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YOUR JOURNEY THROUGH CATARACT SURGERY

If you have been diagnosed to have cataracts and you have decided to have treatment under the care of Mr Manuchehri, here is some information about us, what to do before your appointment and what happens during and after cataract surgery.

THE TEAM

Firstly, let us introduce you to Mr Manuchehri's "team", who will help you through your journey:

At the office:

We are a team of two Personal Assistants of Mr Manuchehri:

Luisa and Celina

We arrange all the administrative parts of your journey, including booking appointments and your operation at the appropriate hospitals. We are the contact point for Mr Manuchehri, therefore, if you have any questions about any part of your journey, please contact us, on 01844 208432 between 9:30am to 3:00pm pm Monday to Friday. However, in case of emergencies we can be contacted out of hours on 07835 977069. You may need to leave a message on an answering machine and we will get back to you as soon as we can, usually within a few hours.

CATARACTS - A QUICK INTRODUCTION

The eye is made like a camera. It has a natural lens to focus the light onto the retina (the "film" at the back of the eye). When the natural lens becomes cloudy, it is called a cataract. The operation involves removing the natural lens and replacing it with a specially made lens that is made of special plastic. This is called the intra-ocular lens implant. Previously we had to wait until such time as the cataract was "ripe" before we performed the surgery, nowadays the operation has been so fine-tuned that most people would notice an improvement in vision, even if there is minimal cataract present. The more significant the cataract, the more you will notice an improvement in vision after the cataract surgery.

Some people wish to undergo “clear lens exchange” in order to reduce their dependence on glasses. This is the same operation as cataract surgery, except that the natural lens has not developed any opacities that affects the vision, and therefore strictly speaking it has not become a “cataract” yet.

BEFORE SURGERY

1. Call the office on 01844 208432 or 07835 977069 to book an appointment for consultation. Mr Manuchehri’s clinics are currently held at the Spire Thames Valley and Spire Harpenden Hospital.
2. If you have a referral letter from your GP or optician, please bring it along to your consultation.
3. Every time you see Mr Manuchehri, he will dilate your pupils to check the structures behind the Iris (the coloured part of the eye which surrounds the pupil), which means that it will be difficult (but not impossible) for you to drive for some hours after the consultation, as the vision will be blurred (the exact time varies from individual to individual but usually lasts between 2-6 hours after the consultation and goes back to complete normality after 24 hours. Therefore, you are likely to always need to be driven back home afterwards.
4. When you book your appointment, please let us know if you are a contact lenses wearer and whether you wear gas-permeable contact lenses or soft contact lenses, as you may need to remove these few days before your appointment (especially if these are gas-permeable “hard” contact lenses, as they can affect the biometry measurement readings). For soft contact lenses, please stop using them at least 3 days before your consultation and for gas-permeable, if possible, for 3 weeks before the consultation.
5. If you are not insured for your treatment, please let us know at the time of booking your consultation, so we can inform you of the fees involved for the initial consultation, the tests, the biometry measurements, the operation and the post-operative consultations in advance.
6. Please allow approximately 1-2 hours at the hospital for this first visit. As well as taking a full medical history, Mr Manuchehri will perform a full ocular examination including dilation of the pupils (which takes 20 minutes after insertion of the drops) and full examination of the retina. If the diagnosis of cataract is confirmed, he will take your biometry measurements himself at the same visit, after which he will talk to you about the **choices of intra-ocular lens implants available (see more information on next section)**.
7. We have attached written information about the risks associated with the surgery. There will be time for you to ask any questions during the consultation, but don’t worry if you forget one, you can always call the office and we will be happy to assist you in answering any questions that you may have forgotten to ask during the consultation.

