Learning surgical skills for eye care

Advances in training methods and technology allow surgical teams to engage in sustained and deliberate practice, initially safely away from patients.

Surgery plays a vital role in global eye care by addressing a wide range of eye conditions, from cataract to more complex eye diseases and injuries.

Our aim with this issue is to support the training and development of eye surgeons and surgical team members by sharing innovative, impactful, and proven ways to learn, practice, and teach surgical and technical skills.

Surgery used to be learnt only on patients, in accordance with the traditional approach of “see one, do one, teach one.” Advances in surgical simulation and the development of surgical competency rubrics have made it possible for surgeons to learn and practice in a systematic way, before operating on patients.

Competency assessment rubrics, such as the Ophthalmology Surgical Competency Assessment Rubrics (OSCARs), divide surgical procedures into individual steps, each with four clearly defined grades: Novice, Beginner, Advanced Beginner, and Competent. Ophthalmic simulated surgical competency assessment rubrics (Sim-OSSCARs) have...
Surgery plays a vital role in global eye care by addressing a wide range of eye conditions, from cataract to more complex eye diseases and injuries. The aim of this issue is to support the training and development of eye surgeons and surgical teams, by sharing proven ways to learn, practice, and teach surgical and technical skills, including the use of competency assessment rubrics and simulation training. We also provide tips and guidance for scrub nurses/technicians. By practising together, in a simulated surgical set-up, teams can develop the communication and manual skills needed to improve surgical outcomes and protect patients.

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The surgical team

In this issue, we also provide tips and guidance for scrub nurses/technicians. By practising together in a simulated surgical set-up, nurses and surgeons can develop the communication and manual skills needed to improve surgical outcomes and protect patients – which includes practising the World Health Organization Safe Surgery check-in and check-out procedures.

All of this is not to say that the old adage of “see one, do one, teach one” has no value – far from it. Once surgeons and their teams have made the most of simulated training opportunities, they will gain vital – and essential – experience by observing experienced colleagues and practising under their supervision, provided that the patients they operate on have been carefully selected to ensure that the operation is both safe for the patient, and a valuable learning opportunity for the surgeon and the surgical team.

References

2. www.ophthalmologyfoundation.org/education/resources/ioscars
Assisting during microsurgery: important first steps

Scrub nurses or technicians can prepare for their role by learning about instruments and instrument trays, learning the steps of procedures, and reviewing surgical procedures with the surgeons they will assist.

When it comes to assisting during microsurgery, there is much you can learn and practise before you enter the operating theatre.

1. Learn about surgical instruments and trays

The first step in learning to assist during microsurgery is to learn the names of the instruments and to become familiar with the different types of instrument trays.

A good place to start is in the sterilisation area, where instruments are reprocessed and packed for sterilisation in preparation for surgery. While you are in the sterilisation area:

- Use an ophthalmic instrument catalogue to identify the different instruments
- Use a magnifying glass to look at the fine tips of hooks or lens manipulators.

Each type of surgery or ophthalmic subspecialty (e.g. cataract, squint, cornea, oculoplastic) has a different instrument tray, containing the instruments the surgeon will need. Instruments on each of these trays are categorised into:

- Forceps and clamps (forceps can be toothed, smooth, serrated, or micro-notched; straight, curved, or angled)
- Scissors (sharp or blunt tips; straight, curved, or angled)
- Needle holders (locking or non-locking; straight or curved)
- Hooks, lens manipulators, retractors, and loops
- Cannulated instruments, e.g., Simcoe and anterior chamber cannulas
- Blade handles
- Speculums, calipers, or rulers.

Ask a senior colleague to show you what each instrument tray should look like. Take a photograph or draw the tray, then label each instrument. Ask your colleague to check everything is correct and in place.

Teaching tip
Create a photograph or drawing of each type of instrument tray and label each instrument with its name. Allow the trainee nurse or technician to arrange the trays accordingly, in preparation for sterilisation (Figure 1).

Note
Ophthalmic microsurgical instruments are very delicate and have fine tips that need to be handled with great care.

Figure 1 A nurse practices arranging microsurgical instruments on a tray before sterilisation. PERU

Figure 2 Nurses watch an operation being performed and note down the surgical steps, in order. PERU
2. Learn the steps of procedures
An excellent and safe way of preparing for a procedure is to learn the surgical steps and practise for them through simulation.

- Watch a video recording of the operation to be performed, or observe a live operation (Figure 2). Write down each surgical step and the instruments and supplies used. You can make a checklist, in table form (see Table 1).
- Next, arrange the surgical instruments on a simulated/mock ‘sterile field’ in the same order as the surgical steps (Figure 3).
- If you have a smartphone, take a photo of the setup to remind yourself of the sequence of steps.

3. Review procedures with the surgeon
A scrub nurse or technician may work with a different surgeon every day. It is helpful to set aside time to review the basic steps of the next day’s surgical procedures with the surgeon, as this will help you to anticipate their needs more effectively.

I found it helpful to create a checklist, in table form, for the most common operations I’m likely to be involved in (Table 1), listing the surgical step, the type of consumable the surgeon may use, and the type of surgical instrument the surgeon may use.

Reviewing these steps with the surgeon may feel daunting at first, but you will become more confident the more you do it. When surgeons see that you are interested in being prepared, they will usually be happy to share this information, as it supports collaboration between surgeon and nurse, which can lead to better outcomes for patients.

Table 1 A checklist summarising the steps of small-incision cataract surgery and the supplies and instruments needed.

<table>
<thead>
<tr>
<th>Description of the step</th>
<th>Consumables/supplies</th>
<th>Surgical instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placing speculum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Place bridal/stay suture</td>
<td>Suture:</td>
<td>Superior rectus forceps</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Needle holder</td>
</tr>
<tr>
<td>Dissect conjunctiva</td>
<td></td>
<td>Clamp</td>
</tr>
<tr>
<td>Cautery to blood vessels</td>
<td>Eraser tip:</td>
<td>Cautery cable/cautery forceps</td>
</tr>
<tr>
<td>First scleral incision</td>
<td>Blade:</td>
<td>Fine-toothed forceps</td>
</tr>
<tr>
<td>Sceral tunnel</td>
<td>Blade:</td>
<td>Fine-toothed forceps</td>
</tr>
<tr>
<td>Paracentesis</td>
<td>Blade:</td>
<td>Fine-toothed forceps</td>
</tr>
<tr>
<td>Stain the anterior capsule</td>
<td>Vision blue/air bubble</td>
<td>Fine-toothed forceps</td>
</tr>
<tr>
<td>Flush with BSS</td>
<td>2cc syringe &amp; 27G cannula</td>
<td>Fine-toothed forceps</td>
</tr>
<tr>
<td>Viscoelastic injection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main sclerocorneal incision</td>
<td>Blade:</td>
<td>Fine-toothed forceps</td>
</tr>
<tr>
<td>Capsulotomy</td>
<td>Cystotome</td>
<td>Capsulorhexis forceps</td>
</tr>
<tr>
<td>Placement of AC maintainer</td>
<td>AC maintainer</td>
<td></td>
</tr>
<tr>
<td>Hydroticsection</td>
<td>2cc syringe</td>
<td>27G hydroticsection cannula</td>
</tr>
<tr>
<td>Enlarge main incision</td>
<td>Blade:</td>
<td>27G hydroticsection cannula</td>
</tr>
<tr>
<td>Remove nucleus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cortex removal</td>
<td>Simcoe and IV tubing</td>
<td>5 or 10cc syringe</td>
</tr>
<tr>
<td>Viscoelastic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insertion of IOL</td>
<td>IOL:</td>
<td>McPherson forceps</td>
</tr>
<tr>
<td>Dial the IOL in place</td>
<td></td>
<td>Holding &amp; folding forceps</td>
</tr>
<tr>
<td>Remove viscoelastic</td>
<td>Simcoe and IV tubing</td>
<td>Sinsky hook</td>
</tr>
<tr>
<td>Hydrate wounds (BSS)</td>
<td>2cc syringe &amp; 27G cannula</td>
<td></td>
</tr>
<tr>
<td>Check wounds for leakage</td>
<td>Microspunge</td>
<td></td>
</tr>
<tr>
<td>Close conjunctiva</td>
<td>Suture:</td>
<td>Cautery cable/cautery forceps</td>
</tr>
<tr>
<td>Subconjunctival injection</td>
<td>1cc syringe &amp; 30G needle</td>
<td></td>
</tr>
<tr>
<td>Remove bridal/stay suture</td>
<td></td>
<td>Scissors</td>
</tr>
<tr>
<td>Eyedrops/ointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye pad/eye shield</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Expert tip
I found it helpful to create basic checklists, in table form, for the most common operations I’m likely to be involved in. Table 1 shows an example of the table I created for small-incision cataract surgery (SICS). There is space to write note about the surgeon’s preferences, such as the type of blade or suture they plan to use.
Assisting during microsurgery: tips for success

