Injection Techniques for the Primary Care Optometrist

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Nate Lighthizer disclosures

• Aerie Pharmaceuticals
• Allergan
• BioTissue
• Diopsys
• Optovue

• No financial disclosures relating to any material in this lecture

Overview

• Asepsis and OSHA
• Injections:
  • Intramuscular
  • Intravenous
  • Subconj
  • Subcutaneous/Intradermal
• Removal of Lesions/Videos
• Lab Time
  • Injections on each other

Asepsis

• PREVENTION OF CONTACT WITH MICROORGANISMS,
  FREEDOM FROM INFECTION
• ANYONE IN SURGICAL SUITE HAS RESPONSIBILITY TO
  PROVIDE AND MAINTAIN A SAFE ENVIRONMENT
• HUMAN BODY MAJOR SOURCE OF CONTAMINATION
• BACTERIA IN SEBACEOUS GLANDS AND AROUND HAIR
  FOLLICLES CANNOT BE DESTROYED

Mechanisms for Asepsis

• SURGICAL ATTIRE
  • BARRIER FROM PERSONNEL TO PATIENT AND PATIENT TO
    PERSONNEL
  • SCRUBS, HAIR COVERING
  • USE EYEWEAR AND MASKS WHEN RISK OF SPLASH
  • NO CLOTH SHOES OR SANDALS
  • SHOE COVERS IF SPLASH OR SPILL POSSIBLE

Mechanisms for Asepsis

• HANDS OF OPERATING TEAM
  • FINGERNAILS SHORT, CLEAN AND HEALTHY
  • SCRUB HANDS
  • NO RINGS OR JEWELRY
  • HAIR BACK (CAPS, MASKS, ETC)
  • DONNING STERILE GLOVES
MECHANISMS FOR ASEPSIS

- Patient’s Skin
  - Wash site
  - Antimicrobial applied, outward circles
  - Sterile hands do not touch skin and then deeper tissues
  - Instruments that touch skin are not reused
  - Sterile drape after site prepared helps

Mechanisms for Asepsis

- Inspect sterilized supplies
  - If tear in packaging discard
  - If glass bottle/vial cracked, discard
  - Open without contamination
- Air particles
  - Minimum number of people in room
  - Minimal movement
  - Doors, windows closed
  - Masks if open sterile items present

Mechanisms of Asepsis

- Sterile field maintenance
  - Site of incision
  - Sterile persons
  - Sterile drape over Mayo stand
  - Create field as close to time of use as possible

Bloodborne Pathogens

- Universal precautions
- Do not recap contaminated needles
- Needle stick safety
- Needle stick policy
- You will have to be aware of these things if doing procedures in your office

OSHA

[OSHA website link]
Informed Consent

• INDICATIONS FOR TREATMENT
• DESCRIPTION OF TREATMENT IN LAYMAN’S TERMS
• ALTERNATIVES TO TREATMENT
• RISKS AND BENEFIT OF TREATMENT
• EXPECTED AND UNEXPECTED OUTCOMES
• PATIENT MUST REQUEST PROCEDURE

Types of Ocular Injections

<table>
<thead>
<tr>
<th>Injections Optometrists Can Perform</th>
<th>Injections Optometrists Can’t Perform</th>
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<tr>
<td>Subcutaneous (Sub-Q)</td>
<td>Intravitreal</td>
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<td>Intramuscular (IM)</td>
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<tr>
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<td>Intracorneal</td>
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<tr>
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<tr>
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<td>Retrobulbar</td>
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*Cannot penetrate the globe

Uses of Eye Care Injections

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Type of Injection</th>
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<tr>
<td>Diagnostic Injections</td>
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Less common include:

• Botox injections
• Antibiotic injections

The Meds.....

