microincision cataract surgery (MICS) was a term first coined in 2002 to describe cataract surgery through a sub–2-mm incision aiming for these goals.\(^1\) The separation of irrigation from phaco tip/aspiration in MICS allows a stabilized anterior chamber, maintaining the distance of the posterior capsule from the phaco tip, a decreased turbulence that leads to less invasive surgery, and less trauma to the surrounding tissue.\(^1\)

Cataract surgery assisted by femtosecond laser was performed for the first time on a human eye in 2008.\(^2\) Technically, the most reliable steps in cataract surgery are corneal incisions, capsulorhexis, and nuclear fragmentation. Femtosecond lasers today can ensure stability, reproducibility, precision, length, width, and design of corneal incisions. This step of the surgery has improved significantly.\(^3\)

We found that the corneal incision created with Femtosecond laser is stable and aberration free with favorable results of the tri-planar configuration (unpublished data, 2013).

The aim of this study was to ascertain how the combination of femtosecond laser-assisted surgery and MICS compares to femtosecond-laser assisted coaxial phacoemulsification.

ABSTRACT

PURPOSE: To compare the efficacy and safety outcomes of bimanual microincision cataract surgery (MICS) versus 2.2-mm coaxial phacoemulsification assisted by Femtosecond LenSx (Alcon-LenSx Inc., Aliso Viejo, CA).

METHODS: This prospective, randomized, observational, comparative case series comprised 50 cataractous eyes of 50 patients receiving femtosecond laser refractive lens surgery followed by a bimanual MICS technique with two 1-mm incisions (25 patients) (FemtoMICS group) and a coaxial phacoemulsification technique with a 1-mm paracentesis and a 2.2-mm principal incision (25 patients) (FemtoCoaxial group). The main outcomes measures were: ultrasound power, effective phacoemulsification time, postoperative spherical equivalent, higher-order aberrations (corneal and internal), corneal thickness, endothelial cell count, macular thickness, and complications during and after surgery. Both groups were absolutely comparable for all variables preoperatively.

RESULTS: Mean ultrasound power was 1.8% ± 0.9% for MICS and 14.7% ± 4.9% for 2.2-mm incisions (\(P < .001\)). Effective phacoemulsification time values for MICS and 2.2-mm incisions were 1.5 ± 0.9 and 4.5 ± 2.9 sec, respectively (\(P = .002\)). Mean postoperative spherical equivalent was -0.26 for FemtoMICS and -0.33 for FemtoCoaxial (\(P > .05\)). The efficacy index at 1 month postoperatively was 160.2% for FemtoMICS and 149% for FemtoCoaxial. No significant differences were found in corneal thickness, endothelial cell count, and macular thickness. Complications included posterior capsule rupture (4%) and anterior capsule rupture with no posterior capsule tear (4%) for FemtoMICS and bridges due to incomplete capsulorhexis (4%) for FemtoCoaxial.

CONCLUSIONS: MICS and coaxial phacoemulsification techniques assisted by the Femtosecond LenSx achieved excellent safety and efficient outcomes. The FemtoMICS technique was surgically and statistically more efficient than the FemtoCoaxial technique.

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The authors have no financial or proprietary interest in the materials presented herein.

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PATIENTS AND METHODS
A prospective, randomized, observational, comparative case series clinical study was done for 50 cataractous eyes selected to undergo femtosecond laser MICS technique with two 1-mm incisions (25 patients; FemtoMICS group) and a coaxial phacoemulsification technique with a 1-mm paracentesis and a 2.2-mm principal incision (25 patients; FemtoCoaxial group).

Both groups were interviewed for demographic data and confirmation of ocular, systemic, and medical histories. All patients signed an informed consent. The study followed the tenets of the Declaration of Helsinki. Ethical Board Committee approval was obtained.

Inclusion criteria were age between 50 and 90 years, a transparent central cornea, pupil dilatation at the preoperative examination of at least 6 mm, grade II nuclear cataract or higher (Lens Opacities Classification System [LOCS] III classification), no glaucoma, normal fundus examination, no previous ocular surgery, and absence of any other ocular or neurological disease that could affect the visual acuity. The patients were randomly assigned to have the FemtoMICS or FemtoCoaxial technique.

