



PATIENT INFORMATION

ICL Surgery

The Implantable Collamer Lens

To achieve the immeasurable, you must measure everything.

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How to use this leaflet

This leaflet is the first stage of your informed consent journey. It is written to be read before your in-person consultation and diagnostic testing, whether or not you have booked one yet, so that you come to that appointment already familiar with the options, the risks and the costs. Read it on screen or print it, and note down anything you want explained further.

About This Leaflet

This leaflet is for patients who are considering surgery with an Implantable Collamer Lens, usually shortened to ICL. It is sometimes described as an implantable contact lens, because it works in a similar way to a contact lens that lives permanently, and invisibly, inside the eye.

A full in-person consultation will follow, along with thorough diagnostic testing. You will then receive a letter summarising the points discussed at that consultation, and an informed consent document accompanying it. This leaflet, that letter and that consent document together form part of your informed consent journey. No single one of them stands alone, and none of them replaces the conversation you will have with your surgeon.

ICL surgery is elective. Nobody needs it, and nothing is lost by deciding against it. You are choosing it because you want to depend less on glasses and contact lenses, not because your eye health requires it. The decision is entirely yours and there is no clinical urgency at all.

Because the surgery is elective, it is governed by professional standards that are deliberately strict. The Royal College of Ophthalmologists requires that your surgeon personally discusses the procedure with you, that you receive written information before you commit, and that you are given an unhurried period to reflect before signing consent.¹ The General Medical Council requires the same, and specifically that the surgeon performing your operation is the person who obtains your consent.²

At Blue Fin Vision®

Your named Blue Fin Vision® consultant surgeon personally performs your assessment, your surgery and your follow-up. Consent is a two-stage process. You will receive your consent form at your consultation and you are never asked to sign it on the day of surgery. There is no deadline and no time-limited offer.

This leaflet is sent to you electronically, so you can read it whenever it suits you, share it with the people whose opinion matters to you, and come back to it as often as you like. Read it more than once. Bring your questions to us.

It is designed to be used alongside the Blue Fin Vision® ICL Surgery Checklist, which turns the content of this leaflet into a set of practical questions you can work through before your consultation: [**ICL Surgery Checklist**](#).

What Is an ICL?

An Implantable Collamer Lens is a soft, flexible lens that is placed inside the eye, in the space between the coloured iris and your own natural lens. It is made of collamer, a biocompatible material containing collagen that the eye tolerates exceptionally well. Once in position it is invisible from the outside, cannot be felt, and needs no cleaning or handling.

The lens is specified individually for your eye and made by STAAR Surgical, the developer of the ICL, in the power and size your measurements require. Your glasses prescription, including astigmatism where present, is built into the implant.

The modern lens used at Blue Fin Vision® is the EVO ICL, with a tiny central port allowing the eye's natural fluid to circulate through the lens. This design removed the routine need for a separate laser iridotomy procedure beforehand and is central to the safety profile of the current lens.³

Figure: ICL surgery

[Figure artwork to be placed at design stage.]

The ICL is injected, folded, through a small self-sealing opening at the edge of the cornea, and unfolds into position behind the iris, in front of your natural lens. No tissue is removed and the cornea is not reshaped.

What makes an ICL different

- It is additive. Nothing is removed from your eye, so you keep your eye's own focusing ability for reading if you are young enough to still have it.
- It is removable. If your needs change, or a problem develops, the lens can be taken out or exchanged.
- It suits eyes that laser cannot treat. Very high prescriptions, thinner or irregular corneas and significantly dry eyes are the classic reasons an ICL is chosen.
- It carries built-in protection against ultraviolet light, a property of the collamer material itself.

An honest alternative, not a consolation prize

Patients are sometimes told about the ICL only after being declined for laser surgery, which can make it feel like second best. It is not. For the right eye, an ICL is the first-choice procedure on its own merits, and some patients suitable for laser choose it anyway for its reversibility and optical quality.

What an ICL is not

It is not a treatment for eye disease. It does not treat keratoconus, glaucoma, or retinal conditions, though it does not prevent those being monitored and treated normally.

It is not permanent in the way laser surgery is, and that is deliberate. The lens can be removed, and if a cataract develops in later life the ICL is removed at cataract surgery, with the correction carried into the new lens implant.

Is an ICL Right For Me?

An ICL suits you best if you are aged between 21 and around 50, your prescription has been stable for at least a year, and one or more of the following applies.

- Your prescription is too strong for laser eye surgery to correct safely, or sits at the edge of the safe range.
- Your corneas are too thin, or your corneal scans are not sufficiently regular, for tissue to be removed from them.
- You have significantly dry eyes, which laser surgery would be likely to worsen and an ICL largely leaves alone.
- You want a correction that is removable, and you value keeping every future option open.
- You are too young for lens replacement surgery, because your natural lens is still clear and still focusing, and giving it up would be an unnecessary loss.

