Tip of the Month

July/August 2019

European Glaucoma Society
Innovation, Education, Communication, Implementation

When performing a laser peripheral iridotomy (LPI) for primary angle closure the position of the iridotomy in relation to the eyelid should always be considered

The Science behind the Tip[1,2,3]

The incidence of reported dysphotopsias after an LPI varies from 2% to 11% with linear dysphotopsia and monocular blurring being the commonest types[1]. Recent prospective studies have debated the benefit of temporal versus superior placement and the effect on these reported symptoms[2,3]. Although the results do contrast and the optimal clock hour location remains debatable (including inferior and nasal positions[3,4]), all studies show that a partially covered LPI poses the greatest risk to potentially disturbing dysphotopsias post-laser.

A superior or temporal placement can therefore equally be selected, depending on anatomy and surgeon preference, but partial exposure of the LPI in relation to the eyelid should be avoided.

References

1) Radhakrishnan S, Chen PP, Junk AK, Nouri-Mahdavi K, Chen TC. Laser Peripheral Iridotomy in Primary Angle Closure. A Report by the American Academy of Ophthalmology. Ophthalmology. 2018 Jul;125(7):1110-1120

2) Vera V, Naqi A, Belovay GW, Varma DK, Ahmed II. Dysphotopsia after temporal versus superior laser peripheral iridotomy: a prospective randomized paired eye trial. Am J Ophthalmol. 2014 May;157(5):929-35

3) Srinivasan K, Zebardast N, Krishnamurthy P, Abdul Kader M, Raman G, Rajendrababu S, Venkatesh R, Ramulu P. Ophthalmology. 2018 Mar;125(3):345-351

4) Ahmadi M, Naderi Beni Z, Naderi Beni A, Kianersi F. Efficacy of neodymiumdoped yttrium aluminum garnet laser iridotomies in primary angle-closure diseases: superior peripheral iridotomy versus inferior peripheral iridotomy. Curr Med Res Opin. 2017 Apr;33(4):687-692.

Contributor: Karl Mercieca - England