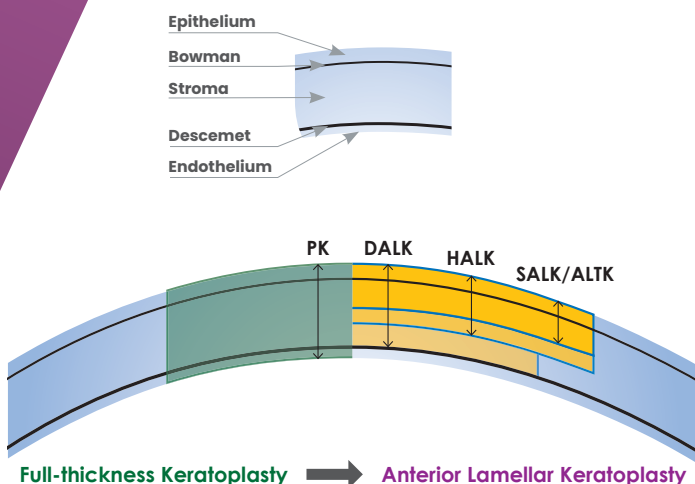


Moria

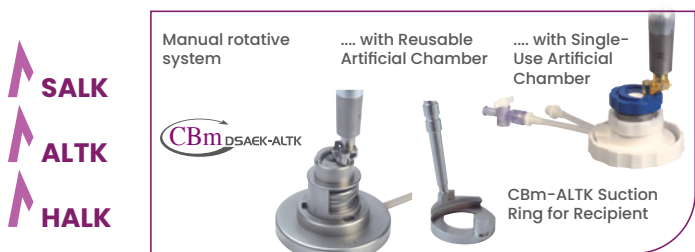
**A compendium of clinical
and laboratory cases**



Anterior Lamellar Keratoplasties



Microkeratome-assisted SALK-HALK-ALTK



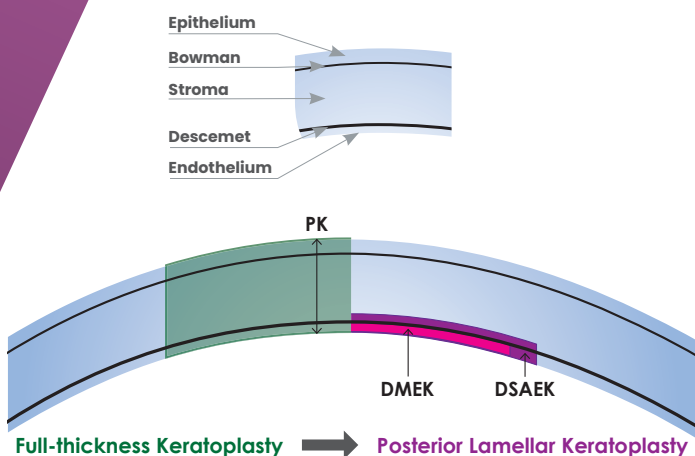
Recipient vacuum trephine-assisted DALK & PK



Vacuum punch-assisted donor preparation



Posterior Lamellar Keratoplasties



Microkeratome-assisted DSAEK graft preparation

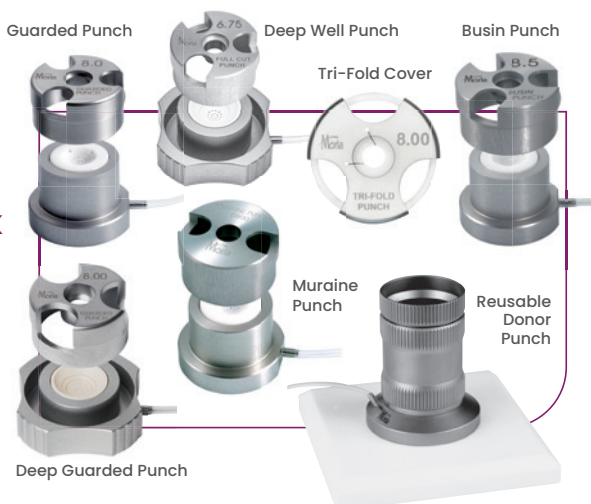
DSA EK



Vacuum punch-assisted DSAEK & DMEK graft preparation

DSA EK

DMEK



SALK ALTK



SALK for anterior stromal opacities

ALTK for mid stromal defects

INDICATIONS

Superficial Anterior Lamellar Keratoplasty (SALK) for the treatment of superficial stromal opacities resulting from:

- previous refractive surgery, infection, degeneration and dystrophy, or trauma¹⁻²
- or after penetrating keratoplasty³.

