Fibrin glue versus sutures for attaching the conjunctival autograft in pterygium surgery: a prospective observer masked clinical trial

S Srinivasan, M Dollin, P McAllum, Y Berger, D S Rootman, A R Slomovic

ABSTRACT

Aims: To compare the degree of conjunctival autograft inflammation, subconjunctival haemorrhage (SCH) and graft stability following the use of sutures or fibrin glue (FG) during pterygium surgery.

Methods: Prospective, observer masked, clinical trial. 40 eyes of 40 patients undergoing primary pterygium surgery with conjunctival autograft were allocated into two groups. Group 1 (n = 20) had FG (Tisseel) for attaching the conjunctival autograft whereas group 2 (n = 20) had sutures. Standardised digital slit-lamp photographs were taken at 1 week, 1 month and 3 months postoperatively. Sutures were masked using commercially available photo-editing software. Two masked observers objectively graded the digital photographs for degree of inflammation, SCH and graft stability.

Results: 34 of the 40 patients completed the study. When using FG, the degree of inflammation was significantly less than with sutures at 1 month (p = 0.019) and 3 months (p = 0.001) postoperatively. No significant difference was found for inflammation at 1 week postoperatively (p = 0.518). Conjunctival grafts secured with FG were as stable as those secured with sutures (p = 0.258, p = 0.076 and p = 0.624, at 1 week, 1 month and 3 months, respectively). No significant difference was found in degree of postoperative SCH between the groups (p = 0.417, p = 1 and p = 1, at 1 week, 1 month and 3 months, respectively).

Conclusion: This is the first prospective clinical trial confirming that conjunctival grafts secured with FG during pterygium surgery not only are as stable as those secured with sutures, but also produce significantly less inflammation.

The prevalence rate of primary pterygium varies from 0.7 to 31% in various populations around the world.1,2 Recent immunohistochemical studies support the theory that p53-mutated limbal epithelial basal stem cells lead to the development of pterygium.3 Several surgical techniques have been described for its management.3 Kenyon et al introduced the surgical technique of using conjunctival autograft in the management of primary advanced and recurrent pterygium.3 Although more time-consuming, this technique was found to be safe and effective in reducing the number of recurrences while avoiding the risk of potentially serious complications.3,4 A meta-analysis on the surgical techniques for pterygium excision showed that the odds for pterygium recurrence following surgical treatment of primary pterygium are close to six and 25 times higher if no conjunctival autograft placement is performed.5

Traditionally, during pterygium surgery the conjunctival autografts are secured in place with either absorbable or non-absorbable sutures. Tisseel (Tisseel, Baxter Corporation, Mississauga, Canada) is a two-component tissue adhesive which mimics the natural fibrin formation. It has been used in neurosurgery, plastic surgery, ear, nose and throat surgery, and ocular surgery.9 The use of fibrin glue (FG) during pterygium surgery was first described by Cohen et al in 1993.10 Since then there have been several reports on the safety and efficacy of FG during pterygium surgery.10–15 A recent retrospective study on a large cohort suggested that pterygium surgery with FG leads to significantly lower recurrence rate when compared with the use of sutures.14 Although it is conceptualised that pterygium surgery with FG produces less postoperative inflammation when compared with sutures,14 to the best of our knowledge, based on a Medline search, there has been no prospective clinical study demonstrating this. We performed a prospective, observer masked clinical trial to compare the degree of conjunctival graft inflammation, subconjunctival haemorrhage (SCH) and graft stability following the use of sutures or FG for attaching the conjunctival autograft during pterygium surgery.

