

trabeculectomy.¹ Certainly, most cases of early postoperative hypotony are transient and resolve spontaneously, but we must not be cavalier with our patients' vision. If they are gainfully employed and in the prime of their lives, but they have to wait weeks to regain useful vision, we have done them a great disservice. We must not take

lightly refractive changes from a shorter axial length, choroidal effusion and hemorrhage, and corneal folds or the risk of hypotony maculopathy.

Good and Kahook showed that the Ex-Press promotes faster visual recovery when compared with trabeculectomy.² The benefit may be due to a lower, more diffuse

Case Study: Managing a Large, Overhanging Bleb Affecting Vision

BY PAUL F. PALMBERG, MD, PhD

A patient presented with reduced visual acuity and a large bleb that was overhanging the cornea (Figure 1). His visual acuity had previously measured 20/60, apparently due to advanced glaucoma, and it had gradually worsened to a BCVA of 20/100, despite an IOP of 10 mm Hg. Retinoscopy revealed irregular astigmatism, suggesting that the bleb—pressed upon by the upper lid—was steepening the superior cornea. Thus, the bleb was decreasing the patient's BCVA by producing irregular astigmatism, much as a pterygium can.

At the slit lamp, the eye was prepared with proparacaine, apraclonidine, and 5% povidone-iodine for 2 minutes. It was then rinsed with proparacaine. Next, 2% lidocaine gel was applied for 2 minutes and then rinsed with sterile saline solution. After placing a lid speculum, I undermined the bleb with a Kimura spatula (Figure 2).

Using a forceps, I lifted the freed inferior border of the bleb and amputated it with a Vannas scissors (Figure 3A). The cut edge was Seidel negative (Figure 3B), and no suture closure was needed, as is usually the case in this situation. The patient's BCVA improved within a week to 20/60, due to resolution of the irregular astigmatism, and the IOP was unchanged. The final appearance of the eye is shown in Figure 4.

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Figure 1. A large, overhanging bleb.



Figure 2. The surgeon undermines the bleb with a Kimura spatula.



Figure 3. The surgeon amputates the inferior border of the bleb (A). Testing showed the cut edge to be Seidel negative (B).



Figure 4. Final appearance of the bleb (A), with the patient looking down (B).