American Journal of
Health, Medicine and Nursing Practice
(AJHMN)

The Graphical Results of Myopia after Refractive Surgical Treatment by Femto^{2nd} Optical Maser-Assisted and Epiboly's LASEK (Eye-Surgery) have Remained Comparable.

Ihsan Ullah, Iftekhar Ahmd, Farrukh Nawab, Khalil Khan Zahir, and Irfanullah Khattak

American Journal of Health, Medicine and Nursing Practice
ISSN 2520-4017 (Online)
Vol.7, Issue 9, pp 1 – 10, 2022
www.ajpojournals.org

The Graphical Results of Myopia after Refractive Surgical Treatment by Femto2nd Optical Maser-Assisted and Epiboly's LASEK (Eye-Surgery) have Remained Comparable.

Ihsan Ullah[1], Iftekhar Ahmed[2], Farrukh Nawab[3], Khalil Khan Zahir[4] and Irfanullah Khattak[5]

[1]Consultant Ophthalmology, DHQ hospital, Timergara, Dir-Lower, Pakistan.

[2]Professor of Ophthalmology, BMC Hospital, Swabi KTH Hospital, Peshawar, Pakistan.

[3]Medical officer Ophthalmology, DHQ Hospital, Timergmira, Lower Dir, Pakistan.

[4]Fellow Pediatric Ophthalmology, HMC, Peshawar, Pakistan.

[5]Assistant Professor, Pediatric Ophthalmology, HMC Hospital, Peshawar, Pakistan.

Corresponding Author: Ihsan Ullah

Corresponding Author's Email: drihsanullah2002@gmail.com

Abstract

Background: In this prospective cohort study (flap-off epi-eye-surgery), the results of femtosecond optical maser-assisted in situkeratomileusis (femto-eye-surgery) and epipolis eye-surgery refractile surgery for myopia were compared.

Purpose: Comparison of the results of eye-surgery myopia or myopic astigmia improvement by a six-multidimensional amaris exciter optical maser and establish that both femto- eye-surgery and flap-off epi-eye-surgery are safe, effective, and predictable in Amanat eye hospital Rawalpindi. The duration of the study was July 2019- July 2021. Sample size was 400 eyes, 200 patients, 81 male and 119 female. The study was conducted after the ethical approval of the hospital ethical committee.

Methods: Four hundred (400) eyes from 200 individuals were divided into two groups in this prospective cohort study. For femto-eye-surgery flaps, a femtosecond optical maser was used, while an epikeratome (flap-off) was used for epi-eye-surgery flaps. The researchers measured uncorrected distance graphicalacuity (u.d.v.a), corrected distance graphical acuity (c.d.v.a), visible bending (m.r), corneal asphericity (q-value), and corneal higher-order aberrations (hoas) before and after surgery. In both groups, the improvement in logmar udva following refractile surgery was statistically significant ($p< 0.001$ for all); it was significantly higher for femto-eye-surgery 1 day and 1 week postoperatively ($p <0.001$ for femto-eye-surgery, respectively).

