Long term effect on intraocular pressure of phacotrabeculectomy compared to trabeculectomy

J Lochhead, R J Casson, J F Salmon

Aim: To compare the long term mean intraocular pressure (IOP) reduction after non-augmented single site phacotrabeculectomy with that after trabeculectomy and to determine the relation between preoperative IOP and IOP reduction.

Methods: A group of 44 consecutive patients with chronic open angle glaucoma who underwent phacotrabeculectomy were matched to a trabeculectomy control group and the results of surgery were compared. Linear regression analysis of preoperative IOP and IOP reduction was undertaken.

Results: The mean IOP reduction was significantly less in the phacotrabeculectomy group (6.7 (SD 2.1) mm Hg) than in the trabeculectomy group (11.0 (1.4) mm Hg) (p=0.0017). There was a significant difference in surgical success between the groups. The preoperative IOP was significantly related to the postoperative reduction in IOP in both groups (p<0.001).

Conclusions: In elderly patients with chronic open angle glaucoma, phacotrabeculectomy is not as effective as trabeculectomy in reducing IOP. In both procedures the magnitude of IOP reduction is proportional to the preoperative IOP.

In recent years, there has been a widespread shift towards the use of combined phacotrabeculectomy as the surgical treatment of choice for coexisting cataract and glaucoma. Despite its popularity, the efficacy of this operation compared to trabeculectomy remains unclear and published follow up periods are generally short, rarely exceeding a year. In addition, the relation between the preoperative IOP and IOP reduction after phacotrabeculectomy has not been previously reported.

In this retrospective study, the long term efficacy of single site phacotrabeculectomy without intraoperative antimetabolites is compared to that of trabeculectomy in a matched group of patients and the relation between preoperative IOP and the magnitude of IOP reduction is examined.

PATIENTS AND METHODS

From September 1996 to July 2000, 44 consecutive patients with chronic open angle glaucoma (COAG) at low risk of bleb failure, underwent combined phacotrabeculectomy without antimetabolites by a single surgeon (JFS). The results of surgery were retrospectively analysed. All patients with COAG who underwent trabeculectomy without antimetabolites during the same period by the same surgeon were identified, and 44 were matched to the phacotrabeculectomy group with respect to age, sex, race, and preoperative IOP. All patients were followed for at least 12 months, with an average follow up of 29 (SD 3.4) months in both groups.

Phacotrabeculectomy was performed using a fornix based superior, one site approach. Phacoemulsification was undertaken through a 3.2 mm incision and a foldable three piece silicone IOL was placed into the capsular bag. The scleral tunnel was incised at its lateral borders to create a scleral flap and a punch was used to create an internal sclerectomy. A peripheral iridectomy was performed and the scleral and conjunctiva were sutured with 10-0 nylon. Postoperative drops consisted of topical chloramphenicol and dexamethasone 1% four times daily for 2 weeks, followed by topical prednisolone 1% four times daily for between 4 and 12 weeks depending on bleb appearance and function.

Trabeculectomy was performed superonasally using a fornix based conjunctival flap. A scleral flap was fashioned and a scleral punch was used to create an internal sclerectomy. A peripheral iridectomy was performed and the sclera and conjunctiva were sutured with 10-0 nylon. The postoperative drop regime was the same as that used in the phacotrabeculectomy group. Each patient was followed up postoperatively at intervals of approximately 1 day, 1 week, 1 month, 3 months, 6 months, 12 months, and then on a 6–12 monthly basis.

In each group were given subconjunctival injections of 5-fluorouracil in the early postoperative period.

The mean (95% CI) postoperative IOP was significantly lower in the phacotrabeculectomy group (6.7 (2.1) mm Hg) than in the trabeculectomy group (13.0 (1.0) mm Hg) at the end of the follow up period (p=0.0017). The mean IOP reduction at the end of the follow up period was significantly less in the phacotrabeculectomy group (6.7 (2.1) mm Hg) than in the trabeculectomy group (15.5 (1.1) mm Hg).

There were no significant differences between groups with respect to age (p=0.75), sex (p=0.83), diagnosis (p=0.22), number of preoperative glaucoma medications (p=0.94), or preoperative IOP (p=0.11).

In the phacotrabeculectomy group, one patient required an anterior vitrectomy and placement of a sulcus fixated IOL while in the trabeculectomy group there were no intraoperative complications recorded. Two patients in the phacotrabeculectomy group and four in the trabeculectomy group developed a choroidal effusion in the early postoperative period which settled spontaneously. Four patients in the trabeculectomy group had a postoperative hyphaema. Two patients in each group were given subconjunctival injections of 5-fluorouracil in the early postoperative period.

The mean (95% CI) postoperative IOP was significantly higher in the phacotrabeculectomy group (15.5 (1.1) mm Hg) than in the trabeculectomy group (13.0 (1.0) mm Hg) at the end of the follow up period (p=0.0017). The mean IOP reduction at the end of the follow up period was significantly less in the phacotrabeculectomy group (6.7 (2.1) mm Hg) than in the trabeculectomy group (13.0 (1.0) mm Hg).
trabeculectomy group (11.0 (1.4) mm Hg) (p=0.0017). The reduction in the mean number of glaucoma medications at the end of the follow up period was not significantly different between the groups (p=0.4). Linear regression analysis revealed that the level of preoperative IOP was significantly related to the postoperative reduction in IOP in both the phacotrabeculectomy group (Fig 1) (R^2=0.735; p<0.001) and in the trabeculectomy group (R^2=0.502; p<0.001). There was a significant difference in surgical success between groups using criterion 1 (p=0.032). (B) Probability of survival for both the phacotrabeculectomy and trabeculectomy groups using criterion 2, when success was defined as an IOP less than 17 mm Hg at any time after the first postoperative month, or the introduction of any glaucoma medication (p<0.001).

