Pulsed electron avalanche knife: new technology for cataract surgery

Siegfried G Priglinger, Daniel Palanker, Claudia S Alge, Thomas C Kreutzer, Christos Haritoglou, Martin Grueterich, Anselm Kampik

Background: The pulsed electron avalanche knife (PEAK-fc) is a new pulsed electrosurgical device that allows for precise, ‘‘cold’’ and traction-free tissue dissection.

Aim: To evaluate the surgical applicability, safety and potential complications of PEAK-fc in complicated cataract surgery.

Methods: The study included five children with congenital cataracts, two patients with advanced senile cataracts, six adults with mature cataracts, three of them with posterior iris synechiae, three patients with post-traumatic cataracts with zonulolysis, one patient with intumescent traumatic cataract and three patients with massive anterior capsule opacification. Anterior and posterior capsulotomies, iris synechialysis, dissection of anterior capsule opacification and fibrotic scar tissue were performed. PEAK-fc was set at voltages of 500–700 V, pulse duration of 0.1 μs and repetition rate of 40–100 Hz.

Results: Anterior and posterior capsulotomies were successfully and safely performed in all eyes. The edges of capsulotomies appeared sharp, showing only limited collateral damage. PEAK-fc worked best by just gently touching the capsule, thereby avoiding tractional forces or pressure on the lens capsule. Posterior iris synechiae could be released and anterior capsule opacification was dissected without complications.

Conclusions: PEAK-fc is a very helpful cutting device for complicated cases of cataract surgery, especially for mature and congenital cataracts, traumatic zonulolysis or anterior segment complications after intraocular inflammation.

MATERIALS AND METHODS

PEAK-fc—second version

In contrast to the first version of PEAK, which was operating with sub-microsecond pulses of 3–6 kV,1,2 the advanced PEAK-fc (fig 1) operates at much lower voltages (300–700 V) and utilises much longer pulses of about 100 μs, consisting of a burst of several tens of biphasic (alternating current) ‘‘mini-pulses’’, each of which is 1–2 μs in duration (corresponding to mini-pulse frequencies of up to 300 kHz). The cutting part of the PEAK-fc probe is a protruding tungsten wire with a diameter of 50 μm, extending from the glass insulator by 0.6 mm (fig 1). In addition to “cold” cutting, a coagulation mode has been integrated.

In the present study, PEAK-fc parameters were set as follows: pulse repetition rate 40–100 Hz, pulse duration 100 μs and number of “mini-pulses” per pulse 60. Amplitude of the biphasic voltage was varied within a range of 500–700 V, corresponding to pulse energies of 6–10 mJ. With a pulse repetition rate of 100 Hz, it corresponds to an average power of 60–100 mW. The average power during coagulation was 2–3 W. Table 1 shows the specific parameters selected for the individual manoeuvres.

Abbreviations: CCC, continuous curvilinear capsulorhexis; PEAK-fc, pulsed electron avalanche knife.
with massive fibrosis covering the iris, pupil and nearly the whole trabecular meshwork.

All patients underwent complete ophthalmological examinations including visual acuity testing (Snellen), slit-lamp examination, intraocular pressure measurement and fundus biomicroscopy during the follow-up examinations at day 3, 4 weeks, 10 weeks, 3 and 6 months postoperatively. To rule out potential adverse effects, corneal endothelial cell counts were performed.

Congenital cataracts were extracted by microincisional lens aspiration using the Megatron S3 viper (Geuder, Heidelberg, Germany) in general anaesthesia. The anterior chamber was expanded with a viscoelastic substance (Healon, AMO, Santa Ana, California, USA). For anterior capsulotomy, the PEAK-fc probe was then slowly moved along the capsule in a circular manner (6.0 mm in diameter), with a velocity of approximately 1 mm/s, and just gently touching the capsule, thereby avoiding tractional forces and pressure on the lens capsule. After lens aspiration and injection of viscoelastic material, one of the clear cornea incisions was enlarged to 2.0 mm and the intraocular lens (AcriSmart, AcriTec, Berlin, Germany) was inserted.

For senile and mature cataracts, cataracts with zonulolysis and intumescent traumatic cataract, anterior capsulotomy with PEAK-fc was performed as described above. However, cataract surgery differed with respect to the access and phaco technique: a superior clear or sclerocorneal incision was created. Cataract extraction was performed using the divide and conquer technique. Trypan blue (vision blue, DORC, Zuiddalik, Netherlands) was used to enhance visualisation of the anterior lens capsule in mature cataracts.

