CONTINUING EDUCATION | GLAUCOMA

Beyond Trabecular MIGS:

Supraciliary Outflow & Modern Glaucoma Co-Management

A 50-minute COPE-approved lecture

Georgia Optometric Association | Summer Meeting

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Financial Disclosures

Speaker financial relationships (12-month look-back):

Dr. Gagan Sawhney serves on the speaker bureau for Iantrek, Inc. — the manufacturer of the bio-interventional cyclodialysis / scleral allograft technology discussed in this lecture. No other relevant financial relationships to disclose.

Off-label / investigational use:

Devices and techniques discussed will be referenced in generic terms. Where applicable, FDA clearance status, indication, and any off-label or investigational use will be identified during the lecture.

No content of this presentation has been reviewed or approved by any commercial entity.

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Learning Objectives

By the end of this lecture, attendees will be able to:

1. Describe the conventional and unconventional aqueous outflow pathways and identify where each MIGS category targets resistance.
2. Explain the rationale for supraciliary/uveoscleral-directed surgery, including its independence from episcleral venous pressure.
3. Summarize the published efficacy and safety data supporting bio-reinforced cyclodialysis as a category of supraciliary MIGS.
4. Identify ideal candidates and contraindications for supraciliary MIGS in real-world co-managed practice.
5. Apply a structured pre- and post-operative co-management framework, including drop tapering and red-flag recognition.

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Roadmap for Today

Aqueous Dynamics Refresher	*7 min*
From Cyclodialysis to Modern Supraciliary MIGS	*6 min*
Mechanism, Surgery & Imaging	*8 min*
Clinical Evidence Across 4 Cohorts	*12 min*
Patient Selection & MIGS Comparison	*6 min*
OD–MD Co-Management Pearls + Cases	*11 min*

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WHY CO-MANAGEMENT MATTERS

The Scale of the Need

>200K/yr	Majority
MIGS procedures performed annually in the US (CMS data)	of new MIGS volume comes from combined phaco + MIGS cases

What this means for the OD–MD relationship:

- Many of your existing patients are already post-MIGS — recognize that adjunctive options exist when efficacy wanes
- Earlier conversations about surgical pathway selection are increasingly relevant in primary eye care
- Pathway diversity (trabecular, canal, subconjunctival, supraciliary) means more patients can be matched to the right procedure

CMS Part B procedure summary data; trends consistent across IRIS Registry analyses (Yang et al., 2024).

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SECTION ONE

Aqueous Humor Dynamics

A working refresher — because every MIGS decision starts here.

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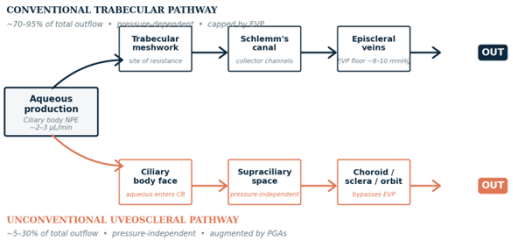
AQUEOUS DYNAMICS

Two Routes, One Aqueous Source



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AQUEOUS DYNAMICS

The Outflow Pathways in Anatomy

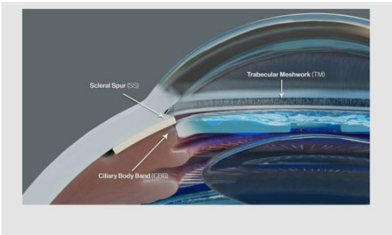

Image courtesy of Iantrek.

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AQUEOUS DYNAMICS

Where Pressure Comes From

Production

- Ciliary body non-pigmented epithelium
- ~2.0–3.0 µL/min in waking state

Outflow

- Conventional (trabecular): ~70–95% of total outflow
- Unconventional (uveoscleral): ~5–30%, varies with age

IOP = (production − outflow) × outflow resistance + episcleral venous pressure

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AQUEOUS DYNAMICS

Conventional Outflow: Where Most MIGS Act

Juxtacanalicular tissue	Primary site of resistance in POAG	*MIGS target:* **Trabecular bypass / ablation**
Schlemm's canal	Receives aqueous after TM resistance	*MIGS target:* **Canaloplasty / 360° viscodilation**
Collector channels & episcleral veins	Distal pathway — sets the IOP floor (~EVP 8–10 mmHg)	*MIGS target:* **Not directly addressed by trabecular MIGS**

Key limit: with EVP ~8–10 mmHg, trabecular-targeted MIGS cannot push IOP much below the low teens.