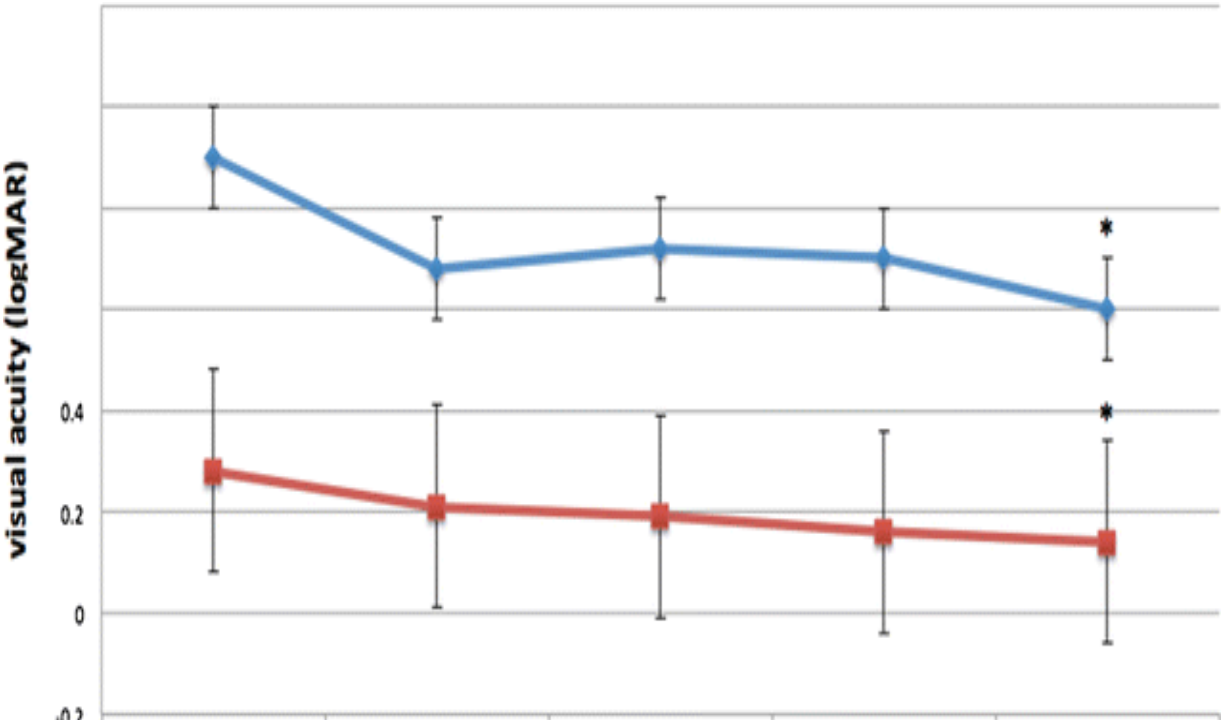
Results: Logarithm of the minimum angle of resolution (logmar) of udva after refractile surgery was statistically significant for both groups ($p = 0.002$); it was significantly higher for femto-eye-surgery than flap-off epi-eye-surgery (0.03 *0.06 logmar (femto-eye-surgery) and 0.54 * 0.31 logmar (flap-off epi-eye-surgery) at 1 day postoperatively; 0.02 *0.05 logmar (f the increase in spherical aberration (z4,0) in flap-off epi-eye-surgery was reater than femto-eye- surgery : 0.626 ± 0.232 µm and 0.479 ± 0.139 µm in the front cornea; 0.556 ± 0.227 µm and 0.430 ± 0.137 µm in thetotal cornea ($p = 0.016$ and $p = 0.017$). There was no significant impact of the changes to the corneal hoa in the back of the eye on the corneal hoa in general.

Conclusion: Despite the fact that femto-eye-surgery generated better early graphics results than flap-off epi-eye-surgery, therewas no significant difference in the results one week following surgery.

Keywords: *Myopia, Refractive Surgical, Femtosecond optical maser, Eye-surgery*

Introduction

Optical power of the eye undergoes modifications as it grows and matures. Myopia has become the most frequent medical issue among children and teenagers, with the cornea focusing light in front of the retina fairly than right on it. Orthokeratology (ortho-k) long utilized in children improve acquired vision and slow axial elongation. Refractile surgery may be more effective than ortho-k lens applicationin cases of moderate or severe myopia in patients older than twenty years. In the early nineteens,[s], photorefractive keratectomy was initially used to correct myopia surgically, and optical maser ablation refractile surgery was frequently employed for anterior segment surgery. It is now possible to entirely remove the epithelium because to developments in epithelium removal procedures. Inthe field of refractile surgery, femtosecond optical maser-assisted eye-surgery (femto-eye-surgery) and epipolis eye-surgery (epi- eye-surgery) have developed as innovative methods. Numerous studies have compared the graphical results of femto-eye-surgery andepi-eye-surgery (flap creation using a microkeratome) by comparing anterior corneal refraction errors. Early after refractile surgery, there was slightly more forward stray light after the femto-eye-surgery procedure than after other refractile surgery techniques; and this was significantly increased throughout the follow-up period after epi-eye-surgery surgery (flap creation using a epikeratome).



	pre-op	1m po	3m po	6m po	1y po
UCVA	0.9	0.68	0.72	0.7	0.6
CDVA	0.28	0.21	0.19	0.16	0.14

Figure 1: Changes in U.D.V.A and C.D.V.A with both groups showing significant improvements

American Journal of Health, Medicine and Nursing Practice
ISSN 2520-4017 (Online)
Vol.7, Issue 9, pp 1 – 10, 2022
www.ajpojournals.org