Three patients, two of them with long-lasting uveitis and the remaining one with a history of trauma, besides advanced cataract formation, were having massive posterior iris synechiae. Superior sclerocorneal incision was performed with a diamond blade and 2.75 mm steel keratome (Alcon, Fort Worth Texas, USA), and the anterior chamber expanded with a viscoelastic substance (Healon, AMO, Santa Ana, California, USA). As iris synechiae in these cases were too tight to be loosened by a conventional “Binkhorst” iris spatula (Geuder, Heidelberg Germany) or high-frequency capsulotomy, PEAK-fc was applied. The PEAK-fc parameters were slowly increased until the desired cutting effect was observed, thereby allowing the probe to be gently moved underneath the iris.

Excision of anterior capsule opacification was performed after formation of two opposite stab incisions at the limbus and expansion of the anterior chamber with a viscoelastic substance (Healon, AMO). The PEAK-fc probe was then slowly moved along the anterior capsule in a circular manner (7.0 mm in diameter) with a velocity of approximately 1 mm/s, just gently touching the capsule without induction of tractional forces.

Excision of massive fibrotic scar tissue on the iris and in the pupil was performed after formation of two opposite stab incisions at the limbus and padding the anterior chamber with a viscoelastic substance (Healon). After excision of the fibrotic membrane in the pupil, tightly attached scar tissue covering the whole iris was carefully separated by accurate dissection of the extensive posterior iris synechiae.

### Table 1: Pulsed electron avalanche knife parameters for each manoeuvre performed

<table>
<thead>
<tr>
<th>Manoeuvre</th>
<th>Voltage [V]</th>
<th>Repetition rate [Hz]</th>
<th>Minipulses/pulse</th>
<th>Pulse duration [μs]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior and posterior capsulotomy</td>
<td>600</td>
<td>60–100</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Synechialysis</td>
<td>300</td>
<td>40–60</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Dissection of anterior capsule phimosis/scar tissue</td>
<td>700</td>
<td>80–100</td>
<td>60</td>
<td>100</td>
</tr>
</tbody>
</table>
All manoeuvres were recorded on videotape, permitting documentation of the efficacy and possible complications.

**RESULTS**

A total of 20 consecutive patients were treated with PEAK-fc. In each manoeuvre, PEAK-fc was initially set at the values that had been determined in animal and in vitro studies as safe and efficient for dissection with only minimal collateral damage. Parameters were increased until the desirable tissue effect was observed. Typical effective settings used for the respective manoeuvre are referred to in table 1.

Anterior capsulotomy was performed successfully in 15 eyes of 15 patients (fig 2). These included patients having congenital cataract (n = 5), mature cataract (n = 6) or post-traumatic cataract (n = 4). In two patients with congenital cataract, a posterior capsulotomy and anterior vitrectomy were additionally performed.

In comparison to dissection of retinal tissue, a higher voltage level and increased repetition rate (600 V, repetition rate 60–100 Hz) were used, resulting in most effective cutting. Successful performance of capsulotomy required a slow movement of the probe along the capsule in a circular manner with a velocity of approximately 1 mm/s. The lens capsule was just gently touched, thereby avoiding tractional forces and pressure on the capsule. PEAK-fc cuts showed sharp edges with hardly visible whitening, indicating very little collateral damage.

