

GLOBAL VISION ADVANTAGE

Global Experience With Presbyopic Intraocular Lenses



American Society of Cataract and Refractive Surgeons
Washington DC, USA
April 17, 2005

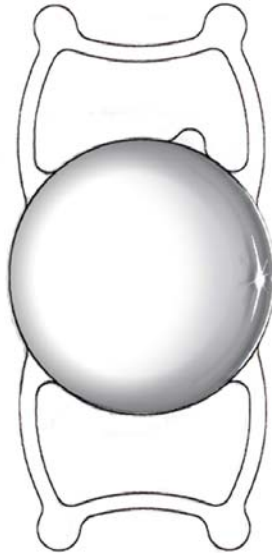


The **Tetraflex**TM
Advanced Intraocular Lens

Introducing...



THE TETRAFLEX™ lens is made from a highly bio-compatible poly-HEMA hydrophilic acrylic material with 26% water content. A large (5.75mm) optic and square-edge design means that there are no design compromises to produce an accommodative effect.



Optic Size:	5.75mm
Optic Type:	Equiconvex
Length:	11.50mm
Haptic Style:	Tetraflex
Angulation:	5 Degrees
Construction:	1 Piece
Positioning Holes:	0
Optic Material:	Acrylic (26% Water Content)
A Constant:	118.0
A/C Depth:	5.10
Dioptrre Increments:	Whole +30.0 to +36.0 Half +5.0 to +18.0 +25.0 to +30.0 0.2 +18.0 to +25.0

THE TETRAFLEX™ is a simple-to-use lens, being injectable via a 1.6mm cartridge and can be used for micro-incision surgery. There is no variation in a surgeons' standard phaco technique and minimal learning curve. Most of all, the lens was designed so as not to require the patient to adopt to unnatural multi-focal duality.

There is no variation in a surgeons' standard phaco technique and minimal learning curve. Most of all, the lens was designed so as not to require the patient to adopt to unnatural multi-focal duality.

A distinguished panel of global tetraflex users discuss their experience with THE TETRAFLEX™ and other surgical options to correct presbyopia

The Tetraflex™ Users Panel - ASCRS 2005

Moderator - Deepak Manchester, MD (UK)

*Professor Dr. Jorgé L. Alio
VISSUM Instituto Oftalmologioc*

*Jose Rincon, MD
Jose L. Rincon Instituto Oftalmologico IUMO*

Robert Kellan, MD

*Carlos Verges, MD
Area Oftalmologica Avanzada*

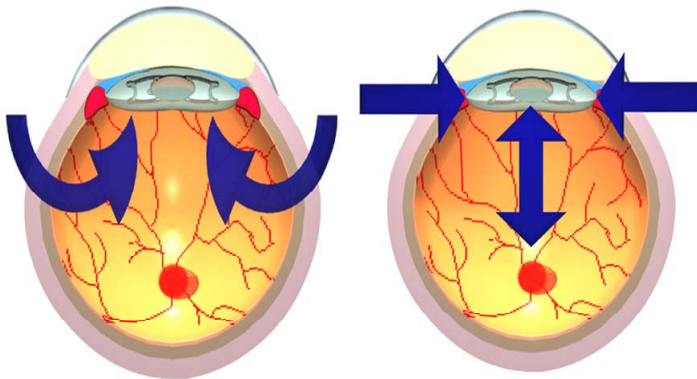
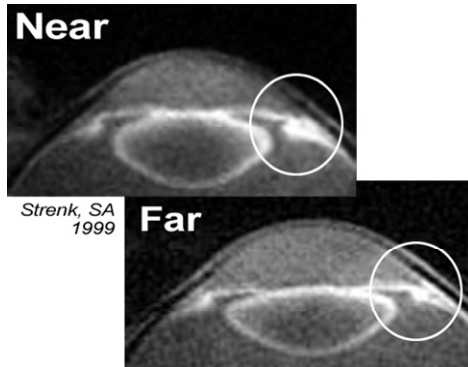
*Sunil Shah, MD
Midland Eye Institute*

Applied Theory of Accommodation

Understanding Accommodation

The ciliary muscle enlarges and redistributes its mass posteriorly.

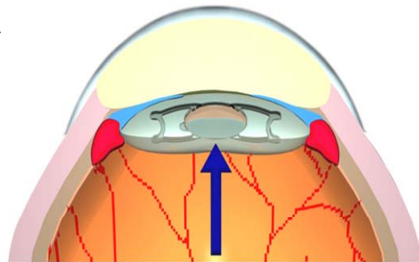
The lens increases in thickness and the anterior chamber shallows.



