600C
ASPHERIC

Rayner

Capture every moment

SUB 2.2 mm

What is important to you? Giving your patients the vision they deserve

Introducing our enhanced lens design for optimal visual quality, and reliable outcomes through sub-2.2 mm incision

Discover more about 600C at **rayner.com/USA**

Rayner manufactured the world's first IOL

When Sir Harold Ridley designed the world's first IOL in 1949, he chose Rayner to manufacture this ground-breaking invention.

Rayner has remained at the forefront of innovation for nearly 70 years, focused on providing you and your patients with the best IOLs – always driven by science to improve patient outcomes and safety.

Rayner is the only manufacturer of IOLs in the United Kingdom, with its state-of-the-art manufacturing facility and global headquarters on the south coast of England.

Rayner USA milestones:

- Choyce Mk VIII was the first global IOL to be approved by the FDA (1979).
- C-flex was the first IOL from a non-American IOL manufacturer to gain FDA approval in over two decades (2007).
- Rayner opened a dedicated USA office in New York City (2017)
- Commercialization of the 600C Aspheric lens (2019).

Accurate, predictable and sustainable refractive outcomes

Built on the clinically-proven Rayner primary IOL platform, the 600C Aspheric is a hydrophilic aspheric monofocal IOL with our Amon-Apple 360° Enhanced Square Edge. Now available in the USA, Rayner's global lens design offers surgeons a sub-2.2 mm incision IOL for minimal wound damage and surgically-induced astigmatism (SIA).

We believe that every patient's vision is important and there is no such thing as the 'average' cornea. That is why the Rayner 600C Aspheric lens is aberration neutral, allowing patients to benefit from the natural residual positive aberration of the cornea.

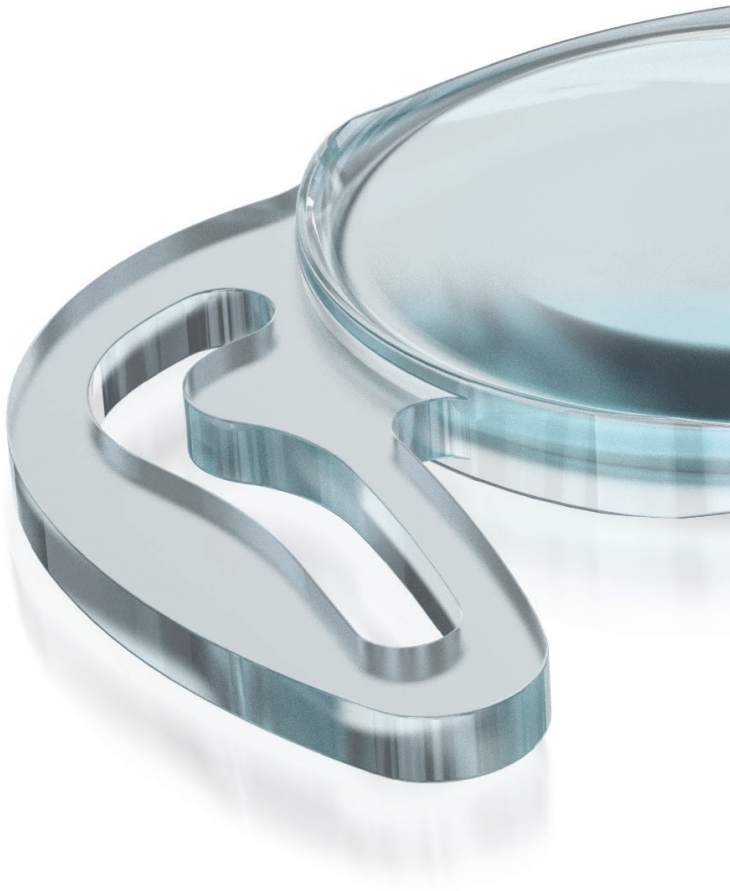
600C Aspheric is available across a wide power range (+8.0 D to +34.0 D).