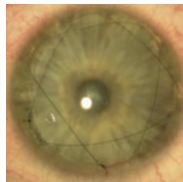
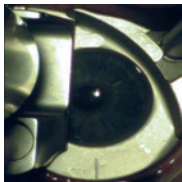
Automated Lamellar Therapeutic Keratoplasty (ALTK) for the treatment of stromal disorders such as: mid scars, moderate keratoconus (central cone), perforations, trauma, trachomatous keratopathy, etc.

TECHNIQUES

► Preparation of the recipient:

- 1) The recipient bed is prepared similarly to a LASIK free cap with:
 - a calibrated CBm-ALTK cutting head:
 - **SALK:** 110-, 130- or 150-micron heads¹⁻³
 - **ALTK:** 200-, 250-, 300- or 350-micron heads
 - a suction ring: to determine the overall flap dimensions.
- 2) The exposed stromal bed is measured (vertically and horizontally) to determine the dimensions of the donor tissue cut:

- **SALK:** same size as the smaller measurement
- **ALTK:** 0.25- to 0.50-mm larger than the residual stromal bed.



► Preparation of the donor graft:

- 1) The donor cornea, mounted on an anterior artificial chamber, is prepared similarly to the recipient, using an equivalent CBm-ALTK head to obtain the flap dimensions.
- 2) The donor graft is laid onto the recipient bed:
 - **SALK:** overlay sutures can be used to secure positioning on the graft, and/or a bandage contact lens may be used.
 - **ALTK:** the lamellar graft is sutured in place under tension with interrupted 10-0 nylon sutures; knots are buried.

CLINICAL OUTCOMES¹⁻²

Final refraction is possible within 1 month from surgery.

In a series of 20 patients:

- SALK successfully managed to clear the central optical zone
- BSCVA improved to > 20/40 as early as 1 month postop
- every single patient experienced a postoperative refractive astigmatism < 4δ
- vision can still improve.

TAKE-HOME MESSAGES¹⁻³

SALK & ALTK share the advantages of a lamellar keratoplasty:

- it is an **extraocular procedure**,
- it **preserves the host endothelium**,
- so **postop steroidal treatment is minimized**.

SALK & ALTK have unique advantages:

the technique is **simple, easy to perform** (like a LASIK flap), and is **standardized**; the time necessary for **visual rehabilitation is much shorter** than usually needed with thicker grafts (DAK & PK).

1. Busin M. *Tech Ophthalmol.* 2006;4(1):1-5

2. Busin M, Arffa RC. SLACK Inc, 2006;Chapter 3:23-30

3. Busin et al. *Cornea* 2012;31(1):101-105



HALK for irregular anterior to mid stromal scarring

RATIONALE

In case of marked corneal irregularities, a microkeratome reproduces them on the recipient bed, potentially compromising visual outcomes.

INDICATION⁴⁻⁵

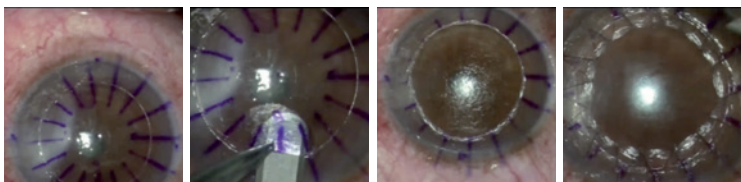
Hemi-Automated Lamellar Keratoplasty (HALK) is a hybrid anterior lamellar keratoplasty in corneas with superficial to mid-stromal scars and topographical irregularities, such as: post-infection scar, post-ptyerygium removal scar, post-trauma/PRK scar, recurrent corneal dystrophy, etc.

TECHNIQUE⁴⁻⁵

HALK combines both **manual and automated steps**:

- a manual recipient lamellar dissection using the reusable Hanna or single-use adjustable trephine,
- an automated donor preparation using the CBm-ALTK microkeratome.

► RepARATION of the recipient:



The recipient cornea is manually dissected using the trephine:

- with a predetermined depth, usually 200 to 300 μm based on localization of the anterior stromal pathology
- with a predetermined diameter: from 7.00 to 10.50 mm.

A crescent knife is used to dissect the anterior lamellae, then corneal scissors to excise the dissected lamellae margins at the edge of trephination.