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AQUEOUS DYNAMICS

The Uveoscleral Pathway: An Alternate Route

- Aqueous → ciliary body face → suprachoroidal space → choroid/sclera/orbit
- **Pressure-independent: not capped by EVP**

WHY IT MATTERS

Pressure-independent outflow

Bypasses distal trabecular resistance and the EVP floor.

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SECTION TWO

From Cyclodialysis to Modern Supraciliary MIGS

100 years of evidence, one cautionary tale, and a renewed era.

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HISTORICAL CONTEXT

Cyclodialysis: A Century of Evidence

>4,000	100 yrs	~72%
eyes pooled across the literature	of cumulative clinical experience	average qualified success in meta-analysis*

Historical limitation:

Wide variability and unpredictable cleft closure — "the operation worked beautifully when it worked," but reproducibility was poor and complications (hyphema, hypotony, reattachment with IOP spike) limited routine use.

**Stamper R, et al. Clin Ophthalmol. 2025. Range 33–97% success across 6–132 mo follow-up.*

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HISTORICAL CONTEXT

The Cautionary Tale: A Suprachoroidal Microstent

What happened (2018):

A polyimide suprachoroidal microstent was voluntarily withdrawn from market after 5-year COMPASS-XT data showed accelerated endothelial cell loss correlated with stent retention zones in the angle.

Lessons that shaped the next generation:

- Long-term endothelial follow-up is essential for any device retained in the angle
- Device material, position, and angle proximity matter enormously
- The supraciliary space remained physiologically attractive — the question was how to access it safely

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HISTORICAL CONTEXT

A Renewed Era: Bio-Interventional Cyclodialysis

Combine the physiologic appeal of supraciliary outflow with two refinements:

1 Controlled cyclodialysis

A reproducible, ab interno cleft created with a dedicated delivery instrument — not freehand spatula technique.

2 Bio-reinforcement

Allograft scleral tissue spacers placed within the cleft to maintain patency without leaving a synthetic device adjacent to the endothelium.

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AUDIENCE POLL

Before We Go Further — A Quick Check

In your current practice, how often do you discuss MIGS as part of a glaucoma management conversation?

- **A** Routinely — it comes up in most moderate-or-worse cases
- **B** Sometimes — when drops are clearly failing
- **C** Rarely — I tend to leave the surgical conversation to the MD
- **D** Almost never — most of my patients don't reach that threshold

Show of hands — no right answer. We'll come back to this at the end.

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SECTION THREE

Mechanism & Surgery

How the procedure works — and what it actually adds to your surgical toolkit.

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BIO-REINFORCED CYCLODIALYSIS

Mechanism of Action

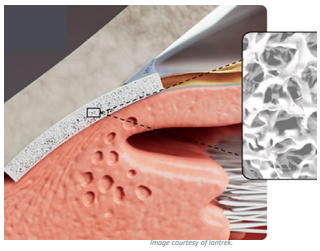

Image courtesy of Iantrek.

Key: no synthetic implant retained adjacent to the corneal endothelium.

1 Controlled cleft

Precise ab-interno cyclodialysis opens a route into the supraciliary space.

2 Allograft scaffold

Acellular scleral allograft maintains patency at the endoscleral surface.

3 Enhanced uveoscleral outflow

Aqueous exits via a pressure-independent pathway — EVP floor is bypassed.

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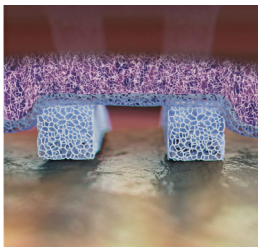
BIO-REINFORCED CYCLODIALYSIS

The Bio-Tissue Spacer



Two scleral allograft bio-spacers maintain the cleft

Images courtesy of Iantrek.

WHAT IT IS

- **Material:** Acellular gamma-sterilized scleral allograft
- **Dimensions:** 500 µm × 5 mm rectangular
- **Structure:** Porous, hydrophilic, stiffness-matched to native sclera
- **Placement:** Two spacers, ab interno, ~0.5–1.5 mm apart

DELIVERY

AlloSert Uveo handpiece — bio-spacers preloaded; deployed ab interno through a standard MIGS clear-corneal incision.