When we will advise against it

We will tell you if an ICL is the wrong choice for you, and we do so regularly. Because Blue Fin Vision® offers laser vision correction, ICL surgery and lens replacement within the same practice, our recommendation is not constrained by what we happen to offer.

- If the space between your cornea and your natural lens, called the anterior chamber, is too shallow, there is not enough room to position the lens safely. This is measured, not guessed.
- If the cell layer on the inner surface of your cornea, the endothelium, is below the healthy range for your age, we will not implant a lens that this layer must live alongside for decades.
- If your natural lens is already showing early cataract change, lens replacement is usually the better operation, because it treats the cause rather than working around it.
- If your prescription is modest and your corneas are healthy, laser vision correction is usually simpler and avoids surgery inside the eye altogether.
- If your expectations cannot realistically be met, we will say so plainly rather than proceed.

Suitability is questioned, not waved through

A consultation that ends in a recommendation not to operate is a successful consultation. Your consultation fee buys an honest answer, not a sales pitch.

Your Alternatives

Doing nothing

Glasses carry no surgical risk at all. This remains a completely reasonable choice and you should never feel pushed away from it. At very high prescriptions glasses do have real optical limitations, with thick lenses, a narrowed field of sharp vision and image minification, and many high myopes find them genuinely limiting, but the choice is yours.

Continuing in contact lenses

Contact lenses give good all-round vision and suit active lives, and at high prescriptions they usually outperform glasses optically. They are not risk free. A large population study found that serious corneal infection affects roughly 2 in every 10 000 daily wear soft lens wearers each year, rising to around 20 in 10 000 for those who sleep in their lenses.⁴ Over decades of wear, that annual risk accumulates, and comfort and tolerance also tend to reduce with age and with dry eye.

Laser vision correction

Laser surgery reshapes the front surface of the eye and involves no implant. Where your prescription, corneal thickness and ocular surface allow it, laser is often the simpler option, and Blue Fin Vision® offers it. It permanently removes corneal tissue, it cannot be reversed, and at high prescriptions the amount of tissue that must be removed becomes the limiting factor.

Lens replacement surgery

Lens replacement removes your natural lens and replaces it with an artificial one. It is usually the better choice from around the mid-forties onwards, once the natural lens has stiffened or begun to change. For younger patients it involves giving up a healthy, still-focusing natural lens, which is why an ICL, which keeps that lens, is generally preferred below that age.

How we decide

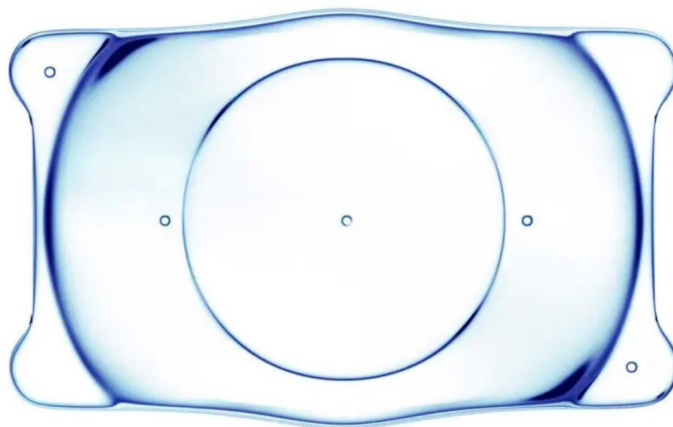
We compare the options against your measurements, your eye health and how you actually use your vision. The safest procedure that achieves your goal is the one we recommend, whichever category it falls into.

The Lens Itself

The ICL has been implanted worldwide for more than two decades and its design has been refined through successive generations. The lens Blue Fin Vision® uses is the EVO family from STAAR Surgical, in spherical and toric versions, so astigmatism is corrected within the same implant rather than needing a separate procedure.

The United States Food and Drug Administration approved the ICL after a formal multi-centre clinical trial, which reported strong and stable results at three years.⁵ The design has since moved on substantially. The defining feature of the current lens is the central port, a microscopic opening in the centre of the lens that lets the eye's internal fluid follow its natural path. This resolved the main design concerns of the earlier generations, and the published literature on the central port lens reports excellent effectiveness alongside a markedly improved safety profile.³

Figure: The EVO ICL



The EVO ICL. The microscopic central port, visible at the centre of the optic, allows the eye's natural fluid to circulate through the lens.

Toric lenses and astigmatism

If you have astigmatism, the lens is manufactured with your cylinder correction built in and is positioned at a precise axis during surgery. The United States FDA trial of the toric ICL, covering 210 eyes, demonstrated effective correction of moderate to high myopic astigmatism.⁶ Because a toric lens only works on its intended axis, planning and placement are exacting, the orientation is checked at your reviews, and a toric lens that rotates away from its axis, which is uncommon, can be repositioned in a short procedure.

How Well Does It Work?

