-month follow-up examination shows more than 1 diopter of hyperopia, then feel free to stop the steroid eyedrops if they are being used. This may speed regression.

UNDERCORRECTION/REGRESSION

If the patient is a type-III healer, which results in more central haze than normal, then you should expect undercorrection. If the patient is on steroid drops, then they should be advised to continue with the same recommended regimen (i.e., no alteration of dosage necessary. If the patient is not on steroid drops (when attempted correction is < -3.50), there is no need to start steroids to control the healing. Remember that it is safer to retreat if necessary to remove moderate to severe haze or to correct residual refractive error than it is to use steroids on a long-term basis.

EPITHELIAL INGROWTH

If corneal epithelial ingrowth (more than 1 mm from the edge of the flap) is noted, the patient should return to the surgeon for evaluation and possible retreatment.

CENTRAL ISLAND

Occasionally, you might have a patient who complains of ghosting after PRK or LASIK. If manifest refraction does not alleviate the problem, then consider performing corneal topography (if it is available to you) to rule out a corneal central island. If you do not have access to corneal topography and it is sooner than the six-month follow-up, then reassure the patient that the ghosting will gradually improve. Clinically, these central islands get better in a few weeks or sometimes in a few months after laser treatment. Prescribing temporary spectacles for any correction needed can help alleviate symptoms. However, if after six months the central corneal island does not resolve, then refer the patient to the surgeon for laser treatment.

SLIPPED CORNEAL FLAP

If the corneal flap for LASIK is dislocated, the patient needs to return to the surgeon immediately to reposition the flap. This complication usually occurs within the first day after treatment and will be handled by the surgeon. Therefore, it will be unlikely that you will encounter this problem.

RETREATMENT

Retreatment for any residual refractive error should be postponed for at least three months after LASIK and six months for PRK to allow the refraction to stabilize for maximum accuracy for retreatment. Retreatment for any residual or induced astigmatism, or central island should be postponed until at least six months after the initial procedure. This allows the refraction to stabilize to allow maximum accuracy for retreatment.

Co-management Fees/Billing

We will collect our fee on the day of each primary procedure. We will inform your patient that the remaining fee is to be paid to your office at the time of the first post-procedural appointment with you as follows:

PROCEDURES	TOTAL COST (per eye)	FEE PAID TO STANFORD (per eye)	FEE PAID TO YOUR OFFICE (per eye)
WAVEFRONT PRK	$2950.00	$2450.00	$500.00
WAVEFRONT LASIK WITH INTRALASE	$2950.00	$2450.00	$500.00
CONVENTIONAL PRK	$2750.00	$2250.00	$500.00
CONVENTIONAL LASIK WITH INTRALASE	$2750.00	$2250.00	$500.00

Your co-management fee does not include the cost of spectacles or contact lenses.

INSURANCE BILLING

Most insurance companies do not cover refractive surgery because it is considered elective or cosmetic. They may cover a procedure due to medical necessity (which is subject to review by the insurance company), but the patient is the sole responsible party for all charges.

When billing for *insurance purposes* for a refractive procedure, you must use the modifier "55" on the billing statement. This modifier reflects post-procedural follow-up care only. We will use the modifier "54" which reflects surgical care only.

If you have any questions regarding insurance information, please contact our office at (650) 498-7020.

About Our Center

The information is provided to you so that we may easily assist you when you call our center. We hope this information will give you a better understanding of our center and staff.

CLINICAL STAFF

- Ophthalmologists: Consult with all potential refractive patients and perform all refractive procedures. Provide support to all co-managing doctors for any medical problems or concerns.

- Ophthalmic Technicians: Assists the surgeons during all eye procedures and perform pre- and post-procedural examinations. Provide support to concerned or anxious pre- or post-procedural patients and assist co-managing doctors with questions regarding follow-up care (i.e., drops, medications, etc.)

- Patient Counselors: Discuss risks and complications of refractive procedures with all potential refractive patients. Coordinate conversations between present/past patients potential patients. Coordinate our co-managing patients' care with their primary eye doctors.