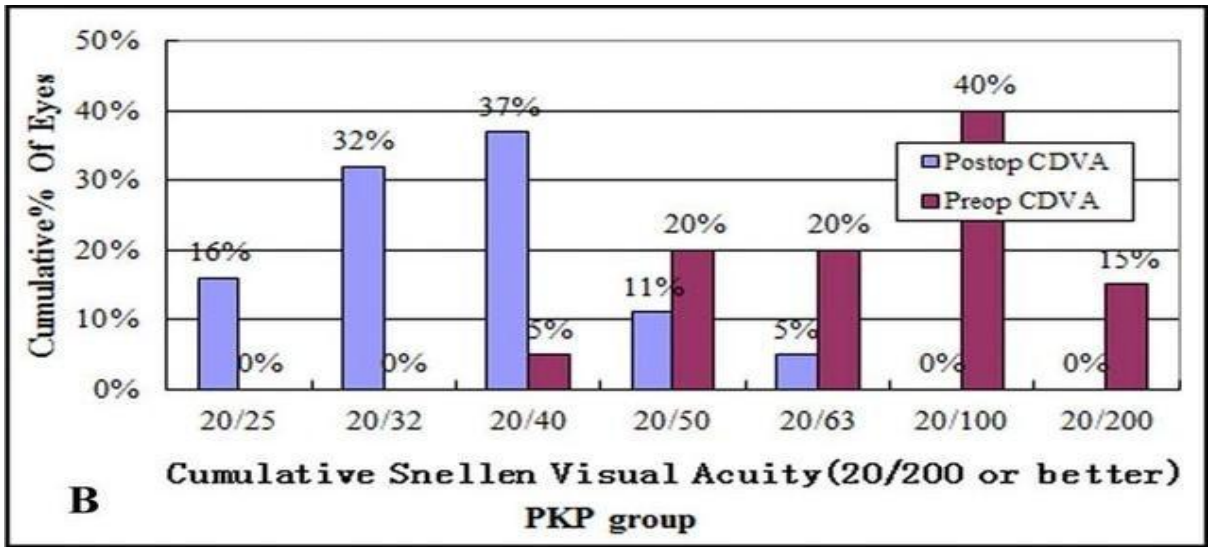


Figure 2: Changes in U.D.V.A and C.D.V.A showing significant improvements in both groups.

Table 1: Femo-eye-surgery and Flap-off Epi-eye-surgery have different preoperative parameters.

	Mean ± Standard Deviation	**N=200**	
Element	Femto-eye-surgery	Flap-off epi-eye-surgery	*P*-value
S.E (D)	-5.92 ± 2.23	-5.93 ± 1.90	0.772
K_1 (D)	39.32 ± 2.06	39.45 ± 2.12	0.827
K_2 (D)	42.53 ± 1.31	42.79 ± 2.20	0.979
A.D (µ.m)	99.15 ± 34.13	89.31 ± 27.57	0.813
A.C.D (m.m)	3.12 ± 0.26	3.25 ± 0.30	0.321
R.B.T (µ.m)[a]	265.01 ± 43.28	231.93 ± 39.11	0.676
C.C.T (µ.m)	497.14 ± 26.67	452.15 ± 29.55	0.459

S.E = spherical- equivalent; K.1 = flat- keratometry; K.2 = steep- keratometry; A.D = ablation- depth; A.C.D = anteriorchamber-depth; R.B.T = preoperative predict residual bed thickness; C.C.T = central corneal

Table 2: Preoperative and postoperative changes in two groups are compared. N=200

	.Mean ± .Stan		
Factor	**Femto-eye-surgery**	**Flap-off epi-eye-surgery**	***P*-value**
.K.1 (D)			
.Pre-op	41.65 ± 1.25	39.81 ± 2.09	0.772
.Post-op	36.95 ±2.52	33.04 ± 2.33	0.827
.*P*-value*....K_2 (D)	0.001	<0.001	
.Pre-op	42.79 ± 1.47	41.84 ± 2.11	0.979
.Post-op	26.74 ± 2.73	36.61 ± 2.40	0.941
.*P*-value*	0.003	<0.001	
.CCT.(μm)	487.15 ± 27.69	452.15 ± 28.76	0.592
.Pre-op			
.Post-op	365.27 ± 28.89	354.89 ± 43.54	0.082
.*P*-value*	<0.001	<0.001	
.ACD.(mm)	2.06 ± 0.24	2.28 ± 0.30	0.051
.Pre-op			
.Post-op	2.98 ± 0.22	3.19 ± 0.28	0.061
.*P*-value*	0.001	<0.001	
.Q-value			
.(Ant.)Pre-op	-0.41 ± 0.13	-0.39 ± 0.18	0.731
.Post-op	0.88 ± 0.65	0.73 ± 0.33	0.730
.*P*-value*	0.001	<0.001	
.Q-value			
.(Post.)Pre-op	-0.30 ± 0.11	-0.30 ± 0.08	0.298
.Post-op	-0.28 ± 0.10	-0.28 ± 0.09	0.229
.*P*-value*	0.068	0.337	

