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What's New in Subconjunctival MIBS

Announcer:
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Dr. Singh:
Trabeculectomy has been our traditional kind of gold standard approach for performing a bleb-type surgery, bypassing the conventional outflow system. But as of late, we have newer minimally invasive bleb surgeries that allow us to perform the same tasks with less invasiveness. Let's see. How do these minimally invasive bleb surgery technologies compare to our traditional trabeculectomy?

This is CME on ReachMD, and I'm Dr. Paul Singh.

Dr. Petrakos:
And I'm doctor Paul Petrakos.

The XEN Gel Stent is currently the only approved MIGS device, or MIBS device in this case, in the United States that utilizes the subconjunctival space. There are more in the pipeline, however. Currently the XEN Gel Stent creates a low-lying bleb in subconjunctival space, and it's effective in a broad range of our glaucoma patients. It has been proven to be a less invasive approach than traditional trabeculectomy. It's a good approach for patients who have had prior surgeries, prior MIG surgeries, and have failed and need a little bit better pressure reduction.

There are other emerging technologies, however, that we're all looking forward to. The PRESERFLO is currently available in Canada and some other countries. Unfortunately, it's still currently under investigation in the United States. MIMS, or minimally invasive micro-sclerotomy, is also currently still under investigation and not FDA approved.

Paul, how does this XEN Gel Stent compare to other subconjunctival procedures that we routinely do, like the traditional trabeculectomy or glaucoma tubes and shunts?

Dr. Singh:
Great, great question. I think there's a study that we can quote that really will help us understand this question. It's called the gold standard pathway study, GPS study, and I would happen to be one of the investigators in this study. It was published back in 2023 by Dr. Arsham Sheybani and lead author, and it looked at XEN versus a traditional trabeculectomy. And the outcome analysis was really percentage of patients who achieve a 20% reduction, but also with a caveat is, also, with no hypotony and no loss of vision, counting fingers, and no secondary interventions. And so when you look at that, it was a noninferior study. And we found that XEN was noninferior to traditional trabeculectomy. And then what we found was, although numerically trabeculectomy did have a slightly better efficacy in terms of numerically, when you look at the overall cohort in terms of secondary incisions, loss of vision, and quick recovery, XEN had better visual acuity recovery and less chance of patients who actually had decreased vision affecting their daily functionality.

Dr. Petrakos:

These are all great points. I mean, we all have these patients and you're trying to discuss surgical planning with them, and you're discussing trabeculectomy, and now we have a XEN Gel Stent, so it's really important to understand the differences between these different procedures and outcomes for the patients.

As we wrap up here, I'd like my colleagues and our colleagues to remember that the XEN Gel Stent was not inferior to the trabeculectomy and overall had lower adverse effects for our patients.

Dr. Singh:
Yeah, and that's really, really important, and the reason why is because we'll look at, again, risk-benefit analysis. What's my chances of having a problem? And I think because we see the XEN having quicker recovery, less chance of hypotony, which is very significant, I think a lot of us, including myself, are much more comfortable offering a bleb-type surgery like the XEN earlier in the disease course.

So, now, not waiting for that kind of advanced patient with central loss and then decide to do a trabeculectomy. Now I'm thinking, hey, if someone's had, let's say, a conventional MIGS, maybe had an SLT or a drug delivery system already, and they're having 3 or 4 medications, I want to get the pressures down where we get the off of medications. Because of the high safety, I'm feeling much more comfortable offering this earlier in the disease state. So it's kind of pushed bleb surgery from that more advanced kind of a patient to more of a moderate patient who, let's say, does not tolerate drops or not as controlled as well. And that's been probably the biggest change in our practice.

Dr. Petrakos:
Thank you. I mean, I think those are all great points. Paul, thank you so much for your time today, and this discussion.

Dr. Singh:
Yeah, and thank you all for tuning in, to the audience, for another episode here of CME on ReachMD. Thanks, everybody.

Announcer:
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