Exclusion criteria were cataracts other than grade II nuclear or higher, previous refractive corneal surgery, corneal pathology (eg, Fuchs’ dystrophy), subluxated lens or weak zonules, failure of pupillary dilatation (< 6 mm), history of uveitis, history of retinal detachment surgery, and other ocular or neurological diseases that may affect visual acuity or the operation.

PREOPERATIVE AND POSTOPERATIVE PATIENT EXAMINATION
Preoperative standard ophthalmic examination was performed. The examination included clinical data, refraction, uncorrected visual acuity (UCVA) and corrected distance visual acuity (CDVA), slit-lamp examination, intraocular pressure measurement by Goldmann applanation tonometry, lenticular status with opacity grading, stereoscopic biomicroscopy of the macula, anterior corneal surface evaluation using the CSO topographer (Compagnia Strumenti Oftalmici, Firenze, Italy), corneal pachymetry using corneal AS-OCT Visante (Zeiss-Meditec AG, Jena, Germany), KR1W Analyzer (Topcon Medical Systems, Oakland, CA) for aberrations evaluation, and macular thickness using TRC-NW300 (Topcon Medical Systems).

Postoperatively, we applied the following examination protocol. Thirty minutes after surgery, clinical slit-lamp examination with localization of the incision and confirmation that the incision was not leaking with Seidel test was performed. Follow-up at 1 month postoperatively included visual acuity, refraction, intraocular pressure, slit-lamp examination, higher-order aberrations (corneal and internal), corneal thickness, endothelial cell count, and macular thickness.

INTRAOCULAR LENS (IOL) CALCULATION
Biometry study was conducted using optical coherence interferometry (IOLMaster; Zeiss-Meditec AG). After the automatic determination provided by the device of the axial length and the dioptic power of the cornea, IOL calculation using third- or fourth-genera tion formulas was made. All calculations were made to achieve emmetropia after cataract surgery: Hoffer Q formula was used for axial lengths 22 mm or greater and 24 mm or less, SRK-T formula for axial lengths greater than 24 mm, and Holladay 2 formula for axial lengths less than 22 mm.

SURGICAL TECHNIQUE
Surgences were done by three experienced surgeons (the FemtoMICS group by JLA and the FemtoCoaxial group by JJ and RF) in Vissum Ophthalmology Corporation, Alicante, Spain, using the Femtosecond LenSx to perform 2.2-mm clear corneal primary incision, 1-mm secondary incision, anterior capsulotomy, and phacofragmentation in the laser operating room, followed by biaxial or coaxial phacoemulsification, IOL implantation, and completion of the surgery in the general operating room.

Topical anesthesia of preservative-free lidocaine 2% and adequate pupil dilatation (6 mm or greater) with cyclopentolate 1.0% were used in all patients before entering the laser operating room.

After careful and adequate handling of the patient, Femtosecond LenSx docking was started, followed by precise adjustment of the lens capsule position, nucleus position, anterior capsulotomy site, and corneal incision configurations under three-dimensional optical coherence tomography image guidance. Then, nucleus fragmentation and anterior capsulotomy (5 mm) followed by clear corneal incisions were achieved. In all cases, a hybrid pattern for the nucleus fragmentation was chosen.

A tri-planar primary corneal incision (2.2 mm) (Figure A, available in the online version of this article) for the purpose of IOL implantation at the positive meridian of the corneal topography was performed (first and third side cut angles 60° to 70° and second side cut angle 15° to 25°), which was used for coaxial technique and IOL implantation (biaxial...
and coaxial techniques) and a 90° apart uni-planar (1 mm) (Figure A) secondary corneal incision (side cut angle 30° to 45°) was performed for lens and IOL manipulating instruments. All of these parameters can be selected by the surgeon in a rational manner according to the corneal characteristics of each patient.

At the time of this study, the Femtosecond LenSx system only allowed creation of the two incisions that are described above. By the time this article was written, new software allows the creation of three incisions (two for the cataract surgery and the third for IOL implantation) that may adapt better to the MICS technique.

The patient was then transferred to the general operating room and placed under the usual operating microscope.