Enhanced 6 mm optic

When considering an intraocular lens, what is important to you?

An IOL free from vacuoles and glistenings

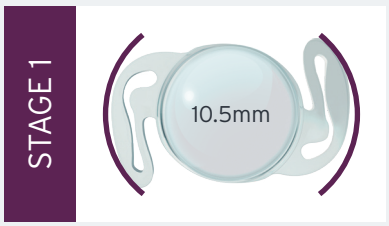
- Single piece IOL created from Rayacryl – a homogeneous material free of microvacuoles, resulting in a glistening free IOL[1]
- Compressible material for delivery through a sub-2.2 mm incision
- Excellent handling characteristics with controlled unfolding within the capsular bag
- Low silicone oil adherence[2]
- Excellent uveal biocompatibility[3]
- Hydrophilic acrylic material with low inflammatory response[4]



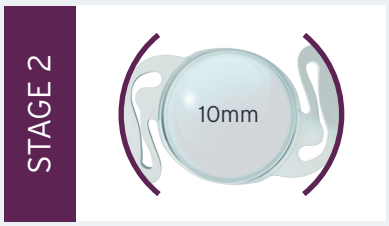
Reducing dysphotopsia by design[8]

- Rayner's enhanced square edge technology shows no general increase in glare from previous models without a square edge[9]
- The low refractive index (1.46) of Rayacryl

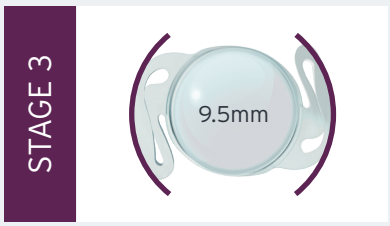
Stability of Rayner 600C Aspheric:



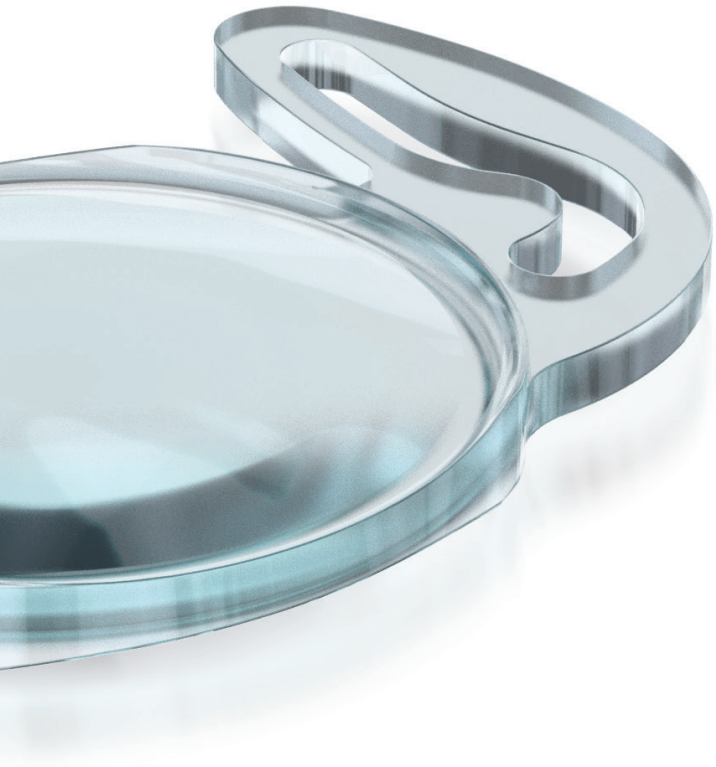
Outer haptics begin to take up the compression forces of post-operative capsule contraction



Outer haptics engage the inner haptics



Haptic tips gently meet the IOL optic and are effectively locked into position



Optimal visual quality in all lighting conditions

- Aspheric optic technology reduces higher order aberrations when compared with spherical IOLs[6,7]
- Excellent contrast sensitivity[6,7] and a retained depth of field from an aberration-neutral aspheric optic