► Preparation of the donor graft:

- 1) The donor cornea, mounted on an anterior artificial chamber, is prepared using the CBm-ALTK microkeratome.
The CBm-ALTK calibrated head is selected to obtain a postoperative total corneal thickness of 550-600 μm .
- 2) The created anterior cap is placed on the donor punch to produce:
 - a straight-edged donor anterior lamellar graft,
 - customized to match the recipient trephination diameter or 0.25 mm oversized.
- 3) The anterior graft is sutured onto the recipient bed using a 10/0 nylon single or an eight-bite double continuous antitorque suturing technique.

CLINICAL OUTCOMES⁵

- 35 eyes of 35 patients with heterogeneous causes of anterior stromal scarring: contact lens associated infectious keratitis (29%), scars (26%), dystrophies (14%), other (31%).
- Almost 7 years of follow-up from the date of surgery.
- No intraoperative complication occurred.
- No postoperative graft rejections occurred.
- **Visual acuity**: UCVA and BSCVA improved significantly in 93.5% patients, due to stromal interface remodeling.
- **Refraction**: stabilization of refractive astigmatism.
- **Kaplan-Meier estimated survival** for all HALK cases was 90.6 months with a survival probability of 96% at 12 months, and 92% at 3, 5 and 7 years of follow-up.

TAKE-HOME MESSAGES ⁴⁻⁵

HALK combines a smooth microkeratome lamellar interface with a sharp accurate recipient manual dissection.

HALK is a safe and effective procedure with:

- **excellent graft survival** in primary cases or with prior keratoplasty,
- **significant improvement in visual acuity,**
- **low complication rates.**

Furthermore: HALK allows use of poor quality endothelial tissue.

4. Tan et al. *British J Ophthalmol.* 2011;95(11):1513-1518

5. Mehta et al. *Clin Exp Ophthalmol.* 2018;46(9):1017-1027



From wet-lab effectiveness...

BACKGROUND

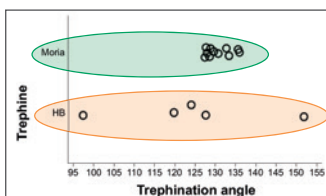
The **Moria single-use adjustable depth trephine (#17202Dxxx)** has unique features that allow to select and target a trephination depth for a DALK surgery.

STUDY DESIGN⁶

- **Design:** Wet-lab study on cadaveric human eyes.
- **Purpose:** To evaluate the 8.0-mm Moria adjustable trephine (#17202D800) in terms of:
 - accuracy of trephination depth
 - angle of trephination
 - compared to competitive Hessburg-Barron® trephine (Katena)
 - **when set at 80% of corneal thickness.**
- **Materials:**
 - Recipient single-use trephines:
 - Moria: 8.0-mm Moria adjustable trephine (#17202D800)
 - Katena: 8.0-mm Hessburg-Barron® trephine
 - Light microscopy to image antero-posterior cross-sections of each corneal specimen.
 - Digital protractor software to evaluate the trephination angle, depth and length.
- **Participants:**
 - Wet-lab study on 11 fresh human cadaveric eyes
 - Trephination depth was set to 80% of average corneal pachymetry in the peripheral 7–10 mm range previously obtained using anterior-segment OCT imaging.

RESULTS⁶

- **Trephination depth** obtained with Moria trephine (% of corneal thickness):
 - mean: $83.7\% \pm 6.5$ [71.3 – 95.3]
 - 95% confidence interval: [79.8 – 87.6] %
- **Trephination angle** obtained:
 - Moria: $130.2 \pm 3.6^\circ$ [126° – 135.5°]
 - Katena: $123.8 \pm 20^\circ$ [97° – 153°]



Top: AS-OCT images of corneal recipient rims created by Moria (left) and Katena (right)
Bottom: light microscopy of corneal recipient rims created by Moria (left) and Katena (right)
Red arrows: remnant corneal tissue due to irregular cuts with Katena trephine

CONCLUSION⁶

The Moria adjustable vacuum trephine is an accurate method of trephination when a specific depth is desired.



... to proven surgical benefits

STUDY DESIGN⁷

► **Design:** Retrospective, non comparative, interventional case series.

► **Purpose:** To evaluate safety & efficacy of deep trephination DALK with peripheral air injection employing the 9.0-mm Moria adjustable trephine intended to a depth within 100 µm from the patient's endothelium.