Knowing how to handle instruments and sharps safely, and pass them correctly during surgery, are some of the key skills scrub nurses/technicians must learn.

Simulation training is very helpful in practicing to pass instruments safely. Nurses can take turns to role play as the surgeon and scrub nurse/technician, and can experience what it is like for the surgeon to perform surgery while looking through the microscope or using magnifying loupes. These tips are equally useful for simulation training and surgical procedures.

Handling sharps safely

1. Hand over sharp instruments to the surgeon with the sharp end facing away from them (Figure 1). The surgeon may reach out their hand towards the sterile field and injure themselves if the sharp end is facing towards them.

2. When loading and removing blades from the Bard Parker blade handle, use a clamp (not your fingers), with the point of the blade facing in a downward position, away from yourself (Figure 4).

3. Never recap a needle. If you need to reuse a syringe, remove the needle from the syringe and replace it with a new needle. Remember: cystotome needles are also considered a sharp.

4. Be aware that a phacoemulsification tip/needle is sharp and should be covered by the plastic test chamber when not in use. It must be removed from the phacoemulsification handpiece before sending it for reprocessing.

Before you start

- Ensure the surgeon is comfortable. Before surgeons begin their pre-surgical handwash and don a sterile gown and gloves, ask them to check the position of the operating microscope in relation to the operating room table and surgical chair being used, and to check the position of the foot switches to ensure they are comfortable.

- Ensure the patient is comfortable. A comfortable patient is better able to cooperate during eye surgery. To keep patients comfortable during cataract surgery (if the eye drape doesn’t have a fluid collecting bag), place a gauze swab at the side of the head to absorb fluid and prevent it from running into the patient’s ear.

- Find out whether the surgeon is right- or left-handed. This will determine how you load sutures and pass instruments.

- Agree how the surgeon will pass sharps back to the scrub nurse/technician after use. The surgeon can say, “Sharp back” and place the used sharp in a receiver provided by the scrub nurse/technician (Figure 2), or place the sharp on the sterile field in an area designated only for sharps, known as the ‘neutral zone’ (Figure 3).

Passing instruments

1. When assisting the surgeon, it is good practice for the scrub nurse or technician to position themselves diagonally across from the surgeon, allowing them to pass instruments safely and comfortably (Figure 5).

2. All surgical instruments have a section on the instrument handle where the surgeon’s fingers will hold or grasp the instrument (Figure 6). When passing an instrument to the surgeon, the scrub nurse/tech must ensure that their fingers do not obscure.
When loading a
suture, ensure
you use the tip of the
needle holder to grip
the needle. Avoid
loading the suture
close to the sharp point
or swage (the connection
point of the suture
and the needle). See

If a suture is missing at the
time of the WHO Safe Surgery
Sign Out (see panel), the surgeon
must inspect the wound,
confirm that the suture needle
is not in the wound,
and sign the intraoperative
notes.

There are different methods
for loading intraocular lenses,
depending on the brand
and packaging. Before
loading the lens,
flush the optic with
balanced salt solution (BSS)
and fill the cartridge with
viscoelastic. Avoid using
fingertips to
touch the intraocular lens.

Always have gauze,
micro sponges
and/or cotton tips
readily available,
and in reach of
the surgeon,
for soaking up
blood or fluids from
the wound.

All cannulated instruments
and cannulas should be
primed before use
to prevent air
bubbles entering the eye.
When priming cannulas,
hold your hand
or a gauze
swab around the
tip of the cannula
to prevent the solution from
being sprayed into the eye
or into the eyes of
a surgical team
member. Using Luer lock
syringes will prevent
 cannulas and
needles from
shooting off
the syringe
under pressure.

Use sterile water
to rinse or wipe
instruments
during surgery
and as soon as the
surgeon returns
the instrument
to the neutral zone
or container.
Do not use saline
or balanced salt
solution (BSS) to
rinse instruments,
as this is harmful
to the instruments.

At the end of the
procedure, flush cannulated
instruments with sterile
water on the surgical field
before sending them for
reprocessing.

Remove any damaged
instruments
and set them
aside in
designated areas.
This will avoid
the frustration
of a damaged
instrument being
reprocessed and ending
up back in the instrument
tray for another operation.

The surgical team must stop
and check the following
before starting the operation:

- The type of implant, if applicable (if an intraocular lens is
planned, confirm the specific power of the lens, whether it is
in the operating theatre, and whether a spare is available)
- The specific equipment needed
- Whether the instruments are sterile
- An initial count of the number of surgical
instruments and consumables on the surgical field, including:
suture needles, sharps (blades, hypodermic needles),
retractors, pledgets (used in glaucoma surgery),
trocars and scleral plugs (used in retinal surgery),
and sponges or gauze
(used in oculoplastic surgery)
- Any anticipated issues or concerns
that may arise
during surgery, and
what equipment,
insstruments and
consumables
must be available
on standby
- Has the surgeon
notified the surgical
team of any
non-routine steps?
After surgery, a final
count of all the surgical
instruments
and consumables
needs to be done
for the
‘Sign Out’ section of
the WHO Safe Site
Surgery Checklist.
The count needs
to be confirmed
with the surgical
team and any
discrepancies
must be
documented
in the
intraoperative
notes.
Basic microsurgical skills: suturing

Operating under magnification is a challenging but vital skill that all ophthalmologists must develop.

From repairing an open globe, to suturing a rectus muscle, or closing a trabeculectomy flap, basic suturing using a microscope (or loupes) is an essential skill.

The tools of microsurgery

Since ocular tissues are so delicate, it is important to use instruments safely and to select the correct instrument for each task (Figure 1). For example, toothed forceps are designed for grasping tissue, while non-toothed forceps have a tying platform that enables the surgeon to grip suture material.

Instruments are usually held as a pen would be (Figure 2). Fine movements are made using the fingers and wrist, with the hand resting to stabilise the motion.