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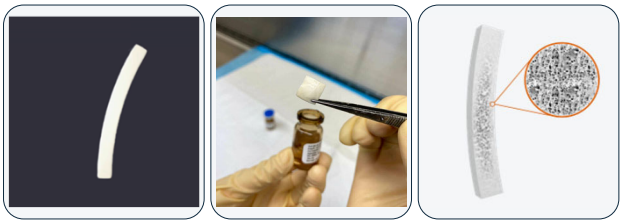
BIO-REINFORCED CYCLODIALYSIS

Bio-Tissue: A Closer Look



THE MATERIAL
Sculpted scleral allograft

IN PREPARATION
Handled in clinical context

PORES & PERMEABILITY
Aqueous conducts through the scaffold

Images courtesy of Iantrek.

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BIO-REINFORCED CYCLODIALYSIS

Surgical Approach: Practical Overview

Procedure characteristics

- Ab interno approach
- Performed alone or combined with phacoemulsification
- No conjunctival dissection — preserves filtration options for the future

What's different vs. trabecular MIGS

- Targets uveoscleral, not trabecular outflow
- Not capped by EVP floor
- Allograft tissue replaces synthetic angle hardware

CPT codes referenced reflect 2026 Medicare descriptors; specific reimbursement varies by setting and payer.

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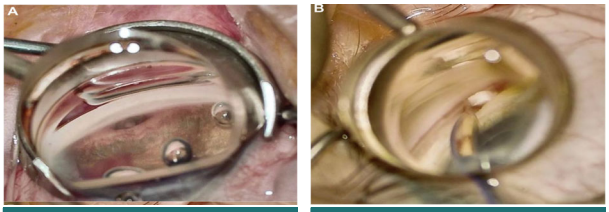
BIO-REINFORCED CYCLODIALYSIS

Surgical Steps: Intraoperative View



STEP 1 Cyclodialysis + viscocycloplasty

STEP 2 Allograft scaffold deployment

Both steps performed ab interno through standard MIGS clear-corneal incision. Source: Calvo et al., Ophthalmol Sci. 2025 (CC BY).

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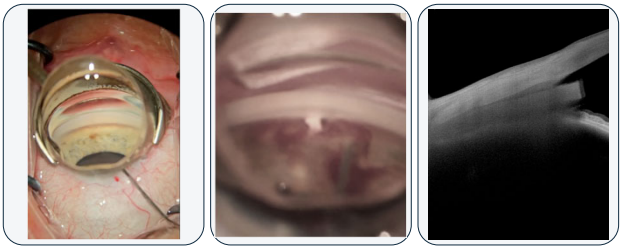
INTRAOPERATIVE

Procedure: Additional Views



Intraop spacer placement | **Post-deployment gonio** | **UBM — spacer in cleft**

Images courtesy of Iantrek.

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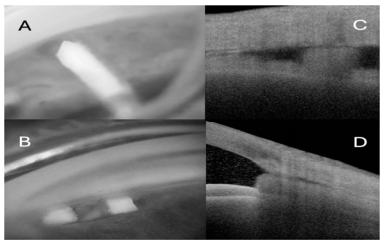
IMAGING

Confirming Placement: Gonio & UBM



What ODs will see if they image the angle post-op:

- **A** Allograft seated in the supraciliary space
- **B** Gonioscopic view — AC-clear deployment, flush with iris root
- **C** UBM cross-section — endoscleral reinforcement
- **D** UBM longitudinal — full-depth scaffolding of cleft

Image source: Ianchulev et al., Clin Ophthalmol. 2024 (CC BY-NC).

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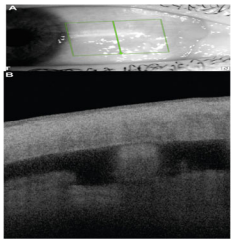
IMAGING

Allograft Integration: Tissue Homology



Why allograft, not synthetic?

- Acellular, gamma-sterilized scleral tissue is biologically homologous to the native scleral wall
- Stiffness-matched to surrounding tissue — reduces foreign-body fibrosis seen with rigid hardware

Imaging source: Calvo et al., Ophthalmol Sci. 2025 (CC BY). En-face coronal (top) and OCT (bottom) showing endoscleral bio-integration.

