



SEEN & HEARD



In Your Head



GT asked: What is one example of dogma in glaucoma care—past or present—that you have been passionate about challenging?

George R. Reiss, MD, answered: A dogma that I still wish to challenge is one that has been drilled in by our retina colleagues regarding choroidal detachment and hemorrhage after glaucoma surgery.

Even in the best surgical hands and with releasable sutures in trabeculectomy and valved aqueous shunt surgery, a rapid reduction in IOP can cause a choroidal detachment (effusion or hemorrhage). This is particularly true when starting with high-pressure cases. Other contributing factors include premature suture lysis, additional postoperative interventions, and coughing or sneezing by the patient.

Retina specialists commonly recommend waiting several weeks to intervene because “most effusions eventually resolve on their own.” Resolution, however, often does not occur until after the flap has stuck down, requiring subsequent intervention. With hemorrhagic detachments, the advice to wait and allow the clot to lyse has been even more adamant.

In my experience, trabeculectomy failure often occurs when there is no aqueous flow through the flap. This is commonly the case with decreased aqueous production due to choroidal detachment. Waiting

to address an effusion increases the risk of subsequent hemorrhage because the highly vascular choroidal is stretched by the effusion.

Many choroidal hemorrhages are a mixture of effusion and hemorrhage. Scleral sclerostomies can provide some relief and decompress this space. Patients with choroidal detachments sometimes experience pain and loss of peripheral vision, but drainage of the effusion typically provides quick pain relief.

With huge persistent choroidal effusions, significant retinal tears can occur when drainage is performed. Why wait for the effusions to grow this large? In my experience, a choroidal detachment should be addressed in 1 week to 10 days if no improvement is seen. Choroidal tap surgery is safe, efficient, and satisfying for both the patient and the surgeon. Restoring the patient's normal anatomy may also improve their visual and IOP outcomes.

In all cases, I leave the sclerostomies open. I often create a scleral punch on one side of the incision for continued drainage. The sooner this anatomic problem is addressed, the sooner the patient is on the road to postoperative recovery.

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Waste in Ophthalmology ORs

On *GT: The Podcast*, Marko Oydanich, MD, discusses the growing environmental burden of the health care sector and offers strategies for reducing waste in ophthalmology ORs, much of which results from single-use equipment and devices. Later, David F. Chang, MD, shares the mission of EyeSustain.org, a web-based resource center for sustainability in ophthalmology.



Meeting Updates

- **European Society of Cataract and Refractive Surgeons (ESCRS) Annual Meeting**
September 8–12; Vienna
- **Interventional Glaucoma Consortium (IGC)**
October 6–8; Salt Lake City
- **IGC Fellows Program** | October 6; Salt Lake City
- **Duke Glaucoma Fellows Course & Wet Lab** | October 13; Durham, North Carolina
- **AAO Annual Meeting** | November 3–6; San Francisco
- **AGS Annual Meeting** | February 29–March 3, 2024; Huntington Beach, California