The ICL is one of the most studied implants in refractive surgery. A meta-analysis of the published literature on the central port lens found high predictability and refractive accuracy, with the large majority of eyes achieving unaided vision at or close to their corrected vision beforehand, and high rates of patient satisfaction.^{3,7}

Durability matters as much as the early result. An eight-year follow-up study of posterior chamber phakic lens implantation for moderate to high myopia found the correction remained stable, with no late loss of effect.⁸ A seven-year follow-up of the central port design specifically reported the same pattern: stable vision, a stable lens position and no sight-threatening complications in the series.⁹

Your own likely result depends on your prescription and your measurements, and we will give you an individual estimate at your consultation rather than quoting averages at you.

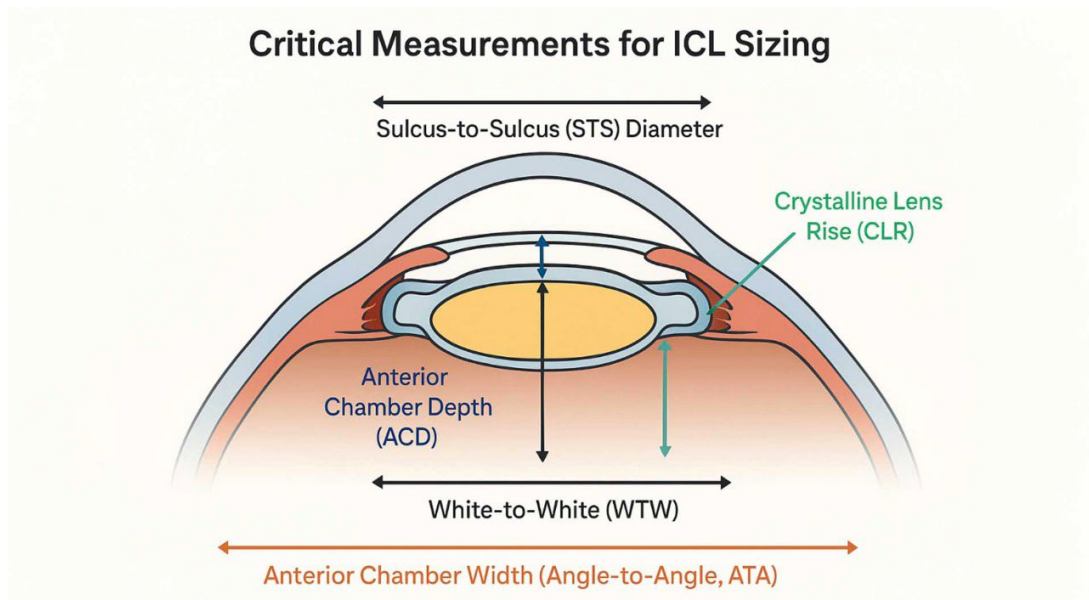
A quality of vision point worth knowing

At high prescriptions, correcting the error inside the eye rather than at the front of it tends to produce sharper, higher-contrast vision than the equivalent correction in glasses, because the image is no longer minified by a strong spectacle lens. Patients moving from strong glasses to an ICL often notice this within days.

Measuring Your Eyes

With an ICL, correct sizing is one of the most important determinants of long-term safety. The lens must sit at the correct height above your natural lens, a distance called the vault, and the size of lens that achieves this is calculated from measurements of the front of your eye. An error of measurement becomes an error of vault.

Figure: The measurements that determine ICL sizing



The dimensions from which the correct lens size is calculated: sulcus-to-sulcus diameter, anterior chamber depth, white-to-white distance, angle-to-angle width and crystalline lens rise.

Blue Fin Vision® therefore applies the same measurement discipline to ICL sizing that it applies to lens surgery biometry. Your eye is measured on more than one instrument, and the results must agree before a lens is ordered.

- High-resolution imaging of the front of the eye, including swept-source OCT of the anterior segment and corneal tomography.
- Measurement of the anterior chamber depth, the space into which the lens must fit.
- White-to-white and sulcus-to-sulcus dimensions, with vault prediction modelling, from which the lens diameter is selected.
- An endothelial cell count, establishing the baseline against which your cornea is monitored for the life of the implant.
- A full dilated examination of your natural lens and retina, because an implant should never be placed in front of a problem.

If two measurements disagree, we repeat them. If they continue to disagree, we do not order a lens. This is the least glamorous part of the process and one of the parts that most determines your long-term safety. How sizing works, and why it matters so much, is explained in more depth in our companion article [Accurate Sizing and Suitability of an Implantable Collamer Lens](#).

Why the lens takes time to arrive

Your ICL is ordered to your individual specification, in your power, cylinder and size. Depending on the specification, this takes from a few days to a few weeks. We regard that interval as a feature rather than an inconvenience: it is also your reflection period, and nothing is committed until you are ready.

Both Eyes On The Same Day

Blue Fin Vision® has performed same-day bilateral lens surgery as routine practice since November 2016, and ICL surgery follows the same discipline. The two eyes are treated as two entirely separate operations performed one after the other, with completely separate instruments, separate gowning, separate drapes and separate lens packaging. Nothing crosses between them.

