

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/eye-on-ocular-health/reoperation-rates-for-primary-open-angle-glaucoma/15516/>

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Reoperation Rates for Primary Open-Angle Glaucoma

Announcer:

You're listening to *Eye on Ocular Health* on ReachMD, and this episode is part of our "Clinical Minute" series. Here's your host, Dr. Neda Shamie.

Dr. Shamie:

In this "Clinical Minute," we'll be discussing a retrospective analysis that evaluated the Medicare claims-based 5-year economic and reintervention burden for patients with primary open-angle glaucoma after incisional glaucoma surgery in the United States. Dr. Paul Singh is here to discuss the findings.

Paul, thank you so much for being here. This is a really important question and one that I think will really impact the way we practice. I'd love to hear kind of an overview of what your study showed and how you think we should use this information.

Dr. Singh:

Thank you, Neda, for having me. Appreciate that. Well, the idea was, you know, we all know with incisional glaucoma surgery, which a lot of our patients and glaucoma patients have to undergo, there's no doubt failure rates, and there's actually reoperation rates and cost to the providers as well as cost to the patient. So we want to understand what was the actual real-life real-world consequences? So we looked at Medicare claims data from patients who had incisional glaucoma surgery like trabeculectomy, Ex-PRESS shunts, tubes, etc. And we looked at for 1 year, those patients, and then with those patients we identified, we looked at a total of 10 years of that patient's lifespan before and after. So at least 5 years after surgery. What were the reoperation rates? What are the failure rates?

And we thought was really interesting. With trabeculectomy and tubes, we found that at about 1 year, about 10 or so percent of them actually failed. About 5 years, it kept going up to about a 4, so 25 to 30% of patients needed some type of secondary incisional surgery, whether it's a trabeculectomy again, another tube surgery, or a reoperation, or wound revision as well. So a good about a fourth of our patients end up failing. And this is the problem with glaucoma, right? You know, we want to identify these patients earlier and do surgery earlier, but we have to educate our patients and realize that no matter how good we think we are, these patients heal, and they scar down and they fail, and they need reoperation sometimes.

And so this is why I think also MIGS procedures early on, if we can prevent the need for these incisional surgeries, is a great option. The earlier we intervene, less chance for progression, less need potentially for incisional surgeries. And if we do have incisional surgeries, we need better tools and better technologies to decrease the chances potentially of reoperation and failure rates.

Dr. Shamie:

And possibly using MIGS to minimize the ocular surface problems, because I know a big percentage of these failures are related to conj scarring and such, right? Ocular surface disease, inflammation.

Dr. Singh:

Absolutely. We do know from many, many datasets out there, the more inflammation we have in the surface of chronic ocular surface disease, all the chemicals on the eye, the more fibrosis, more inflammation on the surface of the eye, the higher risk of failure of these tissues. So we really want to maximize the health of our tissue of our conjunctivae. And I think our technologies are getting better. I think our surgical techniques, the use of mitomycin, higher sometimes strengths that we're using. You know, in this dataset that we have, we weren't able with Medicare claims data to look at the amount of mitomycin they used, the number of drops they had before and after. So there's some limitations with the study. But it just tells us no doubt that there's still the need for better technologies, and we have to understand failure is still part of our postop process, unfortunately.

Dr. Shamie:

Well, thank you so much for your contributions. I look forward to reading your paper in greater detail.

Dr. Singh:

Thank you.

Announcer:

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