K.1 = flattest keratometry reading; K.2 = steepest keratometry reading; C.C.T = central- corneal thickness; Pre-op = preoperative; Post-op = post-operative; A.C.D = anterior chamber depth (between endothelium to anteriorlens surface); A.n.t. = anterior corneal surface; P.o.s.t. = posterior corneal surface; .Q-value. = corneal asphericity.

Helpless arranged whether Epi-eye-surgery remained achieved with or without a flap, it is classified as flap-on or flap-off.Flap-off epi-eye-surgery with mitomycin C (M.M.C) produces less pain, corneal haze, and faster graphical recovery, according to Ang et al. [11] and Zhang et al. [12], while graphical results, refractive results, contrast sensitivity (CS), and higher-order aberrations (HOAs) are comparable to flap-on epi-eye-surgery. To compare graphical findings and quality, Wen and colleagues [13] used a network meta-analysis. They discovered that femto-eye-surgery was more predictable thanany other type of surgery in terms of graphical results (efficacy and safety) and graphical quality (HOAs and CS). Thinner corneas, higher intraocular pressure (IOP), and higher myopia demand more frequent eye doctor visits.

Patients Methods

Between July 2019- July 2021. Sample size 400 eyes 200 patients 81 male and 119 female, at Amant Hospital Rawalpindi Department of Ophthalmology performed eye-surgery surgery on 400 eyes from 200 patients. The Institutional Review Board. Amanat Hospital Rawalpindi official this prospective cohort study procedure, which shadowed the Statement. Before the trial began, all patients signed a written informed permission form. Myopia wasrepaired with refractile surgery in the study participants, and their preoperative topography was normal. Total cases at minimum (one year) of stable alteration before refractile surgery and were monitored for at least one years afterward. Exclusion criteria included ocular pathology, retinal abnormalities, previous ocular surgery, co-morbidities such as diabetes, autoimmune diseases, and endocrine diseases, dry eye complaints, and insufficient follow-up. Cases suffering corneal shakiness, haze, or other problems, as well as cases requiring retreatment, were excluded from the study. Cases were required to stop wearing soft contact lenses for two weeks and rigid gas penetrable (RGP) lenses for four weeks prior to surgery.

Assessment Preoperative

Prior to surgery, all patients suffered a standard ophthalmologic examination. The investigation included a manifest refraction (MR), cycloplegic refraction, slit-lamp examination, ultrasonic pachymetry, dilated funduscopy, and intraocular pressure measurement with a Goldmann applanation tonometer. Uncorrected distance graphicalacuity (UDVA) and corrected distance graphicalacuity (CDVA) were measured using Snellen charts (CDVA). The CDVAwas always tested with trial frames rather than contact lenses. The corneal asphericity (Q-value), corneal HOAs, and keratometry were all assessed using a Pentacam (OCULUS Optikgerate GmbH, Wetzlar, Germany). Under photopic settings (1300 lux), videokeratoscopy (Keratron Scout topographer, Optikon 1850 SpA, Rome, Italy) was used to assess corneal topography and HOAs, matching to thoseapplied below an operational optical microscope to plan a surgery.

Postoperative Evaluation

Postoperative evaluations were calculated on the day of surgery, one week later, one to three weeks later, and six months later, as well as one and one years later. Completely postoperative follow-up visits comprised the assessment of UDVA, CDVA, MR, andthe recording of physical keratometry analyses. The Pentacam was used to measure central corneal thickness (CCT), corneal asphericity (Q-value), and corneal HOAs.