Why we do it this way

- You recover balanced vision immediately instead of spending days or weeks with a large difference between your two eyes, which at high prescriptions can be genuinely disabling.
- One anaesthetic episode, one recovery period, one course of drops, one set of travel arrangements.
- Fewer separate exposures to a hospital environment.

Is it safe?

The concern has always been a serious infection affecting both eyes at once. The largest evidence on this question comes from cataract surgery, which uses the same route into the eye and the same infection-control logic. A Swedish national registry study analysed 1 457 172 operations, including 92 238 same-day bilateral procedures, and found no increased risk of postoperative infection.¹⁰ A separate analysis of the American IRIS Registry reached the same conclusion.¹¹ That evidence concerns cataract surgery rather than ICL surgery specifically, and we are precise about that, but the protective principle it validates, complete separation of the two operations, is exactly the protocol we apply.

The condition that governs it

Same-day bilateral surgery rests on a single rule. The second eye proceeds only if the first operation has been entirely uncomplicated. If anything at all is not straightforward, the second eye does not go ahead that day. That is a clinical decision made in theatre, not a scheduling one, and it is not open to negotiation.

If that happens, your second eye is postponed or cancelled. Should you then choose not to proceed with it, the fee for the eye that was not operated on is returned to you in full. You are never charged for surgery you did not have.

It is always your choice

You may have one eye at a time if you prefer, and some patients do. We will support that decision without argument and without trying to talk you out of it.

On The Day Of Surgery

You may eat and drink normally and take your usual medication. Allow around half a day at the hospital. You will not be able to drive home, so please arrange transport.

Anaesthetic

The operation is performed with anaesthetic eye drops. Your eye is numb. You are awake, comfortable and able to hear and speak to us throughout. Many patients are surprised by how undramatic it is.

If you would like help to feel more relaxed, you have two options.

- A diazepam tablet before surgery, offered to every patient who wants it at no extra cost.
- Intravenous sedation, given and monitored by a consultant anaesthetist. This is a paid optional extra and is not included in the surgical fee. It is charged once per surgical session, so the fee is the same whether one eye or both eyes are treated that day.

Neither is compulsory and most patients need neither. Your anxiety about the procedure is not something to apologise for, so please tell us if you would prefer one of these.

The operation itself

Your pupil is dilated with drops. Your eyelids are held gently open, so you cannot blink at the wrong moment. You will see bright light and movement but no instruments and nothing alarming. Your surgeon and the theatre team will guide you throughout. The procedure itself typically takes well under half an hour per eye, and the time inside the eye is a fraction of that.

- A very small self-sealing opening is made at the edge of the cornea. No stitches are needed.
- A protective gel is placed inside the eye to hold space and shield your natural lens.
- The ICL is injected, folded, through the small opening and unfolds slowly in the eye.
- Its four corners are positioned gently behind the iris, and a toric lens is rotated to its planned axis.
- The protective gel is washed out completely, antibiotic is placed in the eye, and the opening seals itself.

Because the EVO lens has its central port, a separate laser iridotomy is not routinely needed beforehand, which earlier lens generations required. Where an individual eye does need one, it is performed at no extra charge.³ Every procedure is video recorded and archived as part of your record.

After Your Surgery

ICL surgery uses a course of eye drops after the operation. Unlike our lens replacement and cataract pathways, there is no dropless option for ICL surgery, because the anti-inflammatory cover it relies on is not appropriate in an eye that keeps its natural lens.

- Antibiotic drops for the first one to two weeks, to protect against infection while the opening completes its healing.
- Anti-inflammatory drops, tapering over the following weeks as directed.
- Leave at least two minutes between different drops so each is absorbed.
- Set a phone reminder. If you miss one, simply take the next one. Do not double up.

Your exact regime is confirmed in your written discharge summary, and all discharge medication is included in your fee. If you are travelling from overseas, your discharge summary and drop schedule are provided in writing to share with your own doctor or optometrist.

Your first review matters most

You are reviewed the day after surgery. That visit includes a check of the pressure inside your eye and imaging of the vault, the space between the new lens and your natural lens. These two measurements are the foundation of everything that follows, which is why this appointment is never optional.

Your Recovery

When	What to expect
Day of surgery	Vision is bright but hazy while the dilating drops wear off. Halos around lights, light sensitivity and a mild ache are normal. Go home and relax for the remainder of the day.
Day 1	Your review appointment, with a pressure check and vault imaging. Many patients already notice a marked improvement in unaided vision. Shower and wash normally, keeping soap and water out of the eyes.
Days 2 to 7	Most patients return to work and normal routine within a few days. Do not rub your eyes. No swimming and no eye makeup for two weeks.
Weeks 2 to 6	Vision continues to sharpen and stabilise. Halos and rings around lights fade for most patients as the brain adapts. Please attend every scheduled follow-up appointment, even if your eyes feel perfect.

