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https://reachmd.com/programs/cme/effective-migs-for-optimal-iop-control-a-case-based-approach/32251/

Released: 03/05/2025
Valid until: 03/06/2026
Time needed to complete: 58m

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Effective MIGS for Optimal IOP Control: A Case-Based Approach

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Petrakos:
It's an exciting time for MIGS surgeries with several implants to choose from. How do we help patients select a MIGS device that's best for them?

This is CME on ReachMD, and I'm Dr. Paul Petrakos.

Dr. Singh:
And I'm Dr. Paul Singh. And I think that is the million-dollar question, Paul. What is the best procedure? Well, there is no right or wrong, first of all. I think a lot of the decisions we make on what's the best procedure really depends upon, a lot of times, the comfort level of the surgeon, the anatomy of the patient, the technology we're using, depending on medication burden reduction, cataract status. So there's a lot to think about, as well. So it's not a one-size-fits-all. I mean, that's what's so nice about having multiple procedures, multiple technologies that address different parts of the outflow system, as well.

But I think, for me, I'm going to show a case real quick here of a Hydrus implantation. I think if someone has a cataract, mild to moderate glaucoma, on one or two meds, three meds even, I think the 5-year data of the HORIZON trial really does help support that this is a very beneficial stint. And you can see here, some engaged in the TM in upward fashion, but advancing the wheel, and you can see that Hydrus entering into the Schlemm's canal. It's scaffolding in the trabecular meshwork, rather the canal, rather, bypassing the TM. You can see that inlet, 50% of the inlet is in the canal, 50% of the inlet is in the anterior chamber as well. We're getting access to multiple collector channels while we're bypassing TM and scaffolding as well. So I think for me, I think a very efficacious, safe procedure during the time of cataract surgery, and it's been, I think, effective not only in reducing IOP but also reducing the drop burden as well.

But, Paul, what about the procedures that target the subconjunctival space?

Dr. Petrakos:
Yeah, Paul. We're fortunate we have these options that can be used beyond the Schlemm's canal, okay, that are not as invasive as a traditional trabeculectomy.

Here, I have a case of 83-year-old female. She's moderate POAG. She has a BAK allergy, like many of our patients, who's on 3 preservative-free drops, and she's getting a XEN Gel Stent. So I've switched to doing ab externo approach. I don't typically use the handpiece anymore. So I'm using a 27-gauge needle to enter the anterior chamber about 3 mm back from the limbus, and then I just directly implant the XEN Gel Stent using an angled Macpherson. And I found this has actually been really helpful in teaching residents and fellows. It's more similar to a traditional tube shunt surgery for them. You just have to be quick to not get the XEN Gel Stent wet and insert it first, so before it gets soft in the eye.

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This patient had a remarkable recovery afterwards. It's been 3 years out. Both of her eyes, the pressures are 10, usually 10, 11, on no medications.

So, Paul, you prefer to use the loader and an ab interno approach for you XEN Gel Stents. Can you walk us through that pretty quickly?

Dr. Singh:
Sure. I do, actually, a lot of externo approaches as well, but I do use a loader from my externo and my ab interno. But let's look at the ab interno approach, which is kind of how tthe XEN Gel Stent loader was designed. So I'm just using a gonioprism here just to make sure I'm entering at the level anterior to the trabecular meshwork. So I'm just confirming where I'm at. So once I know where I'm at, this is again, during cataract surgery. I've already opened up the eye, already have viscoelastic in the eye, so I figured why not perform an ab interno approach as well? So now that I know where I am, I'm just taking a Kuglen here, second instrument to stabilize the eye. Rotate the eye downward. And with pressure going through the trabecular measure, or rather through the scleral wall, exiting into the subconjunctival space, about 2 and a half millimeters behind the limbus, making sure I can see my load, or my needle, and then retracting it back as well.

And so this is ab interno approach which allows us not to have to cut the conjunctiva as well. But the key is to really manage Tenon's. Tenon's is your enemy for all these procedures, so I do a lot of primary needling to make sure I make sure that there's no Tenon's that could potentially cause fibrosis and block the flow and cause a bleb issue as well. But I think that we have some great examples that you showed and, of course, what I showed as well.

And as we wrap up, I just really want to make sure that we understand, for all of our colleagues out there, that there's a lot of options, and you have to feel comfortable with what you're doing with the technology you're utilizing and look at your outcomes. And depending on patient's anatomy, number of medications, severity, lens status, there's a lot of opportunities to utilize many of these different technologies, as well.

Dr. Petrakos:
That's great advice. I would just add that the XEN Gel Stent's a great option for IOP control and has been proven to have less hypotony and complications than trabeculectomy.

That's all the time we have today. Thank you for being here, Paul.

Dr. Singh:
Yeah. Thank you as well.

Dr. Petrakos:
And thank you all for joining us. This has been CME on ReachMD.

Announcer:
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