Quarter diopter IOL | Bi-Aspheric

Softec HDY™

High Definition Vision
Yellow

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Single piece hydrophilic acrylic Lenstec Softec HDY

- **Most accurate IOL with patented Bi-aspheric design with square edge technology**
- **Greater precision due to quarter diopter increments**
- **Tighter manufacturing diopter tolerance within +/- 0.11 D**
- **Proven quality for the most accurate cataract surgery**

LENSTEC™

more information on

www.lenstec.com

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Technical Specifications†

Optic Size	5.75 mm
Optic Type	Equal Conic Bi-aspheric
Length	12.00 mm
Haptic Style	Modified C
Angulation	0 Degrees
Positioning Holes	0
Construction	1 Piece
Optic Material	Acrylic (26% Water Content)

†A Constant and A/C Depth figures shown are strictly guidelines for the calculation of implant power. Lenstec recommends that surgeons develop their own values based on technique, measuring equipment, and desired postoperative results.

Constants (Optical Interferometry):*

Immersion	A = 118.3
SRK/T	A = 118.3
Holladay1	sf = 1.39
Hoffer Q	pACD = 5.14

*i.e. Using IOL Master, LENSTAR Optical Biometers

Diopter Steps

Whole	+5.0 to +36.0
Half	+10.5 to +29.5
Quarter	+15.0 to +25.0

Softec HDY - The Blue Blocking Lens

Single piece hydrophilic acrylic (26% Water Content)

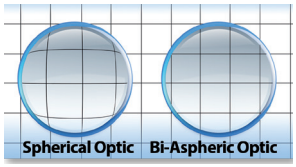
The Softec HDY is fabricated from a material that has been proven stable, particularly with respect to long term exposure to sunlight, using an accelerated aging study that replicates the equivalent of 20 years of exposure for the average person (based on specific ISO standards for the photostability of IOLs). Using blue light absorbers in the fabrication of IOLs has been an ongoing discussion since the late 1980s. Most researchers would agree that blocking certain wavelengths of visible light is beneficial to the eye, and a material proven to provide stable light transmission properties for over 20 years is the obvious choice.

Softec HD New Gold Standard - 0.11 D Tolerance - 3x More Precise!
Optical Prescription Selection and Tolerance Example: eye requires 24.25D Prescription to achieve optimal vision.

Industry Standard IOL			Softec HD IOL		
Lens Presciption	Allowed Tolerance	**Max. Variance for a standard IOL** in an eye that requires a 24.25D lens is **0.65D**. (smaller number is better)	Lens Presciption	Allowed Tolerance	**Max. Variance for a Softec HD IOL** in an eye that requires a 24.25D lens is **0.11D**. (smaller number is better)
24.00	±0.4		24.00	±0.11	
			24.25	±0.11	
24.50	±0.4		24.50	±0.11	
			24.75	±0.11	

Softec HD is the only IOL designed to address both Spherical Aberration and Defocus. Defocus is a more significant aberration than Spherical Aberration.

Bi-Aspheric Equal Conic Zero aberration IOL. Softec HD addresses the issue of spherical aberration inherent in conventional monofocal spherical IOLs by adjusting the optic with a patented design on both the anterior and posterior surfaces.



Studies have shown that Aspheric IOLs provide patients with significant optical benefits over traditional spherical surface IOLs . [1,3,4]

Significant Outcomes. Mean refractive outcome was found to be closer to intended outcome, Depth of field was significantly improved, and Critical print size for fluent reading was smaller when compared to a standard monofocal IOL. [2]

Proven quality

Stability of the biomaterial from which the intraocular Lenstec lenses are made, is long-term study proven and confirmed by millions of implanted lenses worldwide.

1. Thibos L, Hong X, Bradley A, Chang X. Statistical variation of aberration structure and image quality in a normal population of healthy eyes. J. Opt. Soc. Am A, Vol 19. No 21/Dec 2002 » **2.** Craig J, Shah S, Wolffsohn J. Clinical evaluation of the Softec HD aberration-free aspheric intraocular lens. Submitted for publication. » **3.** Sarver E. Theoretical optical performance of an equal conic intraocular lens and comparison to spheri cal and aspheric IOLs. AAO Presentation 2005 » **4.** Nanavaty M, et al. Wavefront aberrations, depth of focus, and contrast sensitivity with aspheric and spherical intraocular lenses: fellow eye study. J Cataract Refract Surg. 2009; 35: 663 - 671

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