• There are really only 3 classes of injectable medications routinely used in Optometric Practice:
  - Local Anesthetics – MOST COMMON
  - Steroids (ex: Kenalog AKA Triamcinolone)
  - Diagnostic Dyes (ex: Fluorescein)

Anatomy of the Syringe

- Tip – connects the needle
- Barrel
  - Holds the injectable solution
  - Volume noted in milliliters on the side
- Plunger

Anatomy of the Needle

- Ports
  - Hub – attaches to the syringe
  - Shaft – length of the needle containing the lumen
  - Bevel – point of the needle
- Sizing
  - Gauge or Lumen size
    - Range from 13 (largest) to 30 (smallest)
- Length
  - Measured in inches from the hub to the tip of the barrel
    - Range from 1/8” to 3 ½”
Needles

- Types of needles
  - Straight stick
  - Butterfly
  - Intravenous

- Remember:
  - Use the right size/length needle for the job!
  - Report any accidental needle sticks!

Medication Containers

- Ampules
  - Glass tubes filled with meds that can be damaged by air
  - Can have shards of glass get into medication – need filter on needle
  - Edges of open ampule are sharp – must go in sharps container!
  - Not as commonly used – more expensive

- Vials
  - Glass bottle topped with rubber stopper and metal cap
  - Does not need a needle filter, but rubber dulls the needle tip
  - Less expensive, more common

Ampule – Loading the Syringe

- Supplies needed
  - Ampule
  - Gauze or alcohol swab
  - Gloves
  - Filtering Needle attached to syringe
  - Injecting needle

- Procedure
  - Tap ampule to make sure medication is in the bottom chamber
  - Place gauze around neck, snap the top off, going away from your body
  - Place ampule on table, throw top into sharps container
  - Use a filtering needle/syringe to draw up medication
  - Hold syringe up, tap, and aspirate off any air
  - Remove filtering needle, place needle and ampule in sharps container
  - Put injection needle on the syringe
Your needle of choice for drawing up medication out of a vial is?

A. 18 GUAGE
B. 25 GUAGE
C. 27 GUAGE
D. 30 GUAGE

Vial – Loading the Syringe

- Supplies needed
  - Vial
  - Alcohol swab
  - Gloves
  - Larger gauge needle to draw up with
    - In clinic, we use an 18 gauge needle
    - NBEO Part III uses only a 30 gauge needle to draw and inject
  - Injecting needle
    - In clinic, we typically use a 27 gauge or 30 gauge

Vial – Loading the Syringe

- Procedure
  - Remove the metal or plastic cap on the vial
  - Alcohol off the top of the vial
  - Remove cap from the needle, draw up slightly more air into the needle than the dosage of medication needed
  - With the vial on a flat surface, insert the needle into the vial
  - Pick up the vial, invert it, inject the air, and withdraw the medication
  - Place the vial back on the table and remove the needle
  - Hold syringe up, tap it, and aspirate off any air
  - Remove the loading needle and place into sharps container
  - Put injection needle on the syringe

General Considerations

- Before performing any type of injection:
  - Ask about allergies!
  - Complete a full patient exam
  - Check and record blood pressure and pulse
  - Check supplies, make sure everything is ready
  - Wash hands and put on gloves
  - Educate the patient about the procedure!
  - Wash hands frequently!

Proper Hand Washing Technique

- Wash your hands with soap and water for at least 20 seconds.
- Rinse your hands with clean water.
- Dry your hands with a clean towel or air dryer.
- Avoid touching your face.
- Use hand sanitizer if soap and water are not available.

Angle of Injections
Which of the following statements is false concerning IM injections?