8. If you are having a clear lens extraction to reduce dependence on glasses the same information as above will apply,
9. In order to make sure that you do not have any concurrent sub-clinical disorder of the macula that can affect your vision after cataract surgery, Mr Manuchehri likes to see a copy of your recent macular **OCT scans before the surgery**. If you have not had this scan done previously at your optician, we can arrange for this to take place before the operation. Please let us know so we can help guide you as to where this scan can be performed.
10. If you are going to see Mr Manuchehri at the Spire Harpenden, the OCT scan can be performed by Mr Manuchehri during your consultation as the equipment is available at this hospital. The hospital charges for this scan separately.
11. Once you have seen Mr Manuchehri and you are happy to go ahead with the surgery, please call the office to book an appointment for the operation.
12. After the surgery, you will need two more follow up appointments. The first is usually 1-2 days after the surgery and the second usually about 2 weeks after the surgery. 90% of people have good vision at the 2 week check up and can either be discharged or have arrangements made for surgery to the second eye any time after 2 weeks. However, 10% of people do not have good vision at two weeks due to cystoid macular oedema or “fluid-logging of the retina”, which can take a couple of months to settle. If you fall into this second category of patients, Mr Manuchehri likes to wait to see an improvement of vision in the operated eye before he operates on the second eye. By 2 months after cataract surgery, over 99% of patients will have good vision in the operated eye.

Options of intra-ocular lens (IOL) implants:

These days there are many types of different intra-ocular lens implants (IOL's) available, each with its own advantage and disadvantages.

These can be broadly categorised into:

1. Standard IOL's : These are by far the commonest type of implant used world-wide and in the UK. The biggest disadvantage of these implants is that they only have one focus and therefore patients who have this kind of implant may need to wear glasses to see objects at other focal lengths clearly.
2. Premium IOL's: These are sub-categorised into 3 further types:
 - a. Toric monofocal IOL's
 - b. Multifocal IOL's
 - c. Toric multifocal IOL's

- d. Toric monofocal IOL's: If your eyeball shape is like that of a rugby ball rather than a football, then you need a rugby ball shaped implant in order to reduce complete dependence on glasses to see well. If your biometry measurements show more than 1.5-2.0 Dioptre of corneal astigmatism, it is probably in your interest to have a toric rather than a standard implant in order to reduce complete dependence on glasses.
- e. Multifocal IOL's: These implants attempt to reduce spectacle dependence post operatively. As with everything else in life there is a trade-off between the advantages and disadvantages of this sort of implant. Some of the disadvantages of multifocal IOLs include:
 - i. Increased cost
 - ii. Increased patient experience of glare and halo's post-operatively especially in low-light conditions such as driving at night
 - iii. Decreased contrast sensitivity compared to standard IOL's, this means that black letters may appear more grey than black
 - iv. Increased chance of positive dysphotopsia, where patients describe seeing "lights" or visual effects, particularly in low light conditions. Most of these usually settle, or improve with the passage of time.
 - v. Increased risk of negative dysphotopsia, where patients describe having a "black ring" around the peripheral vision of the operated eye. Most of these usually settle, or improve with the passage of time.
 - vi. No guarantee of being spectacle free after insertion of multifocal implant
 - vii. Ghosting or doubling of the images happening to very few patients post-operatively – again most of these settle over time.
 - viii. Changes in the shape of the eye leading to need some sort of spectacles with the passage of time, even when originally patients were completely spectacle free
 - ix. Becoming more aware of "floaters" after insertion of multifocal implants
 - x. Some models of multifocal lenses focus on intermediate vision and distance, requiring reading glasses for closely held reading material, while others focus on close near vision, requiring glasses for intermediate vision.
 - xi. For these implants to work well, it is important to make sure that there are no other ocular pathologies present – in particular eye surface disease or macular pathology. This is why we always advise patients to have a macular OCT scan prior to cataract surgery, in particular if they are having premium IOL's inserted, in order to pick up any sub-clinical macular pathology. Although having these co-morbidities reduce the patient satisfaction with multifocal IOL's after cataract surgery, they are not a contra-indication to having multifocal IOL's inserted during cataract surgery.
 - xii. Toric multifocal IOL's: If there is more than 1.0-1.5 Dioptre of corneal astigmatism and you wish to have multifocal IOL's inserted, it is most important to neutralise the corneal astigmatism first otherwise you will still be completely spectacle dependent after multifocal IOL insertion. This is why there are toric multifocal IOL's as without neutralising the corneal astigmatism first, the multifocal IOL cannot cast a focused shadow on the retina at any focus.

