



## **Comparison of Phaco-chop and Divide and Conquer Methods in Grade 3-4 Cataract Patients**

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### **Author's contribution**

*The sole author designed, analysed, interpreted and prepared the manuscript.*

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### **ABSTRACT**

**Purpose:** To compare the outcomes of Grade3-4 cataract surgery performed with 2 phacoemulsification techniques (phaco-chop and divide-and-conquer).

**Setting:** Ministry of Health Tuzla State Hospital, Istanbul, Turkey.

**Design:** Prospective randomized clinical trial.

**Methods:** This is prospective and randomized(double blind) study cataract surgery using two different techniques of nuclear fragmentation performed at the Tuzla State Hospital.100 patients eye with nuclear density from grade 3 to 4 were randomly subdivided into 2 groups (phaco-chop and divide-and-conquer). Intraoperative measurements included Phaco time (PT), effective phaco time(EPT), mean phaco power(MPP). Clinical measurements included preoperative and postoperative 1.day , 7. day, 30. day, and 60.day corrected distance visual acuity(BCVA), time to achieve BCVA, corneal edema rate and time to disappear corneal edema.

**Results:** Intraoperative measurements showed significantly less PT, EPT, and corneal edema with the phaco-chop technique than divide-and-conquer techniques in the grade 3-4 cataract density group (P<0.05).

**Conclusions:** 2 techniques may be effective for cataract surgery in mild and moderate cataracts. However, in eyes with hard cataract the phaco-chop technique can be more effective for lens removal, with less Phaco time and corneal edema, then the divide-and-conquer technique.

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**Keywords:** Phaco-chop; conquer methods; cataract patients; moderate cataracts.

## 1. INTRODUCTION

Since its introduction by Howard Gimbel in 1991, Divide and Conquer have become one of the basic nuclear fragmentation techniques that facilitate the subdivision of the nucleus into small pieces so that they could be removed more efficiently. This technique basically defined deep sculpting until a fracture is possible, nuclear fragmentation of the nuclear rim and posterior plate of the nucleus, fracturing again and breaking away a wedge-shaped section of nuclear material for emulsification, and rotation or repositioning of the nucleus for further fracturing and emulsification. [1] Phaco chop is a nuclear fragmentation technique that is performed under viscoelastic material prior to phacoemulsification. Akahoshi in 1993 divided the nucleus manually into four pieces before phaco. With a high vacuum and high flow setting; each divided nuclear fragment is aspirated and emulsified one by one [2].

## 2. PATIENTS AND METHODS

This prospective study was conducted at a single center (The Tuzla State Hospital Ophthalmology Dept., Istanbul, Turkey) from April 2017 to November 2017. The study comprised 100 eyes of 100 patients with cataract who were randomly assigned to have phacoemulsification using the Nagahara phaco-chop technique or the divide and conquer technique performed by the same surgeon and the same device. (Bausch & Lomb Stellaris, Inc.) In the preoperative biomicroscopic examination, the nucleus of cataract eyes was classified according to their stiffness using the lens opacities classification system (LOCS III).[3] Only grade 3-4 cataract patients were included in terms of preventing chop difficulties. Visual acuity was measured as decimal in Snellen chart. Intraocular pressures were measured by applanation tonometer, pachymetry corneal thickness measured by tonoref III(NIDEK inc.), anterior segment and corneal edema slit lamp biomicroscopic examination and 90 diopter noncontact lens fundus examinations done. In cases where fundus details cannot be selected B mode USG was performed. Exclusion criteria were corneal disease or opacity, glaucoma, uveitis, pupillary dilation problem, and previous ocular trauma or surgery. In all cases, surgery began with a clear corneal incision made with a 2.7 slit knife then two side-port incisions were made with the 20-gauge MVR knife 90 degrees

