The incision for the ACIOL can be made in the cornea if extending a phaco incision. However, a scleral tunnel will reduce surgically induced astigmatism (Figure 54-7). The surgeon makes a conjunctival peritomy followed by the application of cautery to the sclera. Next comes a partial-thickness scleral groove followed by a tunnel using an angled blade. The incision should be approximately 6.5 mm wide (Figure 54-8). Internal calipers ensure an adequate incision, although standard calipers work well also.

The location of the incision can vary depending on multiple factors. Theoretically, the incision can be placed along the axis of astigmatism to reduce the amount of cylinder as long as care is taken not to overtighten the sutures. In my opinion, having good exposure for the surgery and a comfortable approach are more important, so I usually operate temporally. This should result in less astigmatic effect and is much more comfortable.

Figure 54-1. (A, B) In both of these cases, the iris shows preexisting damage, so iris suture fixation is not as good an option as an ACIOL or scleral fixation. Both (C) this aphakic patient with a history of surgical trauma and (D) this pseudophakic patient with a dislocated IOL did well after pupilloplasty then ACIOL placement.

Figure 54-2. Viscoelastic is used to surround the IOL before removal.