Please attend every review appointment

Some problems that need treatment cause no symptoms at all in the early weeks. A vault that is drifting or a pressure that is creeping is found by measurement, not by how the eye feels. Attend every scheduled review even if your eyes feel completely normal.

Risks

ICL surgery is a very safe operation with a strong long-term evidence base, but it is surgery inside your eye, and you are choosing it rather than needing it. That raises the standard of understanding we owe you.

The figures below come from the peer-reviewed literature on the ICL, including the United States FDA trial of the earlier lens generation and the published studies of the current central port design.^{3,5,9} ICL surgery is not covered by the national cataract audit, so no national registry benchmark exists for it in the way it does for cataract surgery. Blue Fin Vision® audits its ICL outcomes internally and reviews them against this published literature.

Cataract forming early

The historic concern with the ICL was that contact with the natural lens, or disturbance of the fluid nourishing it, could trigger a cataract early. In the FDA trial of the earlier lens without a central port, a proportion of eyes developed early opacities at the front of the natural lens over the following years, most of which did not affect vision.¹² The central port was designed specifically to address this, by restoring the natural flow of fluid across the lens, and the published literature on the current design reports that visually significant cataract has become rare.^{3,13} Correct vault is the other protection, which is why we size carefully and monitor it for life. If a cataract does develop, whether early or simply with age, the ICL is removed and lens surgery is performed in the normal way; the pathway and its pricing are published in advance.

Pressure inside the eye

The eye's pressure can rise in the first hours after surgery, usually from residual protective gel, which is why it is measured before you go home and again the next day. A rise is treatable and almost always temporary. The pupil-block pressure rise associated with earlier lens generations is largely designed out by the central port, which keeps the fluid pathway open.³

The corneal cell layer

The endothelium, the single layer of cells on the inner surface of the cornea, keeps the cornea clear and does not regenerate. Everyone loses these cells slowly with age. Long-term studies of the central port lens have found endothelial cell loss consistent with normal ageing in correctly sized eyes.^{9,14} We do not rely on that reassurance alone: your count is measured before surgery and then annually, and the lens is removed electively if the count ever trends towards the published threshold, long before the cornea is in any difficulty. The thresholds are set out in The Long Term section below.

Sizing and rotation

In a small proportion of eyes, the vault after surgery is higher or lower than intended despite careful sizing, and the lens is exchanged for a different size. A toric lens can occasionally rotate away from its axis and is repositioned in a short procedure. Both are corrections, not catastrophes, and both are covered within your fee.

Infection and serious loss of vision

As with any operation inside the eye, infection is possible and is the most feared complication. It is rare, it is the reason antibiotic is placed in the eye at the end of surgery and antibiotic drops are used afterwards, and it is the reason the warning signs later in this leaflet ask you to contact us

without delay. Severe permanent loss of vision from ICL surgery is rare in the published literature.^{3,9}

Retinal detachment

High myopia itself carries a lifetime risk of retinal detachment, whether or not you ever have surgery. The ICL leaves your natural lens in place, which is one of the reasons it is preferred over lens replacement in younger, very short-sighted eyes. Your retina is examined in full before surgery, and your personal risk is discussed with you individually.

Side Effects

Side effects are different from complications. Most patients experience some of these. They usually improve, but they do not always disappear entirely.

Halos and rings around lights

Halos, and sometimes a faint ring around point sources of light at night, are common in the first weeks. The ring effect relates to the optical edge of the lens and its central port. For most patients these effects fade substantially over the first months as the brain learns to filter them. A small number of patients continue to notice them long term, usually mildly.

Dry or gritty eyes

Mild dryness and grittiness are common in the early weeks and usually settle. Because no corneal nerves are cut and no tissue is removed, the ICL disturbs the ocular surface far less than laser surgery, which is one of the reasons it is chosen for patients whose eyes are already dry.

Appearance

Red blotches on the white of the eye are common after any eye surgery. They look dramatic, they are harmless, and they can take up to six weeks to fade completely. The lens itself is not visible to other people. Very occasionally someone standing close in bright light may notice a faint glint within the pupil.

If Your Result Needs Refining

ICL power calculations are accurate but not perfect, and a small proportion of patients end up with a small residual prescription that limits the freedom from glasses they came for. This is a recognised part of refractive care rather than a complication.

Blue Fin Vision® has a published enhancement policy, and it is deliberately simple. Enhancement procedures after self-pay ICL surgery are fully covered by Blue Fin Vision®. There is no cost-sharing and no additional fee to you. Blue Fin Vision® takes responsibility for achieving your refractive outcome. Policies on this vary widely between providers, so wherever you are considering surgery, ask for the enhancement terms in writing.

- Enhancements are considered once your vision has stabilised, typically at around three months.
- There must be a residual refractive error that genuinely affects your functional vision or spectacle independence.
- Clinical assessment must confirm that refinement is safe and appropriate.
- The enhancement window is 12 months from your surgery. If assessment within that window shows that a refinement is likely to be needed, it is automatically extended to 24 months, so there is never pressure to proceed before your vision is fully stable.