Sutures vary by needle type and suture material. Choice of suture depends on the type of tissue, strength and duration of wound support required. There are absorbable and non-absorbable sutures, which may be monofilament or multifilament (braided). Common sutures include:

- Vicryl (polyglactin), an absorbable suture which provides tissue support for 21 days, but induces inflammation as it is absorbed by hydrolysis reaction
- Ethilon (nylon), a non-absorbable suture, which would need removal if no longer required to support wound healing
- Prolene (polypropylene), also a non-absorbable suture.

It is generally best to use the thinnest suture suitable to accomplish the task. For example, 10-0 is preferable for corneal suturing, 8-0 for conjunctival suturing, and 6-0 for skin or tarsal plate suturing and reattaching rectus muscles.

The type of suturing needle can vary as follows:

- By cross-section of the needle, which affects the cutting planes of the needle
- By curvature arc of the needle, with the 3/8 circle needle being most commonly used.

Corneal gluing

Occasionally, corneal gluing may be used as an alternative to suturing. However, avoid gluing if watertight closure cannot be achieved — suturing will be needed instead.

Use a cyanoacrylate or fibrin glue.

Corneal suturing

Corneal suturing is a core microsurgical skill. In low- and middle-income countries, it is usually one of first types of microsurgical suturing skills many trainees will learn.

Corneal suturing is needed to repair traumatic corneal lacerations and, on occasion, cataract surgery incisions.

A 10/0 nylon suture is usually used for corneal suturing. The suture needle must be handled with care, as grasping the tip will blunt the needle, and grasping the swage may cause the suture material to detach from the needle. Further detail on the anatomy of the suture and handling the needle safely can be found in the article on passing sutures, in this issue.

Interrupted sutures are the first type a trainee surgeon is likely to learn. The 3-1-1 technique described in Figure 3 produces a firm knot that is small enough to be buried by rotating the knot into the corneal tissue. This is more comfortable for the patient, and less likely to form a focus for infection. Note: when making more than one interrupted suture, ensure they are equally spaced and of equal length.

The images used to illustrate these steps were adapted from the video ‘Repair of a corneal laceration’ on simulatemedical.com, and show a surgeon practising interrupted corneal suturing on an artificial eye.
Each of these steps can be perfected in a simulated environment, prior to operating on a patient. Operating microscopes or portable training microscopes may be used to practise corneal suturing (Figure 4). Model eyes are available to practise these skills, but foam (even that used in the suture packaging) can also be a good medium to simulate corneal tissue. If a microscope is not available, the same suturing techniques can be practised on a larger scale using 7-0 sutures and the naked eye.

Eyelid laceration repair can be performed without use of a microscope. Silicone suturing pads or fruit (such as banana...
peel) may be used to replicate eyelid tissue. The use of animal models has also been validated, for example Pfaff’s use of a split pig head model to teach eyelid margin repair. Guidance for practicing eyelid closure using simulation is also available on: http://oculoplastics.info/video/thebasics/eyelid-margin-closure/

Feedback
Simulation practice can be enhanced by peer or supervisor feedback, in addition to self-reflection using assessment rubrics. A useful tool called the Ophthalmic Simulated Surgical Competency Assessment Rubric (OSSCAR) has been created to assess various ophthalmic procedures, including corneal laceration repair. By comparing their attempt to the assessment rubric, the trainee surgeon can identify areas for improvement. This may be augmented by video recording their practice sessions.

Beginning with simple linear corneal lacerations, the complexity of surgical techniques can be increased by creating irregular, shelved or stellate lacerations and by practising both right- and left-handed. Once interrupted sutures are mastered, trainees may progress to butterfly, purse-string or continuous sutures.

Useful videos

These videos all demonstrate a good technique for corneal suturing.

Corneal suturing, by Derek Ho
How to suture a corneal laceration, demonstrating 3-1-1 and slipknot techniques, on a model eye. https://bit.ly/Corneal_Ho

How to suture a phaco incision, by Cataract Coach.com

Keys to Corneal Suturing, by Christopher J Rapuano

References

CATARACT: MSICS

Developing the skills needed for successful manual small-incision cataract surgery

Simulation training, preparation, and repeated practice of cataract surgical techniques will help you to become a confident and competent cataract surgeon.

Trainees practice cataract surgical skills on a goat’s eye in the wet lab. INDIA

Cataract simulation training is a valuable part of the journey towards surgical competence. In this article, we suggest ways to:

• Prepare for hands-on surgical training
• Use simulation to learn and practice manual small-incision cataract surgery (MSICS)
• Select patients for your first 50–100 cataract operations.

We also share some tips and clinical pearls to improve your MSICS technique.

How to prepare for hands-on surgical training

• To ensure you are familiar with the anatomy of the eye and the steps of the procedure, study the wealth of material available in previous issues of this journal (www.cehjournal.org), online videos, and manuals of cataract surgery, and on websites such as Cybersight (www.cybersight.org).
• To develop an understanding of the tools of cataract surgery, practice safe handling of the equipment and surgical instruments, including the microscope.
• To better understand the mechanics of cataract surgery, observe senior surgeons performing cataract surgery. Pay attention to the different approaches and surgical techniques. Understanding the surgical process and how the surgical team works, will ensure both quality outcomes and patient safety.
• Participate in patient care to whatever degree your training allows; this will help you to develop a professional attitude towards patients and other eye care providers.

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Learn manual small-incision cataract surgery (MSICS) using simulation

A randomised-controlled clinical trial showed that using synthetic eyes for simulation training in manual small-incision cataract surgery (MSICS) doubled the confidence of trainees and reduced complication rates by 72% when trainees operated on patients. Similarly, a large-scale study in India showed a 52% reduction in posterior capsule rupture rates in procedures performed by trainees after they underwent skills training in the wet laboratory.

A learning and teaching assessment rubric is a valuable tool for learning MSICS, and one has been specifically developed to guide practice of MSICS in simulation. Virtual reality simulators provide a three-dimensional virtual, stereoscopic surgical guide for trainees to practice cataract surgical steps. The MSICS simulators made by HelpMeSee and Orbis/FundamentalVR are discussed in two online-only articles in this issue – see www.cephjournal.org.

In a simulated environment, the basic steps of cataract surgery can be practiced individually – again and again – until the trainee is competent in that environment. The trainee should use the simulation environment to assess their own competence and confidence in each step, and – after honest reflection, or feedback from a trainer – focus their efforts where improvement is needed. Training overlays, that are available in virtual reality simulators, can be especially helpful. Displays of the depth of the dissection plane, intraocular pressure, blade angulation, adverse events, and error-indicators suggest deviations from accepted standards.

Artificial eyes are very useful for practicing scleral tunnels, corneal entry, capsulorhexis, or capsulotomy, as well as intra-ocular lens (IOL) insertion. Apples provide an excellent and very affordable simulation medium that allows trainees to practice scleral tunnel formation using a crescent blade. Tomatoes and grapes are useful for simulating the practice of capsulorhexis, and bovine, porcine, or goat eyes can help trainees to become familiar with the anatomy of the eye, and how it responds to interactions.

How to select patients for your first set of cataract operations

Case selection is vital for your initial 50–100 operations. Select only low-risk patients, as this will minimise the risk of poor patient outcomes. If possible, video record the operations you perform. Reflective learning is very powerful, and it is worth using an assessment tool to evaluate your performance.

An ideal patient for cataract surgery by a novice trainee is described below.