► **Material:**

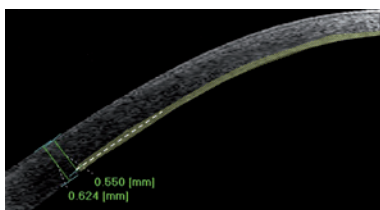
- 9.0-mm Moria single-use adjustable trephine: #17202D900

► **Participants:**

- 88 eyes of 88 patients scheduled for DALK
- Deep trephination was set to a depth within 100 µm from the patient's endothelium in the peripheral 9.0 mm range, previously obtained using anterior-segment OCT imaging

RESULTS⁷

- pneumatic dissection success: 85%
- suction loss during trephination: n=2 (2.3%)
- perforation: n=4 (4.6%)
- DALK converted to full-thickness PK: n=1 case (1.1%)



AS-OCT images illustrating:

- left: the conventional DALK approach
- right: the deep trephination DALK technique with peripheral air injection

SUCCESS RATE INDEPENDENT OF SURGEON'S EXPERIENCE⁸

Group	1	2	3
Surgeon experience	Low: <10 cases	Moderate: [10 – 100]	High: >100 cases
Nb of surgeons	4	2	2
Nb of patients	4 x 10	2 x 10	2 x 10
Success rate	77.5%	95%	90%

CONCLUSION⁷⁻⁸

Setting the 9.0-mm Moria adjustable trephine to a depth within 100 µm from the endothelial surface:

- eliminates the need for reaching the central cornea for successful pneumatic dissection,
- substantially flattens the learning curve of DALK,
- while achieving a constant success rate above 80% and minimizing complications⁷.

With such standardized technique, surgeons are equally successful in achieving pneumatic dissection independent of their surgical experience⁸.

7. Busin et al. *American J Ophthalmol.* 2016;164(4):6-13

8. Busin et al. *Cornea* 2019;38(5):645-647



Surgeons' nomograms to constantly prepare thin DSAEK grafts

BACKGROUND

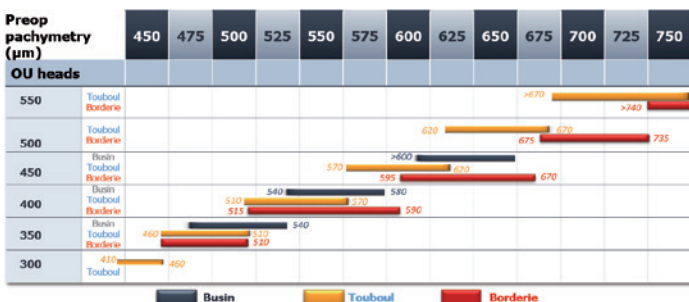
The latest generation of linear microkeratomes by Moria offers the convenience to safely and accurately prepare thin DSAEK grafts.

STUDY DESIGNS⁹⁻¹⁰⁻¹¹

- **Purpose:** To compare the results of One Use turbine-assisted Ultra-Thin DSAEK using nomograms developed by surgeons for a single-pass technique.
- **Material:**
 - One Use turbine by Moria (#19155)
 - One Use Large-Cut heads by Moria (#19184/xxx) in different sizes
 - Graft thicknesses measured by anterior segment OCT imaging
- **Methods:**

Author	Nb of eyes	Intracameral pressure	Cutting process
Busin et al. ⁹	42	90 mmHg	~5 seconds
Touboul et al. ¹⁰	49	90 mmHg	~5-6 seconds
Borderie et al. ¹¹	112	90 mmHg	as slow as possible

RESULTS⁹⁻¹⁰⁻¹¹



- Busin et al.⁹: central graft thickness at 3 months postop:
 - **63 ± 29 µm**
 - <130 µm: 97% of grafts
 - <100 µm: 90% of grafts.
- Touboul et al.¹⁰:
 - central graft thickness at 1 month postop: **102.8 ± 35.9 µm**
 - central graft thickness at 6 months postop: 89.4 ± 26.2 µm
 - endothelial cell loss at 6 months postop: -28 ± 15%.
- Borderie et al.¹¹: central graft thickness was **74 ± 49 µm** at 32 ± 29 months postoperatively.

CONCLUSIONS⁹⁻¹⁰⁻¹¹

Nomograms developed at different institutions allow:

- **reliable single-pass dissection** of donor tissue,
- **creating consistently thin and symmetric grafts⁹⁻¹⁰⁻¹¹.**

Results compare favorably with those reported in the past for double-pass microkeratome-assisted dissection of Ultra-Thin DSAEK¹².