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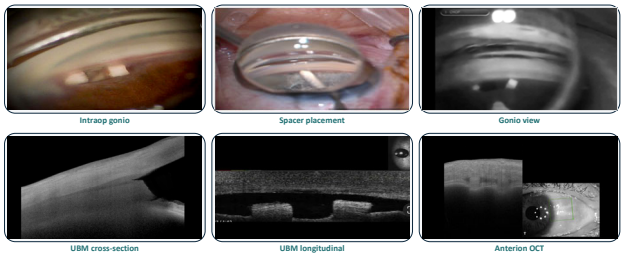
IMAGING

Real-World Clinical Imaging



Images courtesy of Iantrek.

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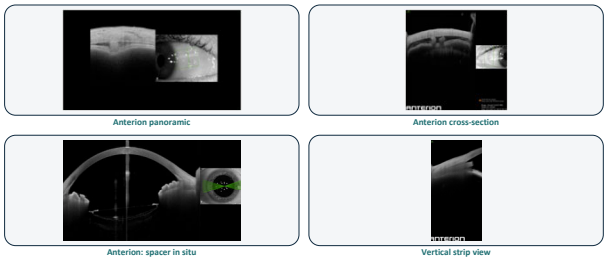
IMAGING

Endoscleral OCT



Images courtesy of Iantrek.

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SECTION FOUR

Clinical Evidence

Efficacy, safety, and what the published data actually show.

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CLINICAL EVIDENCE

Pivotal Prospective Cohort: Study Design

~440	16	2+ yrs	4
eyes across the program*	clinical sites	longest follow-up	peer-reviewed publications

Published cohorts to date:

- 12-month efficacy & safety in open-angle glaucoma (n=117)[1]
- 24-month post-op safety analysis (n=243)[2]
- 24-month efficacy & safety follow-up cohort (n=31)[3]
- 12-month outcomes in medically uncontrolled POAG (n=51)[4]

**Substantial overlap between cohorts is likely (Chaya 2024 is a 243-eye safety registry that includes patients from the prospective cohorts). Cross-cohort numbers are not pooled. All four are prospective single-arm — no RCT data yet. See references 1–4.*

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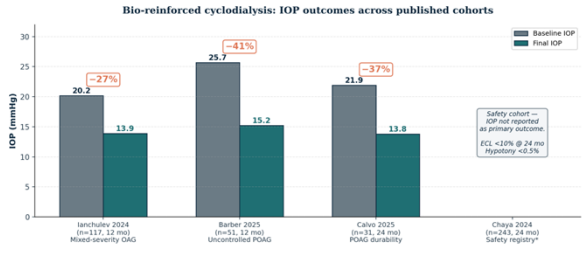
CLINICAL EVIDENCE

IOP Outcomes: Four Cohorts at a Glance



**Chaya 2024 is a 243-eye safety registry; substantial patient overlap with the prospective cohorts is likely. Cross-cohort numbers are not pooled.*

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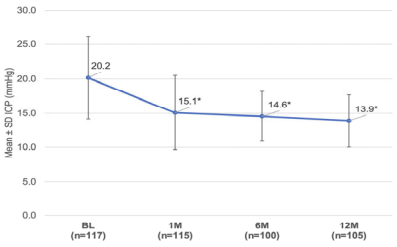
CLINICAL EVIDENCE

Cohort 1: Mixed-Severity OAG + Cataract, 1-Year



Headline results

n = 117 OAG eyes, 12 surgeons

Baseline IOP **20.2 → 13.9 mmHg** (27.1% paired reduction)

Meds **1.4 → 0.8**

81.9% achieved IOP ≤18 with same/fewer meds

Subset with BL IOP >21 (n=45): **39.7%** IOP reduction

96.4% combined with phacoemulsification. Source: Ianchulev et al., Clin Ophthalmol. 2024 (CC BY-NC).