A. A 25 GUAGE NEEDLE IS OFTEN USED TO INJECT THE MEDICATION
B. IT IS THE EASIEST INJECTION TO DO
C. STEROID INJECTIONS FOR CONTACT DERMATITIS, POISON IVY OR POISON OAK AROUND THE EYE ARE A COMMON REASON WHY WE DO IM INJECTIONS

Intramuscular Injections

• Advantages
  • Quick Absorption (10-30 minutes)
  • Minimal irritation from drug due to low number of sensory fibers

• Indications
  • When a patient needs a medication and they cannot take it orally
  • Medication is not effective orally
  • Medication does not come in an oral preparation

Intramuscular Injection Sites

• Shoulder
  • Injecting into the deltoid muscle
  • Feel for the Acromion process, injection site is just below

• Thigh
  • Injecting into the Vastus Lateralis (side of thigh) or the Rectus Femoris (anterior thigh)
Intramuscular Injections Procedure

• Supplies Needed:
  • Medication
  • 1-1½ inch Sterile Needles and 1 cc Syringe
  • 18 gauge needle to draw up suspension
  • 19-26 gauge needle to inject
  • Alcohol Wipes
  • Sterile Gloves

Intramuscular Injections Procedure

• Deltoid Muscle Injection Procedure:
  • Ask the patient to relax their arm. The more they tense the muscle, the more sore it will be.
  • Swab the area with an alcohol wipe
  • Pull the skin tight around the injection site or pinch the skin and muscle up slightly
  • Insert the needle quickly at a 90° angle approximately 2” below top of shoulder
  • Insert the needle as if throwing a dart
  • Hurst worse if you gently insert
  • Patient should hang arm at side relaxed

Intramuscular Injections Procedure

• Deltoid Muscle Injection Procedure Continued:
  • Pull the syringe plunger back to check for penetration of a blood vessel
  • Inject medication at a moderate rate while holding needle steady
  • Withdraw needle quickly
  • Cover puncture with antiseptic swab and massage area
  • Dispose of needle and syringe in the sharps container
  • Record the drug, dose, delivery method, and location of the injection
  • Observe the patient for adverse effects for up to 30 minutes

Intravenous Injections

• Advantages
  • Medication is directly absorbed into the bloodstream
  • Reaches the eye very quickly

• Disadvantages
  • Medication is directly absorbed into the bloodstream, therefore it reaches everything very quickly
  • Highest risk to the patient
  • Impossible to reverse the effects of the drug once delivered

Intravenous Injections Site

• Hand
  • More nerve endings in the hand, so can be more painful
  • Veins tend to be smaller and more delicate, easier to damage
  • Plus side, veins are easy to find and are stable

Intravenous Injections Site

• Arm
  • Standard injection site
  • Relatively few nerves there and the veins are large
  • Veins tend to roll, so must be stabilized
Intravenous Injection Procedure

- Supplies Needed:
  - Medication
  - Fluorescein
  - Indocyanine green
  - Large gauge needle to draw up
  - Butterfly Needle to inject
  - Syringe
  - Alcohol Wipes
  - Sterile Gloves
  - Tourniquet
  - Sterile Gauze
  - Medical Tape

Intravenous Injection Procedure

- Injection Procedure
  - Draw up medication and change needle to butterfly needle
  - Educate the patient about the procedure, including risks and complications
  - Check for allergies to medications, injectable dyes, latex, & tape
  - Apply tourniquet 3-4” above injection site
  - Palpate the vein
  - Clean the injection site with an alcohol swab in a circular motion outward from the injection site

Intravenous Injection Procedure

- Injection Procedure Continued:
  - Stabilize the vein with thumb distal to injection site
  - Grasp the wings firmly and hold at 30-45° from the skin surface
  - Enter the skin with the butterfly needle bevel upward
  - Move the needle nearly parallel to the skin while entering the vein, watching for blood ‘flashback’ into the hub of the needle
  - Slowly pull back on the syringe plunger until blood fills the full length of the tubing

Intravenous Injection Procedure

- Injection Procedure Continued:
  - Remove the tourniquet
  - Inject a small amount of the medication, checking for extravasation or anaphylactic reaction
  - Inject the remainder of the medication
  - Remove the needle using a swift backward motion
  - Apply pressure with gauze or a cotton ball
  - Apply tape over the gauze at the injection site
  - Record the drug, dose, delivery method, and location of the injection
  - Dispose of all needles immediately in sharps container

Intravenous Injection

- After the procedure:
  - Remove gloves and wash hands
  - Document procedure appropriately in records
  - Monitor the patient (especially breathing) for at least 30 minutes
  - Do not leave the patient alone
  - Recheck blood pressure and pulse before release

Which way should the bevel be pointing during an IV injection?

