Q:

- Draw surgical limbus and anatomical corneal limbus and pathological limbus
- Draw point of entrance
- How far back would you go with kelly punch

Q: Looking at Trab

- Causes of high pressure and shallow ac
- Aq misdirection
- Pup block
- Choroidal effusion
- DDx etiology
- PI patent then aq mis unless blocked – the relative depths in the periphery vs center -- iop
- Malignant glaucoma still have bleb!!!! And therefore may have low pressure still
- Now deep ac high pressure 20
- Is bleb big → no → pre sclerostomy – blood, pigment fiber, poor PI apposition, ciliary or iris opposing vs, post sclerostomy tenens cyst, heme in bleb
- Massage first – how? – there is different methods one way is such – step 2 – sterile q tip after anesthesia, press behind flap possibly on flap – do not cut suture on first day (can do if very tight – but can cut day 2 or 3, also depends on level of glaucoma)– hit with steroids – cut suture with hoskins lens or corner of zeiss lens – 50 u, 0.1s, 300-600mw; posterior focus to not burn conj and blanch well and use phenylephrine

- Have low iow pod #1 but deep AC – well done target
- Have low iop pod#1 and flat AC – over 9-0 vicryl and BV needle better than plain for how long it lasts – overfiltration, and no choroidal effusion, and no lens touch, seidel –ve, observe closely, give atropine, lay off on pred forte, and b-blockers for aq suppressant, or patch with large bandage CL, simmons shell,, or patching – diffuse no hole → now hole, patch if no antimetabolite, suture if antimetabolite or big extent, glue on bleb put air bubble first under bleb to have dry interface, put viscoat in ac, and inject autologous blood into bleb, broad beam yag over bleb
- Hypotony maculopathy – who gets it list 5 clinical features – young myopic white male (wrinkling of sclera), choroidal and retinal folds, iop < 6, swelling of macula, (PDS is contrainidication to mitomycin)
- When Trab – maximal medical therapy, depends on patient compliance and medication tolerance, usual b-blocker, trusopt vs alphagan vs xalatan, pilo, ALT, then Trab
- ALT how? – pilo, iopidine, temporal first, 180, goldmann, rich lens, 50u, 50 spots, 300-1000mw – 80 %, attrition of 10% per year
- Post ALT f/u 1 hr later, normal exit rx, pf 1 gtt qid 4 days, 1d, 1w, 1mth f/u vs increased IOP → lower pressure, maybe add drops, maybe add steroid if lots of inflammation, vs steroid responder, rule out malignant glaucoma, reexamine each time come back with complication , if lots of inflammtion and steroid response, ac tap air bleb, if still not emergency trab
- Bleb revision – pressure 50, scarred bleb, because entry of AC, do not do mitomycin on revision ok on new bleb

- Neovascular glauconma – with or without clear media, if not clear U/S rule out tumor – told diabetic, cannot do PRP, NLP eye, cryo, aq suppressants, PF, atropine → cyclodestruction, YAG freq doubled first, contact vs non-contact 1.5 mm posterior limbus, 5-7 Watts, 24 burns altogether, avoid horizontals
- {Contact Transscleral Neodymium:Yttrium-Aluminum-Garnet Cyclophotocoagulation
- Contact transscleral photocoagulation is achieved by using the Nd:YAG laser in the continuous mode via a fiberoptic system in direct contact with the conjunctiva. Effective reduction of IOP is provided using less power than required with the noncontact Nd:YAG laser.
- The fiberoptic laser probe is positioned perpendicularly on the conjunctiva with the anterior edge 0.5-1.0mm posterior to the surgical limbus (Fig. 12.28.2). Laser settings include a power level of 4-9W and a duration of 0.5-0.7s. The number of applications varies in the range 16-40 over the entire area of the ciliary body with the three and nine o'clock positions spared. Efficient energy transfer is facilitated by pushing the probe against the sclera, which increases light transmission through the sclera.}
- HM eye with NVG – cataract, vitrectomy, gas, endolaser → max medical therapy, still high iop, trab with antimetabolite is still first line before seton.
- Doses of Mitomycin is duration and dose – 0.2 mg/cc for 2 mins
- MOREFLOW –

Gonio mirror where do you turn 3 mirror lens away from lesion always!