Glaucma Drainage Device Tube Retraction and Blockage in a Patient with Iridocorneal Endothelial Syndrome Treated With Nd:YAG Membranectomy

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Case presentation

A 62 year-old Chinese female was diagnosed with right eye iridocorneal endothelial syndrome (ICE) in 2012 and her intraocular pressure (IOP) had previously been maintained in the mid-teens with timolol alone over the last 2 years. Gonioscopy showed total synechial angle closure and increasing her medical treatment failed to control the intraocular pressure. Ahmed glaucoma valve was implanted successfully. However, recurrence of raised intraocular pressure from partial tube retraction and tube blockage at its aqueous entry site by an endothelial membrane was noted at 2 weeks after the surgery. Nd:YAG laser membranectomy was performed on 2 occasions to restore the patency of the tube shunt. After the second laser membranectomy, the patient’s intraocular pressure returned to, and remained at, normal level since.

Conclusion: Tube occlusion by membrane is a well-known complication following glaucoma drainage device tube in patients with iridocorneal endothelial syndrome. Nd:YAG membranectomy is effective to restore the patency of tube lumen without subjecting patients to more invasive surgical interventions including tube extender or another glaucoma drainage device. However, more studies are required to ascertain the long term effect of laser membranectomy to a blocked tube, in comparison to other treatment modalities. To our knowledge, this is the first reported case of using laser membranectomy alone in treating Ahmed glaucoma valve tube obstruction due to a retracted tube blocked by endothelial membrane.
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Medical treatment may initially control the IOP but is usually unilateral, and is diagnosed in young to middle-aged women. Glaucoma has been reported to occur in 50%-80% of patients [1]. Specular microscopy finding of disseminated or total involvement of the corneal endothelium with ICE cells, which have irregular size and shape, is a strong predictor of glaucoma development.

The management of glaucoma in ICE syndrome is challenging. Medical treatment may initially control the IOP but often becomes ineffective as the disease progresses [1]. Laser trabeculoplasty is technically not possible due to inaccessibility of the trabecular meshwork from synechial angle-closure and/or the overlying cellular membrane. Some investigators believe that laser trabeculoplasty in ICE syndrome may even exacerbate the condition [2].

The reported success rates for trabeculectomy with antifibrotic agents ranges from 60% to 73% at 1 year and 29% at 5 years [1,3]. However, failure occurs earlier than other types of glaucoma due to younger age of patients, more intense fibrotic response, membrane proliferation and formation of PAS [1,3]. Endothelialization and growth of abnormal basement membrane in the ostium also causes failure. Nd:YAG laser is a non-surgical option way to puncture the ICE membrane occluding the internal ostium.

Glaucoma drainage device (GDD) is a common first line surgical approach for patients with ICE syndrome. As in our patient, the extensive PAS would prevent the creation of an ostium that could communicate with the anterior chamber with trabeculectomy; GDD would be the only surgical option. Long-term surgical outcomes have been reported to be slightly better in GDD than in trabeculectomy [3]. Common complications in GDD include proliferation of the ICE membrane into the tube causing tube occlusion, and the formation of the iridocorneal adhesions and contraction of the membrane could also cause migration of the tube as in our patient. Surgical options include replacement of the retracted tube with a tube extender, tube repositioning to a more anterior position, and introduction of additional GDD. However, all these require an additional surgery and the long-term outcome is uncertain. The use of laser is a promising way to puncture the ICE membrane at the occluded lumen when the tube is still situated within the anterior chamber. It is much easier and faster to perform, eliminates the risks associated with intraocular surgery and the procedure is repeatable. There is a reported case on the use of Nd:YAG laser to restore the tube lumen patency, which was plugged by the PAS and iris and the IOP rose to 28 mmHg [4] and another case which used Nd:YAG laser to puncture the ICE membrane but later required surgical repositioning of the tube 10 weeks later [5].

However, it may be difficult to visualize the transparent membrane during the laser procedure to ensure the patency of the lumen and occlusion may be recurrent, requiring repeated laser treatment. Literature on the use of laser membranectomy is limited, more studies to look for its efficacy is warranted. Nonetheless, as intraocular surgery may be avoided, it is probably worthwhile to attempt laser treatment before considering further surgical intervention.

To conclude, occlusion of GDD tube in ICE patient is not uncommon and additional intervention is often needed to restore tube patency. Laser membranectomy is non-invasive and effective in our patient to restore tube lumen patency although its use was seldom reported in the literature. Further study is needed to compare the effectiveness of different modalities in the management of a blocked GDD tube. To our knowledge, this is the first reported case of treatment with Nd:YAG laser to restore the patency of the AGV tube lumen obstructed by the ICE membrane and the tube remained patent at least 15 months after the initial surgery without additional surgical intervention.

References