IOL material: Historically there were many types of materials used to produce IOL's including PMMA, Silicone, and acrylics. Today most of the implants used worldwide are acrylic implants, as they are foldable and go through smaller incisions. These acrylic implants are generally sub-divided into two types: Hydrophobic and hydrophilic acrylic material. Over the years some types of implant material that were manufactured with the hydrophilic acrylic material were found to have calcified while in the eye and had to be removed. None of the material made from the hydrophilic acrylic material have ever calcified.

AFTER SURGERY

Here are some general post-operative instructions following cataract surgery:

Before you leave the hospital:

1. Make sure that you have your post-operative drops: **MAXITROL to be used four times a day until your visit at around 2 weeks, when Mr Manuchehri normally tapers your drops slowly to 3 times a day for a week, twice a day for a week and then once a day for a week, before stopping the drops completely.**
2. Make sure that you have extra micro-pore tape

Immediately after the operation:

1. Go home and take it easy. You have had what is classed as a major operation on your eye and although everything has gone well so far, it is going to take a little time for the eye to stabilise and settle down.
2. You will have had your cataract surgery with either Topical Anaesthetic (drop anaesthetic only and awake) or a General Anaesthetic (in which case you would have been fully asleep during the operation). Your eye maybe covered with only a plastic "shield" or it may occasionally have a "shield" as well as a dressing over your eye in which case your eye lid may try to open underneath the dressing and this can be uncomfortable. Therefore, if you have an eye-pad as well as a shield, it is important to try to keep the eyelid closed underneath the pad and plastic eye shield if possible as this makes the eye most comfortable. If you only have a shield there is no problem about opening and closing your eye naturally. Other surgeons use a needle (sub-tenon or peri-bulbar) anaesthetic which paralyses the eyelid muscles and keeps the lid closed over the operated eye. You have not had this type of anaesthetic. Therefore, the eyelid will try to open involuntarily.
3. You can be up and about, watch television or read after your operation, but just take things gently, especially in the first few days after the surgery.
4. Leave your "shield" and / or dressing on overnight. The eye may feel gritty or begin to ache a little but usually it will not be very painful. Take Paracetamol if necessary.

The morning after the operation:

5. Take off the shield and dressing (if you have had a dressing) yourself first thing in the morning. Separate the plastic eye shield from the rest of the dressing (if you have another dressing). **KEEP THE EYE SHIELD**, but throw away the rest of the dressing, if there was one on your eye
6. Wash your face **GENTLY** with soap and water, dabbing the eye and eyelids dry **GENTLY** with a clean towel. The lashes may be stuck together by dried tears. The lids should be prised apart without undue pressure on the eyeball. The eye may be red and there may be some bruising and puffiness around the lids but these will all resolve over the next couple of weeks as the eye settles down from the operation.
7. Put the first drop of MAXITROL in the eye, by pulling away the lower lid and inserting a single drop in the conjunctival sac. Please make sure you remove the plastic collar on opening the Maxitrol for the first time to avoid it falling on your eye when the bottle is inverted.
8. Use sunglasses, or your old glasses to protect the operated eye during the day. If you use your old glasses, the prescription for the operated eye will be completely wrong – so do not expect to see clearly out of that eye.
9. Arrive for your first day post-operative visit at the specified time which you should already have. Please bring a driver with you as you should not drive until such time as you are legal to drive after the operation. This may depend on what the vision in your other eye is like and whether you feel safe to drive or not.

