Clinical and scintigraphic comparison of silicone and polyvinylpyrrolidone coated silicone perforated plugs

Th Malet, B Challier, N David, A Bertrand, J-L George

Abstract

Background/aim—Isolated stenosis of the lacrimal punctum is a frequent cause of epiphora. Treatment relies on surgical opening or dilatation with bi- or monocular prosthesis. Recently, silicone perforated punctum plugs (PPP) were proposed. The drawback with these silicone PPP was that secretions accumulate in the central orifice blocking the spontaneous flow of tears. A modification of the surface of the PPP using polyvinylpyrrolidone (PVP) was thus proposed. The aim was to compare silicone PPP with new PVP surface treated PPP.

Methods—A prospective study was conducted of 20 patients with dilatable stenosis of the lacrimal puncta who developed epiphora. Epiphora, tolerance, implantation of the PPP, and lacrimal drainage were evaluated using scintigraphy of the lacrimal ducts.

Results—The raw data and statistical analysis showed evidence of a superior performance of PVP surface treated PPP.

Conclusion—Long term evaluation of the advantages or risks of PVP plugs and comparison with microsurgical punctoplasty are warranted.

(Br J Ophthalmol 1998;82:1416–1419)

Isolated stenosis of the lacrimal punctum is a frequent cause of epiphora. The various methods used to augment punctal size include repeated dilatations (generally considered to be ineffective), surgical opening by the one snip, two snip, three snip, or punch punctoplasty; microsurgical punctoplasty with sutures; electrocautery; laser treatment; or temporary punctal stenting (canalicular tubing, punctum plugs). Surgical opening by punctoplasty usually gives excellent functional results with few complications. However, an advantage of temporary stenting is to spare the punctal fibrous ring.

Recently, perforated punctum plugs (PPP), proposed by Bernard and colleagues in France, were developed from the punctum plugs used for dry eye syndrome. Like ordinary punctum plugs, perforated plugs are made of silicone but are slightly larger and are perforated in the centre. The central orifice measures 0.6 mm in diameter. However, the first trials were disappointing as these perforated plugs became filled with secretions which accumulated in the central orifice thus blocking spontaneous tear flow. The hydrophilic nature of silicone is thought to be the causal factor. New perforated plugs surface treated with hydrophilic polyvinylpyrrolidone (PVP) were thus developed (FCI Laboratories, 20, boulevard Gallieni BP 111, 92134 Issy Les Moulineaux Cedex, France) (Fig 1).

The aim of this study was to compare two types of perforated plugs on the basis of drainage efficacy and functional tolerance. To obtain an objective evaluation of lacrimal drainage under good physiological conditions, we used lacrimal scintigraphy. Our purpose was to conduct a clinical trial and was not, at this stage, to compare this new concept with previous punctoplasty procedures.

Materials and methods (Table 1)

This prospective study was carried out using a single blinded method (patients). Twenty patients gave their informed consent. All 20 patients had epiphora caused exclusively by bilateral dilatable stenosis of the inferior lacrimal puncta. All had patent lacrimal ducts.
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Patients were selected at an initial consultation, if dilating the inferior lacrimal puncta facilitated permeability and canaliculi washing. To be selected, patients had to consider that their epiphora had improved for at least 1–2 days after dilatation. The patients selected were asked to return for an inclusion consultation 8 days to 1 month later.

Table 2  Comparative results at day 60 for 20 patients with silicone PPP on one side and PVP PPP on the other side

<table>
<thead>
<tr>
<th></th>
<th>Silicone PPP (n=20)</th>
<th>PVP PPP (n=20)</th>
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<tbody>
<tr>
<td>Subjective improvement of epiphora</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Tolerance</td>
<td></td>
<td></td>
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<tr>
<td>good</td>
<td>0</td>
<td>15</td>
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<tr>
<td>mild</td>
<td>15</td>
<td>5</td>
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<tr>
<td>poor</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Scintigraphic patency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>improved</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>unchanged</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>worsened</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

EFFECT ON EPIPHORA

The epiphora score improved in most cases (13 of the 20 patients with silicone plugs and 15 of the 20 with PVP plugs) (Table 2).

However, we were able to compare the two types of PPP only in patients whose initial epiphora score was the same on both sides (Fig 2). Thus, data from 15 patients (patients 2–4, 6–10, 13, 15, 20) were retained for statistical analysis. We noted that in five cases, PVP was more effective than silicone.

Taking the epiphora score as a continuous quantitative variable, analysis of variation (initial score minus final score) between PVP plugs and silicone plugs showed that the average improvement in the epiphora score (initial score minus final score) was significantly better (p = 0.03) for PVP plugs (1.35) than for silicone plugs (1.05).
lar in one, and excessive accumulation blocking tear flow and requiring removal of the plug in the others.