**Biaxial Technique (MICS)**

The surgeon created a manual 1-mm incision for the introduction of the MICS phacoemulsification probe and the secondary incision previously created by the femtosecond laser was opened with a Sinskey hook. The grasping of the anterior capsulorhexis and the phacoemulsification was done through the 1-mm manual incision (Figure B, available in the online version of this article). The implantation of the IOL was done by the 2.2-mm incision that was anteriorly created by the femtosecond laser and opened in the exact moment of implanting the IOL.

**Coaxial Technique (2.2 mm)**

The surgeon opened the primary 2.2-mm incision and the secondary 1-mm incision with a Sinskey hook and proceeded to grasp the anterior capsulorhexis and to make the phacoemulsification through the 2.2-mm incision (Figure B). The implantation of the IOLs was done by this same incision.

Phacoemulsification and aspiration of the previously fragmented core was done with a Stellaris machine (Bausch & Lomb, Rochester, NY). The remaining steps, including viscoelastic material aspiration, intraocular preservative-free cefuroxime 1.0% (0.1 cm³), and testing of the sealing corneal wounds with or without hydration of the edges, were done as a conventional cataract procedure. No sutures were used in any eye.

After surgery, patients were allowed to rest for 30 minutes and then examined at the slit lamp for the sealing of the corneal incision using a fluorescein Seidel test comprising 3.0 mL of 2.5 mg fluorescein sodium plus 4.0 mg oxybuprocaine chloride (Colircusi Fluotest).

Postoperative topical therapy included topical ofloxacin 0.3%, dexamethasone alcohol 0.1%, and nonsteroidal anti-inflammatory drugs (diclofenac).

**Main Outcome Measures**

The parameters used to assess the surgical efficiency were determined according to ultrasonic power used and effective phacoemulsification time (EPT) (multiple of the total phacoemulsification time and average percentage power used, which represents a metric for the length of phacoemulsification time for use of 100% power in continuous mode). The indexes used to assess the visual and refractive results were postoperative spherical equivalent, higher-order aberrations (corneal and internal), and visual efficacy index (ratio of postoperative spontaneous visual acuity [UCVA] and preoperative CDVA). Other examinations assessed the corneal thickness, endothelial cell count, macular thickness, and incidents during and after surgery.

**Statistical Analysis**

Statistical analysis was performed by version 19.0 for Windows SPSS (SPSS, Inc., Chicago, IL). Normality of the samples was studied with the Kolmogorov–Smirnov test and homoscedasticity with Levene’s test. For the comparison of two independent samples, the Student’s t test was applied when parametric analysis was possible and the Mann–Whitney test when it was not possible. For the comparison of preoperative and postoperative data, the Student’s t test for paired samples or the Wilcoxon rank sum test was used depending on whether it was possible to apply statistical parametrics. The level of statistical significance was always the same (P < .05).

**RESULTS**

Both groups were preoperatively comparable in all variables (Table 1). Preoperative slit-lamp microscopy evaluation of nuclear opalescence is presented in Table A (available in the online version of this article). There was no statistically significant difference regarding the type of cataract (P = .594, chi-square test).

The mean ultrasound power was 1.8% ± 0.9% for MICS and 14.7% ± 4.9% for 2.2-mm incisions (P < .001). EPT values were 1.5 ± 0.9 and 4.5 ± 2.9 sec for MICS and 2.2-mm incisions, respectively (P = .002) (Figure 1).

The mean UDVA (logMAR) at 1 month postoperatively was 0.27 ± 0.35 for FemtoMICS and 0.26 ± 0.26 for FemtoCoaxial (P > .05). The mean CDVA (logMAR) at 1 month postoperatively was 0.20 ± 0.33 for FemtoMICS and 0.27 ± 0.35 for FemtoMICS and 0.26 ± 0.26 for FemtoCoaxial (P > .05).
and 0.15 ± 0.39 for FemtoCoaxial \((P > .05)\). The mean postoperative spherical equivalent at 1 month postoperatively was -0.26 for FemtoMICS and -0.33 for FemtoCoaxial \((P > .05)\) (\textbf{Figure 2}). The FemtoMICS value was 160.2% and 149% for FemtoCoaxial measured 1 month after surgery.