A. BEVEL UP
B. BEVEL DOWN
C. BEVEL LEFT
D. BEVEL RIGHT
Intravenous Injection Tips

• Other Tips:
  • Avoid a probing, traumatic venipuncture
  • If possible, speak with the patient during the process. The patient who is at ease will be less focused on the procedure
  • Change gloves after each patient and/or when contaminated and wear a lab coat
  • Wash hands frequently!!!

• Dilating the Vein:
  • Have the patient lower their arm and hand
  • Digital pressure
  • Have patient open and close fist 4-6 times and keep it closed
  • Tap vein lightly
  • Warm washcloth
  • If you mistakenly enter an artery, the blood will be bright red, will have a greater force, and may pulsate.

• Selecting a Suitable Vein
  • Non-dominant arm
  • Choose distal vein first
  • Straight and lies on a flat surface
  • Well-fixed, does not roll easily
  • Should feel springy when palpated
  • Back of hand or Antecubital Fossa

• Things to AVOID:
  • Veins that are crooked, hardened, scarred, inflamed, or tender
  • Veins in an edematous arm
  • Affected arm of a mastectomy patient
  • Performing venipuncture distal to a previously used or injured vein
  • Areas that require immobilizing a joint
  • Areas where an arterial pulse is palpable close to the vein
  • Veins of the lower extremities

Intravenous Injection Tips

• Troubleshooting
  • No backflow
  • 'Very little backflow
  • 'Very little backflow and then none

The most common reason optometrists do subconj injections is?

A. STEROID INJECTIONS FOR RECALCITRANT UVIEITS
B. ANTIBIOTIC INJECTIONS FOR SEVERE CORNEAL ULCERS
C. NSAID INJECTIONS FOR CME
D. ANTIVIRAL INJECTIONS FOR HERPES SIMPLEX INFECTIONS
Subconjunctival Injections

**Advantages**
- Provide continuous dosing of medication without need for patient compliance
- Provides highly concentrated dose to specific area for days-weeks

**Disadvantages**
- Some patient report they are uncomfortable (usually more a fear reaction)
- Drug may remain in eye for several days-weeks – no way to remove the drug once you’ve injected

Subconjunctival Injection Site

- Injecting the space between the anterior bulbar conjunctiva and the anterior face of Tenon’s capsule

Subconjunctival Injection Procedure

**Supplies Needed:**
- Medication
- Large gauge needle to draw up
- 27 or smaller gauge needle to inject
- Length should be ½ inch
- Syringe
- Sterile Gloves
- Forceps
- Topical Anesthetic
- Cotton Swab (optional)

**Procedure**
- Wash hands and put on gloves
- Draw up medication and change needle to 27 gauge or smaller needle
- Educate the patient about the procedure, including risks and complications
- Check for allergies to medications, etc.
- Instill 2 drops of topical anesthetic
- Can also swab 4% lidocaine over the injection site to ensure that patient is completely numb

**Procedure Continued:**
- Use forceps to create a "tent" of conjunctival tissue to place your injection
- Watch the needle tip at all times!
- If you are careless with your needle, you could perforate the globe

Subconjunctival Injections

**Indications**
- Antibiotic injection
- Steroid injection
- Anti-metabolite/Anti-inflammatory injection

**Risks and Complications**
- Subconjunctival hemorrhage
- Chemosis
- Pain
- Retained medication deposits
- Perforation of the globe
Subconjunctival Injection Procedure