MATERIALS AND METHODS

Study population

Between October 2005 and January 2006, from a continuous cohort of 55 patients with primary pterygium referred to the Corneal Service at the Toronto Western Hospital, Toronto, 40 subjects were recruited to undergo primary pterygium excision with conjunctival autograft using FG or 10-0 polyglactin (vicryl) sutures. Institutional review board approval was obtained through the Toronto Academic Health Sciences Network/University Health Network Research Ethics Board, Toronto, Canada. The surgical procedures complied with the tenets of the Declaration of Helsinki. Inclusion criteria were a primary nasal pterygium, for which surgery was recommended, and willingness to participate in the clinical study. Exclusion criteria were subjects on anticoagulants, and recurrent or temporal location of pterygium. All patients gave written informed consent to participate in the study.

Surgical procedure

The surgical procedures were performed by two surgeons (SS and PM). The surgical procedures for subjects in group 1 (FG group, n = 20) were...
Table 1  Scoring parameters for each of the three outcome variables

<table>
<thead>
<tr>
<th>Outcome variables</th>
<th>Scoring parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subconjunctival haemorrhage</td>
<td>Grade 0: None</td>
</tr>
<tr>
<td></td>
<td>Grade 1: &lt; 25% of the size of the graft</td>
</tr>
<tr>
<td></td>
<td>Grade 2: &lt; 50% of the size of the graft</td>
</tr>
<tr>
<td></td>
<td>Grade 3: &lt; 75% of the size of the graft</td>
</tr>
<tr>
<td></td>
<td>Grade 4: Haemorrhage involving the entire graft (no subconjunctival vessels visible)</td>
</tr>
<tr>
<td>Inflammation</td>
<td>Grade 0: No dilated corkscrew vessel in the graft</td>
</tr>
<tr>
<td></td>
<td>Grade 1: 1 bright red, dilated corkscrew vessel crossing the graft-bed margin</td>
</tr>
<tr>
<td></td>
<td>Grade 2: 2 bright red, dilated corkscrew vessels crossing the graft-bed margin</td>
</tr>
<tr>
<td></td>
<td>Grade 3: three bright red, dilated corkscrew vessels crossing the graft-bed margin</td>
</tr>
<tr>
<td></td>
<td>Grade 4: &gt;=3 bright red, dilated corkscrew vessels crossing the graft-bed margin</td>
</tr>
<tr>
<td>Graft stability</td>
<td>Grade 0: All four sides of the graft margin are well apposed</td>
</tr>
<tr>
<td></td>
<td>Grade 1: Gaping/displacement of one side of the graft-bed junction</td>
</tr>
<tr>
<td></td>
<td>Grade 2: Gaping/displacement of two sides of the graft-bed junction</td>
</tr>
<tr>
<td></td>
<td>Grade 3: Gaping/displacement of three sides of the graft-bed junction</td>
</tr>
<tr>
<td></td>
<td>Grade 4: Graft completely displaced from the bed</td>
</tr>
</tbody>
</table>

Table 2  Mann–Whitney U test results for each outcome variable at 1 week, 1 month and 3 months postoperatively

<table>
<thead>
<tr>
<th>Outcome variables</th>
<th>1 week postop</th>
<th>1 month postop</th>
<th>3 months postop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tisseel mean rank</td>
<td>Suture mean rank</td>
<td>p Value</td>
</tr>
<tr>
<td>Subconjunctival haemorrhage</td>
<td>18.82</td>
<td>16.18</td>
<td>0.417</td>
</tr>
<tr>
<td>Inflammation</td>
<td>16.44</td>
<td>18.56</td>
<td>0.518</td>
</tr>
<tr>
<td>Graft stability</td>
<td>18.18</td>
<td>15.82</td>
<td>0.258</td>
</tr>
</tbody>
</table>

Significant p values are highlighted in bold.
The conventional level of significance $p < 0.05$ was applied in all comparisons. Outcome variables between the two groups were compared using the non-parametric Mann–Whitney U Test.

RESULTS
The cohort consisted of 17 (42%) males. The mean age was 47 years (range 32 to 72). Thirty-four of the 40 patients completed the 3 months' follow-up. The results are summarised in table 2.