- The two forces activated during accommodation are vitreous movement and ciliary muscle swelling.
- Both of these forces can move the optic forward and/or backward during accommodation.

The Tetraflex Accommodation Advantage

- Designed with a unique anterior angle orientation due to patented 5° contoured haptic design.
- The Tetraflex optic is designed to act as a “sail,” catching the wave of vitreous to provide maximum forward movement for near vision and return to the intended plane in the “flat” position for clear intermediate and distance vision.



Deepak Chitkara:

“When you look at research on the mechanism of accommodation, in a normal phakic eye, when the ciliary muscle contracts, the normal phakic lens does not actually move forward. With THE TETRAFLEX™, What actually happens during accommodation is the anterior and posterior diameter of the lenses change. The lens actually becomes compressed and does not actually move physically forward, so the anterior capsule moves anteriorly and the posterior capsule is pushed backwards, posteriorly.

One of the flaws with the first generation hinged lenses (Crystalens and Humanoptics) is if compressive forces are greater than the vitreous force, the first generation lenses can actually move backwards; negative movement rather than positive movement. Surgeons around the world have reported in some cases the hinged lens actually moves backwards rather than forwards.

So why is THE TETRAFLEX™ different to the hinged lenses? It is designed to utilize maximally the forces that are acting on the capsular bag at the time of accommodation. Instead of being vaulted posteriorly, it is angulated slightly anteriorly by 5 degrees. When the ciliary muscle contracts during accommodation, all those forces are acting maximally allowing the lens to move forward. This lens will always move in the direction that it is intended to move.”

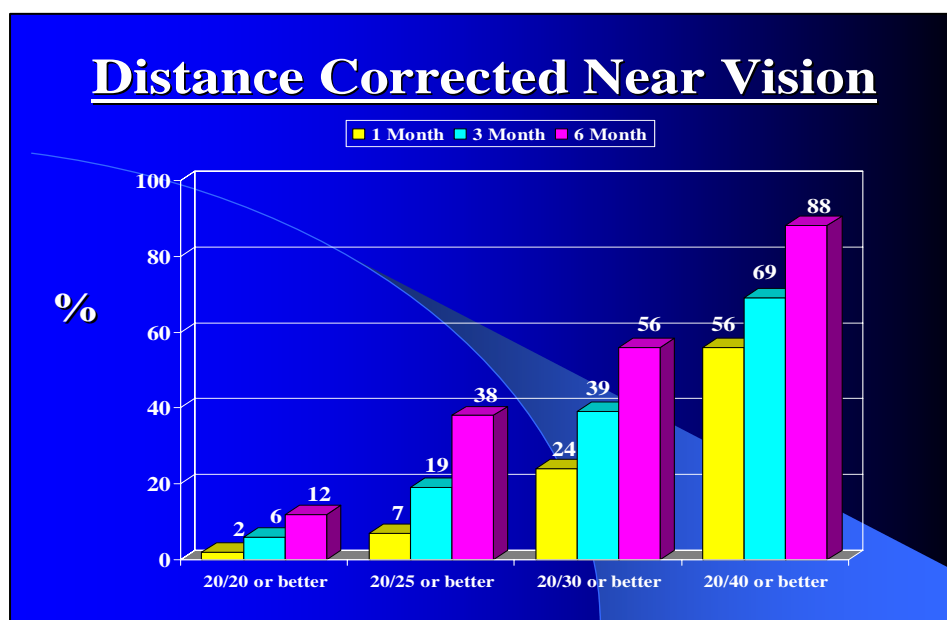
Clinical Results

Deepak Chitkara

“My experience with this lens started in February 2003. I put these lenses in an unselected fashion in any patient who was suitable for cataract or refractive lens surgery. My practice is mainly a refractive surgery practice, and I get a wide variety of refractive errors coming to me for surgery, so I’ve put these lenses in hyperopes and myopes, ranging from -16 to +10.5 dioptres with cylinders ranging from plano to +8 dioptres. This is a wide range. The predictability is exceptional! I am very pleased!

In 138 eyes in 89 patients, 49 were bilaterally implanted. We are continuing to monitor these patients. I have 94 eyes at 6 months follow-up at the moment. We correct for distance and check the near vision, which is the more important measure; almost 90% are getting J3 or better. Patients with both distance corrected – uncorrected near vision and uncorrected distance vision are 20/40 or better; 70% + of the time. Accommodative amplitude measuring with subjective methods are about 80 to 90%, achieving 2 to 3 dioptres of accommodation. About half of the patients have achieved more than that, more than 3 dioptres of accommodation.