9. Busin et al. *Cornea* 2015;34(11):1362-1364

10. Touboul et al. *French J Ophthalmol.* 2016;39(9):780-785

11. Borderie et al. *British J Ophthalmol.* 2020;104(9):1317-1323

12. Busin et al. *Ophthalmology* 2013;120(6):1186-1194



From wet-lab validation...

BACKGROUND

Maintain of intracameral pressure during DSAEK graft preparation erases one variable for an even tighter predictability of calibrated cutting heads.

STUDY DESIGN¹³

► Design

Wet-lab study on 30 human research corneas.

► Purpose

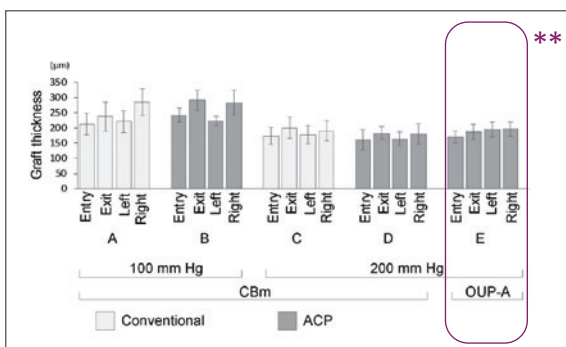
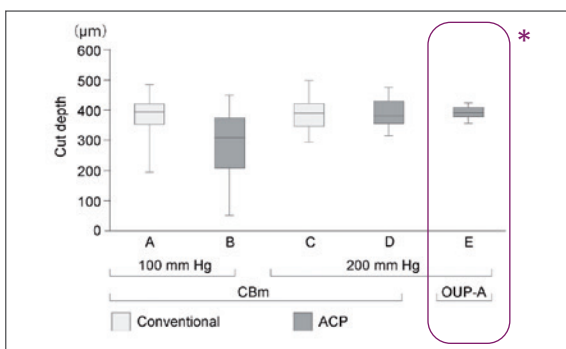
To highlight benefits of using **ACP** in combination with **One Use-Plus** (OUP) microkeratome.

► Materials

- One Use-Plus and CBm microkeratomes by Moria
- ACP system to pressurize artificial chamber at 100 vs 200 mmHg

RESULTS¹³

- **Head performances***: the smallest variation in mean cut depth was observed when combining the OUP microkeratome with ACP at 200 mmHg & open system.
- **Uniformity of DSAEK grafts**** up to 3 mm from the center: again, more uniform-shaped DSAEK grafts were obtained when combining OUP microkeratome with ACP at 200 mmHg & open system.
- **Endothelial cell loss**: changes in endothelial cell density before and after the cuts were from -5.6 to +2.2%, without statistically significant differences among all the groups.
- **Stromal surface**: SEM (Scanning Electron Microscopy) analysis showed that combining the OUP microkeratome with ACP at 200 mmHg & open system didn't compromise smoothness of the residual stromal bed.



CONCLUSION¹³

An intracameral pressure of 200 mmHg in combination with the One Use-Plus microkeratome is the **best setting for UT-DSAEK grafts** with high predictability of cut depth and uniformity of graft thickness with limited endothelial cell damage.



... to added-value eye banking practice

STUDY DESIGN¹⁴

► **Design:** Retrospective study.

► **Purpose:** To compare the reliability of One Use-Plus (OUP) microkeratome with ACP system versus conventional pressurization for Ultra-Thin DSAEK graft preparation.

► **Objective:**

To obtain a central DSAEK graft thickness $\leq 100 \mu\text{m}$.

► **Materials:**

- One Use-Plus microkeratome and ACP system by Moria
- Series of 265 consecutive human corneas processed for surgical purposes as per following:

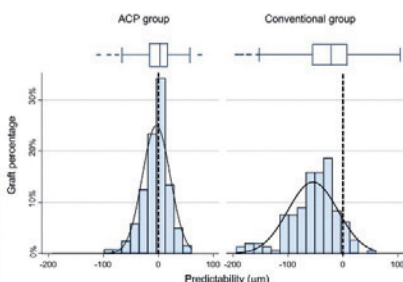
Group study	Nb of corneas	Pressurization method	Intracameral pressure	System open/closed
Group A	120	ACP	240 mmHg	open
Group B	145	Infusion line	200 mmHg	closed

- Corneal & graft thicknesses were measured by anterior segment OCT:
 - before and immediately after the cut,
 - centrally: corneal thickness (CCT) & graft thickness (CGT)
 - peripherally:
- along 2 meridians: horizontal and vertical to the microkeratome pass line,
- up to 9.0 mm diameter: $\pm 0, 1, 3, 4$ and 4.5 mm from the corneal center.