The mean total corneal higher-order aberrations \((6 \text{ mm})\) before and after surgery were 0.6 ± 0.4 and \(0.66 ± 0.2 \mu \text{m}\), respectively \((P = .10)\). The mean value for internal coma \((4 \text{ mm})\) for both procedures was 0.13 \(\mu \text{m}\).

There were no significant changes in postoperative corneal thickness, endothelial cell, or macular thickness values relative to preoperative values in both groups \((P > .05, \text{\textbf{Figure 2}})\).

Complications included posterior capsule rupture (4%) and anterior capsule rupture with no tear to the posterior capsule (4%) in the FemtoMICS group and bridges due to an incomplete capsulorhexis in the FemtoCoaxial group (4%) that were removed with Utrata forceps without complications. There was no vitreous loss associated with these complications.

**DISCUSSION**

Our results demonstrate improved efficiency and equivalent acuity and safety outcomes between femtosecond-laser assisted MICS and femtosecond-laser assisted coaxial phacoemulsification.

The reduction of EPT and ultrasound power settings is an advantage of the MICS technique. In the literature review made comparing MICS and coaxial phacoemulsification, most studies showed better outcomes in EPT values for MICS,\(^6\)\(^\text{--}\)\(^13\) some studies demonstrated equal values,\(^14\)\(^\text{--}\)\(^17\) and only one study presented better EPT values for the coaxial technique.\(^18\) Corneal aberrations following MICS or coaxial techniques have also been studied, achieving less induction in the MICS technique, demonstrating the importance of a microincision.\(^6\)\(^,\)^\(^19\)\(^\text{--}\)\(^26\)

In our analysis of surgical efficacy, we took as reference one of our own publications\(^13\) to compare the values of EPT and ultrasound power for different techniques (FemtoMICS (1 mm), MICS (1.8 mm), FemtoCoaxial (2.2 mm), and Coaxial (2.8 mm). The median age between the current and the reference studies was 68.9 and 67.5 years, respectively. Cataract gradation in both studies followed the same criteria of gradation (nuclear or corticonuclear from 2+ to 4). Also, the phacoemulsification platforms used in both studies were different. Taking into account these differences, the median EPT values were less for FemtoMICS in comparison with MICS \((1.5 ± 0.9 \text{ vs } 2.19 ± 2.77 \text{ sec, } P = .002)\). The