- Good vision in the other eye (the one not being operated on).
- Good access to the eye (known as ‘good ocular exposure’). Exclude patients with deep eye sockets, a large nasal bridge, and/or small eyes.
- Nuclear sclerosis of grades 2–3 (without posterior subcapsular cataract), with no evidence of potential zonular weakness.
- Pupillary dilation of at least 7 mm.
- A clear cornea and healthy endothelium.
- Normal axial length (22–24 mm).
- An absence of pre-existing ocular co-morbidities, including ocular trauma, glaucoma, shallow anterior chamber, pseudoexfoliation, uveitis, or posterior synechiae.
- Good general health, a mobile cervical spine, and the ability to lie still and flat for an extended period of time.
- Someone whose language you, as the surgeon, can understand and speak.

Surgical tips

1. Stabilising the globe is essential for proper tunnel construction and nucleus delivery.
2. Adequate, but light cauterisation of the scleral blood vessel makes it easier to visualise the tunnel depth during scleral groove construction.
3. Marking the scleral incision with calipers helps with the exact placement of the incision and with good tunnel construction.
4. Constructing a slightly oversized scleral tunnel, with the inner opening larger than the outer opening, reduces risk during nucleus delivery.
5. Capsular staining improves visibility and control of the capsular tear during continuous curvilinear capsulorhexis.
6. A 7.5 mm capsulorhexis reduces the risk of capsular entrapment in the capsular bag. Consider a linear or envelope capsulotomy.
7. To reduce the risk of anterior chamber collapse, maintain a slight upward force on the roof of the tunnel during capsulorhexis, hydrodissection, hydrodialysis, and cortical cleanup.
8. Respond quickly to potential capsulorhexis runout by pulling up the apex of the flap towards the centre of the tear (the ‘Brian Little rescue technique’ or by converting to a mini can-opener technique. To help prevent capsular run-out, use viscoelastic or ophthalmic viscosurgical devices or use an anterior chamber maintainer to increase pressure.
9. During hydrodissection, without pressing down on the nucleus, ensure the capsula is placed just below the capsulorhexis margin at 3, 6, and 9 o’clock.
10. Use ophthalmic viscosurgical devices above and below the nucleus during vectis delivery of the nucleus to protect the endothelium, iris, and posterior capsule.
11. Use the aspiration port of the Simcoe cannula to carefully engage and peel cortex off the capsular bag. This reduces stress on the zonules and enhances separation of the cortex from the capsule.
12. Ensure adequate flow of balanced saline during cortical cleanup. However, to reduce the risk of iris prolapse, avoid over-pressurising the anterior chamber.
13. Carefully control aspiration force and maintain the aspiration port in the upright position to reduce the risk of anterior chamber collapse and posterior capsular captures and tears.
14. Use an ophthalmic viscosurgical device to adequately fill the capsular bag before inserting the intraocular lens.
15. At the end of surgery, restore intraocular pressure and double check that it is adequate. A large, single air bubble after surgery is a sign that the anterior chamber is clear of viscoelastic or vitreous. Remove the bubble at the end of the operation.

References

5. Dean WH, Gichuhu S, Buchan JC, Makupa W, Mukome A, Otto-Senger J, et al. A large-scale study in India showed a 52% reduction in posterior capsule rupture rates in procedures performed by trainees after they underwent skills training in the wet laboratory.

Vitreoretinal surgery: an introduction to simulation training

Simulation training can support vitreotomy surgery trainees to develop their skills and build a strong foundation of knowledge and understanding.

Pars plana vitrectomy surgery requires a prolonged period of learning and mentorship and should not be performed without the necessary training and hands-on experience, some of which can be gained through simulation training. A virtual reality (VR) simulator, although expensive, can be a helpful tool for learning techniques; some, such as posterior hyaloid separation, is difficult to simulate in any other way. We recommend choosing a VR simulator that gives direct and immediate feedback and comes with multiple dexterity and navigation modules.

In the absence of a VR simulator, it is still possible to practise vitreotomy skills in more affordable ways. It is important to practise in as realistic a setting as possible: in the operating room used for retinal surgery and while using the operating microscope with indirect viewing system, the operating chair and microscope foot pedal, and resterilised retinal instruments.

The indirect viewing system
Vitreectomy is performed using an indirect viewing system (Figure 1). This generates a wide-field, inverted view of the retina which is corrected with a prism inverter.

How to use the indirect viewing system
Use the microscope controls to move the indirect viewing system closer to or further away from the eye.

This controls the field of view. The closer the lens is to the cornea, the wider the field of view. The lens should be about 5–10 mm from the cornea. If it is too close, the lens may steam up. If it touches the cornea, it needs to be wiped dry.

To focus the image, rotate the focusing knob or dial on the indirect viewing system to alter the distance between its lenses. More advanced systems have electronics attached to the foot switch which can control this.

Figure 1 An indirect viewing system with automated inverter in the microscope.
Note: viewing the retina through the indirect viewing system is very sensitive to eye rotation during surgery. Learn to instinctively adjust the microscope’s X-Y joystick as you rotate the eye to view different parts of the retina. Move the microscope in the same direction as you rotate the eye, but be careful not to move too far or you will lose the optimal view.

Tools for learning & practicing
1. Navigation, with rotation of the eye to view different parts of the retina
To practice navigation, we recommend making the simple model described in a previous issue of this journal (Figure 2a) but make the pupil diameter very small, as shown in Figure 2b. This helps to simulate the dexterity needed to maintain the view during eye rotation, as it requires very accurate microscope adjustments to maintain the view.

2. Trocar insertion and infusion placement
Practise the following on soft silicone eyes. To keep costs in check, we work on eyes previously used for cataract surgery simulation.

• Measuring the position for inserting the trocars (Figure 3)
• The two-step angled (or bevelled) insertion of trocars (Figures 4b and 4c)
• Attachment of the infusion line.

3. Instrument insertion
Practice instrument insertion, usually with the vitrectomy probe and light pipe, while being aware of the correct angle or direction of insertion.

Warning: this process may result in retinal injury or lens injury if the angle of insertion is wrong (Figure 5).

4. Core vitrectomy and air fluid exchange
We practice core vitrectomy on specially designed artificial eyes, which we fill with egg white and ‘stain’ with triamcinolone acetonide. In the absence of a posterior segment machine, we use a 23-gauge anterior vitrectomy handpiece from the phaco machine and a separate light box. By adding a 3-way tap and an air pump (a fish tank pump) we can practice core vitrectomy, blue dye stain of the epiretinal membrane, epiretinal membrane peel, air fluid exchange, and simulated gas injection. See Figure 6.
5. Indentation techniques
We recommend using a compressible artificial eye supported on a screw at the posterior pole which allows free rotation (Figure 7). This is useful for practicing a direct view of the indent (through the microscope only, Figure 8a) and an indirect view (through the indirect viewing system) (Figure 8b). You can also practice indented, ‘shaving’ manoeuvres if a chandelier light is available.

6. Dexterity tasks
It is helpful to learn to use retinal instruments by performing delicate manoeuvres under the indirect viewing system. You can practice these manoeuvres on affordable plastic eyes. Use real retinal forceps and scissors of various designs to become familiar with their squeezing action and practice bimanual techniques, which are usually the most challenging. Refer to the model described in a previous issue of this journal.1

Tips for training others
Trainees should be taught how to set up a vitrectomy machine, as they may not have a skilled nurse to assist. They should also have an understanding of the effects of different settings. For example, a low cut rate removes the core vitreous more quickly than a high cut rate, but a high cut rate is safer when working near the retina. The different models of machines have significantly different settings and capabilities, and trainees need to be familiar with the machine they will use.