ADMINISTRATIVE STAFF

- Phone Counselors: Take all initial patient phone calls and help answer general questions related to refractive procedures (a few of our phone counselors have had refractive treatment and are very knowledgeable about the process). Handle pre- and post-procedural questions and coordinate calls between the technicians and doctors. Schedule the majority of patient appointments. **It is very helpful for patients to let the phone counselors know if they will be co-managing with their primary doctor.**

- Front Office Staff: Greets and checks in/out patients who come to the Stanford Eye Laser Center and schedule patient appointments. Handle the initial billing and payment issues and provide support to the back office.

About Our Doctor

Edward Manche, M.D. is the Director of the Stanford Eye Laser Center and Professor of Ophthalmology at the Stanford University School of Medicine. He specializes in laser and refractive surgical procedures.

REFRACTIVE SURCIAL EXPERIENCE

Dr. Manche is one of the few physicians in the United States who specializes exclusively in laser and surgical techniques for vision correction. He has been invited to give lectures throughout the United States as well as abroad. As a visiting Assistant Professor of Ophthalmology at the Jules Stein Eye Institute-UCLA, he devoted two additional years of specialized training and research in laser and refractive surgery and to develop new laser and refractive techniques for correcting nearsightedness, farsightedness, and astigmatism. He also spent two months at the King Khaled Eye Specialist Hospital in Saudi Arabia as a visiting Assistant Professor teaching and developing advanced laser and refractive surgical procedures. He has published numerous articles, abstracts, and book chapters on refractive surgery.

Stanford University Medical Center is a designated training center for all currently approved excimer laser systems. All physicians who wish to perform laser vision correction are required by the FDA to learn the techniques at an approved training facility. More than 400 U.S. eye surgeons have been trained by Dr. Manche at Stanford University in these techniques. Dr. Manche is authorized by the FDA to conduct investigational laser correction for nearsightedness, farsightedness, and astigmatism.

Dr. Manche and his work have been featured during news telecasts on KGO Chennel 7, KPIX Channel 5, KRON Channel 4, KSTS Channel 48 News, ABC's Health Matters, KQED Forum, New Edge Science Show and ABC's Dr. Dean Edell's Medical Report.

Interviews with him have appeared in *Ocular Surgery News*, *European Ophthalmology News*, *Ophthalmology Times*, *ARGUS-Ophthalmology World News*, *Eye World*, *Stanford Report*, *Stanford Daily*, *San Mateo Times*, *San Jose Business Journal*, *Science News*, and *Eye Net*.

EDUCATION

B.A., Binghamton University
Doctor of Medicine, Albert Einstein College of Medicine
Residency, UMDNJ-New Jersey Medical School
Refractive Surgery Fellowship, Jules Stein Eye Institute-UCLA

PROFESSIONAL SOCIETIES

Board Certified, American Board of Ophthalmology
American Academy of Ophthalmology
Association for Research in Vision and Ophthalmology
International Society of Refractive Surgery
American Medical Association
California Association of Ophthalmology
American Society of Cataract and Refractive Surgeons
Max Fine Corneal Society

Forms

Please find in this section forms used to communicate patient care with our facility and instructions for patients pre- and post-procedure.

Pre-procedural Form

Please fax this form to (650) 498-6488 and have the patient call our office to schedule a consultation with Dr. Manche. **It is very helpful for patients to let the phone counselors know if they will be co-managing with their primary doctor.**

Post-procedural Form

Please fax this form to (650) 498-6488 after each of the scheduled post-operative visits.

Pre-operative Instructions

This should be given to the patient prior to their scheduled surgery date.

These forms are given to patients the day of surgery:

- INTRALASIK Post-operative Instructions

To be used for initial LASIK treatments.

- PRK Post-operative Instructions

To be used for initial and enhancement PRK treatments.

- LASIK Post-operative Instructions

To be used for enhancement LASIK treatments.

STANFORD MEDICINE

Byers Eye Institute at Stanford

New Patient Registration

PATIENT INFORMATION	
LAST Name:	FIRST Name:
Social Security No.:	Date of Birth:
Address:	Gender:
City/State/Zip:	Marital Status:
Home Phone:	Race: ❑ Declined to answer
Mobile/Work Phone:	Religion: ❑ No preference ❑ Declined to answer
EMERGENCY CONTACT	
Name:	Relation:
Address:	Home Phone:
City/State/Zip:	Mobile/Work Phone:
REFERRING DR. INFORMATION	
Name:	Phone:

Please fax to (650) 498-6488

STANFORD EYE LASER CENTER

2452 Watson Court ● Palo Alto, CA 94303

Fax: (650) 498-6488 ● Ph: (650) 498-7020

STANFORD MEDICINE
Byers Eye Institute at Stanford

Edward E. Manche, M.D.
Director of Cornea and Refractive Surgery
Professor of Ophthalmology

CO-MANAGEMENT PRE-PROCEDURAL FORM

(Please fax this form to (650) 498-6488)

Referring Doctor: _____ Date of exam: _____

Phone: (_____) _____

Patient Name	Phone
	H: W:
Address	**DOB**

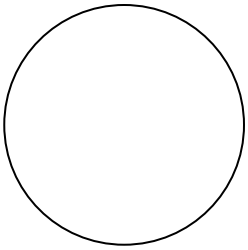
EXAMINATION

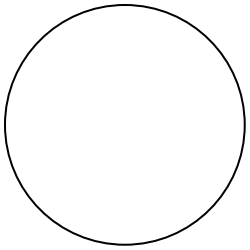
Comments/Chief Complaint: _____

Contact Lenses: ☐ RGP ☐ HCL ☐ SCL

Time CL were out before exam: _____
(SCL 7 days min./ RGP or HCL 4 wks. min.)

OD			OS
_____	20/___	**Current Spectacles**	_____ 20/___
20/_____ J ____		**Uncorrected Vision**	20/_____ J ____
_____	20/___	**Manifest Refraction**	_____ 20/___
_____	20/___	**Cycloplegic Refraction**	_____ 20/___
	_____	**K's**	_____
	____mm Hg	**IOP's**	_____mm Hg
	_____mm	**Pupil Size (Dim)**	_____mm
_____		**Slit Lamp Exam**	_____
_____		**Fundus**	_____





Recommendation/Plan: _____

_____
Doctor signature

2452 Watson Court ● Palo Alto, CA 94303
P (650) 498-7020 ● F (650) 498-6488
eyelaser.stanford.edu

STANFORD MEDICINE
Byers Eye Institute at Stanford

Edward E. Manche, M.D.
Director of Cornea and Refractive Surgery
Professor of Ophthalmology

CO-MANAGEMENT POST-PROCEDURAL FORM

(Please fax this form to (650) 498-6488)

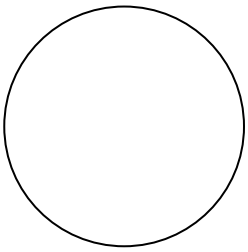
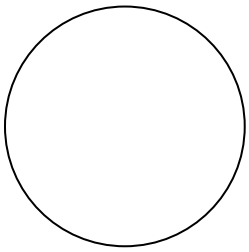
Referring Doctor: _____ Date of exam: _____

Phone: (____) _____

Patient Name	Surgery Date
	OD: _____ OS: _____
Post-Op Exam	**Post-Op Meds**
OD: ☐ 1 week ☐ 1 month ☐ 3 months ☐ 6 months ☐ other OS: ☐ 1 week ☐ 1 month ☐ 3 months ☐ 6 months ☐ other	☐ Vigamox/Zymaxid QID ☐ OmniPred/Pred Forte QID Flarex/FML ☐ QID ☐ BID

EXAMINATION

Comments/Chief Complaint: _____

OD		OS
20/_____ J ____	**Uncorrected Vision**	20/_____ J ____
_____ 20/___	**Manifest Refraction**	_____ 20/___
_____ 20/___	**Cycloplegic Refraction** *(only if enhancement is indicated)*	_____ 20/___
		
_____	**K's**	_____
_____mm Hg	**IOP's**	_____mm Hg
_____	**Slit Lamp Exam**	_____
_____	**Fundus**	_____

Advice to patient: _____

Questions for surgeon: _____

_____
Doctor signature

2452 Watson Court ● Palo Alto, CA 94303
P (650) 498-7020 ● F (650) 498-6488
eyelaser.stanford.edu

STANFORD MEDICINE
Byers Eye Institute at Stanford

Edward Manche, M.D.
Stanford Eye Laser Center
2452 Watson Court
Palo Alto, CA 94303
(650) 498-7020

Pre-operative Instructions

1. If you wear soft contact lenses, do not wear them **7 days** prior to your treatment day in the treated eye. If you wear hard contact lenses, do not wear them for at least **4 weeks** prior to your treatment day in the treated eye.