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Eye</th>
<th>Diagnosis</th>
<th>Operation</th>
<th>PEAK maneuver</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.5</td>
<td>F</td>
<td>R</td>
<td>Congenital cataract</td>
<td>MICS, IOL</td>
<td>Anterior and posterior capsulorhexis</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>F</td>
<td>R</td>
<td>Congenital cataract</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>F</td>
<td>L</td>
<td>Congenital cataract</td>
<td>MICS, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>M</td>
<td>R</td>
<td>Congenital cataract</td>
<td>MICS, IOL</td>
<td>Anterior and posterior capsulorhexis</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>M</td>
<td>L</td>
<td>Congenital cataract</td>
<td>MICS, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>6</td>
<td>75</td>
<td>M</td>
<td>L</td>
<td>Hypermature cataract</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>7</td>
<td>61</td>
<td>M</td>
<td>R</td>
<td>Hypermature cataract</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>8</td>
<td>78</td>
<td>M</td>
<td>L</td>
<td>Hypermature cataract</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>9</td>
<td>81</td>
<td>F</td>
<td>L</td>
<td>Hypermature cataract, posterior iris synechiae</td>
<td>Synecchiolysis, Phaco, IOL</td>
<td>Synecchiolysis, anterior capsulorhexis</td>
</tr>
<tr>
<td>10</td>
<td>75</td>
<td>F</td>
<td>R</td>
<td>Mature cataract, posterior iris synechiae (uveitis)</td>
<td>Synecchiolysis, Phaco, IOL</td>
<td>Synecchiolysis, anterior capsulorhexis</td>
</tr>
<tr>
<td>11</td>
<td>18</td>
<td>F</td>
<td>R</td>
<td>Mature cataract, posterior iris synechiae (uveitis)</td>
<td>Synecchiolysis, Phaco</td>
<td>Synecchiolysis, anterior capsulorhexis</td>
</tr>
<tr>
<td>12</td>
<td>29</td>
<td>M</td>
<td>R</td>
<td>Traumatic cataract, lentodonesis</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>13</td>
<td>62</td>
<td>F</td>
<td>L</td>
<td>Traumatic cataract, lentodonesis</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>14</td>
<td>54</td>
<td>M</td>
<td>L</td>
<td>Traumatic intumescent cataract, lentodonesis</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>15</td>
<td>34</td>
<td>F</td>
<td>R</td>
<td>Traumatic intumescent cataract</td>
<td>Phaco, IOL</td>
<td>Anterior capsulorhexis</td>
</tr>
<tr>
<td>16</td>
<td>75</td>
<td>F</td>
<td>L</td>
<td>Anterior capsular phimosis</td>
<td>See procedure</td>
<td>Dissection of anterior capsule phimosis</td>
</tr>
<tr>
<td>17</td>
<td>66</td>
<td>M</td>
<td>L</td>
<td>Anterior capsular phimosis</td>
<td>See procedure</td>
<td>Dissection of anterior capsule phimosis</td>
</tr>
<tr>
<td>18</td>
<td>55</td>
<td>F</td>
<td>R</td>
<td>Massive anterior chamber fibrosis</td>
<td>See procedure</td>
<td>Dissection of scar tissue</td>
</tr>
<tr>
<td>19</td>
<td>70</td>
<td>M</td>
<td>L</td>
<td>Advanced senile cataract</td>
<td>Phaco, IOL</td>
<td>Completion of circular capsulorhexis after removal of synechiae</td>
</tr>
<tr>
<td>20</td>
<td>75</td>
<td>M</td>
<td>R</td>
<td>Advanced senile cataract</td>
<td>Phaco, IOL</td>
<td>Radial rip due to conventional CCC</td>
</tr>
</tbody>
</table>

CCC, continuous curvilinear capsulorrhexis; F, female; IOL, intraocular lens; L, left, M, male; MICS, microincision cataract surgery; PEAK, pulsed electron avalanche knife; R, right.

Figure 2 Capsulotomy. (A) Patient 12 presenting with traumatic cataract and phacodonesis. Anterior capsulotomy with a pulsed electron avalanche knife (PEAK-fc) at a voltage level of 500 V and with a repetition rate of 100 Hz was performed. Slow probe movement along the surface capsule with a velocity of approximately 1 mm/s was required for tractionless dissection of the anterior capsule. (B) Capsulotomy performed with PEAK-fc reveals very sharp edges. Hardly visible whitening (indicated by arrows) indicates very little collateral damage.
Figure 3  Synechiolysis, capsulotomy. (A) Patient 9 with chronic uveitis for many years. He presented with mature cataract and posterior iris synechiae. Dissection of the synechiae with conventional instruments was not successful. (B) Pulsed electron avalanche knife (PEAK-fc) allowed for selective tissue dissection without affecting adjacent tissues such as lens capsules or iris vessels. (C) After separation of the iris with PEAK-fc, the anterior chamber was again padded with viscoelastic material. Massive iris pigment deposition made a conventional continuous curvilinear capsulorhexis impossible. (D) Capsulotomy performed with PEAK-fc using a voltage level of 500 V and a repetition rate of 100 Hz. (E) Note the sharp edges of the lens capsulotomy. Because of potential inflammatory response, primary implantation of an intraocular lens was resigned.

Figure 4  Anterior capsule phimosis. (A) Patient 16 presenting with distinct anterior capsule opacification. (B) Pulsed electron avalanche knife (PEAK-fc) offers a safe and easy way to remove even tightly attached tissue on intraocular lens (IOL) surface. The anterior capsule opacification has been circularly excised without any damage to the intraocular structure or IOL material. (C) Appearance after removal of the dissected tissue. Arrows indicate the edge of the cut.
In this study, we report the initial clinical experience with the new “cold-cutting” device PEAK-fc for manoeuvres in cataract and advanced anterior segment surgery. PEAK-fc was successfully used for capsulotomies in congenital cataracts, mature and intumescent cataracts, and post-traumatic cataracts with zonulolysis, for separation of massive posterior iris synchiae and dissection of anterior capsule opacification.