<table>
<thead>
<tr>
<th>Preoperative Variables</th>
<th>FemtoMICS</th>
<th>FemtoCoaxial</th>
<th>(P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (y)</td>
<td>67.60 ± 8.46 (53 to 83)</td>
<td>70.50 ± 8.88 (48 to 86)</td>
<td>.188</td>
</tr>
<tr>
<td>UDVA (logMAR)</td>
<td>0.95 ± 0.54 (0.10 to 1.77)</td>
<td>0.75 ± 0.44 (0.15 to 1.47)</td>
<td>.784</td>
</tr>
<tr>
<td>Sphere (D)</td>
<td>-1.52 ± 4.53 (-14.00 to 5.00)</td>
<td>-0.83 ± 4.59 (-16.00 to 4.50)</td>
<td>.550</td>
</tr>
<tr>
<td>Cylinder (D)</td>
<td>-0.89 ± 0.77 (-2.75 to 0.00)</td>
<td>-1.10 ± 0.46 (-2.00 to 0.00)</td>
<td>.228</td>
</tr>
<tr>
<td>Spherical equivalent (D)</td>
<td>-1.97 ± 4.45 (-14.00 to 4.25)</td>
<td>-1.38 ± 4.69 (-17.00 to 4.00)</td>
<td>.670</td>
</tr>
<tr>
<td>CDVA (logMAR)</td>
<td>0.29 ± 0.39 (0.00 to 1.77)</td>
<td>0.33 ± 0.35 (0.00 to 1.47)</td>
<td>.600</td>
</tr>
<tr>
<td>Corneal thickness ((\mu \text{m}))</td>
<td>534 ± 31.07 (464 to 583)</td>
<td>538.62 ± 41.05 (476 to 594)</td>
<td>.662</td>
</tr>
<tr>
<td>K1 (D)</td>
<td>43.85 ± 1.93 (40.74 to 47.19)</td>
<td>43.43 ± 1.28 (41.35 to 46.26)</td>
<td>.441</td>
</tr>
<tr>
<td>K2 (D)</td>
<td>44.94 ± 2.42 (41.28 to 49.89)</td>
<td>44.64 ± 1.40 (41.87 to 47.19)</td>
<td>.660</td>
</tr>
<tr>
<td>KM (D)</td>
<td>44.43 ± 2.10 (41.02 to 48.35)</td>
<td>44.09 ± 1.32 (41.64 to 46.73)</td>
<td>.493</td>
</tr>
<tr>
<td>Ocular total HOA 4 mm ((\mu \text{m}))</td>
<td>0.21 ± 0.07 (0.13 to 0.33)</td>
<td>0.43 ± 0.53 (0.02 to 1.61)</td>
<td>.366</td>
</tr>
<tr>
<td>Corneal total HOA 4 mm ((\mu \text{m}))</td>
<td>0.14 ± 0.05 (0.08 to 0.19)</td>
<td>0.31 ± 0.43 (0.11 to 1.40)</td>
<td>.142</td>
</tr>
<tr>
<td>Corneal total HOA 6 mm ((\mu \text{m}))</td>
<td>0.49 ± 0.15 (0.28 to 0.68)</td>
<td>0.66 ± 0.58 (0.40 to 1.99)</td>
<td>.628</td>
</tr>
<tr>
<td>Internal total HOA 4 mm ((\mu \text{m}))</td>
<td>0.18 ± 0.13 (0.08 to 0.43)</td>
<td>0.26 ± 0.23 (0.09 to 0.68)</td>
<td>.181</td>
</tr>
<tr>
<td>Endothelial cell</td>
<td>2,290 ± 460 (1,450 to 3,090)</td>
<td>2,359 ± 634 (1,950 to 3,040) &gt; .05</td>
<td></td>
</tr>
<tr>
<td>Macular thickness ((\mu \text{m}))</td>
<td>7.76 ± 0.55 (6.88 to 8.79)</td>
<td>7.62 ± 0.43 (6.90 to 8.15) &gt; .05</td>
<td></td>
</tr>
</tbody>
</table>

FemtoMICS = femtosecond laser refractive lens surgery followed by a bimanual microincision cataract surgery technique; FemtoCoaxial = coaxial phacoemulsification technique with a 1-mm paracentesis and a 2.2-mm principal incision; UDVA = uncorrected distance visual acuity; D = diopters; CDVA = corrected distance visual acuity; K1 = maximum keratometry; K2 = minimum keratometry; KM = mean keratometry; HOA = higher-order aberrations.

\(*\text{All values mean ± standard deviation (range).}\)
median EPT value was also less for FemtoCoaxial compared with Coaxial (4.5 ± 2.9 vs 9.2 ± 12.38, \( P < .05 \)). The mean ultrasound power was less in FemtoMICS than in MICS (1.8 ± 0.9% vs 5.28 ± 3.91%, \( P < .05 \)) and in FemtoCoaxial than in Coaxial (14.7 ± 4.9 vs 19.2 ± 10.98, \( P < .05 \)). Another study found a 56% reduction in ultrasound power comparing ultrasound power of FemtoCoaxial and Coaxial.\(^{27}\)

The results obtained in the current study with significant reductions of EPT and ultrasound powers between FemtoMICS and FemtoCoaxial are comparable to the significant reduction between MICS and Coaxial, thus demonstrating the benefits of microincisions used in cataract surgery protecting the tissue.\(^{9}\) Compared to previously published studies of our group on efficiency of the procedure, we found a similar decrease in phacoemulsification time and use of ultrasound\(^ {2,28-30}\).

We also found in the current study a trend for higher safety with the MICS technique regarding endothelial cell count, corneal thickness, and macular thickness, although the difference in these variables was not significant (\( P > .05 \)).

