COMORBID CATARACT AND GLAUCOMA

Surgeons' attitudes about and approaches to treatment have changed.

BY STEVEN R. SARKISIAN JR, MD

CASE PRESENTATION

A healthy 66-year-old retiree is referred for combined cataract surgery and MIGS on both eyes. The patient has visually significant cataracts and mild to moderate open-angle glaucoma with early peripheral visual field changes in each eye that match the retinal nerve fiber layer on OCT scans. The central visual field is full in each eye. Examinations of the retina and anterior segment are unremarkable.

The patient's BCVA is plano +0.50 x 90° = 20/40 OD and +0.50 +0.50 x 90° = 20/40 OS. The right eye is dominant. An attempt at monovision with a contact lens worn on his nondominant eye failed owing to the anisometropia, and he refuses to consider a monovision strategy. IOP is 16 mm Hg OU, and he is administering latanoprost in both eyes.

The patient's wife underwent bilateral cataract surgery with trifocal IOL implantation last year and is highly satisfied with her outcome. The patient would like to discontinue topical glaucoma drops and eliminate his dependence on reading glasses.

Which MIGS procedure would you choose for this patient? Which make and model of IOL would you select?

DISCUSSION

Many glaucoma and cataract surgeons encounter situations like that described in the case presentation every day—patients with visually significant cataracts and glaucoma that is controlled on one medication. Ten or more years ago, most surgeons would have performed standalone cataract surgery and implanted a monofocal IOL. If the IOP was high or the patient was administering more than one glaucoma medication, the decision whether to combine one-site or two-site surgery with trabeculectomy might have been controversial. Some ophthalmologists might have combined cataract surgery with endoscopic cyclophotocoagulation (ECP) because the latter procedure was an option before ab interno canal surgery was available. The purpose of this article is to demonstrate how far ophthalmologists have come in treating comorbid cataract and glaucoma and to show how surgeons' attitudes toward the use of presbyopia-correcting IOLs in patients with glaucoma have changed.

"RATHER THAN ADHERE TO THE COLUMN'S USUAL FORMAT, I AM SYNTHESIZING THE RESPONSES OF 16 MEMBERS OF *GT*'S EDITORIAL ADVISORY BOARD TO THE CASE PRESENTATION. I ASKED THAT THEY OFFER ONE-WORD RESPONSES FOR THE GLAUCOMA PROCEDURE AND IOL THEY WOULD CHOOSE FOR EACH OF THE PATIENT'S EYES."

Rather than adhere to the column's usual format, I am synthesizing the responses of 16 members of *GT*'s Editorial Advisory Board to the case presentation. I asked that they offer one-word responses for the glaucoma procedure and IOL they would choose for each of the patient's eyes. Panelists' anonymity is being maintained to encourage unbiased responses.

Glaucoma surgery. When I talk to patients about combined surgery, I divide the discussion into the glaucoma talk and the IOL talk. The first is easier. In a situation like I have described, where the patient has mild to moderate glaucoma and the IOP

is on target with one medication, I usually implant an iStent inject W (Glaukos) in each eye.

Six of the panelists (37.5%) also chose the iStent, whereas another six of the panelists (37.5%) chose the Hydrus Microstent (Alcon). Other panelists chose the Kahook Dual Blade (New World Medical; 12.5% [n = 2]), the Omni Surgical System (Sight Sciences; 12.5% [n = 2]), the Streamline (New World Medical; 6.25% [n = 1]), or ECP (6.25% [n = 1]). Confounding the results is that one respondent chose to combine the Omni and Hydrus and another opted to combine ECP with the iStent. These are counted as separate responses. One panelist stated that, if one of the eyes had mild glaucoma, they would choose the iStent, but if the glaucoma were moderate, they would choose the Hydrus. The case presentation describes mild to moderate glaucoma, disease severity was about the same in the patient's two eyes, and severity was not great enough according to the respondent's criterion to warrant the Hydrus. The iStent inject W is therefore listed as the response.

Notably, none of the panelists chose cataract surgery as a standalone procedure.

IOL selection. For me, the scenario presented was less complicated than most I encounter because the patient had reasonable expectations regarding presbyopia-correcting IOLs, he was not worried about the financial aspects of his decision, and he knew what he wanted. Our discussion centered on the AcrySof IQ PanOptix versus the AcrySof IQ Vivity (both from Alcon). I often recommend the Vivity to patients with moderate glaucoma and good central vision. This patient, however, wanted to be able to read without glasses, and under no circumstance would he agree to even a mini-monovision strategy. He did not have significant astigmatism, and the amount he had was corrected with laser arcuate incisions.

I selected a PanOptix for this patient, as did 50% (n = 8) of the panelists. The Vivity was selected by 12.5% (n = 2) of respondents, the Tecnis Symfony (Johnson & Johnson Vision) by 12.5% (n = 2), and the Tecnis Synergy (Johnson & Johnson Vision) by 6.25% (n = 1). Interestingly, four respondents (25%) decided to ignore the patient's request for a presbyopia-correcting IOL and chose a monofocal IOL instead. Two of them selected the AcrySof IQ IOL (model SN60WF, Alcon), and two chose the enVista IOL (Bausch + Lomb).

CONCLUSION

The majority (75%) of respondents chose trabecular microbypass surgery for the patient. This suggests a clear shift in practice patterns, even compared to 3 to 5 years ago. As for IOL selection, 75% of the panelists selected a presbyopia-correcting IOL, and all of them were willing to correct astigmatism, even when a monofocal IOL was selected. I hope that these survey responses influence readers to confront their biases and broaden their scope of care for patients. ■

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- Financial disclosure: Consultant (Alcon, Allergan, Bausch + Lomb, Beaver-Visitec International, Glaukos, Sight Sciences); Equity owner (Sight Sciences); Grant support (Alcon, Allergan, Elios, Glaukos, iStar Medical, Sight Sciences); Lecture fees (Alcon, Allergan, Bausch + Lomb)