In conclusion, in my experience, THE TETRAFLEX™ lens is well tolerated, provides good distance vision, and provides very useful near distance vision, and the effect is stable. I can say, although I haven’t presented the results, that even at two years the results are perfectly stable. So much so, that I have now changed completely to using THE TETRAFLEX™ lens, this is my preferred—this is my lens of choice for any form of cataract or refractive lens exchange surgery.”



Source: Deepak Chitkara

“Accommodative Amplitude demonstrate 90% gain 2 to 3 dioptres of accommodation and 50% achieved more than 3D”

Clinical Results

Jorgé Alio:

“First, THE TETRAFLEX™ is very easy to implant. I have been trained and have experience in the Humanoptics and Crystalens, now in this 3rd model. The theory of forces utilized to generate the accommodative effect is the same as first generation accommodating lenses, and basically THE TETRAFLEX™ design is different. This is the main issue: THE TETRAFLEX™ design is really much more compatible with a presumed effect that we should obtain, and surgically THE TETRAFLEX™ is definitely better.

The first generation lenses, we had to open up to 4 mm because the lens could not be injected. TETRAFLEX™ is injectable, and it is true that it can be injected through incisions of about 2.0 to 2.5mm. We had a very high Posterior Capsule Opacification (PCO) rate with the Crystalens, and the result of the Crystalens in terms of near vision performance:- The small diameter of the lens was inadequate. The first surgery with THE TETRAFLEX™ was very well conducted, and the surgery was never complicated. THE TETRAFLEX™ is very handy for the surgeon, and you will find it quite easy to implant and indeed very handy inside the eye.

Second THE TETRAFLEX™ lens far vision is very good. THE TETRAFLEX™ haptics are well sustained and very well-designed mechanically, and so the immediate post-op was very good, with immediate and excellent results.

The A-Constant is very well calculated and indeed most of my cases were well in the frame of -.75 to 0, which was the target that we aimed in the non-dominant eye. What about near vision? All of my patients are around J3 or J4 or better, and J4 means social performance. So my conclusion is:

- 1. I need more experience with this lens.*
- 2. THE TETRAFLEX™ in terms of surgical behavior is excellent.*
- 3. Far vision is very good; no night vision problems have been detected, no reparation at all due to any inadequate stability inside the capsular bag.*
- 4. Near vision is better than with mono-focals.*

My final conclusions is that THE TETRAFLEX™ is a promising lens. Indeed we need something for near vision because, there is no question this is the main issue at this moment in my practice, how to make my patients happier for near vision without using multi-focals.”

“All of my patients are around J3 or J4 or better” - Jorgé Alio

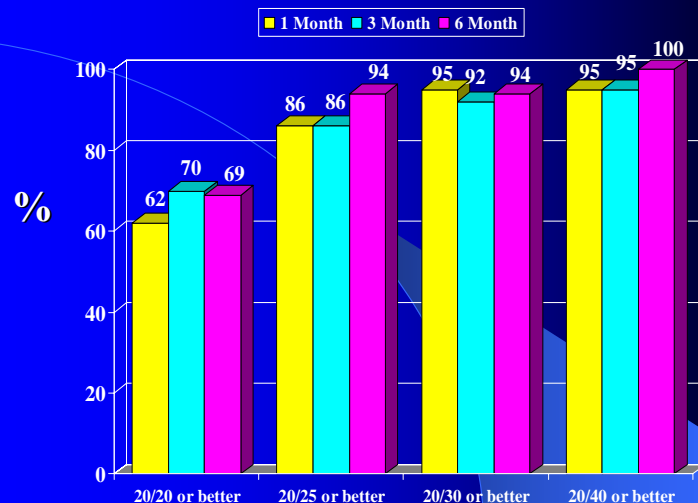
Clinical Results

Jose Rincon: "I have 24 eyes, 12 patients, all bi-lateral implants, 8 female, 4 male, age range from 50 yrs old to 64 yrs old, mean of 61, 11 hyper-opics. I have 9 months follow-up.

My results are: distance on correct visual acuity I have 10 patients 20/25 or better, 12 patients of 20/40 or better. Distant correct visual acuity, I have all 12 patients 20/20 plus. Far vision with THE TETRAFLEX™ is excellent, and I think we need to understand this lens may have not just good reading vision, but maybe the best in industry far vision results. My results uncorrected near vision: I have Jaeger 1 or better 10%; Jaeger 2 or better 20%; Jaeger 3 or better 60%, Jaeger 4 or better, 100%.

