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Endoscopic Cyclophotocoagulation for the Treatment of Glaucoma in Boston Keratoprosthesis Type II Patient

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CASE REPORT  
A 61-year-old woman with ocular cicatrical pemphigoid OU was referred to this hospital in April of 2011 for evaluation of possible Boston Kpro type II surgery. She had undergone multiple surgeries including amniotic membrane grafts OU and a later corneal patch graft for a perforated cornea OD. She also had glaucoma, which had been treated with brimonidine tartrate 0.2% and timolol maleate 0.5% OU. On her first visit, she was only able to see hand motions OU. She had extensive symblepharon and opacified corneas OU. Disc photography and visual fields (VFs) could not be obtained because of corneal opacification.

The patient underwent combined Kpro type II surgery, lens extraction, pars plana vitrectomy, pars plana Ahmed valve surgery, and permanent tarsorrhaphy OD. The surgery was uncomplicated but was notable for a vitreous hemorrhage which lasted for 2 months. An external eye photo OD of the patient after surgery is shown in Figure 1. At 6 months after surgery, the patient’s right eye had a best-corrected visual acuity (VA) of 20/20, normal intraocular pressures (IOPs), a cup-to-disc ratio of 0.5, and a mild VF defect (Figs. 2A, B). At the time, she was on oral acetazolamide 500 mg twice a day.

However, at 3 years after the initial Kpro type II surgery, glaucoma progression was detected in her right eye with increased cupping (cup-to-disc ratio 0.8) and worsening VFs (Figs. 2C, D), with stable 20/20 vision OD and counting finger vision OS. Because her initial Kpro type II surgery was associated with a long visual rehabilitation time of >2 months, she opted for the quicker postoperative recovery period of a pars plana ECP over repeat Ahmed valve surgery. Thus, pars plana ECP OD was performed in December of 2014.

The surgery was performed under general anesthesia. After the upper lid was injected with 1% lidocaine with epinephrine, pars plana vitrectomy, pars plana Ahmed valve surgery, and extraction, pars plana vitrectomy, pars plana Ahmed valve surgery, and permanent tarsorrhaphy. The patient underwent combined Kpro type II surgery, lens extraction, pars plana vitrectomy, pars plana Ahmed valve surgery, and permanent tarsorrhaphy OD. The surgery was uncomplicated but was notable for a vitreous hemorrhage which lasted for 2 months. An external eye photo OD of the patient after surgery is shown in Figure 1. At 6 months after surgery, the patient’s right eye had a best-corrected visual acuity (VA) of 20/20, normal intraocular pressures (IOPs), a cup-to-disc ratio of 0.5, and a mild VF defect (Figs. 2A, B). At the time, she was on oral acetazolamide 500 mg twice a day.

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The surgery was performed under general anesthesia. After the upper lid was injected with 1% lidocaine with epinephrine, 2 skin incisions were made through the upper lid in the superotemporal and superonasal regions 10 mm posterior from the center of the keratoprosthesis optic. The skin was dissected.
carefully down to bare sclera. After gentle cauterization of the scleral vessels, an infusion port was placed using a 25-G trocar and cannula in the superonasal quadrant, and another 25-G trocar and cannula in the superotemporal quadrant, both 10 mm posterior from the center of the keratoprosthesis optic. A light pipe with wide view system was inserted through the superotemporal cannula to inspect the posterior segment, which revealed a cupped nerve, no peripheral retinal breaks, and a patent Ahmed valve tube without vitreous blockage. The light pipe and cannula were then removed, and a MVR blade (20 G) was used to enlarge the superotemporal wound to a size able to accommodate an 18-G curved ECP probe (Fig. 3A). Once placed in the eye, ECP was performed with the power set to 250 mW, and the ciliary body was treated for 240 degrees. Upon completion, the superonasal infusion port and cannula was removed. The scleral wounds were closed with 7-0 vicryl sutures, and the eyelid wounds were closed with interrupted 7-0 vicryl sutures in the deep layers, and running 8-0 sutures in the superficial layers. A periocular injection of triamcinolone 30 mg was given at the end of the surgery.

On postoperative day 1, the eye pressure by palpation was around 15 mm Hg, and there was a moderate amount of vitreous haze, which was thought to be sterile vitritis, that obscured the view of the fundus. However, the vitritis resolved in one month after an oral regimen of prednisolone 60 mg/d tapering to 10 mg/d over 8 days. At 18 months after ECP, the patient’s best-corrected VA was 20/30, with IOPs ranging between 12 and 15 mm Hg, and with stable VFs.

**DISCUSSION**

Two types of Boston keratoprosthesis surgeries are currently available: type I and type II. Although Kpro type I surgery is more common, Kpro type II surgery is beneficial in patients with very severe ocular surface disease involving both the eyelids and ocular surface, such as those with extensive symblepharon, ankyblepharon, and ocular surface keratinization. The surgical method in type II keratoprosthesis implantation involves additional steps to the type I keratoprosthesis method, and consists of stripping of the bulbar and palpebral conjunctiva, shaping of the eyelids around the anterior extension of Kpro type II optic, and tarsorrhaphy to permanently close the eyelids around the keratoprosthesis optic.
Because patients who undergo Kpro type II surgery often contribute to a greater amount of postoperative inflammation, the globe surface for repeat tube shunt surgery may also concomitantly reopen the tarsorrhaphy to expose a large area of the valve surgery,5–7,9 with or without pars plana vitrectomy, often performed concomitantly with prophylactic Ahmed valve surgery,5–7,9 which may have been lost after the union of eyelid submucosal tissue to the ocular surface.5 Creating a large wound by separating the eyelids from the globe can be a challenge as the normal tissue plane may be necessary for both Ahmed valve implantation and pars plana. The use of ECP has been described in Kpro type II patients4,10,12 however, because the lids of Kpro type II patients are sutured shut and because the limbus cannot be easily visualized, ECP surgery in Kpro type II patients easily be directly visualized, ECP surgery in Kpro type II patients require a different surgical approach.

In conclusion, we describe the general surgical approach of performing ECP in Kpro type II patients, while also describing 2 possible incision types (Fig. 3). Compared with Ahmed valve implantation which requires reopening the initial complete tarsorrhaphy, ECP has the advantages of a smaller incision, shorter surgery time, and quicker recovery. Furthermore, the minimally invasive approach through the eyelid minimizes potential excessive surgical trauma to the eye.

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**REFERENCES**


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