Post-operative care:

1. DROPS:

A drop of **MAXITROL** needs to be instilled **four times a day** into your operated eye. You will need to **continue with these drops until your next outpatient clinic appointment.** They need to be spaced out over the waking day (e.g. first thing in the morning, lunch-time, tea-time, bedtime). It is essential that you use these drops regularly. Your GP will have been informed about these drops so if you should lose them or if it looks as though you are running low please contact your GP surgery who will be able to organise a repeat prescription for you. Do not let yourself run out. **DO NOT STOP THESE DROPS UNTIL YOU HAVE BEEN SEEN IN CLINIC.** It would be very helpful if you could remember to bring your drops with you when you attend clinic for your post-operative appointment.

2. PLASTIC EYE SHIELD:

Wear the plastic eye shield over your operated eye just before you go to bed and take it off on waking up for **one week**. Secure it to the skin around the eye with micro-pore tape that you were provided with at the hospital.

3. GLASSES

The glasses you currently have will be “wrong” for the “new” eye. You will need to see your own optician and organise a new prescription and glasses usually six weeks after the date of the surgery.

Until then, you may either use your old glasses or dispense with them, whichever you find the best. You may find that the vision in your unoperated eye is better with your old glasses but your “new” eye is better without, in which case you could ask your optician to simply push the lens out of the “new” side as a temporary measure and leave it like that or to put in plain glass instead until you are tested for your new prescription in due course.

You will not damage your eye by using your old glasses nor by not using them. If you wish to wear sunglasses or prescription sunglasses because you find the light a bit bright and dazzling, feel free to do so.

4. DO'S AND DON'TS

Don't.....

- Rub the operated eye for at least 2 weeks
- Bend down if you can avoid it
- Lift heavy weights
- Swim for one month
- Play contact sports/golf/tennis for at least two weeks
- Wear makeup for two weeks
- Make any dental treatment appointments for two weeks before and after the surgery
- Drive if you feel unsafe to do so or if you cannot read a number plate a 20meters with both eyes open
- Don't get new glasses until Mr Manuchehri advises you

Do.....

- Wash your hair
- Wash your face
- Have a bath
- Have a shower
- Be up and about
- Use your eyes as much as you like
 - Reading, watching television, using a computer

Beware of

- Pouring kettles and teapots
- Going downstairs and stepping on and off kerbs
- Straining, either due to constipation or coughing
- Young children with flinging arms,
- Bouncy pets,
- Branches flicking back into your face

Remember that you have just undergone a major operation on your eye. The eye has been taken apart and put together again and usually without even a stitch to hold it together. If you rub your eye too hard or knock it accidentally you may dislodge the wound and that could cause the eye to leak and could be a disaster! Just be gentle with the eye. When you wash your face, dab it gently rather than pummel the eyes dry.

5. DRIVING:

Your brain will now be somewhat confused by the after-effects of the anaesthetic that you have had and also by the fact that you are not using your “new” eye. You have always been used to using the two eyes together as a pair to judge speeds and distances. Your brain is going to have to get used to using the “new” eye and until then the two will not work properly together. You will adapt but it is going to take a few days to become comfortable again. Of course, once we have organised your new glasses, your brain will be restored to its normal, fully-functional self.

As far as driving is concerned, your judgment of distances and speeds is awry and until you are confident you should not drive. If your vision is good and within the legal limit for driving (You must be able to read a car number plate from 20 metres) you may drive when you are confident but I would suggest that you wait four or five days.

If you are still not confident at that stage then further delay until you get your new glasses would be advisable.

6. PLEASE REMEMBER TO:

1. Report any increasing pain or reducing vision in the operated eye by contacting my secretary on **07835 977069** immediately
2. Report any sudden increase in floaters and/or flashing lights immediately
3. Follow the instructions given to you regarding the wearing of the eye shield at the end of the operation. This will vary from patient to patient depending on the angle of the incision and if a suture was inserted or not for astigmatic correction.
4. Clean the eye with warm boiled water and cotton wool if sticky in the mornings
5. Use your drops as per instructions given on the bottles.
6. Wear dark glasses if the light hurts your eye
7. Eat plenty of fruit and vegetables to avoid constipation.