We recommend breaking vitrectomy surgery into individual surgical steps. Teach trainees details of the relevant ocular anatomy and pathology relevant to each step. Discuss surgical instrument design, handling, and the goals of the step, so that trainees have a detailed understanding of how to perform it accurately. Then demonstrate the step a few times, while giving a detailed explanation. Trainees should then perform the step and explain their actions. This is followed by sustained, deliberate practice, performing the step repeatedly. Trainers should observe and give feedback.

We provide trainees with written, descriptive guidelines for each step, which they refer to as they practice. Structured feedback and assessment tools, such as the Ophthalmology Surgical Competency Assessment Rubric for Vitrectomy,4 are available for live vitrectomy surgery. They are not fully transferrable to the simulation lab, but we still find them useful.4

Next, trainees should combine the steps to perform more complete procedures on a virtual reality simulator or on plastic eyes, as described above. Observe and give feedback and encourage the trainees to reflect on their performance. If video equipment is available, trainees should record and critically review their performance, preferably with the trainer.

References
Passing sutures

It is important to load sutures correctly before passing them to the surgeon. Pay attention to where and how you grip the needle, and be aware that a different position may be needed for left-handed surgeons.

Most sutures used in ophthalmic surgery are loaded onto curved needles, which should always be passed with the sharp tip and swage curving up, towards the ceiling.

Ask the surgeon ahead of time how they would like their needle to be loaded (or held) in the needle holder. Also, check whether they are right-handed or left-handed.

**Forehand or backhand pass?**

Most surgeons prefer to make **forehand** suture passes, working from the side of their dominant hand **towards the centre** of the operating field. For a right-handed surgeon, the needle tip must point to the left, and for a left-handed surgeon, it must point to the right.

Ask the surgeon to tell you if they want to make a **backhand** suture pass, i.e., working **away from the centre** of the operating field. A backhand pass for a right-handed surgeon would be loaded in the same orientation as a forehand pass for a left-handed surgeon, and vice versa.

**Loading the needle holder**

You will need:
- A needle holder (also known as a needle driver)
- The suture needle, with a suture attached to it
- A second instrument, such as tying forceps

**Steps**

1. Use the second instrument, such as tying forceps, to pick up the needle. Note: **Do not touch the needle with your hands**, even when wearing gloves. This will help to avoid injury.

2. Open the needle holder. Use the tip of the needle holder to grip the needle **just to the rear of the centre of the needle**; in other words, slightly closer to the swage than to the tip of the needle. Figures 1 and 2 show the correct position when loading a suture needle for a right-handed surgeon making a forehand pass; Figure 3 is the position for a left-handed surgeon.

   - **Needle holder**
     - **Needle**
     - **Suture**
     - **Swage**

3. Grasp the needle holder in the centre and pass to the surgeon.

   - **Figure 1** The suture needle, suture, and needle holder. The centre or body of the needle is gripped by the tip of the needle holder. The surgeon is right-handed, so the sharp point of the needle faces to the left.

   - **Figure 2** Suture needle gripped correctly for a **forehand pass** by **right-handed** surgeon.

   - **Figure 3** Suture needle gripped correctly for a **forehand pass** by **left-handed** surgeon.

**Using a curved needle holder**

Curved needle holders have a tip that is curved (or bent) to one side; this allows the surgeon more room to manipulate the suturing needle, without the needle holder getting in the way. To grip a suturing needle using a curved needle holder, rotate the needle holder so that the tip bends, or curves, in the direction of the swage (see Figures 2 and 3).

**Picture quiz**

Spot the error(s), if any, in these images. Say what is wrong in each case (select as many options as needed).

1. **Suture ready for forehand pass for right-handed surgeon**

   - **Select as many options as needed:**
     - a. Everything is correct.
     - b. The wrong part of the needle is being gripped
     - c. The wrong part of the needle holder is used
     - d. The needle faces the wrong direction
     - e. The tip of the needle holder is curved/bent in the wrong direction, relative to the needle.

2. **Suture ready for forehand pass for left-handed surgeon**

   - **Select as many options as needed:**
     - a. Everything is correct.
     - b. The wrong part of the needle is being gripped
     - c. The wrong part of the needle holder is used
     - d. The needle faces the wrong direction
     - e. The tip of the needle holder is curved/bent in the wrong direction, relative to the needle.

3. **Suture ready for forehand pass for right-handed surgeon**

   - **Select as many options as needed:**
     - a. Everything is correct.
     - b. The wrong part of the needle is being gripped
     - c. The wrong part of the needle holder is used
     - d. The needle faces the wrong direction
     - e. The tip of the needle holder is curved/bent in the wrong direction, relative to the needle.

4. **Suture ready for forehand pass for left-handed surgeon**

   - **Select as many options as needed:**
     - a. Everything is correct.
     - b. The wrong part of the needle is being gripped
     - c. The wrong part of the needle holder is used
     - d. The needle faces the wrong direction
     - e. The tip of the needle holder is curved/bent in the wrong direction, relative to the needle.

**ANSWERS**

1. c. The wrong part of the needle is being gripped.
   - d. The needle faces the wrong direction.
   - e. The tip of the needle holder is curved/bent in the wrong direction, relative to the needle.

2. d. The needle holder should not curve/bend in the wrong direction relative to the needle.
   - e. The tip of the needle holder is curved/bent in the wrong direction, relative to the needle.

3. d. The image is correct for a left-handed surgeon making a forehand pass.
   - e. The wrong part of the needle holder is used.

4. c. The wrong part of the needle holder is used.
   - d. The needle faces the wrong direction.
   - e. The tip of the needle holder is curved/bent in the wrong direction, relative to the needle.
Phacoemulsification cataract surgery: what you need to know

The need for phaco is increasing – especially for those patients with less mature cataracts.

Setting up a phacoemulsification (phaco) cataract service from the ground up can be daunting, as it requires suitable equipment and preparation. Ensure your facility is prepared to handle phaco surgery with properly maintained equipment, adequate supplies of phaco cassettes and consumables, ophthalmic viscosurgical devices (OVD), specialised phaco instruments, and an adequate microscope with an excellent coaxial illumination source.

There are also several considerations beyond the training of surgeons and teams. Biometry will be essential, along with a reliable supply of foldable IOLs across a whole range of powers. Supplies are more expensive than those needed for manual small-incision cataract surgery (MSICS), and these will need to be budgeted for. The equipment will need regular maintenance, and personnel will need to know how to troubleshoot in case of problems. A voltage stabiliser and uninterruptable power supply will be needed if electrical supply is unreliable at your facility. Is there vitreo retinal support available from surgeons in the area, in case of a dropped nucleus? Speak to colleagues for advice.

How to practice skills for phaco using simulation

Learn the basics of phacodynamics and fluidics by reading standard manuals and visiting websites (listed below in ‘Useful training resources’). Remember that there is a steep learning curve. Learn the feel of the phaco foot pedal while listening to the sounds of the machine in various pedal positions and sampling other functions you may need. Familiarise yourself with the settings on the machine (phaco power, vacuum, aspiration rate).

Before operating on live patients, surgeons learning phaco must undergo simulation training (on animal or artificial eyes) in as realistic an operating theatre environment as possible. Practice finger positioning on the large handpiece, hand positioning to manage the weight of the handpiece, and foot pedal activation until you can control the handpiece easily and intuitively.

