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Lessening Glaucoma Treatment Burden: Clinical Cases (Part 2)

Announcer:

Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

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Dr. Grover:

Hi, this is CME on ReachMD, and I'm Dr. Davinder Grover. We're going to talk about, now, about the MIGS approach and really individualizing a patient's care, and I want to show some examples of clinical cases where I've really kind of found that these MIGS devices have been very appropriate for patients.

So case Number 1 is a 75-year-old male with a visually significant cataract, and he has mild glaucoma. He has definitely thinning on the inferior rim of his optic nerve, and he has just a mild nasal step on visual field, with a mean deviation of -3.5 dB. His IOP [intraocular pressure] is 20 mmHg on 2 antiglaucoma medications, and my goal is to get him around 17 on 1 drop. He's had a prior SLT [selective laser trabeculoplasty] which had a pretty good response, and he's been on glaucoma drops for about 4 years. He's also on blood thinners, and he needs to stay on them for Afib. On exam, in addition to his mild glaucoma and his optic neuropathy, he has wide open angles with well-defined structures and landmarks. And he's also relatively active and he still exercises on a regular basis. Given his need for blood thinners, as well as his stage of glaucoma and his active lifestyle, I chose to perform a Hydrus implant as opposed to a goniotomy or a trabeculotomy given the risk of a high – recurrent hyphema. His case went well, and during the surgery I could visualize the entire Hydrus implant in the canal, for the entirety of the length. Postoperatively, he had a very fast visual recovery and physical recovery. He did not have a postoperative hyphema. I treated him on antibiotics and steroids, as I would for routine cataract surgery, with the exception that he was on topical steroids for maybe an additional week. He is now over a year out, and his IOP has been well controlled, in the mid-teens, on 1 prostaglandin drop at night.

Now the second case I want to highlight is an 82-year-old female, with moderate to advanced glaucoma. She has previously undergone cataract surgery and a goniotomy a few years ago, but her IOP has been slowly increasing. My goal for her is to be under 15 on as few medications as possible. Her IOP is 18 on 4 agents, and I've detected, just over the last couple years, a slow decline in her nerve fiber layer on OCT, and her family tells me they're concerned that she may not be getting her drops in as frequently because she's just not as compliant as she has been lately.

The patient does report that her eyes are getting a little red and irritated, and they're drying them out. She has definitive glaucoma on her visual field. She has a mean deviation of -8, and a dense nasal step as well as a mild inferior arcuate defect. She's had, prior, 2 SLTs previously, and as I mentioned, a phaco goniotomy. Her conjunctiva superiorly is very mobile, and given my goal for IOP in the low teens, as well as trying get her off as many drops as possible, I opted for an ab interno, close conj, XEN-45 Gel Stent, and I used 40 µg of mytomycin C. The technique that I used is really, I've described as kind of the POST technique, where while after I implant the XEN, I sweep away the Tenon's, essentially kind of doing a primary needling on the table, with a microshunt spatula. And that's been reported by a couple of different groups. She tolerated the procedure well. Given her prior goniotomy, she did have a little microhyphema on postoperative week 1, but it resolved pretty quickly, and on post-op day 1, her pressure was a 7, her anterior chamber was formed and deep, and her vision was actually unchanged. I treated her with topical antibiotics and steroids, similar to what I would do for

a cataract surgery, but I tapered her steroids over a 5-6 week period. After about 10-14 days, she was able to return to her normal activity. She is now over 18 months out. Her pressure is around 12, on 1 drop of timolol in the morning, and she thankfully has a nice, diffuse low bleb that's mildly vascularized.

You know, I think these 2 cases exemplify kind of how we're now able to tailor the surgery to the patient's lifestyle, their disease state, their comorbidities, their blood thinner status, and their activity. And that's the exciting time – it's an exciting time to be a glaucoma doctor. We have a lot of options, and we're truly able to intervene the way we need to, and it's much safer than it was 20, 30 years ago, when all we had were trabs and tubes.

Again, this is Davinder Grover. Thank you for tuning in, and this has been CME on ReachMD.

Announcer:

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