7. WHAT TO DO IF SOMETHING GOES WRONG

Your operation has gone well but:

1. Should the vision plummet
2. The eye become painful
3. You get a mucky discharge

Something is not right

**DO NOT SIT AT HOME HOPING IT WILL GET BETTER, RING IMMEDIATELY MR
MANUCHEHRI'S SECRETARY ON 07835 977069 (24/7)**

Important

**If you experience severe persistent ocular discomfort, or headache, or increasing redness of the eye after the operation, or if the sight falls dramatically after having been good at first, it is very important that you contact us straight away on
07835 977069.**

The risks of cataract surgery - what can go wrong?

Most cataract operations are straightforward, with the patient achieving good vision afterwards, but as with any surgery, complications can occur. Most complications can be dealt with effectively and cause no long-term problems, but some rare complications can be very serious. Although some patients do not wish to know anything about the things that can go wrong, others want to know about these in detail and so they are set out below.

Summary

A severe complication will occur in about 1 in 500 cataract operations. In about 1 in 1,000 operations the eye will be left with little or no sight. Following probably about 1 in 10,000 operations the patient will lose the eye. Some of the complications mean that a second operation will be necessary either to complete the cataract surgery or to treat the complication itself. There is virtually no risk to the other eye.

Specific complications (this list is not exhaustive)

- **Bruising:** of the white of the eye or the eyelids. Very common, temporary and very rarely more than a mild cosmetic problem.
- **Allergy to eye drops:** fairly common, causing an itchy and/or swollen eye until the drops are stopped. Uncomfortable but very rarely serious.
- **Post-operative pressure rise inside the eye:** common, and can usually be treated easily with eye drops or tablets without being admitted to hospital.
- **Post-operative inflammation of the eye:** common, and usually treated just with an increase in the frequency of post-operative eye drops.
- **Posterior capsular opacification (PCO):** very common, often after months or years. Occurs in probably around 1 in 4 operations to some extent. The back wall of the lens capsule is usually left in place to support the artificial lens, and in PCO it becomes cloudy and may cause blurring. If significant, PCO can be treated using a laser to make a small opening in the capsule. The laser procedure ("capsulotomy") is painless and takes just a few minutes in the clinic.
- **Posterior capsular rupture/vitreous disturbance (vitreous "loss"):** a split in the fragile back wall of the lens capsule, allowing the gel which fills the back compartment of the eye to escape. This is relatively common (about 1 in 50 cataract operations) and usually means that the length of the surgery is increased while the gel is carefully removed. Sometimes a second operation may be needed to clear the gel or to insert a special type of artificial lens, before which the sight will be very blurred. Usually the sight in the eye settles well, though sometimes it may not.
- **Zonular dehiscence:** the lens capsule is anchored in place by microscopic ligaments, the zonules, and occasionally these break ("dehisce") during surgery. The vitreous gel may be disturbed, with the same implications as posterior capsular rupture (see above).
- **Dropped nucleus:** about 1 in 500 operations. The hard central part of the cataract falls through a capsular rupture, usually meaning that cataract removal and lens implantation have to be completed with a second operation within a week or so, before which your vision will be very blurred. Other implications are as for posterior capsular rupture above.
- **Endophthalmitis:** infection inside the eye. A serious complication occurring in about 1 in 1,000 operations, usually in the first few days after surgery. Treated in most

patients with intensive antibiotic treatment, including another operation, but the response to treatment is sometimes poor and in some cases the eye is lost.