2. Please remove all eye and facial make-up before you come in for your procedure.

3. Eat a very light meal at the mealtime prior to your treatment.

4. Wear comfortable clothing.

5. Please arrive 15 minutes prior to your scheduled appointment time for check-in. You can expect to be here for approximately 1 ½ hours.

6. The day of surgery please have a driver bring you to and from your appointment. You will also need a driver for your one day follow-up appointment.

7. Payment for your treatment must be made upon your arrival. We accept check, Visa, MasterCard, American Express and Discover. **Payments made by check need to be made payable to Stanford Hospital and Clinics**.

8. If unable to keep your scheduled appointment, please notify us at least 48 hours in advance to reschedule.

9. You will be given a prescription for pain medication. Please have this prescription filled on the day of your treatment.

10. Future appointment times will be arranged after your treatment day.

_____@_____ am/pm $_____

Date and time of procedure *Amount due*

STANFORD MEDICINE
Byers Eye Institute at Stanford

Edward Manche, M.D.
Stanford Eye Laser Center
2452 Watson Court
Palo Alto, CA 94303
(650) 498-7020

INTRA-LASIK POST OPERATIVE INSTRUCTIONS

1. It is not unusual to experience varying degrees of discomfort on the day of surgery. Your eye(s) may experience occasional irritation such as light sensitivity, tearing, or a scratchy sensation. You make take Advil, Nuprin, Aspirin, Tylenol, or Vicodin to reduce discomfort.

2. Avoid yard work and strenuous exercise for the first week. Eye makeup or lotions, swimming, saunas and Jacuzzis should also be avoided for the first week while the corneal surface is healing. You may shower or bathe, but avoid getting water directly into the eye.

3. Daily fluctuations in your vision are normal after surgery. Your vision will probably be blurry for 2-3 weeks following surgery. It is common to have localized red spots on the white part of your eye(s). This is normal. These red spots will fade away in 1-3 weeks.

4. Clear plastic goggles will be placed over your eyes following the procedure. Do not remove the goggles until the following morning. You will not use any eye drops until after you see us for your one-day postoperative visit. Wear the goggles over your eyes each night for 1 week while you sleep. This prevents you from accidentally rubbing your eye and disturbing the surgical result.

5. Please keep your eyes closed following the procedure and do not read, watch T.V. or work on the computer for the remainder of the day.

6. UV protection (sunglasses) should be worn at all times outdoors.

7. Do not rub your eye(s) after surgery for 1 month.

.

8. **Medications:**

Wait 5 minutes in between all drops.

❑ **Vigamox** ❑ **Zymaxid** ❑ **Ocuflox** ❑ **Besivance**	One drop in operated eye(s) 4 times per day (while awake) for 4 days. Start this drop after your 1-day post-operative visit.
❑ **Predisolone** ❑ **Pred Forte** ❑ **Flarex** ❑ **FML**	One drop in operated eye(s) 4 times per day (while awake) for 7 days. Start this drop after your 1-day post-operative visit.
Artificial Tears	Use anytime after your one-day post operative visit. You may use Soothe, Refresh, Systane, Genteal, Thera Tears, Bion Tears, Optive or Celluvisc.
Vicodin (500 mg)	Take this optional pain medication, 1 tablet orally every 4 hours as needed for pain. This medication may upset your stomach even when taken with food.

Please call **(650) 498-7020 if you have any questions during business hours. After office hours/weekends, please call the pager operator at **(650) 723-6661** and ask them to page Dr. Manche directly.

Rev. 08/12

STANFORD MEDICINE
Byers Eye Institute at Stanford

Edward Manche, M.D.
Stanford Eye Laser Center
2452 Watson Court
Palo Alto, CA 94303
(650) 498-7020

PRK POST OPERATIVE INSTRUCTIONS

1. It is not unusual to experience varying degrees of discomfort on the day of surgery. Your eye(s) may experience occasional irritation such as light sensitivity, tearing, or a scratchy sensation. You may take Advil, Nuprin, Aspirin, Tylenol, or Vicodin to reduce discomfort.

2. Avoid yard work and strenuous exercise for the first week. Eye makeup or lotions, swimming, saunas and Jacuzzis should also be avoided for the first week while the corneal surface is healing. You may shower or bathe, but avoid getting water directly into the eye.