- Procedure Continued:
  - Insert the needle into the “tent”
  - Always point needle away from the globe!
  - No need to pull back if needle tip is angled this way
  - Inject the medication
  - Pull back at a moderate rate
  - Advise patient not to rub eye, redness may last for a few weeks

Subcutaneous Injections

- Purpose: Administer a small amount of medication in a bolus that will be slowly absorbed

- Anatomy
  - Injecting into the fatty tissue just beneath the dermis and above the muscle

- Uses
  - Injectable anesthetics
  - PPD testing
  - Steroid injections of chalazia

- Risks and Complications
  - Irritation, infection, scarring

Subcutaneous Injections Procedure

- Supplies Needed:
  - Medication
  - ½ inch Sterile Needles and 1 cc Syringes
  - 18 gauge needle to draw up suspension
  - 27 or smaller gauge needle to inject
  - Alcohol Wipes
  - Sterile Gloves

- Injection Procedure:
  - Pull the skin tight, then pierce the skin 30-45° angle to the skin. When the needle tip has pierced the skin, lower the syringe to ~10° angle.
  - Push the needle forward slightly and inject. You should start to see a bolus forming.
  - Continue injecting till you’ve injected the desired amount or the bolus is as large as desired.
  - Dispose of the needle immediately in the sharps container
  - Wipe off skin, bandage as necessary.

Intralesional Steroid Injection

- Indications
  - Over 6 months old
  - Large (4 – 6 + mm)
  - Located in medial aspect of lid (won’t be able to do I & C)

- Patient Choice

- Contraindications
  - Allergy/sensitivity to steroid

- Risks and Complications
  - Depigmentation
  - Infection
  - No resolution of lesion
Intralesional Steroid Injection Technique

- Multiuse Vial
- Alcohol Top
- Put air in syringe
- Push air into vial
- Load syringe with med
- Alcohol top of vial
- Dilute Kenalog 40 to 20 or 10

What is Radio Surgery?

- Electro Surgery at Radiofrequency
- Why Radio Surgery

- Radio Surgery vs. Electrocautery vs. Hyfrecation

What is Radiofrequency (RF) Surgery?

- Radiosurgery is the passage of high frequency radio waves through soft tissue to cut, coagulate, and/or remove the target tissue
- Resistance of the tissue to the radio waves causes water in the cells to heat and the cell vaporizes
- Radio-surgical unit consists of
  - Transformer
  - Active electrode
  - Antennae (passive electrode)
  - Vacuum unit
- Ideal frequency = 3.8 - 4.0 MHz

Ellman Unit - Dual 120
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- Radio-surgical unit consists of:
  - Transformer
  - Active electrode
  - Antennae (Passive electrode)
  - Vacuum unit
- Ideal frequency = 3.8 - 4.0 MHz

Advantages of Radiosurgery

- Cuts and coagulates at the same time
- Nearly bloodless field
- Minimal biopsy artifact damage
- Quick and easy (to do and to learn)
- Pressureless & bacteria-free incisions
- Minimal lateral heat
- Minimal post-op pain
- Rapid healing
- Fine control with variety of tips
- No muscle contractions or nerve stimulation from radiowaves (Faradic effects)

Hazards/Contraindications

- Do not perform shave excision on pigmented lesion unless certain is not melanoma!!!
- Don’t use in presence of flammable fumes/liquids.
- Pacemaker:
  - “Do not work near the heart and place the antenna (or grounding) plate well away from the heart. Use the least power possible. Activate the handpiece intermittently rather than continuously. The cutting mode is the most risky. So avoid it if possible. Use another form of treatment if it is an option. The pacers are purportedly “shielded” and the current in the ESUs should not affect them, but all things are not perfect. Therefore caution is needed. Asystole and tachycardia are potential adverse outcomes.”
- Pfenninger and Fowler’s Procedures for Primary Care, 3rd Edition. John L. Pfenninger, MD, FAAFP and Grant C. Fowler, MD
Radiofrequency (RF) Surgery