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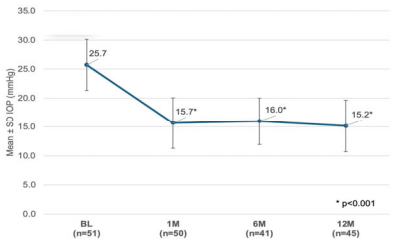
CLINICAL EVIDENCE

Cohort 2: Medically Uncontrolled POAG, 1-Year



Headline results

n = 51 uncontrolled POAG eyes *(BL medicated IOP > 21 mmHg)*

Baseline IOP **25.7 → 15.2 mmHg** (~40% reduction, >10 mmHg)

Meds **1.2 → 0.7** (42% reduction)

77.8% reached IOP <18 with same/fewer meds

Stand-alone subset (n=9): **30%** IOP reduction

Demonstrates clinically meaningful effect in patients failing medical therapy. Source: Barber et al., Ther Adv Ophthalmol. 2025 (CC BY-NC).

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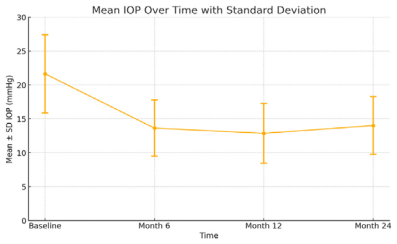
CLINICAL EVIDENCE

Cohort 3: 24-Month Durability



Headline results

n = 31 POAG + cataract eyes *Followed through 24 months*

Baseline IOP **21.9 → 13.8 mmHg** (34% reduction, sustained at 24 mo)

Meds **1.4 → 0.5**

74% achieved ≥20% IOP reduction with same/fewer meds

ECL **<10%** at 24 mo; no eye >30%

Demonstrates durability through 2 years and corneal endothelial safety. Source: Calva et al., Ophthalmol Sci. 2025 (CC BY).

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CLINICAL EVIDENCE

Safety Profile: Published Numbers

243-eye safety analysis at 24 months[2]

Adverse event	Timeframe	Rate
Clinical hypotony	≥ 30 days	< 0.5%
Elevated IOP (>30 mmHg or +10 from baseline, procedure-related)	At/after 1 month post-op	< 5%

31-eye endothelial cell loss cohort at 24 months[3]

Outcome	Timeframe	Mean ECL
Endothelial cell loss	24 months	< 10%

No eyes had significant (>30%) endothelial cell loss. Consistent with loss expected after cataract and MIGS procedures.

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CLINICAL EVIDENCE

How Does It Compare to Trabecular MIGS?

All three were combined with cataract surgery. Effect sizes from real-world cohort data:

Outcome	Hydrus (2-yr, n=120)	iStent inject (2-yr, n=224)	Bio-reinforced cyclodialysis (1-yr, n=117)
Baseline IOP (mmHg)	18.1	16.3	**20.2**
Final IOP (mmHg)	15.1	14.1	**13.9**
Mean IOP reduction	−3.1 mmHg	−2.2 mmHg	**−6.3 mmHg**
Mean medication reduction	−0.8	−0.8	**−0.5**
Complete success at ≤18 mmHg, off meds	15.8%	22.3%	**26.7%**

IMPORTANT CAVEAT: This is a cross-study comparison, NOT a head-to-head trial. Hydrus and iStent inject have 24-month data; the supraciliary cohort shown here is 12-month. Baseline IOPs differ (16.3–20.2 mmHg). Patient populations are not identical. Larger numerical effect size may reflect higher baseline IOP, not procedure superiority. Treat with appropriate caution.

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AUDIENCE POLL

Which Patient Would You Refer First?

Same severity, same target IOP. Which patient is the strongest MIGS candidate?

A 72 y/o, mild POAG OU, on latanoprost monotherapy, IOP 16, no OSD, stable VF

B 58 y/o, mild POAG OU, on PGA + timolol, MMP-9 positive, 2+ corneal staining

C 67 y/o, mild POAG OU, on PGA, IOP 17, well controlled but reports cost barrier

D 74 y/o, mild POAG OU, on PGA + brimonidine, IOP 18, visually significant cataract

No "wrong" answer — we'll explore the trade-offs across the rest of the lecture.

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SECTION FIVE

Patient Selection & MIGS Comparison

Picking the right tool — and the right patient — for the right pathway.