Reliable refractive outcomes and a low rate of post-operative complications

Rayner's anti-vaulting haptic (AVH) technology provides excellent fixation in the capsular bag[5]:

- **Superb centration** – maximum offset of only 0.4 mm 3 to 6 months after surgery[11]
- **Excellent rotational and torsional stability** – 2.3° mean IOL rotation 3 to 6 months after surgery[11]

Nd:YAG capsulotomy rates

Rayner's 360° Amon-Apple Enhanced Square Edge creates an optimum barrier to reduce epithelial cell migration including at the haptic-optic junction.[9,10]

ND:YAG CAPSULOTOMY RATES[9]		MEAN TIME TO ND:YAG CAPSULOTOMY[9]
At 12 months	0.6%	9.3 ± 5.5 months (range 2.6 - 22.7 months) Follow-up period: 5.3 - 29 months
At 24 months	1.7%	

A study of 3,461 patients receiving Rayner 570C IOLs over a 24 month period, Nd:YAG capsulotomy rates were extremely low and comparable with hydrophobic acrylic lenses with square-edge optics.[9]

Rayner 600C has optical and material equivalence to the Rayner C-*flex* 570C and 970C IOLs.

Technical specification

600C Aspheric Monofocal IOL	
Material:	Single piece Rayacryl hydrophilic acrylic
Water Content:	26% in equilibrium
UV Protection:	Benzophenone UV absorbing agent
UV Light Transmission:	UV 10% cut-off is 380 nm
Refractive Index:	1.46
ABBE:	56
Overall Diameter:	12.5 mm
Optic Diameter:	6.0 mm
Optic Shape:	Biconvex
Asphericity:	Anterior aspheric surface with aberration-neutral technology
Optic Edge Design:	Amon-Apple 360° Enhanced Square Edge
Haptic Angulation:	0°, uniplanar
Haptic Style:	Open loop with anti-vaulting haptic (AVH) technology
Power range:	+8.0 D to +30.0 D (0.5 D increments) +31.0 D to +34.0 D (1.0 D increments)

Estimated Constants for Optical Biometry						
	SRK/T	Haigis			HofferQ	Holladay
	A-constant	a0	a1	a2	pACD	SF
600C Aspheric	118.6	1.17	0.40	0.10	5.32	1.56

For Contact Ultrasound, the estimated A-constant is 118.0.

Please note that the constants indicated for all Rayner lenses are estimates and are for guidance purposes only. Surgeons must always expect to personalize their own constants based on initial patient outcomes, with further personalization as the number of eyes increases.

Rayner 600C Aspheric Intraocular Lenses (IOLs)

CAUTION: Federal U.S law restricts this device to the sale by, or on the order of a physician.

INDICATIONS: The Rayner 600C intraocular lens is indicated for primary implantation for the visual correction of aphakia in adults in whom a cataractous lens has been removed by phacoemulsification. The lens is intended to be placed in the capsular bag.

CONTRAINDICATIONS: Apart from non-specific contraindications related to any form of ocular surgery, the following specific contraindications must be respected:

1. Microphthalmia
2. Active ocular disease (e.g. chronic severe uveitis, proliferative diabetic retinopathy, chronic glaucoma not responsive to medication)
3. Children under the age of 21 years
4. Corneal decompensation or corneal endothelial cell insufficiency
5. Persons who are pregnant or nursing.

WARNINGS: A risk/benefit ratio must be assessed before confirming a patient as a candidate for the Rayner 600C IOL implantation, if they are suffering from any of the following conditions:

1. Recurrent ocular disease (e.g. uveitis, diabetic retinopathy, glaucoma, corneal decompensation)
2. Previous ocular surgery
3. Non-age related cataract
4. Vitreous loss
5. Iris atrophy
6. Severe Aniseikonia
7. Ocular Hemorrhage
8. Macular degeneration
9. Zonular dehiscence
10. Ruptured posterior capsule
11. Patients in whom the intraocular lens may affect the ability to observe, diagnose, or treat posterior segment diseases.
12. Surgical difficulties at the time of cataract extraction which might increase the potential for complications (e.g. persistent bleeding, significant iris damage, uncontrolled positive pressure, or significant vitreous prolapse or loss).
13. A distorted eye due to previous trauma or developmental defect in which appropriate support of the IOL is not possible.
14. Circumstances that would result in damage to the endothelium during implantation.
15. Suspected microbial infection.
16. Children under the age of 2 years are not suitable candidates for intraocular lenses.