- **Retinal detachment:** peeling off of the seeing membrane lining the inside of the back of the eye, more common in short-sighted patients and after vitreous loss (see above). A serious complication eventually occurring in one in several hundred eyes after cataract surgery, though some of these would have occurred anyway. It is treated by operation, though sometimes vision is permanently reduced and very occasionally lost completely.
- **Suprachoroidal haemorrhage:** bleeding inside the eye may mean that the operation has to be stopped before finishing, and completed on another day. If the bleeding is very severe, it is possible for the sight or even the eye to be lost, though with modern surgical techniques this outcome is now extremely rare.
- **Corneal clouding (“decompensation”):** clouding of the normally clear front window of the eye. Common (up to 1 in 10 cataract operations) but usually temporary, though may require more frequent post-operative eye drops than usual if it occurs. Very occasionally the clouding fails to clear and a corneal transplant operation may then be required.
- **Unexpected refractive outcome:** despite sophisticated modern techniques to determine the correct power of artificial lens implant required, sometimes the result is more long- or short-sighted than planned. Usually this is mild and correctable by glasses. If severe, particularly if there is a large imbalance between the eyes, a lens implant exchange operation may be proposed, though contact lens wear may enable this to be avoided.
- **In younger people, loss of the ability of the eye to focus at different distances:** in everybody over the age of about 45, the ability to focus for close-up objects is gradually lost as the natural lens becomes less flexible. Reading glasses usually compensate fully. After cataract surgery, because the artificial lens implant is also rigid and cannot focus for different distances, reading glasses will also usually be required. Patients younger than about 50 therefore need to be aware that they will experience the sudden loss of active focusing and that it may take a while to adjust.
- **Surgical astigmatism:** though rare with modern small-incision surgery, occasionally the surface of the eye can be distorted by the effect of the surgical incision. This is usually correctable by glasses, contact lenses, or occasionally further surgery. Sometimes a stitch is put in during surgery to try to reduce pre-existing astigmatism.
- **Wound leak:** following about 1 in 100 operations, the surgical incision is not secure. Usually, this is suspected during the operation and a stitch is put in at the time but sometimes a further short operation may be required to stitch the wound.
- **Cystoid macular oedema:** though less common with modern surgical techniques, fluid can accumulate in the centre of the retina (the “macula”), affecting central vision. It is more common if posterior capsular rupture has occurred (see above), and in the presence of inflammation. If severe it can reduce vision significantly and be very difficult to treat.
- **Dislocation of the artificial lens:** very rare. The artificial lens may be displaced from its initial position within the eye and this may lead to reduced or double vision. If completely displaced, an operation may be needed to retrieve it and replace it with a special type of implant.
- **Droopy eyelid:** in some patients, the upper eyelid may droop following the operation. Usually this gradually corrects itself but if severe an eyelid operation can be carried out to lift the lid.

- **Double vision:** although double vision is common in the first few hours after surgery, very occasionally it persists. A further operation may be curative.

Risks of the anaesthesia

You will not be asked to sign a separate form giving permission for the anaesthesia needed for the operation. Local anaesthesia carries a very low risk of problems, though some of these have the potential to be very serious including loss of the eye and even – in exceptionally unusual circumstances – death. Things that can go wrong include allergy to the anaesthetic agent, severe bleeding behind the eye, severe damage to the eye from the needle or metal tube used for anaesthesia, and unintended passage of the anaesthetic agent into other important areas such as the fluid surrounding the brain.

Consent for Cataract Surgery

You should read and understand this information. You may also wish to go through the information with a relative or carer. You will be asked to sign a consent form on the day of the operation and there will be a chance to discuss things with Mr Manuchehri who will take your signature and who will also sign the consent form to show that he is satisfied that you understand what is involved in the surgery, including the risks. You will be able to keep these information sheets to remind you of what has been discussed.

What is a cataract?

A cataract is a clouding of part of your eye called the lens. The lens in the eye works like the lens in a camera, focusing light on the “retina”, the layer at the back of the eye corresponding to the film in a camera. Your vision becomes blurred because the cataract is like frosted glass, interfering with your sight. It is not a layer that grows over the surface of your eye.

If Mr Manuchehri has told you that you have a cataract, don't be alarmed. Many people over 60 have some cataract and the vast majority can be treated successfully.

What problems might you notice if you have a cataract?

Blurry sight: this is very common. You may notice that your sight has become blurred or misty, or that your glasses seem dirty.

Dazzle or glare: you may be dazzled by bright lights such as car headlamps and sunlight.