Refinement after ICL surgery is usually a small laser correction on the cornea, or occasionally exchange of the lens for a different power. Whichever is appropriate, the reassessment, the planning and the surgery are all performed by your Blue Fin Vision® consultant within the same practice. Enhancements are never outsourced. The policy is published in full: [**Blue Fin Vision® Enhancement Policy**](#).

The Long Term

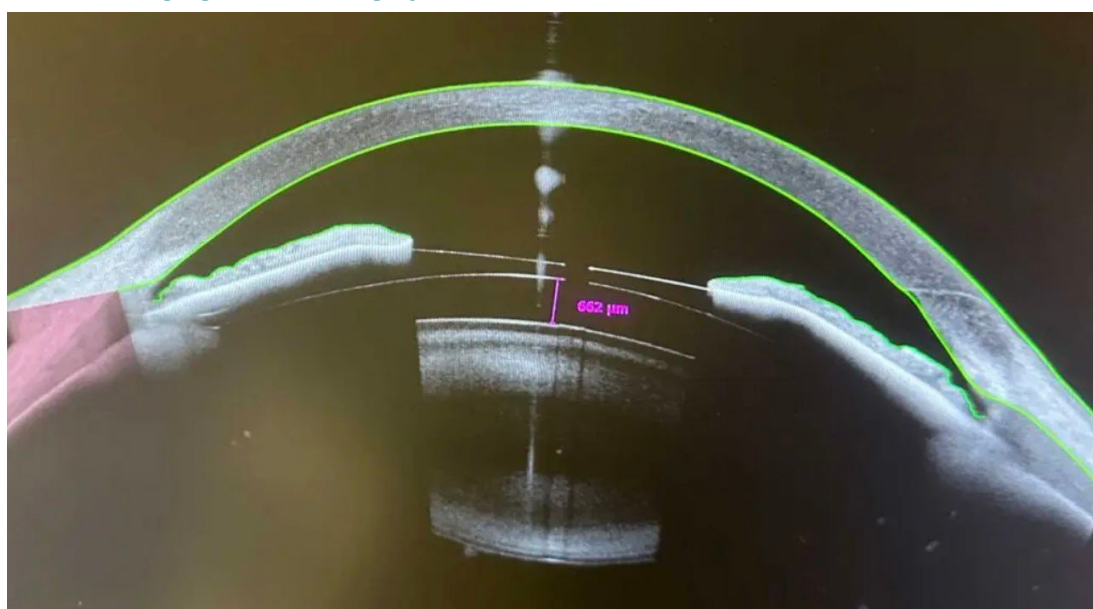
An ICL is a medical device that lives inside your eye for decades. Blue Fin Vision® takes the view that implanting it creates a permanent measurement responsibility, and that responsibility is written down rather than implied.

The ICL Lifetime Monitoring Protocol™

Every Blue Fin Vision® ICL patient is enrolled in the ICL Lifetime Monitoring Protocol™, which is included in your surgical fee for the life of the implant. It is a defined programme, not a vague promise of aftercare. Your post-operative consultant reviews at months 1, 3 and 12 sit within the surgical fee itself; the Protocol then takes over from month 12 onwards, annually, for life.

- Annual imaging of the vault, the space between the ICL and your natural lens, reviewed against the published safe range of 250 to 750 microns.
- Annual endothelial cell counts, reviewed against your own baseline, with elective lens removal discussed if the count ever trends towards 2 000 cells/mm².
- Annual consultant review of your natural lens for any developing cataract change, and of the lens position and orientation. Vault imaging is available at every site; endothelial cell counts are performed at The Harley Street Eye Centre.
- A written monitoring report after each visit, and a consultant-led review at no additional cost if any measurement crosses a defined threshold.
- Everything measured, documented and archived, so that decisions decades from now are made against your own data rather than guesswork.

Figure: Vault imaging after ICL surgery



Anterior segment OCT of an eye after ICL surgery. The vault, the space between the ICL and the natural lens, here measures 662 microns, comfortably within the published safe range of 250 to 750 microns.

The protocol, its thresholds and its inclusions are published in full: [ICL Lifetime Monitoring Protocol™](#). Why this long view matters is explained in plain language in our companion article [Life After ICL: Why Clear Vision Is Not the End of the Story](#).

Cataract surgery later in life

Having an ICL does not prevent you developing a cataract in your natural lens as part of normal ageing, decades from now, exactly as you would have without it. When that day comes, the ICL is removed during the same operation and your correction is carried into the new lens implant. The person best placed to plan the far end of an ICL journey is somebody who performs that destination operation for a living, and lens surgery is the core of this practice. Blue Fin Vision® publishes a Post-ICL Cataract Surgery Pathway with pricing set out in advance on the monitoring protocol page, so the long-term cost picture is never a surprise.