3. Daily fluctuations in your vision are normal after surgery. Your vision will probably be blurry for 2-3 weeks following surgery. It is common to have localized red spots on the white part of your eye(s). This is normal. These red spots will fade away in 1-3 weeks.

4. UV protection (sunglasses) should be worn at all times outdoors.

5. A thin soft contact lens will be placed on your eye at the end of the treatment to help with healing and comfort. The medical staff will remove it once the corneal surface has healed, usually 3-6 days after treatment.

.

6. **Medications:**

Wait 5 minutes in between all drops.

❑ **Vigamox** ❑ **Zymaxid** ❑ **Ocuflox** ❑ **Besivance**	One drop in operated eye(s) 4 times per day (while awake) until the doctor instructs you to stop. Start the drops 2 hours following surgery.
❑ **Prednisolone** ❑ **Pred Forte** ❑ **Flarex** ❑ **FML**	One drop in operated eye(s) 4 times per day (while awake) until the doctor instructs you to stop. Start the drops 2 hours following surgery.
Artificial Tears	Use anytime after your procedure. You may use Soothe, Refresh, Systane, Genteal, Thera Tears, Bion Tears, Optive or Celluvisc.
Vicodin (750 mg)	Take this optional pain medication, 1 tablet orally every 4 hours as needed for pain. This medication may upset your stomach even when taken with food.
Valium (10 mg)	Take this optional sedative medication as needed.
Vitamin C	1000 mg a day orally for 3 months.

Please call **(650) 498-7020 if you have any questions during business hours. After office hours/weekends, please call the pager operator at **(650) 723-6661** and ask them to page Dr. Manche directly.

Rev. 08/12

STANFORD MEDICINE
Byers Eye Institute at Stanford

Edward Manche, M.D.
Stanford Eye Laser Center
2452 Watson Court
Palo Alto, CA 94303
(650) 498-7020

LASIK POST OPERATIVE INSTRUCTIONS

1. It is not unusual to experience varying degrees of discomfort on the day of surgery. Your eye(s) may experience occasional irritation such as light sensitivity, tearing, or a scratchy sensation. You make take Advil, Nuprin, Aspirin, Tylenol, or Vicodin to reduce discomfort.

2. Avoid yard work and strenuous exercise for the first week. Eye makeup or lotions, swimming, saunas and Jacuzzis should also be avoided for the first week while the corneal surface is healing. You may shower or bathe, but avoid getting water directly into the eye.

3. Daily fluctuations in your vision are normal after surgery. Your vision will probably be blurry for 2-3 weeks following surgery. It is common to have localized red spots on the white part of your eye(s). This is normal. These red spots will fade away in 1-3 weeks.

4. Clear plastic goggles will be placed over your eyes following the procedure. Do not remove the goggles until the following morning. You will not use any eye drops until after you see us for your one-day postoperative visit. Wear the goggles over your eyes each night for 1 week while you sleep. This prevents you from accidentally rubbing your eye and disturbing the surgical result.

5. Please keep both eyes closed following the procedure and do not read, watch T.V. or work on the computer for the remainder of the day. A soft contact lens will be placed on the eye(s) overnight and will be removed by your doctor the following day.

6. UV protection (sunglasses) should be worn at all times outdoors.

7. Do not rub your eye(s) after surgery for 1 month.

.

8. **Medications:**

Wait 5 minutes in between all drops.

❑ **Vigamox** ❑ **Zymaxid** ❑ **Ocuflox** ❑ **Besivance**	One drop in operated eye(s) 4 times per day (while awake) for 4 days. Start this drop after your 1-day post-operative visit.
❑ **Prednisolone** ❑ **Pred Forte** ❑ **Flarex** ❑ **FML**	One drop in operated eye(s) 4 times per day (while awake) for 4 days. Start this drop after your 1-day post-operative visit.
Artificial Tears	Use anytime after your one-day post operative visit. You may use Soothe, Refresh, Systane, Genteal, Thera Tears, Bion Tears, Optive or Celluvisc.
Vicodin (500 mg)	Take this optional pain medication, 1 tablet orally every 4 hours as needed for pain. This medication may upset your stomach even when taken with food.

Please call **(650) 498-7020 if you have any questions during business hours. After office hours/weekends, please call the pager operator at **(650) 723-6661** and ask them to page Dr. Manche directly.

Rev. 08/12