Virtual reality (VR) simulation training in phacoemulsification is also possible using the training modules available with the Eyesi® surgical simulator, which has been shown to reduce complication rates in operations performed by trainee surgeons by up to 38%. The Eyesi® is especially useful for practicing capsulorrhexis. Any virtual reality or other simulation training must always be supported by live surgical observation as well as supervised practice.

Useful training resources

The PGY2, PGY3 and PGY4 Residents’ videos on cataractcoach.com are an excellent resource: https://bit.ly/46CBYjm and an interactive version from the iBooks store.

Orbis International’s Cybersight website has a ‘Fundamentals of Phacoemulsification’ course: https://cybersight.org/online-learning/


Simulatedocularsurgery.com offers videos for practicing phaco cataract surgery: https://simulatedocularsurgery.com/cataracts

A longer version of this article is available at www.cehjournal.org and on our app.

From the field

The need for phaco

Hillary Rono is an ophthalmologist working in Kenya’s Ministry of Health. He is also the Country Director of Peek Vision in Kenya.

“In Kenya, patients are increasingly demanding phacoemulsification (phaco) cataract surgery, partially due to its reputation for more rapid healing and better visual outcomes.

“Preliminary results from the Rapid Assessment of Avoidable Blindness (RAAB) survey study in Kenya show that existing cataract surgical services (using the Manual Small- Incision Cataract Surgery, or MSICS, technique) are reaching those who are blind or have severe visual impairment due to cataract. However, people with mild or moderate visual impairment due to cataract are not offered MSICS surgery, due to the risks associated with MSICS procedures in patients with less mature cataracts.

“To address this gap, there is a need for more surgeons to learn phaco surgery. It is important that surgeons retain their MSICS training, however, as it will be needed at various times in their practice, including when they encounter difficulties during phaco surgery.”
Maintaining high quality trichiasis surgery before and after trachoma elimination

Surgical simulation training can help to maintain the quality of trichiasis surgery in a post-elimination setting.

Trachoma, the world’s leading infectious cause of blindness, is targeted for global elimination as a public health problem by 2030. The World Health Organization (WHO) criteria for elimination of trachoma as a public health problem are (i) a prevalence of trachomatous trichiasis (TT) unknown to the health system of <0.2% in adults aged ≥15 years and (ii) a prevalence of trachomatous inflammation—follicular (TF) in children aged 1–9 years of <5%, and (iii) evidence that the health system can continue to identify and manage incident cases of TT.1

Maintaining the quality of TT surgery – as countries approach and go beyond trachoma elimination – is complicated by the fact that surgeons are conducting fewer operations, which can result in declining surgical skills. Suboptimal surgical quality is not only bad for the patient, but also threatens the achievement of the global elimination of trachoma, as it increases the likelihood that TT will recur, thereby undermining community confidence in trachoma programmes. To maintain the quality of TT surgery, several programmatic activities have been recommended, including certification for surgeons, ongoing supportive supervision, surgeon audits, and refresher training.

Trichiasis surgery for trachoma,2 the third edition of which will soon be published by WHO, provides a framework for certifying health workers in either bilamellar tarsal rotation or modified Trabut surgery for TT. In order to be certified to carry out TT surgery, health workers must:

1. Complete training in TT surgery in a course of accepted minimum depth and practical content (depending on national policy) and have conducted surgery on at least ten eyelids independently
2. Receive a recommendation for certification from an instructor
3. Successfully perform five sequential operations under observation by the certification examiner, with ‘success’ defined as fewer than 10 unsatisfactory marks on the certification checklist and none in critical areas.

Since the first edition of the WHO manual was published in 1993, it has been used by trainers as a training tool and by surgeons as a reference work, to increase the quality of surgery in settings where trachoma is endemic.

Surgical simulation

In many trachoma-endemic settings, HEAD START is being used to support trainee surgeons to build their skills and confidence before performing surgery on patients. HEAD START is a surgical simulator on which surgeons can practise surgical skills. The simulator is small and portable, allowing training to take place in remote settings. Previous research has demonstrated that simulation training with HEAD START prior to operating on patients reduces the number of times the trainer needs to intervene when the trainee makes an error and reduces the overall time required for surgery.3 HEAD START is also used to provide refresher training and regular professional development for experienced surgeons.

Recent work shows that using HEAD START as part of refresher training for trichiasis surgeons also improves long-term surgical outcomes.4 Other work also suggests that the use of HEAD START is readily accepted by surgeons and could be used during periods with low TT surgical activity (such as during the rainy season, when – in many settings – presentations decline).

In many countries, there are not enough trained eye care providers to deliver the surgical services needed to eliminate trachoma as a public health problem, or to ensure that high quality surgical services remain available in a post-elimination setting. HEAD START facilitates the training of general health workers to conduct TT surgery and has the potential to be integrated into tertiary eye health centres. Plans are currently in development to equip secondary and tertiary eye care units in Ethiopia with HEAD START to enable eye care workers to practise their skills. This is essential for the sustainability of programmes and for maximising the impact of limited resources.

The WHO World Report on Vision (bit.ly/world-report-on-vision) emphasises that people who need eye care must be able to receive high-quality interventions. The global trachoma programme provides examples of how continuous professional development systems, including certification and innovative training materials with supportive supervision, can improve the quality of outcomes. However, the trachoma community cannot become complacent. Achieving the elimination of trachoma as a public health problem makes it challenging to maintain quality in post-elimination settings. Doing so requires forward thinking to ensure that trachoma interventions, including training, supervision, and certification, are integrated into routine health systems.

References
1. www.trachomacoalition.org/about-trachoma
Cybersight: improving remote access to surgical training and mentoring

Remote mentoring can provide affordable access to surgical training, even in low-resource settings.

Cataract remains the leading cause of blindness, disproportionately affecting low- and middle-income countries. As global populations continue to age, cataract-related vision impairment is projected to rise. A survey conducted in 2017 across twenty low- and middle-income countries revealed that only 36.7% of operable cataracts had been successfully treated. To address this pressing issue, an increase in trained ophthalmologists is required to provide high-quality, accessible surgery.

Regrettably, some ophthalmology residency programmes suffer a shortage of mentored, hands-on surgical training opportunities, while others offer no surgical training at all. Recognising this disparity, Orbis has been making significant efforts, since 1982, to bring teaching physicians together with those in need of mentorship. However, the COVID-19 pandemic profoundly impacted hands-on surgical training models, such as hospital-based training, the Flying Eye Hospital, and face-to-face fellowships.

To continue supporting eye health professionals worldwide, Orbis has developed remote surgical mentorship models.

Remote mentoring in surgical skills is a method of professional development whereby an expert ophthalmologist uses live video and audio feedback to guide a less experienced ophthalmologist (or ophthalmology resident) during live or simulated surgery, regardless of their geographical distance from one another. Remote surgical mentorship offers unique advantages, including increased access to hands-on training and exposure to a diverse range of mentors using a range of different approaches. This can be challenging to achieve through traditional in-person mentoring.

Simulation training improves the hand-eye coordination of trainee surgeons before they transition into an actual operating room setting. It also has the potential to improve patient safety and enhance outcomes while also maximising the impact of scarce teaching resources. Improving trainees’ access to simulation training is therefore critical for helping them to develop their skills in a safe environment, thereby reducing patient complications during their training.

