

Garry P. Condon, MD

Dr. Condon shares his reasons for coming to and remaining in the United States as well as the inspiration for his suture fixation of an IOL.

What is the greatest benefit of a glaucoma fellowship?

The most rewarding aspect of my fellowship with Richard J. Simmons, MD, was becoming comfortable taking care of patients with advanced disease in whom multiple forms of therapy have failed. These individuals are losing their vision and have real fears about where they are going to end up in terms of their visual function. The whole idea of taking care of patients is making them feel better, letting them know you care even if you do not have all of the answers. The more skilful you are at developing a rapport with patients, the better they will be at following up with you and adhering to prescribed therapy, which improves their overall outcome.

What brought you to the United States?

I grew up in Canada and completed my undergraduate medical education and residency training there. At the time, there were few surgically oriented glaucoma fellowships available in Canada, and that was where my interest lay. One of my mentors recommended that I apply for a fellowship with Dr. Simmons in Boston. I borrowed a suit from a friend and went for an interview during the summer between my first and second years of residency. I ended up spending a year and a half in Boston. While there, I encountered some of the most

challenging glaucoma surgical cases that anybody could imagine. Dr. Simmons believed that achieving a low IOP was critical for patients with advanced glaucoma and that, for the most part, it was achieved with surgery. That was the aspect of glaucoma I wanted to “get my teeth into.”



When I was finishing my glaucoma fellowship in the mid-to-late 1980s, I expected to return to Canada, but the health care landscape was dramatically different there than in the United States. In Canada, I would have encountered a limited availability of OR time and resources at any academic center. As an ophthalmology resident, I had developed an instant connection with John Kennerdell, MD, when he came to speak at my institution. As a neuro-ophthalmologist and orbital surgeon, he had left

the University of Pittsburgh to establish a department of ophthalmology at Allegheny General Hospital in Pittsburgh. He told me to call him when I finished my training. I did, and he invited me to visit. I was shown a secretary, my choice of offices, and my pick of operating day. The facility had numerous exam rooms. My mother was a US citizen, so I had a green card and did not have to leave. I thought I would stay for a year or 2. I never left Pittsburgh. I never even left the building.

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FAST FACTS

- Director, Division of Glaucoma (1990 to present), and chairman, Department of Ophthalmology (2007 to present), Allegheny General Hospital, Pittsburgh
- Clinical assistant professor, Department of Ophthalmology, University of Pittsburgh, 2004 to present
- Associate professor of ophthalmology, Department of Ophthalmology, Drexel University College of Medicine, Allegheny General Hospital Campus, Pittsburgh, 2000 to present
- Named one of America's top ophthalmologists, cataract/glaucoma surgery, by the Consumer's Research Council of America, 2008
- Elected to the International Intra-Ocular Implant Club, 2006
- Named one of the Best Doctors in America, 2005 to 2008
- Recipient of the AAO's Honor Award, 2001

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What are the pros and cons of working at an academic center?

Being a part of an academic institution forces you to stay current in the field. It is also rewarding to interact with people who are interested in learning about glaucoma and to see residents and fellows grow. On the downside, an academic institution involves a lot of politics and demands a great deal of your time. You are expected to produce in terms of publications, education, and the lecture circuit. It is tough to combine and fulfill these obligations every day.

Sometimes, I would rather not be in academics. On other days, I feel lucky to be in my position. Just last week, I was in Toronto and had dinner with a few colleagues and one of my former fellows, who mentioned something he had learned from me 10 years ago. It is amazing the influence you can have on how someone takes care of patients. The problem is you do not realize how old you are until you see these individuals and how far they have gotten in their career.

How has glaucoma surgery evolved during your career, and what changes do you anticipate in the next 10 years?

I began using mitomycin C (MMC) during glaucoma filtering surgery fairly routinely in 1991. Within 7 years, it was obvious to me that, although trabeculectomy with MMC was quite successful in terms of lowering the IOP, it was also associated with problems that were often quite difficult to remedy such as bleb leaks and late hypotony.¹

I became interested in surgical options that avoided complications related to wound healing. Early efforts at nonpenetrating surgery showed that we could “unroof” and expose Schlemm’s canal with careful dissection. This work gave rise to the question of whether there were a way to rejuvenate the indigenous outflow system rather than make a hole in the eye.

When Reay Brown, MD, asked me in 2004 if I would be interested in helping to study the Eyepass for use in Schlemm’s canal, I jumped on board. Unfortunately, although the surgery was successful in terms of the technique, we were not seeing sufficient pressure lowering for the FDA to bring the device to market.

I became interested in the cannulation of Schlemm’s canal and began working with iScience Interventional (Menlo Park, CA) in 2005 on passing and “retensioning” a suture around 360° of the canal. Several ophthalmologists are reporting impressive results with more than 2 years of follow-up with canaloplasty surgery. Technically, however, the procedure is more time con-

suming than trabeculectomy, and it requires a distinct learning curve. My colleagues and I are still working on making our canal procedures more predictable.

Despite the theoretical niceties of sending aqueous fluid directly into Schlemm’s canal, these procedures and devices still do not produce pressures as low as we might like in some cases, so conventional filtering surgery with an antimetabolite remains the most popular surgical approach to glaucoma. In the next 10 years, I hope to see a breakthrough with a device that produces predictable outflow, whether with filtering surgery or rejuvenation of the indigenous system. What I anticipate in terms of innovation, however, is nothing huge. While we continue to work toward a breakthrough, I think we should focus on making current glaucoma surgery better—including with aqueous drainage devices, which have not changed much at all since their development.

How did you develop your technique for the suture fixation of an IOL?

In 1999, I saw a patient with UGH syndrome and an anterior chamber IOL. To save his vision and control the IOP, I removed the IOL and performed filtering surgery on the eye in the same sitting. Approximately 6 months later, the patient said he could no longer tolerate his contact lens and asked if I could implant an IOL. A filtering bleb lay over the sclera, and the thought of another anterior chamber lens was out of the question for the patient and me. Suturing an IOL to the sclera would have involved violating the conjunctiva and perhaps ruining the filtering bleb.

I had been implanting foldable acrylic IOLs for several years and found them easier to manipulate in the eye as they unfolded than silicone lenses. In addition, I had learned from Malcolm McCannell, MD, how to reposition a dislocated IOL. I thought that I could unfold an acrylic IOL slowly enough that the haptics would extend behind the iris while the optic was captured by the pupil. After suturing the haptics to the iris, I could then place the optic in the posterior chamber.

I told the patient that he would be a perfect candidate for a technique I thought would work but had never tried. His was my first case, and the technique proved successful.² As a result, although I started out in glaucoma, my clinical practice now includes just as many complex cataract/IOL cases, a balance I truly enjoy. □

1. Bindlish R, Condon GP, Lehrer RA, et al. Efficacy and safety of mitomycin-C in primary trabeculectomy—five-year followup. *Ophthalmology*. 2002;109:1336-1341.

2. Condon GP, Ahmed I, Masket S, et al. Peripheral iris fixation of foldable acrylic posterior chamber IOLs: efficacy and complications. *Ophthalmology*. 2007;114:1311-1318.