from the main incision. Following the injection of sodium hyaluronate 3% (protectalon, VSY Biotechnology) into the anterior chamber, a capsulorhexis was performed. Hydrodissection was done with a 27-gauge flat cannula and phacoemulsification was performed. In Phaco-chop method, The nucleus was fractured using a 'phaco chop' method by using a Nagahara left hand phaco chopper (Katena Inc.) to break the nuclei into multiple smaller fragments and then removing them with phacoemulsification. After phacoemulsification epinucleus fragments were removed with irrigation – aspiration cannulas. After injection %1.4 sodium hyaluronate intraocular lens inserted in the capsular bag. And all viscoelastic material removed with irrigation –aspiration cannulas and side ports hydrated to finish operation. Phacoemulsification parameters were vacuum 500 mmHg, flow 24cc/min, phaco power %40 and bottle height 75 cm was applied. In divide-and-conquer technique, 4 trenches were sculpted with phaco power % 40 vacuum set at 0 mm Hg so the nucleus could be cracked bimanually into 4 segments. The 4 quadrants were emulsified in the capsular bag using an increased vacuum (up to 90 mm Hg). The rest of the procedure was similar to that used in the phaco-chop technique. The intraoperative metric chosen as the primary outcome measure was PT-EPT. PT and EPT are displayed automatically on the interface of device (Bausch & Lomb Stellaris, Inc.) and it's measured in second. PT indicates entire phaco time while the EPT indicates total energy dissipated at the wound site in foot position 3, including a combination of torsional and longitudinal ultrasound energies.

The chi-square test and the independent-samples t-test were used to compare the groups for statistical significance. In terms of randomization, double blind method was used. All tests were 2-sided, and P values of 0.05 or less were considered statistically significant.

## 3. RESULTS

100 cataract cases were evaluated in 2 groups of 50 each. The demographic comparison of the patients included in the study is demonstrated in Table 1.

Phaco-Chop and Divide and Conquer Nucleotomy Techniques.

**Table 1. Patients' characteristics**

Characteristic	Group 1 (phaco-chop) n:50	Group 2 (divide and conquer) n:50	p values
Age (y)	65.3±10.5	64.9±9.3	0.406
Sex (male/female)	27/23	30/20	0.359
Right eye/left eye	30/20	29/21	0.399
Initial visual acuity	0.17±0.34	0.23±0.25	0.246
Follow-up period (d)	130.4±38.2	140.2±22.6	0.358
Nuclear density	3.7±0.3	3.9±0.6	0.381

**Table 2. Average phaco time and average effective phaco time by groups**

	Phaco time	Effective phaco time
Group 1(Phaco-chop)	41.2± 20.12	63±19.14
Group 2(divide and conquer)	22.54±11.76	30.62±15.13
P values	0.013	0.024

**Table 3. Corneal edema and disappearing time by groups**

	Corneal edema	Mean disappearing time (day)
Phaco-chop group(n:50)	10(%20)	5.12±13.5
Divide and conquer group (n:50)	17(%34)	9.36±14.1 P:(0.011)

**Table 4. BCVA changes and time to achieve BCVA**

	Preoperative visual acuity	Postoperative BCVA	Time to achieve BCVA
Phaco-Chop	0.17±0.34	0.74±0.34	7.51±3.47
Divide and Conquer	0.23±0.25	0.68±0.21	8.62±4.57
P values	0.246	0.352	0.104

There was no statistically significant difference in demographic measurement among the patients. Mean phaco power was % 30.2 ±2.2% (range 15% to 50%) in the phaco chop group and % 32.9 ±%1.7 (range %18 to %53) in the divide and conquer group. Although phaco chop group seemed to need less phaco energy, the difference was not statistically significant. (p:0.0701) Comparing to the phaco time, there were a statistically significant (p:0.016) differences between the two groups. In Phaco-Chop group PT was 41.2± 20.12 and in Divide and Conquer group PT was 63±19.14. Effective Phaco Time in phaco chop and divide and conquer were 22.54±11.76 and 30.62±15.13 respectively. Table 2 demonstrates the alteration between two variations during the procedures. (Table 2).

Temporary corneal edema rate statistically significantly lower and disappeared time statistically significant faster in phaco chop group than divide and conquer group. Temporary

corneal edema and mean disappearing time comparison between 2 groups demonstrated in Table 3.