In cases of mature cataract, post-traumatic cataract, pseudoexfoliation with weak zonules and in congenital cataract, the risk of peripheral extension of the continuous curvilinear capsulorhexis is markedly increased. In contrast with CCC, which usually exerts a certain degree of traction on the capsule, thus increasing the risk of peripheral extension of the cut, PEAK-fc dissects tissue without any traction, thus preventing unintended tears. Our case series demonstrated that PEAK-fc, in a safe and rapid manner, allows surgeons to perform traction-free and controlled capsulotomies, even in cases of massive pigment deposition on the lens capsule. Cuts with PEAK-fc showed almost no thermal damage at the edges of the tissue.

A major advantage of PEAK-fc is the short learning curve. Except for one surgeon (SGP), who had carried out prior animal studies and vitreoretinal studies in humans, none of the other surgeons participating in the present case series was experienced with PEAK-fc technology. Before surgery of complicated anterior segment cases, surgeons were instructed
orally and by a video demonstration. This confirms that PEAK-fc indeed increases the safety of surgery in the specific manoeuvres described without the need of practice on cadaver or animal eyes.

Other devices for anterior capsulotomy, such as ERBE- DIACAPSUTOM high-frequency capsulotomy,13–16 and the recently introduced Fugo Blade, have been associated with a higher risk for capsule tears and intraoperative and postoperative complications than CCC.17–20 Vitrectorhexis,21 another procedure for anterior capsulotomy, preferentially used in paediatric cataract surgery, showed radial tears in 7.7% of cases.16 Additionally, in contrast to PEAK-fc, vitrectorhexis requires a long learning curve. This is a major advantage of PEAK-fc, as only a few cases of paediatric cataract surgery are usually performed by one surgeon during a year.

PEAK-fc allowed for excision of anterior capsule phimosis and dissection of iris synchiae, while damage of lens capsules and iris vessels was avoided and the risk of bleeding minimised. However, even if intraoperative bleeding occurred, it could immediately be stopped using PEAK-fc’s coagulation mode without having to remove the instrument, as required during conventional surgery. As opposed to PEAK-fc, all conventional techniques available for separation of posterior iris synchiae have an increased risk of complications such as capsule damage and uncontrolled bleeding in the iris vessels.

One side effect of PEAK-fc is the formation of gas bubbles, potentially impairing the surgeon’s view of the operating field. The amount of gas bubbles generated by PEAK-fc can be compared with the gas development in conventional intracocular diathermy. However, in the present study, in none of the performed procedures did the development of gas impair vision to such a degree as to make surgery unsafe or impossible.

In summary, PEAK-fc was successfully used for a variety of surgical manoeuvres commonly encountered in patients undergoing complicated anterior segment surgery. PEAK-fc allowed for surgical cutting in a very precise manner, resulting in reproducible and reliable dissection, with induction of only minimal collateral damage at the edges of the cut.

ACKNOWLEDGEMENTS
We thank Harald Kroehn for expert technical assistance.

Authors’ affiliations
Siegfried G Priglinger, Claudia S Alge, Thomas C Kreutzer, Christos Haritoglou, Martin Grueterich, Anselm Kampik, Department of Ophthalmology, Ludwig-Maximilians-University, Munich, Germany
Daniel Palanker, Department of Ophthalmology and Hansen Experimental Physics Laboratory, Stanford University, Stanford, California, USA

Funding: Part of this project (Stanford University) was provided by the NIH R01 EY01288 grant, and by the Whitaker Foundation grant RG-03-0042.

Competing interests: DP has patent-related financial interest in PEAK.

Part of this work has been presented at the ESCRs 2005 and at ARVO 2006.

REFERENCES

www.bjophthalmol.com
Pulsed electron avalanche knife: new technology for cataract surgery

Siegfried G Priglinger, Daniel Palanker, Claudia S Alge, Thomas C Kreutzer, Christos Haritoglou, Martin Grueterich and Anselm Kampik

doi: 10.1136/bjo.2006.109546

Updated information and services can be found at:
http://bjo.bmj.com/content/91/7/949

These include:

**References**
This article cites 17 articles, 1 of which you can access for free at:
http://bjo.bmj.com/content/91/7/949#BIBL

**Email alerting service**
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Topic Collections**
Articles on similar topics can be found in the following collections

- Lens and zonules (807)
- Paediatrics (358)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/