RESULTS¹⁴

There was a statistical gain of accuracy and predictability with ACP:

Group	ACP	Infusion line
Nb of corneas	120	145
CCT (μm)	522.6 ± 52.5	538.6 ± 69.8
CGT (μm)	89.5 ± 16.7	94.6 ± 23.6
CGT $\leq 130\mu\text{m}$	100%	97.2%
CGT $\leq 100\mu\text{m}$	72.5%	58.6%
Predictability (μm)	-3.9 ± 2.3	-54.6 ± 3.7



CONCLUSION¹⁴

ACP system at 240 mmHg improved single-pass OUP-assisted preparation reliability of Ultra-Thin DSAEK grafts:

- achieving central graft thickness $\leq 100 \mu\text{m}$
- with significantly higher frequency
- and predictability compared to conventional pressurization.



Different approaches & techniques: dedicated donor punches

BACKGROUND

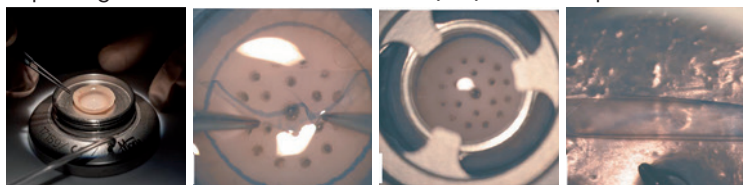
Since introduction of DMEK by Dr Melles in 2006¹⁵, different iterations have been proposed requiring the use of dedicated donor punches. Here we'll briefly review main DMEK graft harvesting techniques using 3 different types of donor punches by Moria.

I) "SCUBA" PEELING TECHNIQUES¹⁶⁻²³

a) Vacuum-assisted Hanna donor punch¹⁶⁻²²

Kruse et al. (Erlangen, Germany)¹⁶⁻¹⁹ then Seitz et al. (Homburg, Germany) have both standardized their bi-manual underwater technique by positioning corneoscleral buttons onto the **Hanna donor punch** connected to the **Evolution 3E console** for an ~730 mmHg vacuum.

A 8.0- & 7.5-mm disposable Hanna blade is respectively used to superficially mark borders of the future DMEK grafts, followed by peeling off the Descemet Membrane (DM) with forceps, then DM



is completely trephined with the same Hanna blade.

b) Guarded blade technology to find DM cleavage plan²³

Team from Rocky Mountain Lions Eye Bank (Denver, CO, USA) is routinely using:

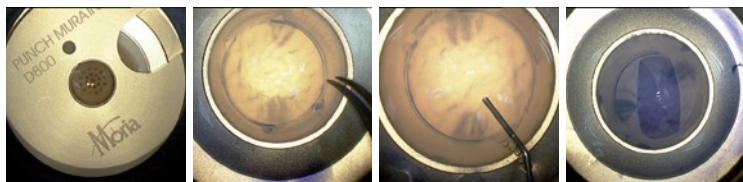
- a **9.5-mm guarded donor punch (#17207D950)** to find a proper cleavage plan to peel the DM off
- until approximately 90% of the DM disc is separated,
- then a regular **8.0-mm full-thickness Busin donor punch (#17200D800)** is used to finalize the DMEK graft diameter.

Their results of acceptable endothelial cell loss confirms that complete DMEK graft preparation can be conducted in an eye bank setting without compromising graft viability.

II) HYDRODISSECTION TECHNIQUE WITH REVERSED CORNEA²⁴

Muraine et al. (Rouen, France) reported an innovative and efficient hydrodissection harvesting technique²⁴:

- by generating two access endothelial flaps (uncut hinges) on opposite sides of the cornea thanks to the **8.0-mm Muraine donor punch (#17209D800)**,
- then reversing the donor cornea, endothelium up, onto an artificial chamber,
- then hydrodissection is performed using a 27G Rycroft cannula filled with corneal storage medium or BSS,
- allowing DM to be folded in a **"burrito" shape similar to a DSAEK** graft with the endothelium inside the burrito.



TAKE-HOME MESSAGE

The Descemet Membrane being delicate and prone to tears, a critical step in DMEK surgery is preparation of the donor endothelial graft.

Moria developed a wide range of donor punches to accompany every harvesting technique in order to:

- maximize preservation of the endothelial cell density
- secure long-term graft survival
- reduce loss of precious donor tissue.