Surgical Procedures

All treatment were directed towards emmetropia, and the treatment plan followed the Custom

Ablation Manager methodology. The ablations were carried out with the The Scholar 740^{S} exciter visual maser (SCHWIND Eye-TechSolutions, Kleinostheim, Germany). In the aberration-free mode, ablation was done with an optimised aspheric profile. All of the surgeries were carried out by a single skilled surgeon (CKJ). Topical anaesthetic eye drops containing proparacaine (Alcaine, Alcon-Couvreur, Puur, Belgium) were utilised. The iFS Advanced Femtosecond Optical maser (Abbott Medical Optics, Inc., Irvine, CA, USA) was utilised to create femtosecond optical maser-assisted eye-surgery flaps with superior hinges, a flap thickness of 98 millimetres, and flap diameters of 8.2 or 8.5 millimetres. The flap-off epi-eye-surgery procedure was performed with the Epi-KTM epikeratome (Moria SA, Antony, France). After the flap was lifted, ablation was done on a 6.3-mm-diameter opticalzone.

Statistical Analaysis

Data was entered into statistical analysis was achieved by S.P.S.S for version 21. To see if the statistics distribution wasnormal, the Shapiro-Wilk test was utilized. The Wilcoxon rank-sum test and the Mann-Whitney U -test were working for nonparametric analysis. P-values under 0.03 were considered significant.

Results

A total of 400 eyes from 200 cases was divided on two groups founded on whether a flap was generated during femtosecond optical maser surgery (femto-eye-surgery) (flap-off epi-eye-surgery). The patients were all treatedwith the optical maser in the aberration-free mode. The characteristics of the two groups are summarized in table 1. The two groups' baseline ophthalmic features were not significantly different. Table 2 shows a comparison of pre- and postoperative changes in the two groups. keratometry was measured using a manual keratometer. there were no significant differences between the two groups for the flattest keratometry reading (k1), steepest keratometry reading (k.2), c.c.t, or q.vaule (ant. and post.). Both groups demonstrated significant changes in k.1, k.2, c.c.t, and q-value (ant.)before and after surgery (p 0.05 in femto-eye-surgery; total p 0.002 in flap-off epi-eye-surgery) shows the changes in the corneal thickness spatialprofile (ctsp). at the 0-mm, 2-mm, 4-mm, and 8-mm rings of the cornea, there were no statistically significant differences in preoperative and postoperative values between the two groups (total $p > 0.05$), yet, after flap-offepi-lalsik, the 6-mm ring was statistically significantly thinner than after femto-eye-surgery ($p = 0.039$). Additional info can be obtained in figure 1 which shows changes in UDVA and CDVA. Both groups showed significant improvements in LogMAR UDVA (improvement) after surgery (total P 0.001). Femto-eye-surgery improved vision more than conventionaleye-surgery at 1 day and 1 week (P 0.001 and $P = 0.019$, respectively). CDVA differences between the femto- eye-surgery and flap-off epi-eye-surgery groups were statistically significant at 1 day and 1 week postoperatively($P = 0.026$ and $P = 0.008$, respectively). The despicable preoperative visible alteration round equal (MRSE) for the femto-eye-surgery and flap-off epi- eye-surgery groups, respectively, was -5.94 2.23 and -5.94 1.62 D ($P = 0.904$). After 1 day and 1 week, the flap-off epi-eye-surgery group had statistically higher myopic refraction errors than the femto-eye-surgery group ($P = 0.01$ and $P = 0.009$, respectively).

Discussion

Study shows that looked into whether consuming a femto-second optical maser to make flaps is more successful than using a epi-eye surgery. In this study, we associated the results of femto-eye-

surgery with epi-eye-surgery (flap creation using a epikeratome which is more higher flap formation than microkeratome). In addition, Kalyvianaki MI etal. found that epi-eye-surgery and off-flap epi-eye-surgery gave equivalent graphical and refractive results in the treatment of low and middle myopia. In another study, Na et al. discovered that off-flap epi-eye-surgery surgery produced greater graphical recovery and corneal re-epithelialization than epi-eye-surgery surgery in the early postoperative period. Moreover, despite the fact that femto-eye-surgery provides for precise, safe, and predictable flap implantation, intraoperative or postoperative problems can occur in some cases as a result of the procedure. As a result, in the current study, The researchers examined the graphical and refractive results of femto-EYE- SURGERY and flap-off epi-eye-surgery surgery in myopic and myopic astigmatism; nevertheless, there were no significant differences in these results after one years.