The mean UDVA (logMAR) at 1 month postoperatively was 0.20 ± 0.33 for FemtoMICS and 0.15 ± 0.39 for FemtoCoaxial (\( P > .05 \)). The mean postoperative spherical equivalent in the current study was -0.26 for FemtoMICS and -0.33 for FemtoCoaxial. These values are comparable to a previous report where they obtained a mean postoperative spherical equivalent of -0.30.\(^ {2}\)

With respect to higher-order aberrations (corneal and internal), both preoperative and postoperative values did not reflect a significant change. In one study,\(^ {30}\) femtosecond laser-assisted cataract surgery had a statistically significant lower internal aberrations induction compared to a conventional phacoemulsification procedure. Our study is the first to assess corneal higher-order aberrations (corneal and internal).

In our case series, we observed 4.0% gap junctions and bridges due to incomplete capsulorhexis compared to 10.5% observed in the study of Bali et al.\(^ {31}\) Complications observed by Bali et al.\(^ {31}\) such as central corneal edema, cystoid macular edema, and posterior lens dislocation, were not observed for both procedures in the current study. Finally, subconjunctival petechiae produced by the suction cone was generally seen in older patients (< 70 years). We believe that our complication rates were lower due to the previous high experience of the surgeons in the use of femtosecond laser technology for cornea procedures; thus, the coupling of the system was more accurate,
achieving a more perpendicular surface for the laser pulses and determining a good capsulorhexis, a key stage in cataract surgery.

The precise identification by the surgeon of what the femtosecond laser was unable to complete during the procedure is crucial before starting the phacoemulsification procedure to reduce complications. The most critical complication would represent not recognizing an incomplete capsulorhexis and making an aggressive approach in terms of rapid decompression of the anterior chamber without checking the existence of adhesions or bridges of the capsulorhexis. Marques et al. showed an extension of rupture of anterior to posterior capsule of 40% of the cases.32

Based on the results of this study, the use of the Len-Sx femtosecond laser technology is safe with good visual outcomes and is efficient in the nuclear fragmentation. The FemtoMICS technique for cataract surgery adds to the safety and effectiveness of the procedure, minimizing the EPT and ultrasound values causing a protection of the tissues. Considering the complications experienced during the cases presented, it is imperative that the surgeon recognizes which steps the femtosecond laser performed incompletely, mostly in the capsulorhexis performance, to avoid anterior capsular tears that can extend posteriorly.

To our best knowledge, this is the first study evaluating the FemtoMICS technique. More research with a larger number of patients and a longer follow-up is necessary to justify the cost of femtosecond laser technology.

**AUTHOR CONTRIBUTIONS**

Study concept and design (JLA); data collection (AAA, JLA, RF-B, PP-G, JJ, FS); analysis and interpretation of data (AAA, JLA, PP-G, FS); drafting of the manuscript (AAA, JLA, PP-G, FS); critical revision of the manuscript (AAA, JLA, RF-B, PP-G, JJ, FS); statistical expertise (PP-G); administrative, technical, or material support (JLA); supervision (JLA, RF-B, JJ)

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23. Denoyer A, Denoyer L, Marotte D, Gérard M, Pisella PJ. Intra-individual comparative study of corneal and ocular wavefront aberrations after biaxial microincision versus coaxial small-
Figure A. (A) A tri-planar primary corneal incision (2.2 mm) was performed for coaxial technique and intraocular lens implantation and (B) a 90° apart uni-planar (1 mm) secondary corneal incision was performed for lens and intraocular lens manipulating instruments.

Figure B. Grasping of the anterior capsulorhexis and the phacoemulsification was done through the (A) 1-mm manual incision in the biaxial technique and the (B) 2.2-mm incision in the coaxial technique.

### TABLE A

<table>
<thead>
<tr>
<th>Type of Cataract (LOCS III)</th>
<th>FemtoMICS</th>
<th>FemtoCoaxial</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO2</td>
<td>10 (40%)</td>
<td>8 (32%)</td>
</tr>
<tr>
<td>NO3</td>
<td>10 (40%)</td>
<td>15 (56%)</td>
</tr>
<tr>
<td>NO4</td>
<td>20 (20%)</td>
<td>3 (12%)</td>
</tr>
</tbody>
</table>

LOCS = Lens Opacity Classification Score; FemtoMICS = femtosecond laser refractive lens surgery followed by a bimanual microincision cataract surgery technique; FemtoCoaxial = coaxial phacoemulsification technique with a 1-mm paracentesis and a 2.2-mm principal incision.