

Glaucoma Surgery: Will There Ever Be a Consensus?

It is not easy always being right, especially when it comes to surgery. "I know how to do it," "I've always done it this way," and "It works for me." These are three common lines uttered by sur-

geons when they face something new or when a colleague challenges their approach to a specific step of a procedure. The less people understand something, seemingly the more controversy there is. Trabeculectomy is a good example. Surgeons cannot agree on the placement of the incision (limbus vs fornix), the configuration of the scleral flap, or the duration, location, or type of antifibrotic agent.

Trabeculectomy was first described in the 1960s, when proponents touted the procedure as a means of improving aqueous flow into the canal of Schlemm and outflow system. In fact, trabeculectomy was one of the first proposed canal-based procedures! It lowered IOP but not by removing trabecular tissue; within a few weeks, the trabecular ostia directing flow to the canal is scarred. The patent scleral and/or corneal fistula, however, allows aqueous to egress and a conjunctival bleb to form. Despite the term *trabeculectomy*, the procedure is actually a keratectomy or sclerectomy with the creation of a fistula to the subconjunctival space.

In spite of various surgical innovations and the passage of 40 years, there is still little consensus on the

optimal form of filtering surgery. In this same period of time, cataract surgery went through three major iterations to become a standardized procedure.

Discussion in that field now focuses on new technology and managing complications, seldom on the steps of the procedure. It seems unlikely that glaucoma surgery will ever be as definitive or successful as cataract surgery. One could argue that the comparison is unfair, because glaucoma is progressive and only indirectly affected by the reduction in IOP from a trabeculectomy. I nevertheless dream of participating in a meeting on glaucoma surgery that focuses on treating the true source of visual loss with no mention of the conjunctival incision or the

wound's closure. At present, ophthalmologists remain bogged down in controversy without well-controlled studies to advance the field.

This edition of *Glaucoma Today* tackles two contentious subjects in glaucoma management. Four surgeons debate the use of one versus two sites for combined trabeculectomy and cataract surgery. In addition, Vital Costa, MD, and Alon Harris, PhD, MS, describe the possible usefulness of measuring diurnal perfusion pressure when managing glaucoma. Douglas Mackenzie, MD, and Malik Kahook, MD, provide a discussion of the issue.

My advice is to keep an open mind, because there is plenty of room for improvement in the diagnosis and treatment of glaucoma. □



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