Editorial: Combined cataract and glaucoma surgery

The presence of both cataract and glaucoma in the same eye has always presented the surgeon with a difficult problem. Very often the cause of the glaucoma is unclear. For example, is the glaucoma in those patients who present with cupping and field loss and very narrow angles the result of a primary narrow angle glaucoma, chronic angle closure from increasing size of the lens, or are the peripheral anterior synechiae and cataract the result of low grade intraocular inflammation? Even those patients who are known to have primary open angle glaucoma which has been controlled with medication do not present a homogeneous group, for many have rigid and unreactive pupils and many have gross abnormalities in the trabecular meshwork; in addition is that curious group of patients who develop an intractable glaucoma after cataract operations. Thus, although there is now a large literature covering the combination of cataract and glaucoma, the best method of management is still in doubt for the individual patient. The decision as to the correct method of treatment depends on a careful pre-operative assessment of the nature of the glaucoma and the adequacy of its control. Several alternatives are possible: to control the intraocular pressure medically and remove the cataract intra or extracapsularly; to control the glaucoma surgically and remove the cataract by either method; to combine the procedures for the glaucoma and the cataract; and finally to do any of the above operations with the introduction of an intraocular lens.

Simply removing the cataract rarely has a lasting effect in controlling the glaucoma. Glaucoma surgery in aphakic eyes is less successful than in phakic eyes, and success is dependent on a total absence of complications, because the prognosis becomes very poor if there is vitreous loss, vitreous plugging of a previous filtering procedure, or an excess of soft lens matter plugging an already compromised angle. Pretreatment of the glaucoma by filtering surgery is much more successful and very safe, but a fair proportion of blebs fail to function after cataract surgery. The combined operation of cataract extraction and trabeculectomy is successful but is often followed by a shallowing of the anterior chamber. For this reason anterior chamber and pupil supported intraocular lenses with the optic in front of the pupil are regarded as contraindicated, because corneal contact is almost inevitable. Implantation of posterior chamber intraocular lenses of the pupil supported type described in the article in this issue are very satisfactory in that they tend to draw the lens/iris diaphragm backwards and, particularly with the use of pilocarpine, will open the trabecular pores (if any normal function remains). However, the rigid pupil presents problems which make not only the cataract extraction more difficult but the chances of lens dislocation high. Extracapsular cataract extraction and posterior chamber lens with filtering surgery are also possible, but the difficulties of performing a perfect extracapsular extraction with a possibly poorly dilating pupil are considerable.

Techniques change fast, so fast that well controlled studies have become impossible, so it will probably be some time before we have the perfect answer to this difficult problem.