Your future eye care

Having an ICL does not prevent the diagnosis or treatment of any future eye condition. Glaucoma, diabetic eye disease and retinal conditions are all monitored and treated exactly as normal, and your annual visits mean changes tend to be found early.

If Something Is Not Straightforward

Complications are rare, but the true measure of a surgical practice is what happens when one occurs.

If a problem arises after your ICL surgery, your care remains entirely within Blue Fin Vision®. Where retinal surgery is ever required, a Blue Fin Vision® vitreoretinal consultant performs it. You are never discharged into an anonymous pathway or an external waiting list for a complication of your private surgery.

- There is no additional surgical fee for managing a complication of your surgery.
- Your consultant surgeon remains personally involved throughout.
- Your records, scans and surgical video move seamlessly within the same system.
- Transport is arranged and funded if travel is difficult.

The team responsible for your operation remains responsible for your recovery.

Warning Signs

Contact us immediately, or attend an eye casualty department, if you experience any of the following.

Contact us without delay

Increasing aching pain that is not relieved by simple painkillers. Pain with worsening halos, a misty cornea or nausea, which can indicate a pressure rise. Increasing redness. Increasing sensitivity to light. Vision that is getting worse rather than better.

The following may indicate a retinal detachment. They are particularly important if you are short-sighted. Seek assessment the same day.

- A sudden new shower of floaters.
- Flashes of light, including with your eyes closed.
- A shadow or curtain spreading across any part of your vision.

Most retinal detachments are repaired successfully, and the chances are considerably better if treatment happens before the detachment reaches the centre of your vision. Do not wait to see whether it settles.

Costs

ICL surgery is performed to reduce dependence on glasses and contact lenses. It is therefore not available on the NHS and is generally not covered by private medical insurance, although some policies cover consultations or diagnostics, which we can help you confirm. All fees are self-pay.

Item	Fee
ICL surgery, both eyes, non-toric, including your STAAR lenses	£7,500
ICL surgery, both eyes, one toric and one non-toric lens	£8,250
ICL surgery, both eyes, both lenses toric	£9,000
Intravenous sedation with consultant anaesthetist, optional extra	£700 per session
Diazepam tablet before surgery, if you would prefer it	No charge
Consultation and diagnostic scans	£500, prepaid separately

Your consultation fee is paid in advance and is separate from the surgical fee. It is not deducted from the cost of surgery, the diagnostic pathway it covers is subsidised, and it is payable whether or not you go on to have surgery, because it buys an honest assessment rather than a sales appointment. You will receive a written quotation confirming your exact total before you commit to anything.

What your surgical fee includes

- Your operation on both eyes, your individually specified STAAR lenses, theatre and hospital fees.
- All routine follow-up appointments.
- All discharge medication, including your antibiotic and anti-inflammatory drops.
- The ICL Lifetime Monitoring Protocol™, with annual vault imaging, endothelial cell counts and consultant review for the life of the implant.
- Any enhancement procedure that applies, in full, under the Blue Fin Vision® enhancement policy.
- Management of any complication of your surgery, including repositioning or exchange of a lens and, wherever required, vitreoretinal surgery, with no additional surgical fee.

What is not included

- Your consultation and diagnostic scans fee, which is prepaid separately.
- Treatment of a new and unrelated eye condition.
- Glasses or spectacle prescriptions after surgery.
- Cataract surgery later in life, which is priced in advance under the published Post-ICL Cataract Surgery Pathway.

Sedation is charged once per surgical session, not per eye. Medical treatment of this kind is exempt from VAT, so no VAT is added to any of the fees shown. Fees are correct at the date of this leaflet and may change. Your written quotation is the definitive figure.

A full and current breakdown of fees is maintained online and is updated whenever prices change: [ICL surgery costs](#).

Questions Worth Asking

You are entitled to clear answers to all of these, from us or from any other provider you are considering.

- Who will actually perform my surgery, and will I meet them before the day?
- How is my lens sized, on how many instruments, and what happens if the measurements disagree?
- What is my endothelial cell count now, and how will it be monitored afterwards, for how long, and at what cost?
- What vault range do you regard as acceptable, and what happens if mine falls outside it?
- What is the total cost, including everything that might be needed afterwards?
- What happens, and what does it cost, if my result needs refining?
- What happens, and what does it cost, if a complication occurs?
- What happens when I eventually develop a cataract, and what will that cost?
- What am I giving up by choosing this option?

Taking your time

There is no clinical reason to hurry. Blue Fin Vision® does not use time-limited discounts, deposits to hold prices, or pressure of any kind. Read this leaflet as many times as you need to, discuss it with the people who matter to you, and contact us when you are ready.

If you decide not to proceed, that is a perfectly good outcome and no explanation is required.

Further Reading

These documents are maintained online and are always current. Where anything in them differs from this leaflet, the online version is the more recent.