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PATIENT SELECTION

Ideal Candidates for Supraciliary MIGS

Mild-to-moderate POAG	Classic MIGS profile — meaningful disease but not requiring trabeculectomy-level pressures.
Post-MIGS with waning efficacy	Patients who have already had a trabecular procedure and need an additional outflow strategy without burning bleb-forming options.
Medication intolerance / OSD	Heavy ocular surface disease, allergic conjunctivitis, or compliance struggles where drop reduction itself is the win.
Cataract + glaucoma	Combined approach during phaco for additive IOP and medication benefit.
Risk concerns about a bleb	Patients in whom a bleb-forming procedure feels too aggressive, but trabecular MIGS alone may be insufficient.

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PATIENT SELECTION

Approach With Caution / Avoid

Advanced glaucoma, very low target IOP	Severe disease likely needs trabeculectomy or tube — MIGS alone rarely reaches single-digit targets.
Active or unstable uveitis	Inflammation increases risk of cleft closure and unpredictable outcomes.
Pre-existing hypotony or thin sclera	Higher-risk anatomy for any cyclodialysis-based approach.
Angle anatomy that precludes ab interno access	Crowded angles, prior trauma, or extensive PAS may make safe cleft creation impossible.
Significant corneal endothelial compromise	While no synthetic device sits in the angle long-term, any intraocular surgery in a low-cell-count cornea warrants caution.

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COMPARISON

MIGS at a Glance: Where Each Category Fits

Category	Mechanism	Strength	Limitation
Trabecular bypass / ablation	Bypass juxtacanalicular TM resistance	Excellent safety, predictable	Capped by EVP floor
Schlemm's canal procedures	360° viscodilation / canaloplasty	Restores physiologic outflow	Moderate effect; same EVP floor
Subconjunctival	Bleb-based external drainage	Lower target IOP achievable	Bleb management; higher risk profile
Supraciliary (bio-reinforced)	Enhanced uveoscleral outflow	EVP-independent; preserves bleb option	Newer category; cohort (not RCT) data

Takeaway: no one-size-fits-all. The right MIGS depends on disease severity, angle anatomy, ocular surface, and prior surgery.

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WORKFLOW

Reimbursement Context for Co-Managing ODs

Medicare National Average Reimbursement Rates, 2026:

CPT code	Descriptor	Physician	ASC	HOPD
67255	Scleral reinforcement (separate procedure with graft)	$597	$2,204	$4,223
66740	Ciliary body destruction; cyclodialysis	$335	$1,088	$2,429

Practical notes:

- AAO has published guidance supporting concurrent coding for scleral reinforcement and cyclodialysis when both are performed in the same session
- Secondary procedures may be reduced 50% depending on payer
- HOPD payment defaults to the highest-paying APC when multiple APCs are billed
- Full fees shown; actual reimbursement varies by region, payer, and setting

CPT codes and rates as published; verify current rates and payer-specific policies before relying on these for clinical or financial decisions.

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SECTION SIX

OD–MD Co-Management

Pre-op, post-op, and the red flags every co-managing OD should own.

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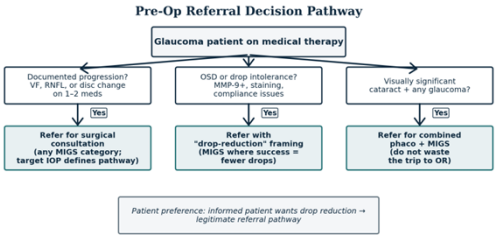
CO-MANAGEMENT

Pre-Op: When to Refer



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CO-MANAGEMENT

Pre-Op: Setting Realistic Expectations

What MIGS will do

- Modestly lower IOP (typically into the mid-to-high teens)
- Reduce medication burden
- Improve OSD by reducing drops
- Slow progression in many patients
- Preserve future surgical options

What MIGS won't do

- Achieve trabeculectomy-level low single-digit IOP
- Eliminate the need for ongoing glaucoma surveillance
- Guarantee permanent drop independence
- Reverse existing optic nerve or visual field damage
- Replace good informed consent and shared decision-making

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CO-MANAGEMENT

Post-Op: What ODs Will See

Day 1	Mild AC reaction, possibly a small hyphema, BCVA usually near baseline if combined with phaco. IOP may be soft or mildly elevated — both are normal early on.
Week 1	Inflammation tapering, AC clearing. Watch for IOP spike from steroid response or transient cleft closure. Vision improving.
Month 1	Steroid taper completing in most cases. IOP stabilizing. This is usually when the medication conversation begins.
Month 3	Real steady-state IOP visible. Decisions about long-term medication regimen made jointly with surgeon.
Month 6+	Standard glaucoma surveillance resumes — VF, OCT, IOP curves on the new regimen.