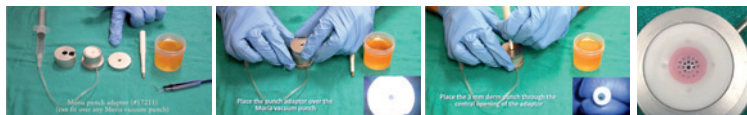


Punch adapter for paired concentric donor trephination

BACKGROUND

Difficulties in achieving concentric double punches of the donor tissue have been reported as regards the type 1 Boston K-Pro keratoprosthesis²⁵⁻²⁷.

The Moria punch adapter (#17211) used with the Busin punch, is a simple and cost-effective device to standardize such crucial step:



STUDY DESIGN²⁸

► Design

1:1:1 three-arm wet-lab study.

► Purpose

To assess gain of centration accuracy when using the Moria punch adapter (#17211) in combination with the Busin punch.

► Materials

- 30 human corneas not suitable for transplantation
- 8.0-mm Busin single-use vacuum-assisted donor punch: #17200D800
- Reusable punch adapter: #17211

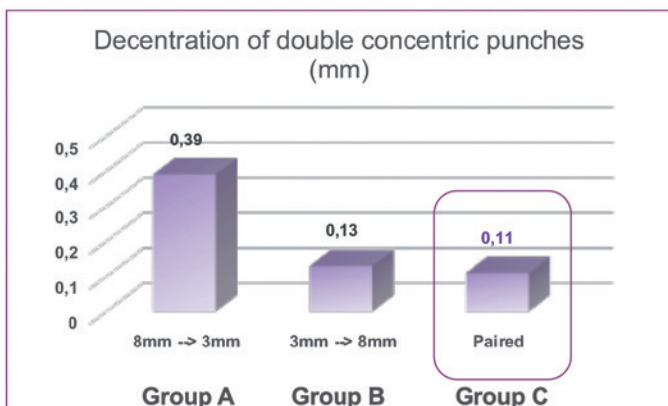
► Method

Centration of the two punches were measured using PhotoShop® (Adobe, USA) by a masked examiner.

Group study	Nb of corneas	1 st punch	2 nd punch
Group A	10	8-mm	3-mm
Group B	10	3-mm	8-mm
Group C	10	Paired 3- & 8-mm simultaneous punches using punch adapter	

RESULTS²⁸

Mean decentration was statistically lower when simultaneously pairing the two punches rather than consecutively.



CONCLUSION²⁸

Pairing the two punches on the donor cornea with the use of punch adapter by Moria leads to **increased predictability and ease of trephination for Boston K-Pro preparation**. This may be an ideal and cost-effective method to prepare the donor corneal rim for surgery.

25. Moshirfar et al. *Clin Ophthalmol*. 2010;4:931-933

26. John T. *Tech Ophthalmol*. 2009;7(4):127-130

27. Moshirfar et al. *Clin Ophthalmol*. 2011;5:1017-1020

28. Baig et al. ESCRS Fall 2014, Sept 16th, London, UK

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▲ **SALK-ALTK: with CBm-ALTK system**

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2. **Busin M, Arffa RC.** Atlas of microkeratome-assisted superficial anterior lamellar keratoplasty. *SLACK Incorporated*, 2006;Chapter 3:23-30
3. **Busin et al.** Microkeratome-assisted superficial anterior lamellar keratoplasty for anterior stromal corneal opacities after penetrating keratoplasty. *Cornea* 2012;31(1):101-105

▲ **HALK: with CBm-ALTK system & Reusable Donor Punch**

4. **Tan et al.** Hemi-automated lamellar keratoplasty (HALK). *British J Ophthalmol.* 2011;95(11):1513-1518
5. **Mehta et al.** Long-term outcomes of HALK. *Clin Exp Ophthalmol.* 2018;46(9):1017-1027

▲ **DALK: with Single-Use Vacuum-Assisted Adjustable Recipient Trephine**

6. **Moshirfar et al.** Accuracy of corneal trephination depth using the Moria single-use adjustable depth vacuum trephine system. *Clin Ophthalmol.* 2014;8:2391-2396
7. **Busin et al.** Outcomes of air injection within 2 mm inside a deep trephination for DALK in eyes with keratoconus. *American J Ophthalmol.* 2016;164(4):6-13
8. **Busin et al.** Deep trephination allows high rates of successful pneumatic dissection for DALK independent of surgical experience. *Cornea* 2019;38(5):645-647