The degree of inflammation was significantly less in the FG group at both 1 month ($p = 0.019$) and 3 months ($p = 0.001$) postoperatively (fig 1). There was no significant difference in the degree of inflammation between the groups at 1 week postoperatively ($p = 0.518$). Conjunctival graft stability with FG was the same as with sutures over the 3 months' course of follow-up ($p = 0.258$, $p = 0.076$ and $p = 0.624$, at 1 week, 1 month and 3 months, respectively). There was no significant difference in the degree of SCH between the groups at any point during the follow-up period ($p = 0.417$, $p = 1$ and $p = 1$, at 1 week, 1 month and 3 months, respectively).

DISCUSSION
Pterygium recurrence is the most common complication of pterygium surgery and is a frequent source of frustration for patients and surgeons. With the aim of reducing recurrence rates, several surgical techniques have been described in the literature. These include bare sclera excision,15 conjunctival and conjunctival–limbal autograft,16–20 and the use of amniotic membrane.21 In addition, several adjunctive therapies, including the use of beta irradiation18 and mitomycin C (MMC),19 have been recommended due to their anti-fibrotic and anti-angiogenic properties.

From 1960 to the early 1980s, bare sclera closure was the most popular method for surgical removal of a primary pterygium.4 However, it has been shown that it is by far the least satisfactory method with respect to recurrence rates, which can be as high as 80%.4 The use of conjunctival autograft gained popularity in the 1980s following the landmark article by Kenyon et al in 1985.5 He reported a low recurrence rate of 5.3% using the conjunctival autograft technique. Since his publication, other prospective, randomised studies of conjunctival autografting during pterygium surgery have reported higher recurrence rates (16–39%) in high-risk populations.19,20 Nonetheless, a recent detailed review on the treatment of pterygium concluded that conjunctival autograft remains the safest technique and offers the lowest rate of recurrence in the management of primary pterygium.4

There is evidence that UV light-induced limbal stem-cell damage can act as a precursor to the development of pterygium and pterygium.21 Thus, conceptually, one could possibly reduce pterygium recurrence rates by including the limbus in the harvested conjunctival autograft. Conjunctival–limbal autograft has been shown to be effective in the management of both primary and recurrent pterygia.22 There is little scientific data on the preoperative morphological appearance, epidemiological status or surgical factors that influence pterygium recurrence rate. Tan et al in a prospective study were able to demonstrate that fleshiness of the pterygium is a significant risk factor for recurrence if bare sclera excision is performed.23

Tisseel is a commercially available two-component fibrin sealant which mimics the natural fibrin and acts as tissue glue with sealing, haemostatic and gluing properties. The glue has two components: (1) sealant protein, a freeze-dried powder composed of human fibrinogen, fibrinonectin, plasminogen and Factor XIII reconstituted in a bovine aprotinin solution; (2) sealant setting, a solution composed of human thrombin reconstituted in a calcium chloride solution. When both of these solutions interact, through the action of thrombin, the fibrinopeptides are broken down to fibrin monomers. These monomers aggregate by cross-linking, leading to the formation of fibrin clot. Use of FG during pterygium surgery not only is statistically significant decreased recurrence rate with the use of FG when compared with the use of sutures.18,19 They postulated that a possible reduction in the migration of fibroblast cells
caused by the rapid adhesion of the graft with the FG may lead to decreased postoperative inflammation.

In our prospective, photo-documented, observer-masked clinical trial, we were able to demonstrate decreased postoperative inflammation (at both a 1-month and 3-month time gate) with the use of FG compared with polyglactin sutures. Although the aetiopathogenesis of pterygium recurrence may be multifactorial, we believe that reducing postoperative inflammation may play a significant role in reducing the recurrence rate. Larger, prospective studies are required to evaluate the long-term efficacy on the use of FG in reducing the recurrence rate.

Competing interests: None.

Ethics approval: Ethics approval was provided by the Toronto Academic Health Sciences Network/University Health Network Research Ethics Board, Toronto, Canada.

Patient consent: Obtained.

REFERENCES