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CO-MANAGEMENT

Post-Op: Drop Management Framework

General principles — confirm with the operating surgeon for any individual patient:

Steroid	Standard post-op taper (typically 4 weeks). Be alert for steroid-induced IOP rise — known responders may need an earlier taper.
Antibiotic	Routine post-op course; no special considerations versus other intraocular surgery.
Glaucoma drops	Often held immediately post-op. Reintroduce based on IOP at week 1–4. Restart prostaglandin first if needed; aqueous suppressants next.
Reintroduction	If IOP creeps above target during taper, restart drops promptly — don't wait for the next scheduled visit.
OSD-driven cases	Be intentional about which drops you bring back. Preservative-free options first if surface disease was the original problem.

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POST-OP PEARL

Steroid Response in Supraciliary MIGS

WHAT THE LITERATURE NOW SUGGESTS

Patients after supraciliary MIGS may be more steroid-responsive than patients after other MIGS categories.

Proposed mechanism: as the cleft contracts post-op, outflow occurs through both the uveoscleral pathway and partially through the trabecular pathway — putting the trabecular meshwork back in the pressure-regulation loop, where steroids exert their effect.

WHAT IT MEANS FOR CO-MANAGEMENT

Taper sooner, watch closely.

- Anticipate steroid-driven IOP spikes around 2–3 weeks post-op.
- Consider a faster taper than your standard post-cataract regimen.
- When IOP rises during taper, dropping steroid frequency first is often more effective than adding meds.
- Loop in the operating surgeon early — pattern is procedure-specific, not patient-specific.

Observation reported by Chaya CJ. Glaucoma Today. 2025;Sept/Oct:24–26. Mechanism is hypothesis-generating; confirm with the operating surgeon for individual cases.

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CO-MANAGEMENT

Red Flags: When to Call the Surgeon

Persistent hypotony with maculopathy	Especially with vision change. Rare but consequential. Same-day surgical contact.
IOP spike >30 mmHg	Steroid response vs. cleft closure vs. other. Treat acutely; loop in surgeon same day.
Rapid pain or vision drop	Rule out endophthalmitis, sustained hypotony, or hyphema with secondary IOP rise.
AC reaction not improving on steroids	Consider missed inflammation, IOL issue, or unrelated uveitis. Don't sit on it.
Cystoid macular edema	Standard post-cataract differential applies; treat per surgeon protocol.

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KNOWLEDGE CHECK

Quick Self-Assessment

POST-OP WEEK 1, IOP 26 mmHg in a patient s/p phaco + supraciliary MIGS.

Pre-op IOP was 17. Mild AC reaction. On prednisolone QID, glaucoma drops held.
What is the most appropriate next step?

- **A** Restart prostaglandin first — it's the most potent option
- **B** Restart aqueous suppressant, taper steroid frequency if AC clearing, call surgeon same day
- **C** Refer back to surgeon urgently — likely needs surgical intervention
- **D** Watchful waiting — IOP often normalizes by week 2

Answer: B. Differential here is steroid response vs. cleft closure vs. inflammatory IOP rise — treat acutely and loop in the surgeon. PGA in active inflammation is not first-line.

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SECTION SEVEN

Case-Based Discussion

Three patients you'll see this month.

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CASE 1 — YOUR MOVE

Mild POAG + Cataract + Dry Eye

Presentation

- 68-year-old, mild POAG OU
- Latanoprost OU; reports stinging and chronic redness
- MMP-9 positive, fluorescein staining grade 2
- Visually significant cataract OD > OS
- Stable VF and OCT, IOP 17–19 OD on therapy

YOUR MOVE?

What's your next step?

- **A** Switch latanoprost to a preservative-free PGA, defer surgery
- **B** Refer for cataract surgery alone, address glaucoma post-op
- **C** Refer for combined phaco + MIGS, frame as drop-reduction
- **D** Continue current regimen, recheck in 6 months

Discuss with your neighbor — answer on the next slide.