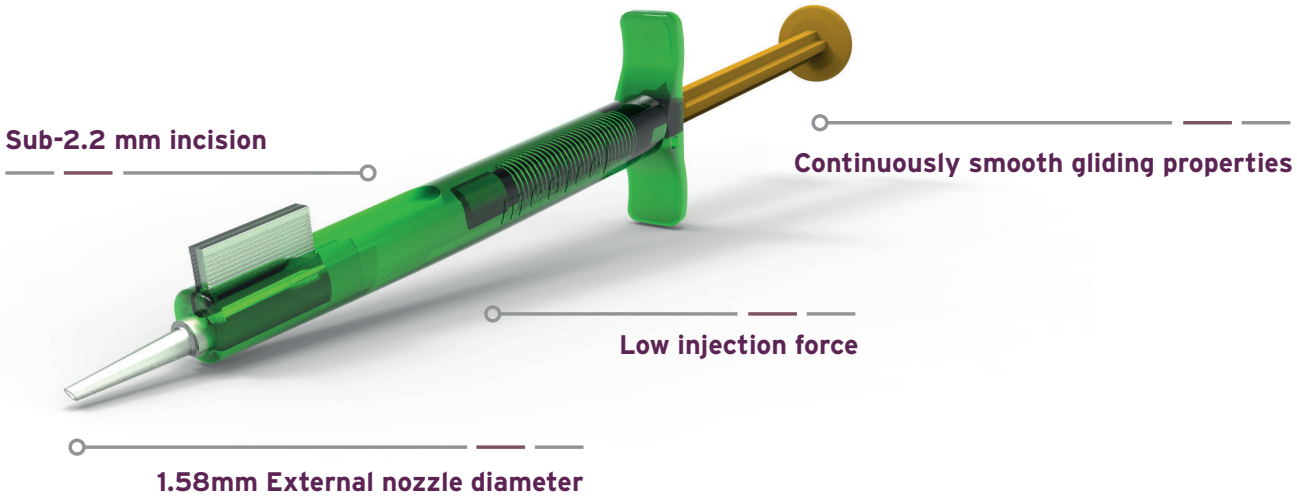
The Rayner 600C has optical and material equivalence to the Rayner C-*flex* 570C IOL.

ATTENTION: Reference the Instructions for Use labelling for a complete listing of Indications and precautions.

Medicel Viscoject 1.8

The world's most frequently used universal IOL injector

Validated for use and supplied with 600C



For optimal visual quality and reliable outcomes, choose the Rayner 600C Aspheric

600C Aspheric Monofocal IOL	
Optic diameter:	6.0 mm
Overall length:	12.5 mm
Estimated A-Constant:	118.6 (optical biometry) 118.0 (contact ultrasound)
Power range:	+8.0 D to +30.0 D (0.5 D increments) +31.0 D to +34.0 D (1.0 D increments)

References:
1. Rayner. Data on File. White paper
2. McLoone E et al. Br J Ophthalmol. 2001; 85:543–545
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8. Cezón Prieto J and Bautista MJ. J Cataract Refract Surg. 2010; 36:1508-1516
9. Mathew RG and Coombes AGA. Ophthalmic Surg Lasers Imaging. 2010 Nov-Dec; 41(6):651-5
10. Vyas AV et al. J Cataract Refract Surg 2007; 33:81-87
11. Bhogal-Bhamra Gk et al. Data presented at ESCRS congress 2017

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