Indications

• SKIN PAPILLOMAS/SKIN TAGS
• SEBORRHEIC KERATOSES
• VERRUCA
• SEBACEOUS CYSTS
• BENIGN NEVI
• PYOGENIC GRANULOMAS
• INCISION INTO CHALAZION
• TRICHIASIS
• XANTHELASMA
• BLEPHAROPLASTY INCISIONS
• BIOPSIES OF SUSPICIOUS LESIONS (BCC, SCC, MELANOMA)

Procedure Technique

• PRE-OP (PHOTOS, CONSENT, BP AND PULSE, VA)
• PACEMAKER? ALLERGIES?
• CLEAN AREA, DRAPE IF NEEDED
• BETADINE NEEDS 3 MINS ON SKIN!
• ANESTHETIZE (INFILTRATIVE USUALLY)
• TURN ON ELLMAN UNIT: WARM UP FOR AT LEAST 30 SECONDS
• CHOOSE APPROPRIATE WAVEFORM
• CHOOSE INITIAL POWER SETTING (WILL OFTEN NEED TO ADJUST DEPENDING ON TISSUE RESPONSE TO ENERGY LEVEL CHosen)

Procedure Technique

• HAVE ASSISTANT TURN ON/POSITION VACUUM UNIT – USE VACUUM AND MASKS!
• HAVE ISOLATED HPV AND HIV IN SMOKE
• PLACE YOURSELF IN COMFORTABLE/STABLE POSITION TO DO PROCEDURE
• BRACE YOUR HANDPIECE WRIST ON PATIENT FOR STABILITY

Excision Techniques

Feathering Technique

Procedure Technique

• ELECTRODE TIP SHOULD BE APPLIED PERPENDICULARLY TO ALLOW EVEN DISTRIBUTION OF ENERGY
• PRESS FOOTPLATE ACTIVATOR WHEN READY TO BEGIN PROCEDURE
• MOVE IN EXPEDITIOUS BUT CONTROLLED FASHION: ALWAYS KEEP ELECTRODE MOVING WHEN CONTACTING TISSUE
**Procedure Technique**

- **KEEP THE TISSUE AROUND THE LESION TAUT**
- **KEEP SURGICAL SITE MOIST (SALINE GAUZE) TO AVOID TISSUE DRAG**
- **REMOVES DEBRIS ON SURGICAL FIELD**
- **ALSO WIPE ENERGIZED TIP TO REMOVE TISSUE STUCK TO IT**
- **WHEN FEATHERING DOWN A LESION WITH A LOOP, KEEP PERPENDICULAR --- REMOVE UNTIL HEALTHY TISSUE SEEN**
- **CAN USE FORCEPS CLOSED TIPS TO TOUCH END OF AREA OF BLEEDING, TOUCH ELECTRODE TO FORCEPS TO TRANSFER ENERGY TO AREA TO STOP BLEEDING**

**Post-procedure Technique**

- **CLEAN AREA OF BETADINE**
- **APPLY ANTIBIOTIC UNG**
  - **PT ED ABOUT MOIST HEALING**
- **DON'T LET PATIENT JUMP AND RUN AS YOU SIT THEM UP!**
- **BLOOD PRESSURE AND PULSE POST-OP**
- **WRITE OP REPORT IN CHART ALONG WITH PATIENT INSTRUCTIONS ON WOUND CARE AND FOLLOW-UP SCHEDULE**

**Radiofrequency (RF) Surgery Indications**

- **SKIN PAPILLOSAS/SKIN TAGS**
- **SEBORRHEIC KERATOSES**
- **VERRUCA**
- **SEBACEOUS CYSTS**
- **BENIGN NEVI**
- **PYOGENIC GRANULOMAS**
- **INCISION INTO CHALAZION**
- **TRICHIASIS**
- **XANTHELASMA**
- **BLEPHAROPLASTY INCISIONS**