Change in colour vision: colours may gradually become washed-out or faded.

What causes a cataract?

Cataracts can form at any age. Most develop as people get older but we don't yet know why, although research is being done into a number of possible causes. In younger people we know that they can result from conditions such as diabetes, certain medications, trauma to the eye and related to other long standing eye problems.

What treatment is available?

The only treatment for cataract is an operation to remove the cloudy natural lens and replace it with a plastic lens. Diets or drugs, including eye drops, have not been shown to slow or stop the development of cataract.

When should I have the operation?

In the past, eye specialists often waited until the cataract became “ripe” and your vision was very poor before suggesting that you had the cataract removed. Nowadays, with modern surgery, the operation is usually done as soon as your eyesight interferes with your daily life and your ability to read, to work, or to do the things you enjoy. You will probably want to consider surgery if this is the case.

Waiting for a longer period is not likely to make the operation more difficult, unless the cataract becomes so dense that your eyesight is very poor. Cataract, even if dense, hardly ever does any harm to the rest of the eye. If you do not have the operation now, the vision is likely to worsen slowly but it is very unlikely to result in any permanent harm to the eye.

If you are a driver you must reach the visual standard required by the Drivers and Vehicle Licensing Authority (DVLA) and may need to have surgery in order to keep your licence.

What happens during the operation?

Just before the operation eye drops will be given to enlarge your pupil, blurring the vision.

Almost everyone has a local anaesthetic for the surgery, during which you will be wide awake but feel no pain in your eye. Drops to numb the eye are given. In some cases, a needle is placed in the back of your hand before the anaesthetic is given, so that drugs can be given by this route if necessary.

Some cataract operations are carried out under a general anaesthetic. If this is the case, you will be completely unconscious, as if you were sleeping deeply throughout the surgery.

Mr Manuchehri carries out the surgery with the aid of a microscope. The opening into the eye is so small that stitches are not usually necessary – if needed they cannot be seen or felt afterwards and are easily removed later in the out-patient clinic. The operation usually takes 15-20 minutes, although it can last longer. The lens containing the cataract is removed and replaced with a plastic lens, which remains in your eye permanently. The cataract is removed by a technique called phacoemulsification, in which the lens is softened with sound waves and removed through a fine tube. The operation cannot be performed by laser.

After the operation

A pad and/or a plastic shield may be taped over your eye at the end of the operation to protect it until the anaesthetic wears off.

With local anaesthetic, you will be able to eat and drink as normal straight after the surgery.

Most people notice an improvement in sight by the next day, although complete healing may take several months. You will be given eye drops to use at home, and these will usually need to be continued for a few weeks. It is a good idea to have some help at home at first, especially if you find it difficult to put your eye drops in.

You will probably go home on the day of the operation, and in most cases will be able to carry on with normal daily activities, but it is important to remember the following: avoid rubbing your eye, don't do any heavy lifting, strenuous exercise or swimming for about four weeks.

We recommend your use the eye shield in bed for the first week at least.

If you have discomfort, you should take your usual dose of a pain reliever such as paracetamol every 4-6 hours. It is normal to feel itching, sticky eyelids and mild discomfort.

Some watery and mildly bloodstained discharge is common. After a few days even mild discomfort usually disappears, though occasionally grittiness may persist for a few weeks.

You will be seen in consultation the next day after the operation and again two weeks later. During this consultation Mr Manuchehri will advise you when to see your optician for new glasses, and when you can go back to work, drive and return to any other activities.

It is important to realise that most people will still need glasses after cataract surgery, usually at least for reading. Most patients prefer to have clear distance vision without glasses, with glasses still needed to see close up. Sometimes a patient may prefer to be able to read without glasses and to keep glasses for distance vision, particularly if he or she was short-sighted before the cataract surgery. In many patients, glasses may still be needed for both distance and near, particularly if crisp vision is required, for example when driving. The "astigmatism" element of a spectacle prescription is not corrected in most cataract operations and glasses may still be needed for good vision at both distance and near if this is significant.