Sunil Shah: "I've put in about 200 of THE TETRAFLEX™ now, with about 18 months or so of follow-up. I have a practice mixed with cataract and refractive. I've changed routinely to THE TETRAFLEX™ lens, so every single patient gets this lens. Results-wise, I can quote you the distance in the clear lens extraction patients which we've audited recently and I think 96% are within plus or minus 1 dioptre, and that's for a range of preoperatively something like +10 to -16. The A-constant is accurate, the consistency that we are getting of the results is superb. Near vision - the studies that we've done on THE TETRAFLEX™: at 3 months we are getting subjective accommodative amplitude of 3.6 dioptries. So this is far in excess of any of the other lenses. At 6 months this has dropped to about 2.1 dioptries. But there is a range - the highest we had in a patient at 6 months had 5.4 dioptries. We don't really understand why these work, and why somebody has 5.4 and somebody might have a lot less, but in general patients are very happy. I've have no intention of changing back to the other lenses. My father has had cataract surgery and this is the lens we put in. He is 20/25 in either eye, and he's N6 which is about Jaeger 2 unaided. I haven't had a single problem with this lens. I've let my residents inject it; there's no problem with that."

Uncorrected Distance Vision

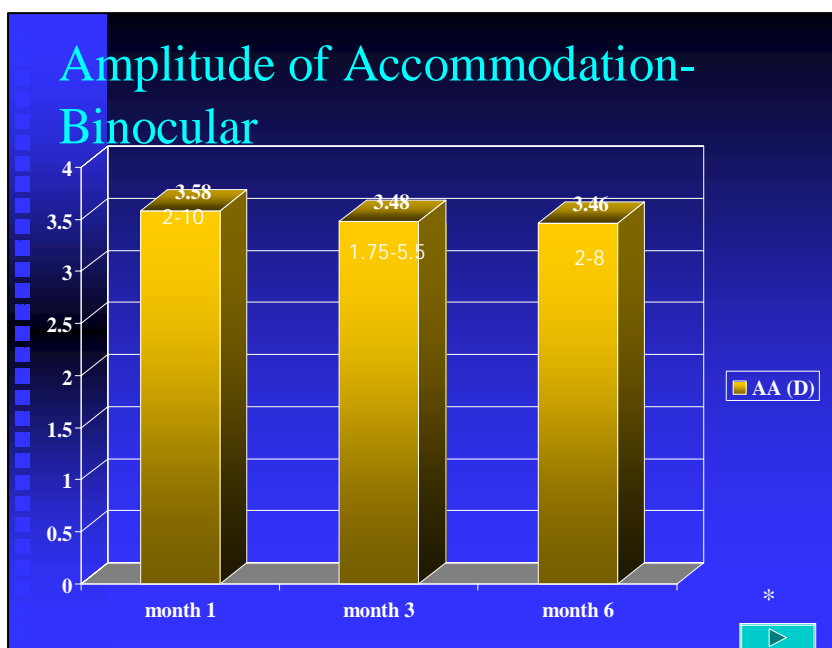


Source: Deepak Chitkara

Clinical Results

Carlos Verges: “First, I would like to tell you that I have more than 4 years experience with accommodative lenses. So we have learnt different things. We don’t understand yet the complete physiological mechanics that explain accommodation, so that is important because we have different hypothesis but nothing completely understood in order to design the appropriate lens for presbyopia treatment. With this previous experience, especially with the Crystalens, and the Humanoptics, we have learnt in some cases these first generation accommodating lenses worked. That’s true, but there are other factors that we don’t know. If the theory presented here is partially correct, then the idea to implant a lens like THE TETRAFLEX™ which works different than the Humanoptics or the Crystalens, because it is placed in an anterior position, and the angulation is different, this explains the results we have in these cases.

I have a short experience because my follow-up is only 3 months, and we know that it is after these three months when the capsular bag changes, so we have to wait for more time to know more about these lenses. In my short experience these patients with THE TETRAFLEX™ have very a nice distance visual acuity; about 20/25; 20/20. And the near vision acuity is about 20/40, J3, J4 is the near social vision acuity. During these 3 months we have the same results in this near vision acuity, so it is interesting because we have a new device; we have a new lens that can improve our patients, because we need more in order to treat our patients, but for those patients who require global vision, I mean distant intermediate, especially intermediate patients, we feel very comfortable with THE TETRAFLEX™ for these patients.”



Source: Deepak Chitkara

Multi-focal Comparisons

Deepak Chitkara: “Well, how do you think THE TETRAFLEX™ compares to multi-focals?”