It is possible to pay up to $20,000 USD for live surgical mentorship equipment and systems. In our experience, however, it is possible to do this for much less. For example, a simple operating microscope can be used with artificial eyes, while streaming the learner’s feed over Zoom (www.zoom.com) using the free version of the Microrec app (https://customsurgical.co/microrec-app/). The learners join the video call via their phones or tablets and can then engage directly with the Orbis Volunteer Faculty mentors via audio and video. There are sometimes bandwidth or connectivity issues, depending on the location and local internet infrastructure. However, the bandwidth needed for access to platforms such as Zoom is generally sufficient.

Within Orbis programmes, remote surgical mentorship usually develops out of existing long-term relationships with clinical partners in low- or middle-income countries (see case studies) and are not currently offered to the general public. However, anyone can create an account on Orbis’ digital training and telehealth platform, Cybersight, and immediately gain access, at no cost, to the same online courses used as part of the remote training. Access to free courses and webinars are also available to everyone with a Cybersight account. An additional feature, e-Consultation, requires users to have an active medical license in one of the low-resource countries included in this list: https://cybersight.org/where-we-work.
**Case study 1. Remote, asynchronous wet lab training in manual small incision cataract surgery**

One of our first surgical mentoring projects, back in 2020, involved instructing ophthalmology residents in India in manual small-incision cataract surgery (MSICS).

Trainees signed into the Cybersight platform and attended one live lecture a week, covering one of the specific steps in MSICS. Residents recorded two videos in the wet lab, practicing the surgical step of the week on artificial eyes – one before attending the live lecture, and one after attending it. These pre- and post-lecture surgical simulation videos were uploaded to the Cybersight platform, where they were masked, anonymised and then graded using the Ophthalmic Simulated Surgical Competency Assessment Rubric for MSICS. The residents also completed an anonymous post-training satisfaction survey.

Nine residents successfully completed the training, submitting a total of 54 surgical simulation videos. The residents’ average competency score increased by 5.6 points on average, which was a statistically significant improvement. Post-training satisfaction survey results indicated improved knowledge (average score of 8.7 out of 10), satisfaction with the course (8.6 out of 10), and a willingness to recommend this course to other eye health professionals (8.7 out of 10).

This virtual wet lab training yielded a substantial enhancement in the surgical simulation skills of participating residents. Such training models can be successfully applied in locations where access to in-person training is challenging and can also support residency curriculums.

**Case study 2. Remote, synchronous wet lab training in advanced phacoemulsification skills**

A more recent model of remote wet lab training focused on improving advanced phacoemulsification skills. The goal was to train six learners via synchronous (real-time) online simulation. For four months, learners joined two-day online simulation workshops, at two locations in Santiago, Chile. Learners connected their simulation microscope to an online video call and practiced their advanced phacoemulsification techniques on artificial eyes in real time, while Orbis Volunteer Faculty mentors located in either Mexico or the United States provided guidance and feedback. On day two of the monthly workshop, learners and mentors convened for follow-up lectures and discussion of the hands-on simulation training sessions of the previous day. Based on learners’ experience levels, the virtual simulation training included four topics: anterior vitrectomy, iris suturing, aphakia, and small pupil. Participants’ survey results showed increasing levels of comfort as the workshops progressed.

**Case study 3. Remote, synchronous virtual reality training**

Orbis is working on a novel virtual reality (VR) MSICS simulation system in partnership with FundamentalVR (https://fundamentalsurgery.com) to explore the role of VR technology in remote surgical training.

The aim is to create a VR surgery experience that surgeons can share with their mentors via remote video call, in real time. The simulator will ultimately be able to score active participants on the quality of their technique, giving quantitative feedback on mistakes, while a mentor provides guidance and qualitative feedback at the end of the session.

A prototype system was implemented at six partner institutions in Bangladesh, Mongolia, India, and Ethiopia, where residents took part in VR training focused on improving MSICS skills over the course of one 40-hour week. Participant surveys indicated an increase in confidence in MSICS surgical skills at the end of the week. Development is ongoing and Orbis is looking to launch the system in 2024. At this time, the technology is too new to estimate an exact price and to describe details around accessibility, but this will become clear as the platform continues to develop.

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**References**

Simulation in ophthalmology is not a new concept. The use of animal eyes, vegetative material, and inanimate objects to learn and practice surgical skills has been around for many years, allowing trainees to practice surgical techniques in a safe and controlled environment.

Virtual reality (VR) ophthalmic surgery simulators are able to provide a surgical training environment that is visually realistic (Figure 1) and includes built-in haptic (motor-sensory) feedback systems; these create a realistic experience by mimicking the complexities of real-life surgery.

HelpMeSee, a non-profit organisation with headquarters in the USA, has developed an eye surgery simulator that is specifically designed to support the cataract surgery training courses offered at its training centres in India, France, the USA, China, and Madagascar. The courses include manual small-incision surgery, phacoemulsification, suturing, and complications management. Each course includes self-study, classroom sessions, hands-on laboratory exercises (depending on the course), and instructor-led simulation-based training and feedback.

To make training available and affordable, HelpMeSee offers subsidised training in MSICS in India, China, and Madagascar.

Key principles in HelpMeSee simulation-based training

There is an old adage in training. “A simulator simulates, it does not train.” A comprehensive pre-reading resource, experienced instructors, and individualised,
objective assessment of surgeons’ performance are important components of the HelpMeSee simulation-based training curriculum. Our experience has shown that each of these components play crucial roles in a trainee’s learning journey.

1. Pre-reading and assessment
On enrolment, before the start of the course, every trainee is given access to an interactive e-book that is available both online and offline. The e-book begins with an overview of the anatomy of the eye, the surgical instruments needed, and the surgical steps. Next, it demonstrates each step using high quality videos and animations that are accompanied by audio commentary from expert surgeons, who also give tips on how to avoid complications. There is a test at the end of each chapter that trainees must pass before the programme starts; this ensures that everyone on the course has a solid theoretical understanding before the practical training begins.

2. Instructor-led training
External feedback has always been thought to be crucial to technical skill development in novice surgeons, and it has been demonstrated that verbal feedback from an expert instructor leads to lasting improvements in performance. Therefore, all simulator-based training courses offered at HelpMeSee are led by an instructor who has been specially trained to provide this type of training.

The constant presence of an instructor by the side of someone undergoing training on the simulator is invaluable.”

3. Supervised practice and individualised feedback
The course includes sessions of supervised practice on the simulator, followed by feedback or debriefing sessions at the end of each day of training. Here, the instructor reviews the performance of each trainee, giving individuals positive feedback about tasks that were done well, feedback about what went wrong, and advice on how to improve.

4. Simulator-supported learning
The HelpMeSee eye surgical simulator software assesses surgical performance by comparing it with objective parameters (Figure 2) and competency assessment rubrics. This provides an objective way for instructors to understand trainees’ performance and to qualify and assess their competency.

The system also supports trainees by offering immediate feedback during the procedure (e.g., by providing a real-time alert when a trainee makes an error). Trainees can view a video recording of each task they perform on the simulator, which is accompanied by audio commentary from expert surgeons, who also give tips on how to avoid complications.

The instructor is also responsible for assessing trainees’ surgical competency on the simulator at the end of training.

References
Inspecting and unbending surgical needle holders

A needle holder, also called a needle driver (Figure 1), is made from stainless steel and is used to hold a suturing needle during surgical procedures. To maintain a firm grip on the needle, the jaws have textured patterns either etched directly on the stainless steel or on a replaceable tungsten carbide insert, which grips the suture needle more precisely and wears out much slower than stainless steel. Needle holders with tungsten carbide inserts normally have gold-plated rings. A needle holder must be matched to the needle size for which it is intended.