DISCUSSION

All of the patients included in this study were elderly (mean age 77 years) and white. It is important therefore to appreciate that these results are not necessarily applicable to younger individuals or to other ethnic groups.

A recent review of the literature reveals that the mean IOP reduction achieved by phacotrabeculectomy augmented with mitomycin C (MMC) is similar to that achieved by trabeculectomy, albeit with a higher complication rate, and that augmentation with 5-fluorouracil (5-FU) produces variable results. However, without the use of MMC, the evidence suggests that phacotrabeculectomy does not achieve the same IOP reduction as that of trabeculectomy alone, regardless of the operative technique.

We found that the mean IOP reduction at the end of our follow up period was significantly greater in the trabeculectomy group. Other investigators have reported similar results. However, in a prospective study, Guggenbach et al reported that after 1 year the mean IOP reduction was not significantly different between the two groups. These patients were not randomised and the patients in the group undergoing phacotrabeculectomy were significantly older (p<0.001) than those in the group undergoing trabeculectomy.

Our results for trabeculectomy are similar to those reported by Watson and Grierson who found a linear relation between preoperative IOP and the reduction in IOP achieved by trabeculectomy. Using regression analysis we also found a linear relation between preoperative IOP and postoperative IOP reduction after phacotrabeculectomy. At moderately elevated preoperative IOP levels the reduction achieved by phacotrabeculectomy was less than that achieved by trabeculectomy.

In terms of surgical success, using the criteria that we set, trabeculectomy alone had a better outcome. The reason for this is not clear but it may involve the breakdown of the blood-aqueous barrier that accompanies phacoemulsification and the release of inflammatory mediators leading to reduced bleb function. Differences in bleb position may also have had a role.

Phacotrabeculectomy has been shown to be an effective procedure in terms of visual improvement and our results are similar to those previously reported. In comparison, trabeculectomy tended to result in a long term reduction in visual acuity, principally because of the development of cataract. The complication rates for these two procedures were found to be otherwise similar.

In preoperative decision making, two important implications arise from these data: firstly, phacotrabeculectomy without antimetabolites is unlikely to achieve a low target pressure without additional glaucoma medication and, secondly, in elderly white patients with chronic open angle glaucoma, a high preoperative IOP is not a contraindication to phacotrabeculectomy if only a moderate target pressure (in the mid to high teens) has been set.

Authors' affiliations
J Lochhead, R J Casson, J F Salmon, Oxford Eye Hospital, Woodstock Road, Oxford OX2 6HE, UK

Correspondence to: Mr John Salmon, Oxford Eye Hospital, Radcliffe Infirmary, Woodstock Road, Oxford OX2 6HE, UK; john.salmon@orh.nhs.uk

Accepted for publication 28 October 2002

REFERENCES


Clinical Evidence—Call for contributors

Clinical Evidence is a regularly updated evidence based journal available worldwide both as a paper version and on the internet. Clinical Evidence needs to recruit a number of new contributors. Contributors are health care professionals or epidemiologists with experience in evidence based medicine and the ability to write in a concise and structured way.

Currently, we are interested in finding contributors with an interest in the following clinical areas:

Altitude sickness; Autism; Basal cell carcinoma; Breast feeding; Carbon monoxide poisoning; Cervical cancer; Cystic fibrosis; Ectopic pregnancy; Grief/bereavement; Hodgitk disease; Infectious mononucleosis (glandular fever); Kidney stones; Malignant melanoma (metastatic); Mesothelioma; Myeloma; Ovarian cyst; Pancreatitis (acute); Pancreatitis (chronic); Polymyalgia rheumatica; Post-partum haemorrhage; Pulmonary embolism; Recurrent miscarriage; Repetitive strain injury; Scoliosis; Seasonal affective disorder; Squint; Systemic lupus erythematous; Testicular cancer; Varicocoele; Viral meningitis; Vitiligo

However, we are always looking for others, so do not let this list discourage you.

Being a contributor involves:

• Appraising the results of literature searches (performed by our Information Specialists) to identify high quality evidence for inclusion in the journal.

• Writing to a highly structured template (about 2000–3000 words), using evidence from selected studies, within 6–8 weeks of receiving the literature search results.

• Working with Clinical Evidence Editors to ensure that the text meets rigorous epidemiological and style standards.

• Updating the text every eight months to incorporate new evidence.

• Expanding the topic to include new questions once every 12–18 months.

If you would like to become a contributor for Clinical Evidence or require more information about what this involves please send your contact details and a copy of your CV, clearly stating the clinical area you are interested in, to Claire Folkes (cfolkes@bmjgroup.com).

Call for peer reviewers

Clinical Evidence also needs to recruit a number of new peer reviewers specifically with an interest in the clinical areas stated above, and also others related to general practice. Peer reviewers are health care professionals or epidemiologists with experience in evidence based medicine. As a peer reviewer you would be asked for your views on the clinical relevance, validity, and accessibility of specific topics within the journal, and their usefulness to the intended audience (international generalists and health care professionals, possibly with limited statistical knowledge). Topics are usually 2000–3000 words in length and we would ask you to review between 2–5 topics per year. The peer review process takes place throughout the year, and our turnaround time for each review is ideally 10–14 days.

If you are interested in becoming a peer reviewer for Clinical Evidence, please complete the peer review questionnaire at www.clinical-evidence.com or contact Claire Folkes (cfolkes@bmjgroup.com).