Carlos Verges: “Completely different. With the diffractive design (ReStor) we can obtain a more predictable visual acuity for near vision, but of course we have halos and other problems.”

Deepak Chitkara: “So there are always compromises with multi-focal lenses.”

Carlos Verges: “Always a compromise. It’s important to understand the expectation of your patients, and help them understand the compromises with multi-focal lenses. We do not see compromises with THE TETRAFLEX™ if the results hold up over time.”

Deepak Chitkara: “Jorgé, you’ve had a lot of experience with the other lenses. Can you tell us what do you think of the advantages and disadvantages of multi-focals.”

Jorgé Alio: “Multi-focals make about 40% of my practice at this moment, so I really implant a lot of multi-focal lenses of the new generation. The new generation of the multi-focals is very different to the previous one. We are facing a much better future with multi-focals as far as night vision is much improved; near vision performance is much better, and indeed the optics of the lens is better, but in spite of that and admitting that the outcomes are good, the problem is that the physiology is not multi-focality. And even in the best situation and in the best environment, with the experience some patients are unhappy even with good near and far vision because probably their neuro-processing is not ready for multi-focality in every case. I tend to believe that, and this is my personal experience. Cases which have a good outcome and, in my studies, a good percentage with excellent outcomes, but still patients are not happy because I think it is related to the use of the quality of vision, and this quality of vision is not good. It is simply that multi-focality is a different way to see the environment, to see the universe.”

Jorgé Alio: “I am fully convinced that we know nearly everything about accommodation. Accommodation theories, especially the Helmholtz is true. It is working; it has been challenged and it has not been defeated. The problem is that accommodation is not near vision. I am convinced that we are dealing with a technology, not only with THE TETRAFLEX™, but with those technologies that are working with mono-focal lenses that try to achieve near vision performance in a different way than multi-focals that work in something related to an increased depth of focus. The increased depth of field is related to the pupil size, and is related to the position of the lens. Very probably, the size of the lens is an issue, and very probably another issue is the refraction”.

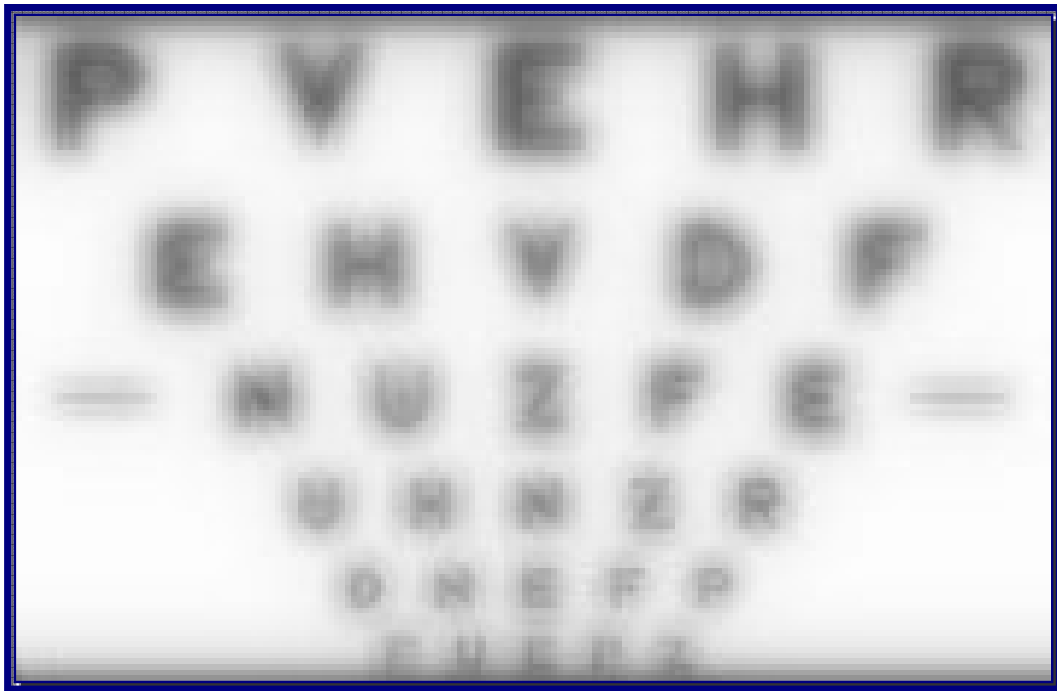
Multi-focal Comparisons

Jorgé Alio: “Accommodation as defined by a change in the power of the eyes’ optical system. It is changing the position or changing something that revives near vision for our patients. Keeping this in mind, I agree that we don’t know all the factors related with what is near vision performance in the aphakic eye. But indeed accommodation in the living human eye is indeed well studied and is proven.”