Surface ablation techniques (e.g., photorefractive keratectomy , transepithelial photorefractive keratectomy optical maser epithelial keratomileusis eye surgery and epipolis optical maser in situ keratomileusis epi-eye-surgery are less painful and provide faster graphical therapy than stromal ablation methods (such as optical maser in situ keratomileusis with a flap created either automatically with a microkeratome or with a femtosecond optical maser- based microkeratome [femto-eye-surgery]). Corneal haze, on either side, is caused by cornea backward light scattering paired with a decrease in corneal transparency. Increased ablation volume which has been shown to increase backscattering], and cases of severe myopia require higher ablation may require a higher dose of MMC during the refractile surgery According to Sia et al. and Chen et al. , M.M.C was effective in reducing corneal haze without delaying epithelialization. There were no significant differences detected in the current investigation. When comparedto the flap-off epi-eye-surgery group, the femto-eye-surgery group had statistically significant improvements in graphicalacuity and refractive errors after 1 day and 1 week; nevertheless, the two surgical procedures had equal effectsfor the rest of the follow-up period.

Refractile surgery works by inducing positive SA shifts for myopia correction and negative shifts for myopia correction Furthermore, the S.C.H.W.I.N.D Amaris 740S excimer optical maser concept includes the use of an optimised aspheric profile to avoid surgically induced HOAs, particularly SA and coma aberration. In low and moderate myopic patients, however, there was a statistically significant and slight induction of SA between preoperative and postoperative eye-surgery surgery (0.122 0.216 in femto-eye-surgery and 0.123 0.217 in epi-eye-surgery, respectively; data not shown), and a much more significant induction of SA inhigh myopic patients (0.304 0.130 in femto-eye-surgery and 0.457 0.147 in epi-eye-surgery. Adaptive optics systems were used to investigate the effect of SA on depth of focus. For a fixed f-number, the depth of focus is relatively insensitive to focal length and subject distance. Myopia is a condition in which lightfocuses in front of rather than on the retina. The goal of myopic or hyperopic refractile surgery is to change thekeratometric power to correct the Acquired vision

The elements that influence optical and graphical quality following epi-eye-surgery in high myopia individuals wereinvestigated, and it was determined that constructing a wider optical zone diameter was advised for improved graphical quality after surgery. Wider studies with a larger population of patients are needed to assure more trustworthy results due to the small sample size in this study.

Conclusions

Refractile surgery is a common surgical technique that removes the need for glasses or contact lenses. Our researchdemonstrated that both femto-eye-surgery and flap-off epi-eye-surgery are safe, successful, and predictable refractive procedures. We also discovered that flap-off epi-eye-surgery was an efficient surgical procedure for patients who did not have corneal ectasia after refractile surgery. Femto-eye-surgery is a viable option and can be a better surgical method that results in less postoperative SA and better pictorial results in the early stages of recovery.

References

1. Cheung SW, Boost MV, Cho P. Pre-treatment observation of axial elongation for evidence-based selection ofchildren in Hong Kong for myopia control. Cont Lens Anterior Eye 2018;pii: S1367- 0484(18)30870-1.

2. Wang B, Naidu RK, Qu X. Factors related to axial length elongation and myopia progression inorthokeratology practice. PLoS One 2017;12:e0175913.

3. Munnerlyn CR, Koons SJ, Marshall J. Photorefractive keratometry: a technique for optical maser refractilesurgery. J Cataract Refract Surg 1988;14:46-52.

4. Patel SV, Maguire LJ, McLaren JW, Hodge DO, Bourne WM. Femtosecond optical maser versus mechanical microkeratome for EYE-SURGERY: a randomized controlled study. Ophthalmology 2007;114:1482-1490.

5. Lim T, Yang S, Kim M, Tchah H. Comparison of the IntraLase femtosecond optical maser and mechanical microkeratome for optical maser in situ keratomileusis. Am J Ophthalmol 2006;141:833-9.

6. Kezirian GM, Stonecipher KG. Comparison of the IntraLase femtosecond optical maser and mechanical keratomes for optical maser in situ keratomileusis. J Cataract Refract Surg 2004;30:804-11.

7. Durrie DS, Kezirian GM. Femtosecond optical maser versus mechanical keratome flaps in wavefront-guided optical maser in situ keratomileusis: prospective contralateral eye study. J Cataract Refract Surg 2005;31:120- 6.

8. Tanna M, Schallhorn SC, Hettinger KA. Femtosecond optical maser versus mechanical microkeratome: aretrospective comparison of graphicalresults at 3 months. J Refract Surg 2009;25:S668-671.