Postoperative care
Open the needle holder by separating the ratchet. Prevent blood from drying onto the instrument by soaking it in an enzymatic solution. Alternatively, place a moist towel, saturated with water, over it within 20 minutes of use.

Inspection and testing
A needle holder should be able to hold a hair on the back of your hand. If not, it is not functioning properly. With use, the jaw surfaces will wear out and stop making full contact, which affects their grip. Bends and cracks can also develop on the jaws and other parts of the needle holder.

It is important to inspect needle holders after each procedure and before sterilising them. Use a bright lamp and a magnifying glass or microscope to check for any of the following flaws.

- **Bent or worn jaws.** When the needle holder is held up to a bright light in the closed position, no light should shine through between the jaw surfaces. If the light only shines through a small portion of the jaws, either the jaw or the jaw insert is worn out. A worn jaw insert must be replaced by the manufacturer or a qualified vendor. If the jaw surface is worn (Figure 2), the entire needle holder must be replaced. If the light shines through a significant portion of the surface (Figure 3), one of the jaws is probably bent. Follow the procedure described later in this article to correct it.

- **Cracks in the jaws or joint.** Even small cracks compromise the integrity of the instrument. This means it should be sent to the vendor or manufacturer for repair.

- **Cracks in the jaw inserts.** The majority of insert damage occurs at the tips. The insert must be replaced if cracks are seen. If the tip of an insert looks and feels significantly less coarse than the rest of the insert, it should be replaced.

- **Rust and stains.** In order to determine whether a brown or orange discoloration is rust or a stain, rub a pencil eraser aggressively over part of the discoloration. If the discoloration cannot be removed and if there are pit marks, then it is rust and requires soaking in a rust removal solution and/or brushing carefully with a brass brush. If it can be removed and the metal underneath is smooth, then it is a stain and it can be removed by soaking in a stain removal solution.

- **Loose joint.** Open the instrument, grab one ring handle in each hand and gently push one handle up and down. There should be some give-and-take in the instrument, but if it feels too loose it should be repaired.

- **Poor ratchet fit.** Check that the jaw tips close in the first ratchet position and that the entire jaw closes in the third ratchet position. If a needle held in the jaws of a needle holder can be easily turned by hand with the instrument locked in the second ratchet position, repair is needed.

Preparing for sterilisation
If any dried blood or discoloration is discovered on the needle holder, the instrument must be cleaned before being sterilised. Needle holders should always be sterilised with the ratchets disengaged.

Correcting bent instruments
Bent needle holders can sometimes be corrected using a pair of flat-tipped pliers using the steps below. (Note: these procedures should not be used for needle holders with tungsten carbide inserts since they are brittle and can fracture easily.)

1. Close the needle holder, and look at it from the side. If you notice that the jaw tips are not aligned (Figure 4), then at least one tip is bent and you can try to straighten it with flat-tipped pliers (Figure 5). If it is not obvious which tip is bent, you can take turns bending both tips so that they align. **Note:** do not use too much force; bend the tips little by little.

2. Close the needle holders completely and hold them against a light. If light shines through the jaw surfaces (Figure 3) then you will need to bend one or both of the jaws towards each other.

3. If the ratchets do not hold anymore, bend the handles towards each other.

Sources
Sharpening and tightening surgical scissors

Surgical scissors consist of a pair of metal blades, pivoted so that the sharpened edges of each blade slide against each other when the handles opposite to the joint or pivot are closed.

The cutting edge of each blade is where the inner surface and the cutting surface meet (Figure 1). The two cutting edges cut as they slide over each other. The angle of the cutting surface is usually between 0 and 15 degrees from the horizontal. Scissors with a very steep angle (nearer 15 degrees) are extremely sharp and are meant for cutting soft tissues such as conjunctiva. Scissors with a less steep angle are meant for cutting harder tissues.

With repeated use, the sharp cutting edges become rounded and pits or gaps can appear, making the scissors blunt. These pits will be visible as changes in the reflection when you examine the cutting surfaces in bright light.

The sharper the cutting edge, the quicker the scissors will become blunt. You should never use scissors to cut material that the scissors are not suitable for, or they will become blunt very quickly. If blunt scissors are used, the tissue will be clasped instead of cut, resulting in contusion and ineffective wound healing.

Testing the scissors
1. Stretch a piece of cotton wool so that a small, straight piece is formed, with the width equal to the length of the scissors blades.
2. Cut this piece using the whole length of the scissors.
3. Gently pull the cotton wool out while the scissors are still in the closed position. If the scissors are working well, there should be a nice, straight cut in the cotton wool. If not, and the scissors clasp the cotton wool, this may be because the scissors blades are blunt or because the joint is too loose.

Sharpening the scissors
A pair of scissors is sharpened by filing off a very thin layer of the cutting surface to create a new cutting edge.

You may use a small, fine triangular file; however, if you have access to a triangular sharpening stone (800-1,200 grit) you will achieve even better results.

To obtain the smoothest surface possible, place a few drops of sewing machine oil on the sharpening stone.

Note: Always sharpen scissors by filing along the cutting surface, never on the inner surface.

1. Hold the scissors firmly in one hand (your left hand if you are right-handed, and vice versa), with the back of one blade resting on the end of your index finger and the cutting surface visible (Figure 2). Keep the joint open by pressing your thumb against the hand-piece of the scissors.
2. Place a bright desk lamp at the same height as your eyes. Let the light reflect on the cutting surface. Rotate the scissors slowly in both directions. When the reflection is at its brightest, the surface is horizontal. If you keep the sharpening stone horizontal as well, you will preserve the original angle.

3. Always start sharpening at the tip of the instrument, to prevent rounding off the tip. Make a gentle stroke in a forwards direction (away from you) and simultaneously towards the joint. Make sure to cover the whole surface with each stroke so that you do not create different levels along the length of the blade. Do not apply too much force. The repetition of the movement is what sharpens the scissors.

4. Repeat until most of the pit reflections are gone. If the pits are too deep, the amount that has to be filed off to get rid of them may be too large and you run the risk that the cutting surfaces of the scissors blades no longer touch each other. It may be necessary to remove such scissors from circulation.

5. After sharpening, a burr (an accumulation of filed metal) may be formed on the inner surface. This burr has to be removed. If not, it will damage the cutting edge on the opposite side during cutting. You can remove any burrs by scratching them off with your fingernail.

6. Repeat the procedure for the other scissors blade. Always sharpen both blades.

7. Clean the scissors thoroughly after sharpening. Any remnants of oil and metal on the instrument can cause inflammation in the eye.

Tightening a loose joint
Another reason why scissors may not cut properly is a loose joint. If the screw or rivet is not tight, the distance between the two inner surfaces will be too large, causing the cutting surfaces to not touch each other. As a result, tissues will be clasped instead of cut.

1. Place the scissors on a flat, hard surface.
2. Close the scissors so that the blades are top of each other.
3. If the joint has a screw, then tighten it. If it has a rivet, then proceed to the next step.
4. Place the tip of a pin punch on top of the rivet head, keeping the pin punch perpendicular to the scissors.
5. While holding the scissors down, have someone else hit the top of the pin punch with a small hammer.
6. Test the scissors after every hit, to prevent them from becoming too tight.