BCVA and time to achieve BCVA(day) measured and there were no statistically significant differences between these variations and it can be seen in Table 4.

#### 4. DISCUSSION

Nagahara introduced the phaco-chop technique concept at the ASCRS Symposium in1993. [4] This technique is mainly based on the fact that the phaco tip is embedded into the nucleus and cut into small pieces by the chopper. The phaco-chop technique can reduce phaco time and power because manual chopping is used to divide the nucleus into manageable fragments and the only significant use of phaco energy is during fragment emulsification [5].

The divide-and-conquer technique introduced to crack the nucleus and facilitate phacoemulsification [1]. This technique requires additional phaco energy for sculpting to divide the nucleus before the fragments are emulsified [1]. Therefore, different nuclear-chopping techniques were introduced to further decrease postoperative complications [5].

The phaco chop technique is related to reduced phaco time and power because manual chopping is used to divide the nucleus into manageable fragments and the only significant use of phaco energy is during fragment emulsification [5-10-11]. The divide and conquer technique requires additional phaco energy for sculpting to divide the nucleus before the fragments are emulsified. [1] In our study, we found the phaco and effective phaco time significantly lower in phaco chop technique. In addition, the phaco chop technique prone to direct the ultrasound energy away from the cornea, yet the phaco tip is farther from the posterior capsule than in divide and conquer. [6-7] Phaco chop also requires fewer intraocular surgical maneuvers and it is associated with fewer ocular complications than the divide-and-conquer and stop-and-chop techniques. [7-8-10] Wong, et al. [8] used a Legacy system (Alcon) and found a mean phacoemulsification time of 1.2 minutes for the phaco-chop technique and 2.4 minutes for the divide-and-conquer technique. [8] Although we didn't measure endothelial cell shorter case times have been reported to be associated with less endothelial cell loss and fewer surgical complications [7-12-13-14].

Nevertheless, divide and conquer has been practiced successfully, safely and more established technique than phaco chop [1]. Potential drawbacks to phaco chop include greater generation of heat during the occlusion phase of chopping, as it requires phaco energy during occlusion and technical difficulty in dislodging the tightly packed segments so that the first nuclear fragments may have to be pulled up into the anterior chamber for emulsification [5].

Comparing the Phaco techniques studies are common. Coppola M, et al. compared divide and conquer and stop and chop techniques in training surgeons and they found all surgeons seemed to be efficient to learn both techniques, stop and chop dissipates less energy in harder nucleus.

[15] Additionally Gross F, et al. compared divide and conquer and pop and chop techniques in resident surgeons and they found pop and chop is a more time- and energy-efficient nuclear fragmentation technique than divide and conquer for resident surgeons. [16] Park Juwan, et al. compared the microincision 3 methods phaco surgery in their study and compared the biggest deficiency of our study endothelial cell count preoperatively and postoperatively. Although the percentage loss of endothelial cells appears to be less in the Phaco chop group, the difference was not statistically significant. They also found less ultrasound time (UST), mean cumulative dissipated energy (CDE), and balanced salt solution use in phaco chop than divide and conquer and sop and chop which was similar to our study. [9] Wong, et al. found the phaco chop technique required less phaco time than divide and conquer. However, they found no significant difference in phaco power required between those two techniques. [8] In our study, we found the phaco chop technique less required phaco time and effective phaco time. (p:0.013 and 0.024 respectively), however, comparing the phaco power was not statistically significant. (p:0.0701).

## 5. CONCLUSION

In this study, we tried to compare two phaco techniques. Our findings show that the phaco chop technique is more practical in terms of phaco time, effective phaco time and corneal edema formation and disappearance time than divide and conquer. In our study, there were some limitations: the most important of these were endothelial cell counting, inability to show results with different devices, and not to compare with another nucleus breaking techniques.

## CONSENT AND ETHICAL APPROVAL

The study was conducted in accordance with the official regulations for clinical research and the Declaration of Helsinki. We have obtained signed informed consent for participation in this study and consent to publish from each participant to report individual patient data.

## COMPETING INTERESTS

Author has declared that no competing interests exist.

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