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CASE DISCUSSION

Case 1: Mild POAG + Cataract + Dry Eye

Presentation

- 68-year-old, mild POAG OU
- Latanoprost OU; reports stinging and chronic redness
- MMP-9 positive, fluorescein staining grade 2
- Visually significant cataract OD > OS
- Stable VF and OCT, IOP 17–19 OD on therapy

Discussion points

- Combined phaco + MIGS is the natural conversation
- Goal here is drop reduction as much as IOP reduction
- Trabecular MIGS is reasonable; supraciliary may be considered, particularly if EVP-independence or post-op flexibility is desired
- OD continues OSD optimization pre- and post-op

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CASE 2 — YOUR MOVE

Progression on Two Medications

Presentation

- 62-year-old, moderate POAG
- On latanoprost + timolol; IOP 18 OU
- RNFL thinning of 6 µm over 18 months
- Repeatable inferior arcuate progression on 24-2
- Pseudophakic OU

YOUR MOVE?

What's your next step?

- **A** Add a third medication (alpha agonist or CAI)
- **B** SLT first — minimally invasive next step
- **C** Refer now — discuss MIGS vs. bleb-forming surgery
- **D** Repeat OCT and VF in 3 months before deciding

Discuss with your neighbor — answer on the next slide.

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CASE DISCUSSION

Case 2: Progression on Two Medications

Presentation

- 62-year-old, moderate POAG
- On latanoprost + timolol; IOP 18 OU
- RNFL thinning of 6 µm over 18 months
- Repeatable inferior arcuate progression on 24-2
- Pseudophakic OU

Discussion points

- Don't wait for the third drop — referral now
- Phaco-trigger is gone (already pseudophakic), so this is a standalone surgical decision
- Lower target IOP needed — discussion may include subconjunctival options as well as supraciliary
- Document progression objectively to support the surgical conversation

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CASE 3 — YOUR MOVE

The Co-Managed Post-Op Visit

Presentation

- Status post phaco + supraciliary MIGS, OD
- BCVA 20/30 → 20/25 from day 1
- IOP 26 mmHg (was 17 pre-op)
- 1+ AC cell, no hyphema
- Patient on prednisolone QID, glaucoma drops held

YOUR MOVE?

What's your next step?

A. Restart latanoprost immediately, recheck in 1 week

B. Restart aqueous suppressant, call surgeon same day

C. Send to ED for urgent angle/cleft evaluation

D. Watch and wait — likely steroid response

Discuss with your neighbor — answer on the next slide.

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CASE DISCUSSION

Case 3: The Co-Managed Post-Op Visit

Week 1 visit

- Status post phaco + supraciliary MIGS, OD
- BCVA 20/30 → 20/25 from day 1
- IOP 26 mmHg (was 17 pre-op)
- 1+ AC cell, no hyphema
- Patient on prednisolone QID, glaucoma drops held

Your move

- Differential: steroid response vs. cleft closure vs. inflammatory IOP rise
- Reasonable initial step: restart aqueous suppressant, taper steroid frequency if AC clearing
- Notify surgeon same day; close follow-up in 24–72 hours
- Don't reflexively restart prostaglandin in active inflammation

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FUTURE DIRECTIONS

Looking Ahead

Comparative effectiveness data

Head-to-head comparisons across MIGS categories — and combinations of trabecular + supraciliary in selected eyes.

Earlier intervention paradigm

Surgical drop-reduction as a first-line option in OSD-burdened patients, not only when meds fail.

Sustained drug delivery + MIGS

Combining sustained-release IOP-lowering platforms with outflow surgery to address compliance and floor effect simultaneously.

Personalized outflow surgery

Imaging and biometrics to predict which pathway — trabecular, Schlemm's, or uveoscleral — is the rate-limiting step in a given eye.

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Key Takeaways

1. MIGS is a category, not a procedure. Pathway matters.
2. The supraciliary route is pressure-independent and historically promising — but lessons from prior devices shape today's safer designs.
3. Bio-reinforced cyclodialysis combines a controlled cleft with allograft scleral spacers to enhance uveoscleral outflow.
4. Published cohort data show meaningful IOP and medication reductions; comparative RCT data are still maturing.
5. Co-managing ODs are the early-warning system: progression on minimal therapy, surface disease, and post-op red flags belong in their hands.

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