Deepak Chitkara: “So you think that multi-focals have the fundamental issue, that they are an unnatural situation.”

Jorgé Alio: “That is the fact and thank you for this because my issue is that I am looking for something that is more physiologically targeting near vision process.”

Deepak Chitkara: “Yes. Although we don’t have a perfect lens, this lens goes somewhere towards addressing the true nature of accommodation and providing a much more physiological vision to the patient than say a multi-focal.”



**"Multi-focal lenses have the fundamental issue
that they are an unnatural situation"**

-Deepak Chitkara

Multi-focal Comparisons

Deepak Chitkara: “What goes through your mind when you choose the Tetraflex lens as opposed to some other lens in your patient. Would you use this on every patient? Do you have a preference for certain type of patients? Is there any criteria that you use to chose this patient?”

Sunil Shah: “No, you don’t have to worry about the patients because they are not going to get halos; they’re not going to get glare, so all I say to the patients in the counseling is that at worst it won’t work and it will be no different from a mono-focal lens.”

Carlos Verges: “For me, I choose my patients when they want to achieve a global vision, especially intermediate patients, and they require near vision in the J4 to J3 range. In these cases, the expectations, it’s good with THE TETRAFLEX™ lenses.”

Deepak Chitkara: “It’s the expectation that matters. The result from all the panelists is that all are achieving near vision, which is acceptable for social reading, and this is what this lens is designed for. It’s not designed to achieve very close near vision for everybody. We all agree that all presbyopic correcting options today, if done properly, we need to counsel patients to have realistic expectation. I tell my patients: “if you are expecting to read small print then this may not be achieved and you may not meet your expectation; however, what we can offer you is freedom from glasses for 95% of your daily activity... so there will be certain situations such as reading very small print or if you are trying to read in very dim light or if you are trying to read for any length of time, say half an hour or more, then you may need a supplementary lens, a supplementary pair of glasses”. As long as patients understand that, then they are very happy at the end of it. And this has been shown by all of our results, not just mine, and we are all achieving that level of near vision.”

Carlos Verges: “It’s critical especially in these cases when people are thinking about near vision. You explain that you have technology that can improve near vision, and they understand this. They are happy. But if you promise things that you can’t achieve, you will have problems. For Multi-focal lenses we have to balance between the effective near vision and the secondary problems due to halos, compromised visual quality, and other related problems. For me intermediate vision is critical for those people who work with computers, and they have to work with intermediate distance. In this case I think the Tetraflex lens is much better.”

Multi-focal Comparisons

Deepak Chitkara: “Let’s move on a little bit. From the surgical point of view, apart from choosing the patients with the right expectations, we’ve discussed that this lens can be put in anybody really who qualifies. One of the things that I’ve learned by implanting close to 200 Tetraflex patients is that when expectations are not met in certain situations this could be the result of underlying problems. As an example people who have very dry eyes. They will not get the expectations that I’ve told them. So you just have to be very careful with those patients. Patients who are on anti-depressives is another group of patients who tend to not listen to you when you are telling them about the expectations. So just be very careful with these subsets of patients.”

Dr. William F. Maloney uses the chart below to guide multi-focal patients toward proper expectations. He tells the patient to pick 3 contiguous categories they could “live with” and the other areas will be out of focus:

Figure 3. Focus zone chart

Near Zone 1 12-20"	Zone 2 2'-4'	Zone 3 6'-20'	Zone 4 20'-100'	Far Zone 5 100' >
Newsprint	Headlines	Indoor	Day-far	Night-far
Phone book	Computer	TV	Driving	Night driving
NYSE	Birthday card	Cooking	Golf	Movies
Map	Bridge	Clocks	Tennis	Theater
Makeup	Menu	Meals	Sightseeing	Candlelight
Sewing	Price tags	Cleaning	Road signs	

Chart of focus zones is useful to determine a patient’s expectations for vision correction. After discussion of his visual needs and expectations, the patient is asked which three contiguous focus zones he wants for the uncorrected portion of his vision. Because most patients achieve closer to four zones of uncorrected acuity, expectations are usually exceeded.

Source: Maloney WF

Surgical Notes

Deepak Chitkara: “Let’s look at the actual surgical technique. During surgery, are there any pearls that the panel can give us?”