9. Xu L, Wang Y, Li J, et al. Comparison of forward light scatter changes between smile, femtosecond opticalmaser-assisted EYE-SURGERY , and epipolis EYE-SURGERY : Results of a 1-year prospective study. J Refract Surg 2015;31:752-8.

10. RE, Reyes KB, Hernandez JA, Tchah H. Wavefront-guided epithelial optical maser in situ keratomileusis with mitomycin-C for myopia and myopic astigmatism: flap-on versus flap-off technique. J Cataract RefractSurg 2011;37:1133-9.

11. Zhang Y, Chen YG, Xia YJ, Qi H. Comparison of tear cytokines and clinical results between off-flap and on-flap epi-EYE-SURGERY with mitomycin C. J Refract Surg 2012;28:632-8.

12. Wen D, McAlinden C, Flitcroft I, et al. Postoperative efficacy, predictability, safety, and graphicalquality ofoptical maser corneal refractile surgery : A network meta-analysis. Am J Ophthalmol 2017;178:65-78.

13. Baek T, Lee K, Kagaya F, Tomidokoro A, Amano S, Oshika T. Factors affecting the forward shift of posterior corneal surface after optical maser in situ keratomileusis. Ophthalmology 2001;108:317-320.

14. Ambrosio R, Caiado AL, Guerra FP, et al. Novel pachymetric parameters based on corneal tomography for diagnosing keratoconus. J Refract Surg 2011;27:753-8.

15. Muftuoglu O, Ayar O, Ozulken K, Ozyol E, Akinci A. Posterior corneal elevation and back difference corneal elevation in diagnosing forme fruste keratoconus in the fellow eyes of unilateral keratoconuspatients. J Cataract Refract Surg 2013;39:1348-1357.

16. Byun YS, Chung SH, Park YG, Joo CK. Posterior corneal curvature assessment after Epi-EYE-SURGERY for myopia: comparison of Orbscan and Pentacam imaging. Korean J Ophthalmol 2012;26:6-9.

17. Piao J, Li YJ, Whang WJ, et al. Comaprative evaluation of graphicalresults and corneal asphericityafter optical maser-assisted in situ keratomileusis with the six-dimension Amaris excimer optical maser system. PLoSOne 2017;12:e0171851.

18. Kalyvianaki MI, Kymionis GD, Kounis GA, Panagopoulou SI, Grentzelos MA, Pallikaris IG. Comparisonofepi-EYE-SURGERY and off-flap epi-EYE-SURGERY for the treatment of low and moderate myopia. Ophthalmology 2008;115:2174-2180.

19. Na KS, Lee KM, Park SH, Lee HS, Joo CK. Effect of flap removal in myopic epi-EYE-SURGERY surgery on graphicalrehabilitation and postoperative pain: a prospective intraindividual study. Opthalmologica2010;224:325-331.

20. dos Santos AM, Torricelli AA, Marino GK, et al. Femtosecond optical maser-assisted eye-surgery flapcomplications.J Refract Surg 2016;32:52-9.

21. Braunstein RE, Jain S, McCally RL, Stark WJ, Connolly PJ, Azar DT. Objective measurement of corneal light scattering after excimer optical maser keratectomy. Ophthalmoloy 1996;103:439-443.

22. Shojaei A, Ramezanzadeh M, Soleyman-Jahi S, Almasi-Nasrabadi M, Rezazadeh P, Eslani M. Shor-time mitomycin-C application during photorefractive keratectomy in patients with low myopia. J Cataract RefractSurg 2013;39:197-203.

23. Virasch VV, Majmudar PA, Epstein RJ, Vaidya NS, Dennis RF. Reduced application time forprophylactic mitomycin C in photorefractive keratectomy. Ophthalmology 2010;117:885-9.

24. Sia RK, Ryan DS, Edwards JD, Stutzman RD, Bower KS. The U.S. Army Surface Ablation Study: comparison of PRK, MMC-PRK, and LASEK in moderate to high myopia. J Refract Surg 2014;30:256-264.

25. Cheung SW, Cho P. Long-term effect of orthokeratology on the anterior segment length. Cont Lens Anterior Eye2016;39:262-5.hen J, Chen Y, Han SN. Comparison of TGF-β1 in tears and corneal haze following Epi-EYE- SURGERY with and without mitomycin C. Int J Ophthalmol 2013;6:312-5.

26. McAlinden C, Moore J. Comparison of higher order aberrations after EYE-SURGERY and LASEK for myopia. JRefract Surg 2010;26:45-51.