capability of this material. To provide each haptic with sufficient flexibility and retain the superior stability and centration with material having plastic memory, each haptic has a diameter of approximately 0.14 millimeters with a tolerance of plus or minus 0.01 millimeters. Ends **34**, **36** of haptics **12**, **14**, respectively, are rolled or rounded.

Most prior art intraocular lenses have an optic of six (6) millimeters in diameter. This size provides an acceptable compromise between the chord length of the incision necessary and the size of the optic area. By forming edge **20** of the optic to be extremely thin, rounded and smooth, an optic of 6.5 millimeters can be used without requiring any greater chord length incision than that for conventional six (6) millimeter diameter optics. A preferred radius for edge **20** is 0.12 millimeters with a tolerance of plus or minus 0.01 millimeters.

Optic **16** may be formed convex posterior/plano anterior, plano posterior/convex anterior or biconvex, depending upon the particular requirements of the patient and the judgment of the surgeon. For illustrative purposes, a biconvex optic is shown in FIG. **3** while a plano convex optic is illustrated in FIG. **5**.

Referring jointly to FIGS. **4** and **5**, the operation of and function performed by intraocular lens **10** implanted within an eyeball **40** will be described. The eyeball consists of a cornea **42** that encapsulates anterior chamber **44** and iris **46**. The iris defines pupillary aperature **48**. Posterior chamber **50** includes capsular bag **52** adjacent vitreous cavity **64**. Through extracapsular cataract surgery, the cataract or crystaline lens is removed to leave posterior capsule **54** and an annular anterior capsule flap **56**. The remaining part of capsular bag **52** is retained by zonular fibers **58** attached to ciliary muscle **60**.

Intraocular lens **10** may be implanted within capsular bag **52** by known surgical procedures. As pointed out above, the thin, smooth and rounded edge **20** of optic **16** permits the use of a chord length incision for conventionally configured six (6) millimeter diameter optics even though optic **16** is approximately 6.5 millimeters in diameter. Implantation of the intraocular lens, as illustrated in FIG. **5**, permits the reversed S shape configuration of haptics **12** and **14** to distribute the forces exerted along a substantial length adjacent inner circumference **62** of capsular bag **52**. The haptics, being manufactured of PMMA and to have a free standing curvature of approximately six (6) millimeters radius, will tend to return to such configuration due to the plastic memory capability of the PMMA. Upon implantation, haptics **12** and **14** will be somewhat compressed to a more acute curvature than their free standing curvature. Such recurving of the haptics tends to cause them to be in contact with diametrically opposed segments of the inner circumference **62** of capsular bag **52** for a substantial distance, as illustrated in FIGS. **1** and **4**. The resulting stretching imposed upon the capsular bag will tend to assist in retention of the haptics within the capsular bag and prevent undesired haptic escape or withdrawal as a result of pressure or blow imparted to eyeball **40**.

The seven degree (7°) angulation of the haptics posteriorly from the plane of the iris, as illustrated in FIG. **5**, reduces iris and pupil margin contact of the haptics and optic to prevent posterior iris chafe and pupilary capture. Moreover, the haptics, being of PMMA and somewhat compressed within the capsular bag, also tend to induce a posteriorly oriented force upon optic **16**. The combination of the seven degree (7°) posterior angulation in combination with the overall thirteen (13) millimeter diameter of intraocular lens **10** provides a very stable fixation and centration within the capsular bag. Additionally, the seven degree (7°) posterior angulation allows unimpeded pupillary miosis on accommodation and anterior movement on ciliary contraction with accommodative effort. Furthermore, the posterior bias placed upon optic **16** against posterior capsule **54** gently stretches the posterior capsule and the resulting contact creates a barrier to lens epithelial cell migration after implantation. The slight pressure exerted by optic **16** against the posterior capsule also tends to prevent wrinkles and stress lines in the posterior capsule. With the intimate contact between optic **16** and posterior capsule **54**, there has been no pseudophakodenisis and experiments have also indicated a reduction in capsular opacification. Other benefits experienced have included: a reduction in the incidence of and the need for secondary posterior capsulotomies; no problems with elevated intraocular pressure; no problems with iris bleeding, iris chafe nor pupillary block; no tenderness to the patient; rare problems with CME or retinal detachment; and, a very high level of patient satisfaction.

As particularly illustrated in FIG. **4**, the approximately 6.5 millimeter diameter of optic **16** permits positioning holes **18** to be radially outwardly of the six (6) millimeter optic zone. Such relocation increases by more than fifty percent (50%) the clear optical area when compared to presently available prior art lenses having a six (6) millimeter optic with positioning holes within such diameter. As is visually evident from FIG. **4**, glare or reflection from the edges of positioning holes **18** and edge **20** of optic **16** is completely precluded by the overlap provided by iris **48** even with abnormally shaped or dilated pupils.

I claim:

1. An intraocular lens for implantation in the capsular bag of an eye upon which extracapsular cataract surgery has been performed, said intraocular lens comprising in combination:

(a) an optic, said optic including a thin, rounded, polished perimeter edge having a radius of 0.12 millimeters with a tolerance of plus or minus 0.01 millimeters;

(b) a pair of curved haptics extending in generally opposed directions from diametrically opposed locations of said optic for contactingly engaging the inner circumference of the capsular bag;

(c) each haptic of said pair of haptics being angled anteriorly of said optic at an angle of seven degrees (7°) and at a location outwardly of the perimeter of said optic for locating said optic adjacent the posterior capsule of said capsular bag; and

(d) each haptic of said pair of haptics being configured of a material having plastic memory for urging said optic against the posterior capsule upon implantation.

2. The intraocular lens as set forth in claim **1** wherein each haptic of said pair of haptics extends from said optic at an angle of approximately thirty degrees (30°) from the sagital plane of said optic.

3. The intraocular lens as set forth in claim **1** wherein each haptic, in an uncompressed state, of said pair of haptics defines a curve having a radius of six (6) millimeters.