Jorgé Alio: “Simply just follow the instructions of the company. This lens has a “nub” on the optic that needs to be facing down and right, and this is the right way to implant the lenses, very easy to recognize. The injector is very good. My opinion is that everything has been surgically designed perfectly. My advice is to follow the advice of the company to have somebody with you in the first cases, just to know that you are placing THE TETRAFLEX™ correctly into the cartridge. With THE TETRAFLEX™ I like to introduce the injector inside the eye and to put it closer to the center of the anterior chamber and then the first haptic is released inside the capsular bag and then the second haptic is immediately released inside the capsular bag. So in most cases I achieve in the bag implantation just with one maneuver, and the lens is self positioned inside the capsular bag without any further maneuver. So it’s a very nice surgical technique. Very easy, very simple.”

Carlos Verges: “I have a question to Dr. Alio. Do you have any experience with this lens in micro-incision cataract surgery?”

Jorgé Alio: “Yes, I did all my cases with micro-incision cataract surgery.”

Deepak Chitkara: “What about capsular rhexis Any issues with capsular rhexis?”

José Rincon: “I usually do 6 mm capsular...”

Jorgé Alio: “5.5mm is my size. And you, Sunil?”

Sunil Shah: “Same”

Jorgé Alio: “Because we were told with the Crystalens to do 4 mm which is a problem because capsular fibrosis comes much more frequently and you have capsular fibrosis even with silicone lenses so this is a disadvantage of the Crystalens.”

Carlos Verges: “Usually in my surgical procedure I prefer 5.5 to 6 mm in general in order to avoid the anterior capsular retraction.”

Deepak Chitkara: “Traditionally we are told to have the capsular rhexis just within the size of the lens implants so 5.5 mm for this, but really you don’t need to change your technique. THE TETRAFLEX™ lens will tolerate any size of capsular rhexis that you normally do for your cataract surgery.”



Post Operative Notes

Deepak Chitkara: “What about post-operatively? Has anybody had patients disappointed early on, and what do you think were the reasons? What do you think may be the reason some patients who are not happy with their near vision immediately, or distance vision immediately, what do you think that might be related to? Jorgé again.”

Jorgé Alio: “My advice to the patient is to try to read without the aid of any spectacles because neuro-processing is needed for the use of near vision with these lenses. It takes some time. The visual phenomena that is associate with THE TETRAFLEX™ lens is that near vision capabilities increase with time. Usually the peak for me is after the 4th month. I usually expect a learning curve from the patients from the 1st to the 4th month for improvement, and this why I told you that from my experience with one month follow up to three months, my experience is J4 as an average, but it might be better in the future. And I don't use any special drug regiment in the Tetraflex cases. In other cases with Crystalens I did have to use atropine for 7 days which was quite unpleasant to my patients. I strongly advocate to you with THE TETRAFLEX™ lens that you tell the patients to try to use no spectacles for near since the very beginning just to adapt to near vision performance.”

José Rincon: “I also give similar instructions to what Dr. Alio is speaking of.”

Sunil Shah: “I agree with Jorgé that there is some learning and quite a lot when they may not be quite as happy with the first reading but then doing the second eye and getting them to practice. The practice is probably just keeping them happy that they are doing something, but they do come back happier after a few months.”

Carlos Verges: “I haven't changed my routine cataract surgical procedure with the Tetraflex. On this learning curve matter, all lenses with more than one-focal point have a learning curve to your patients and then you have to explain this learning curve and how the lens works. Anyway the post-op with THE TETRAFLEX™ is really the same as my normal surgery procedure.”

Deepak Chitkara: “Jorgé, you wanted to add something.”

Jorgé Alio: “Yes, I think that it is important to think that if you want to get the best result with the Tetraflex lens you need to have an astigmatic free patient up to the level to -1 at 90 degrees, because this increases multi-focality. Any degree of astigmatism larger than that should be operated on and corrected, and I am in favor like Sunil with correcting incisions at the moment of surgery, and you should select your patients. High astigmatism is not a good case for this technology.”

Deepak Chitkara: “How about refractive errors hyperopia or myopia? Do you aim to leave them myopic or hyperopic or emmetropic? Or something in between?”

Jorgé Alio: “In theory, the hyperopes should be the ideal patient. No question on that.”

Post Operative Notes

Deepak Chitkara: “One thing I’ve noticed with my patients is that if you leave them slightly myopic, minus a half, they’re happy. If you leave them plus a half, they’re not happy with the near vision especially, so any patients that are slight hyperopic you need to really make an effort to correct that, whether it requires a Lasik or whatever technique you want to do to get them either emmetropic or slightly myopic.”

Jorgé Alio: “Exactly, and I try to put the non-dominant eye as slight myopic intentionally just to increase the near vision capability.”