With the PVP plugs, tolerance was good in 15 cases and mild in five. For these cases, pruritus at the internal angle was the main finding but no secretions were observed in the plug orifice.

SCINTIGRAPHY (TABLE 2, FIG 3)

Scintigraphy results showed an improvement over the initial score for the silicone plug in nine cases, an unchanged score in six, and a worsened score in five.

For the PVP plugs, the initial score was improved in 15 cases and remained unchanged in five. There were no cases with a worse score.

Analysis of the variations in scintigraphy scores (initial minus final) taken as a continuous quantitative variable showed that the difference in the scintigraphy score was significantly greater (p = 0.004) for PVP plugs (1.21) than for silicone plugs (0.16).

STATISTICAL ANALYSIS

The statistical analysis of these results must be done prudently, as transposing an evaluation of significant difference to one of cause and effect requires random distribution in both groups (PVP and silicone) for all factors which could affect epiphora and scintigraphy. In this trial, each subject was his own control, but the side was not randomised. The two types of plugs were implanted systematically on the same side. Thus, assuming that side had no effect on disease progression, it can be concluded (with reservation) that PVP was superior to silicone.

LATE RESULTS

In the second month, we removed most of the plugs (all the silicone plugs and 10 of the 20 PVP plugs). All patients were seen again at 6 months: a new stenosis of the lacrimal punctum had developed where the plugs had been removed. After initial improvement, epiphora again developed. Surgical opening was required at this point.

The 10 patients with a PVP plug at 6 months did not have epiphora and tolerance was excellent, in particular no secretions were observed in the orifice.

Discussion

Epiphora with lacrimal flow is caused by many, often intricate, factors. Stenosis of the lacrimal puncta is one of the most frequent causes, suggested by the narrow biomicroscopic aspect of the puncta and the difficulty in dilating the puncta followed by good lacrimal flow in the canaliculi after dilatation. One good clinical argument for punctum stenosis, is transient improvement in tear flow several days after dilatation, before the punctum narrows again. Other arguments for poor tear drainage include a negative taste test, a negative secondary dye test and, most importantly, the dacrysocintigram which allows good assessment of the physiological situation.

Among the methods proposed for stenosis of the lacrimal puncta, microsurgical opening of the posterior wall of the punctum is the treatment of choice. Despite the high success rate, microsurgery sections the fibrous ring of the punctum, with the subsequent increased risk of stricturotomy if bicanalicular intubation is later required.

Perforated punctum plugs (PPP) were proposed by Bernard et al with the objective of obtaining a true artificial lacrimal punctum. The advantage over surgery is that the lacrimal sphincter is not ruptured. The qualities of the first PPP, developed from punctum plugs made out of silicone, were their flexibility, elasticity, and antiadherence properties. Unfortunately, this latter property means that the material is hydrophobic, and consequently has a weak surface energy. It cannot be moistened and does not favour regular flow of an aqueous fluid. These perforated silicone plugs therefore rapidly became non-functional due to secretions obstructing the central
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Role of the superior punctum and canaliculi

Canal whose function is difficult to assess. The role of the superior punctum and canaliculi were also eliminated.11

Our results confirmed an improvement in functional signs, both with the silicone and the PVP plugs, for nearly three quarters of patients. Inversely, the objective results (tolerance, secretions in the central orifice of the perforated plugs) showed that the perforated plug with a PVP surface was superior. Scintigraphy of the lacrimal ducts is a recognised method for assessing spontaneous tear drainage in physiological conditions.12 13 As the scintigraphy curves are objective data, the two types of plugs were not implanted according to a random distribution.

Our scintigraphy recordings before and after implantation of the perforated plugs, confirmed the superior lacrimal drainage with PVP surface treated perforated plugs. There were no cases with poorer isotopic tear flow with the PVP plugs, while we did find evidence of aggravation for five cases with silicone plugs.

Re-stenosis of the lacrimal punctum, observed after ablation of the PPP, raises a problem concerning the concept of lacrimal prostheses: these prostheses should be maintained permanently. Complications can arise with PPP (punctum may tear during the insertion, pyogenic granuloma, expulsion, migration, local irritation),14 15 Canalicular stenosis has been described14 15 with punctum plugs and may be observed with perforated plugs. In our study, treating the surface with PVP improved tolerance, lumen vacuity, and efficacy of lacrimal drainage compared with the earlier silicone perforated plugs. We feel that the PVP plugs could be used as permanent prostheses. Further follow up of patients with these implants is obviously necessary to verify long term tolerance, notably concerning proximal canalicular stenosis.

Conclusion

Renewed interest in the treatment of lacrimal punctum results from the development of perforated plugs with a PVP surface. Efficacy and tolerance are improved during the first months. If the risk of stenosis after ablation is confirmed, these plugs should be maintained permanently, warranting long term evaluation of the advantages or risks of PVP plugs.

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