▲ **DSAEK: With One Use manually-driven turbine:**

9. **Busin et al.** Postoperative graft thickness obtained with single-pass microkeratome-assisted UT DSAEK. *Cornea* 2015;34(11):1362-1364
10. **Touboul et al.** Reproducibility of single-pass donor DSAEK tissue preparation with the Moria single-use microkeratome. *French J Ophthalmol.* 2016;39(9):780-785
11. **Borderie et al.** Influence of graft thickness and regularity on vision recovery after endothelial keratoplasty. *British J Ophthalmol.* 2020;104(9):1317-1323
12. **Busin et al.** UT-DSAEK with the microkeratome double-pass technique: two-year outcomes. *Ophthalmology* 2013;120(6):1186-1194

With One Use-Plus automated microkeratome & ACP system:

13. **Shimazaki et al.** Comparison of artificial anterior chamber internal pressures and cutting systems for DSAEK. *Trans Vis Sci Tech.* 2018;7(6):11
14. **Quaranta et al.** Single-pass microkeratome and ACP for the Ultra-Thin DSAEK graft preparation. *Cornea* 2021;40(6):755-763

▲ **DMEK: With Reusable Vacuum-Assisted Hanna Donor Punch & Evolution 3E Console:**

15. **Melles et al.** Descemet Membrane Endothelial Keratoplasty (DMEK). *Cornea* 2006;25(8):987-990
16. **Kruse et al.** A stepwise approach to donor preparation and insertion increases safety and outcome of DMEK. *Cornea* 2011;30(5):580-587
17. **Kruse et al.** Characterization of the cleavage plane in DMEK. *Ophthalmology* 2011;118(10):1950-1957
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20. **Seitz et al.** Anatomy-based DMEK wetlab in Homburg/Saar: novel aspects of donor preparation and host maneuvers to teach DMEK. *Clin Anatomy.* 2018;31(1):16-27
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With Single-Use Vacuum-Assisted Guarded Donor Punch:

23. **Eghrari et al.** Viability of DMEK grafts folded in the eye bank. *Cornea* 2018;37(11):1474-1477

With Single-Use Vacuum-Assisted Muraine Guarded Donor Punch:

24. **Muraine et al.** Novel technique for the preparation of corneal grafts for DMEK. *American J Ophthalmol.* 2013;156(5):851-859

▲ **KERATOPROSTHESIS: with Reusable Punch Adapter**

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FINANCIAL DISCLOSURE

Massimo Busin, MD, PhD (Forlì, Italy) is a paid consultant for Moria. None of the other authors has financial interest in Moria products or is a paid consultant for Moria.

**MORIA SA**

27, rue du Pied de Fourche
03160 Bourbon L'Archambault
FRANCE

Phone: +33 (0)1 46 74 46 74

Fax: +33 (0)1 46 74 46 00

moria@moria-int.com

www.moria-surgical.com

MORIA Inc

1050 Cross Keys Drive

Doylestown, PA 18902

USA

Phone: (800) 441 1314

Fax: + 1 (215) 230 7670

orders@moriusa.com

www.moria-surgical.com

Moria Surgical Spain

C. de Pablo Iglesias, 58

08908 L'Hospitalet de Llobregat

Barcelona - SPAIN

Phone: +34932896270

info@moria-spain.com

www.oftaltech.com

Moria Japan K.K.

Arcadia Building 6F

1-12-3 Kanda

SudachoChiyoda-Ku

Tokyo 101-0041

JAPAN

Phone: 81-3-6260-8309

Fax: 81-3-6260-8310

moria@moriajapan.com

www.moriajapan.com

AL.CHI.MI.A. S.R.L.

(a Moria company)

Viale Austria, 14

35020 - Ponte San Nicoló (PD)

ITALY

Phone: +39 049 89.62.074

Fax: +39 049 89.62.071

info@alchimiasrl.com

www.alchimiasrl.com

Moria COMMERCIAL

(CHINA) CO., LTD.

上海目利亚贸易有限公司

Room H 6F Kaili Building NO.432

West Huai Hai Road, Changning

district, Shanghai, 200052, P.R.C

中国上海市长宁区淮海西路432号

凯利大厦6楼08室

Phone/Fax : +86 021 52586095

moria@moria-int.com

Moria Limited

Suite 1904, 19th Floor,

ST. George's Building,

No. 2 Ice House Street,

Central - HONG KONG

moria@moria-int.com

www.moria-surgical.com



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