Deepak Chitkara: What about loss of effect? Does anybody in the panel have any ideas on why that happens and how to deal with that?”

Sunil Shah: “It’s not usually a problem. Occasionally you get a patient, with even a very fine posterior capsular opacification, and I have lasered them reasonably early in two or three months and that’s cleared the problem. Posterior capsular opacification hasn’t been a major issue with the Tetraflex lens, certainly at 6 months, where I’ve got the most follow-up. I think that is certainly one of the possibilities and you have to look very carefully at that. Sometimes you just see some very fine wrinkles immediately in the visual axis, but it is possible that that is enough to drop the vision just a little bit.”

Deepak Chitkara: “Carlos have you had any patients who seem to have lost the effect from their immediate results at one week, two weeks, and then suddenly they feel that they can’t see as well?”

Carlos Verges: “During the 1st three months they feel more or less the same, during the first control.”

Deepak Chitkara: “I have one or two patients out of nearly 200 that had less than optimal results. A theory I have, but it is something that needs working on – these patients have not had use of their ciliary muscle for a long, long time. They’re presbyopic and there is a lot to be said for giving these patients some reading exercises after 2 to 4 weeks after surgery. And you will notice that a lot of them will have some improvement in their near vision by at least a line or so. The type of reading exercises I am talking about is just convergence exercises, and it doesn’t take long to do, it’ll just take 5 minutes of their time, 4 times a day just to practice convergence exercises. And you’ll find it just helps to get the lens moving better. And that is something that I noticed when I first started using THE TETRAFLEX™, and it has worked.”

Deepak Chitkara: “PCO is an issue that has been raised. There have been a lot of talk about lenses angulated by 5 degrees forward; what is the effect on PCO? It’s a theoretical disadvantage, but has anybody noticed any high incidence of PCO. I certainly haven’t. “Out of 200 patients, I have lasered 2 patients. PCO really haven’t been an issue; just because the lens is

Post Operative Notes

angulated 5 degrees forward doesn't mean that the capsule isn't touching the implant. " The capsule is still touching the implant so that lens and capsular touch is still there which is a barrier to cell migration; however, if with this lens there is a bit of PCO, the first thing that suffers is the near vision because the contrast is reduced. And in those cases early YAG restores their vision. That has been my experience. I'd just like to ask the panel what made them choose to use this lens, apart from Lenstec asking them to use it."

Jorgé Alio: "I wanted to have something that is not multi-focal to provide my patients with better near vision, and indeed this is my experience in short follow-up at this moment with the Tetraflex. I am encouraged with the Tetraflex as far as I am following-up this study, but indeed only a 6 months follow-up can really tell you what is going on. And the near vision improves with time. Multi-focals have the immediate results, both good and bad. With accommodative lenses you need time for the patients and the neuro-processing that is involved in the near vision performance. Tetraflex provides patients a near vision improvement, excellent far vision and intermediate vision, and no visual disturbance. Indeed it is an alternative for a significant group of patients that requires the social capability for near vision and definitely they don't want or don't need to have any problem with night vision or the problems related to the photopic phenomena related to multi-focality."

Sunil Shah: "I feel the Tetraflex is the best presbyopic lens at the moment and I don't use multi-focal lenses anymore at all."

Carlos Vergas: "Well, I think everybody is looking for something to correct presbyopia and multi-focality is not the answer, so I think we have a promising lens in the Tetraflex that can improve our patients near vision and also provide excellent far and intermediate vision with no loss of quality of vision or life."

Deepak Chitkara: "Bob, I think I will let you have the final word on this. Do you think your expectations are being met here?"

Bob Kellan: "Remember we're watching an evolutionary process. What I am encouraged by is that we are getting some results. Indeed you can increase the quality of life for patients, the ones who are your most frustrated patients, the ones who come up to you everyday and say: "I want to get rid of these glasses. I want to be able to read the paper, I want to look at a menu when I go out to dinner, I want to be free of these glasses.". The reports from this esteem group of physicians is very encouraging. There are over 2500 of the Tetraflex lenses implanted; there has not been one explant., and well over 90% would say I would have this operation again. The perfect lens doesn't exist, but we have direction here, we have a process going on here, and I think this is a stepping stone to whatever will be the ultimate result and I am encouraged."

GLOBAL VISION ADVANTAGE

“Tetraflex provides patients a near vision improvement, excellent far vision and intermediate vision, and no visual disturbance.”

- *Jorgé Alio*



The **Tetraflex**TM
Advanced Intraocular Lens

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