

Caring for your child's tearing condition is a big concern for you and knowing the options available is important. Talk with your Ophthalmologist about the LacriCATH Balloon DCP procedure, so you can both choose what is best for your child.

With over fifteen years of successful surgical procedures, LacriCATH physicians confirm:

"The success rate certainly meets or more likely exceeds in my hands, the success rate of silicone intubation and without the usual hemorrhage, tissue trauma and nuisance of tube extrusion."

Amy Aiello Leverant, M.D., Arizona Pediatric Eye Specialists PLC., Phoenix, AZ

"It is a relatively easy surgical technique, and saves me time in the operating room compared to the nasolacrimal duct stents. It is less traumatic, and reduces the operating room and recovery time."

Donny W. Suh, M.D., Wolf Eye Clinic, Marshalltown, IA

"The high success rate (>90%) along with the ease of placement and avoidance of permanent implants has benefits of avoiding securing tubes in children, and often an additional surgery to remove the tubes."

Lance M. Siegel, M.D., Children's Eye Institute, Upland, CA

"The success rate which I have found is greater than 95% in patients who have previously failed a routine tear duct probe... I would endorse this product without hesitation for use in congenital nasolacrimal duct obstruction."

Deborah R. Fishman, M.D., Pediatric Eye Associates, Wilmette, IL

LacriCATH[®]

Developed by Bruce B. Becker, M.D.



For proper diagnosis, contact your ophthalmologist or physician to learn more about the LacriCATH Balloon DCP or Balloon DCR treatment for your tearing condition.

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Treatment Options
for pediatric chronic tearing



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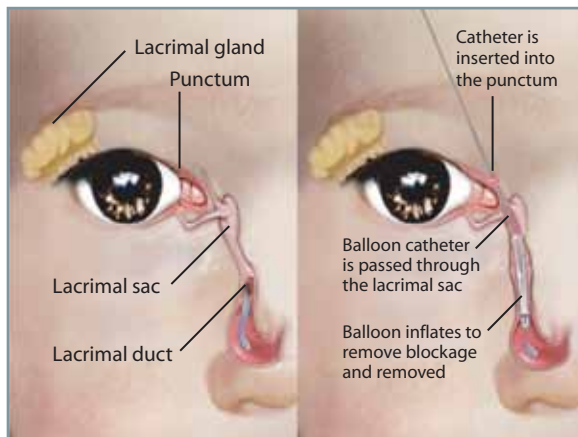
Over 15 years of better outcomes.

LacriCATH[®]

Blocked Tear Duct

Chronic tearing in children is usually caused by a membrane that blocks the end of the tear duct inside the nose. This causes tears to spill over the eyelid and run down the cheek.

Tears normally drain from the eye through small tubes called tear ducts that extend from the eye into the nose. A blocked tear duct occurs when the duct that normally allows tears to drain from the eyes is obstructed or fails to open properly.



Chronic Tearing: A Common Concern

Nearly one-third of all infants experience constant tearing. Usually, this disappears within 6 months of age. If the blockage persists, symptoms may include:

- Excessive tearing or watery eyes
- Pain or discomfort
- Persistent tearing
- Eye mucus discharge
- Infection

Balloon Catheter Treatment Options

The most common treatments for chronic tearing include antibiotic eye drops, tear duct massage, and tear duct probing (passing a small probe down the duct to open the obstruction).

Sometimes, even probing will not open the blocked tear duct. Silicone tubes may need to be placed in the tear drainage system as the “traditional” next step. Limitations to this procedure include:

- Tubes remain in place for 3 to 4 months.
- Up to 20% of children with silicone tubes will pull them out.¹ This causes stress for the child and parents, requiring an emergency visit to either the physician or hospital.
- Additionally, a second appointment or hospital procedure with anesthesia may be needed to remove the tubes.

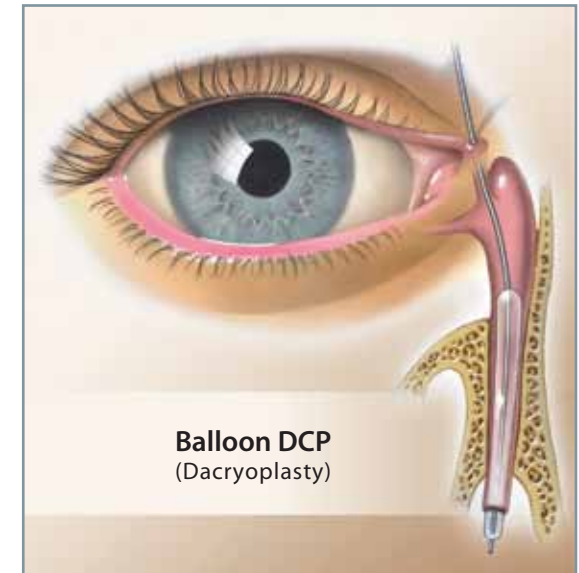
One Quick Procedure — Less Anesthesia

LacriCATH Balloon DCP provides parents and physicians a highly successful treatment for chronic tearing with the following advantages:

- Reduced trauma
- No tubes to remove – or pull out
- No need for a second procedure with anesthesia for tube removal

Innovative, Less Invasive Approach

The LacriCATH balloon catheter shown in the illustration, is inserted through an opening in the corner of the eye and down into the tear duct.



The balloon is inflated with sterile water to dilate the tear duct, then deflated and withdrawn from the duct. Nothing is left behind to cause trauma or be accidentally pulled out.

In over 15 years of use by physicians, the Balloon DCP procedure has proven to be highly successful in up to 95% of pediatric patients.²

¹ J Ped Ophthal and Strab 2006, 43: 73-76

² American Journal of Ophthalmology 1996, 121: 304-309