- ICL Surgery Checklist, the companion to this leaflet: bluefinvision.com/blog/icl-surgery-checklist
- ICL surgery costs, the full and current fee breakdown: bluefinvision.com/implantable-collamer-lens-surgery/costs
- The ICL Lifetime Monitoring Protocol™, in full, including the Post-ICL Cataract Surgery Pathway: bluefinvision.com/implantable-collamer-lens-surgery/lifetime-monitoring
- Accurate Sizing and Suitability of an Implantable Collamer Lens, how a lens is sized to your eye: bluefinvision.com/blog/accurate-sizing-and-suitability-of-an-implantable-collamer-lens-icl
- Life After ICL: Why Clear Vision Is Not the End of the Story, the long view in plain language: bluefinvision.com/blog/life-after-icl-why-clear-vision-isnt-the-end-of-the-story
- The Blue Fin Vision® Advantage, what our structure of care commits us to: bluefinvision.com/advantage
- The Blue Fin Vision® Enhancement Policy, in full: bluefinvision.com/blog/enhancement-policy

Where We Operate

Blue Fin Vision® works across six sites. Governance, protocols, measurement pathways and follow-up standards are the same at every one of them. Standards do not vary by postcode.

Site	Address
The Harley Street Eye Centre	22A Harley Street, London W1G 9PB
Weymouth Street Hospital	42-46 Weymouth Street, London W1G 6NP
Phoenix Hospital Chelmsford	Essex Healthcare Park, West Hanningfield Road, Chelmsford CM2 8HN
One Hatfield Hospital	3 Hatfield Avenue, Hatfield, Hertfordshire AL10 9UA
Chase Lodge Hospital	Page Street, Mill Hill, London NW7 2ED
Abbey Wood Hospital	The Cottage, Bostall Hill, Abbey Wood, London SE2 0GD. Blue Fin Vision® services starting soon

Your consultation, your surgery and your follow-up are all performed by your named Blue Fin Vision® consultant surgeon regardless of which site you attend. We will agree the most convenient location for you at your consultation.

Clinical Data Summary

This section is provided for patients, referring optometrists and general practitioners who want the underlying numbers in one place.

Measure	Blue Fin Vision®
Procedures performed, all types	more than 57 000
Consecutive years of published outcome data through the National Ophthalmology Database, covering cataract and lens surgery	six
Same-day bilateral surgery	routine since November 2016
ICL vault range monitored against	250 to 750 microns
Endothelial cell threshold for elective removal discussion	trending towards 2 000 cells/mm ²
ICL monitoring schedule	annual, for the life of the implant

The National Ophthalmology Database audit covers cataract surgery and does not include ICL procedures, so no national registry benchmark exists for ICL outcomes. Blue Fin Vision® audits its ICL outcomes internally and reviews them against the published peer-reviewed literature cited in this leaflet. The Royal College of Ophthalmologists requires that any claim of superior outcomes is supported by independently verifiable or peer-reviewed evidence, and we apply that same standard to how our ICL results are described.¹

Your Surgical Team

Blue Fin Vision® is a consultant-led practice. Your consultation, your surgery and your follow-up are performed by a named Blue Fin Vision® consultant surgeon, who is the person who obtains your consent and remains responsible for your care. You meet your surgeon before you commit to anything. This document is authored and clinically governed by our Medical Director.

Mr Mfazo Hove

MBChB MD FRCOphth CertLRS

Consultant Ophthalmic Surgeon, Founder and Medical Director, Blue Fin Vision®

Mr Mfazo Hove is a Consultant Ophthalmic Surgeon with experience spanning more than 57 000 procedures. He completed 6.5 years of specialist training at Moorfields Eye Hospital and served as a consultant at the Western Eye Hospital, Imperial College Healthcare NHS Trust, from 2017 to 2022. He is the founder of Blue Fin Vision®, a consultant-led private ophthalmology practice operating across London, Essex and Hertfordshire.

He has published six consecutive years of outcome data through the National Ophthalmology Database, with a posterior capsule rupture rate in cataract and lens surgery of approximately 0.2 per cent. He is a ZEISS Key Opinion Leader and an invited international speaker, with faculty roles at the ZEISS EMEA and APAC user meetings, the Annual Congress of The Royal College of Ophthalmologists and the Annual Congress of the European Society of Cataract and Refractive Surgeons.

He underwent cataract surgery himself in April 2024 and lives with trifocal intraocular lenses in both eyes. For an ICL patient this matters twice over: the experience of living with a surgical vision correction is one he knows personally, and the operation that may one day replace an ICL, decades from now, is one he both performs at high volume and has received.

Document control

Author and medical reviewer: Mr Mfazo Hove MBChB MD FRCOphth CertLRS. Version 1.0, August 2026. Review date: August 2027. Produced in accordance with the Professional Standards for Refractive Surgery of The Royal College of Ophthalmologists and the cosmetic interventions guidance of the General Medical Council. This document is original to Blue Fin Vision® and reproduces no third-party copyright material.

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Contact Blue Fin Vision®

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