Ab Externum Canaloplasty – An Overview

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Abstract

Canaloplasty is a non-penetrating glaucoma surgery used to treat patients with open-angle glaucoma. It was developed as an alternative method to traditional glaucoma surgery and is one of the recent techniques of non-penetrating glaucoma surgery. Studies have shown its efficacy and safety in the reduction of intraocular pressure, having a lower rate of intraoperative and post-operative complications compared to trabeculectomy. A combination of canaloplasty with phacoemulsification represents a good option for patients with concomitant cataract. Canaloplasty appears to be a good alternative for the treatment of open-angle glaucoma.

Introduction

Glaucoma is the main cause of irreversible blindness in the world. The global prevalence of glaucoma in the population aged 40–80 years old is 3.54%. In 2013, it was estimated that there were 64.3 million people suffering from glaucoma (40–80 years old), which are expected to reach 76 million in 2020 and 1118 million in 2040 [1].

Open-angle glaucoma constitutes 90% of cases with glaucoma in the USA and Europe. Raised intraocular pressure (IOP) remains the main risk factor for glaucoma and also the target of treatment as lowering of IOP is the only proven way of slowing down or halting the progression of the disease [2], [3], [4], [5], [6], [7], [8]. Medications, laser treatments, or surgery can be used for this purpose. There are different surgical techniques, trabeculectomy still being considered the gold standard in the surgical treatment of glaucoma. Nowadays, newer techniques include non-penetrating glaucoma surgeries, such as deep sclerectomy, viscocanaloplasty, and recently canaloplasty.

Ab externum canaloplasty is a non-filtering, bleb-free method aiming to restore the natural conventional aqueous outflow pathway. This is believed to be achieved by catheterization of the Schlemm’s canal. Thinking to achieve a 360° widening of the Schlemm’s canal, a special catheter was developed, leading to the new surgical technique and canaloplasty. During this procedure, the catheter is used to pass a suture through the entire circumference of the Schlemm’s canal, which, after being tied, exerts a centripetal force in the inner wall of the Schlemm’s canal. Consequently, the canal remains open. The surgery can be performed in any quadrant of the sclera, although the superior part is preferred one. Canaloplasty can be performed under local or general anesthesia, depending on the surgeon’s preference.

Surgical technique

A fornix-based conjunctival peritomy and dissection of the conjunctiva are performed. A parabolic scleral flap measuring 5 × 5 mm is created. The parabolic shape makes the watertight closure at the end of the procedure more effective. A crescent knife is used to dissect the flap, which has to be approximately about 1/3 of the scleral thickness (200–300 µm). The flap has to reach the clear cornea anteriorly (Figure 1).

Then, the second internal flap is created, being 1 mm smaller than the superior one. The crescent knife helps again to advance the flap dissection anteriorly toward the Schlemm’s canal. The crescent flap is covered by a very thin layer of the sclera (Figure 2). Finding the proper plane of the dissection is very important. Going too deep will lead to perforation. Going too superficial would lead the flap over the Schlemm’s canal itself, without going through it.
a new deeper dissection needs to be done. The identification of anatomical structures is critical at this point. The scleral spur fibers run parallel to the limbus. Once the scleral spur fibers are visualized, we check for the external wall of the Schlemm’s canal under the deep flap. A paracentesis is performed to reduce the intraocular pressure, preventing the Descemet membrane bulging, and making the further dissection anteriorly more safe and easy. The dissection is extended for further 1 mm anteriorly, exposing the Descemet membrane. A thin strip of tissue from the internal wall of the Schlemm’s canal is removed using a Mermoud forceps. This is believed to increase the perfusion of aqueous through the trabeculo-Descemet window. The Descemet membrane has to be clear of corneal tissue. An excess of pressure exerted at this point, even from a dry sponge, could easily perforate the trabeculo-Descemet membrane. This is the reason for which the tip of the sponge should always be wet. A minimal amount of BSS (balanced salt solution) is used for this purpose. Once the trabeculo-Descemet window is created, the deep flap is amputated using Vannas scissors. A small amount of high viscosity sodium hyaluronate is injected in each of the Schlemm’s canal ends (Figure 3), making the catheterization easier.

![Figure 1: Creation of the superficial scleral flap](image1)

The catheter is passed through 360° of Schlemm’s canal circumference (Figure 4). A 10–0 Prolene suture is tied at the leading tip, and the catheter is withdrawn backward until it comes out from the insertion end of the Schlemm’s canal. The suture comes out also, being passed through the whole circumference of the canal. The catheter is removed, and the suture ends are tied in a slipknot fashion (Figure 5). It is believed that the suture exerts a similar effect to pilocarpine, increasing the aqueous flow through the Schlemm’s canal and its collector channels. The tension that the suture exerts plays a very important role in the final result of canaloplasty [9]. Stegmann canal expander can be implanted in the Schlemm’s canal instead of the tensioning suture. The superficial scleral flap is sutured in its initial position (Figure 6), using five interrupted sutures (10–0 nylon or 10–0 vicryl). The aim is to achieve a watertight closure of the flap (Figure 6). A scleral lake is created under

![Figure 2: Creation of the deep scleral flap](image2)

![Figure 3: Injection of viscoelastic in both ends of the Schlemm’s canal](image3)

![Figure 4: Insertion of glauconite catheter in the Schlemm’s canal](image4)
the scleral flap. High viscosity sodium hyaluronate is preferred to be injected under the scleral flap before its closure. This helps to keep the space open. Watertight closure of the conjunctiva with 10–0 vicryl suture remains the last step of the surgery.

**Discussion**

It is a well-known that trabeculectomy is still considered the gold standard procedure for the treatment of glaucoma, despite the high rate of complications related to the penetrating nature of the technique. Consequently, non-penetrating glaucoma surgery was developed. Sclerectomy was introduced, followed by viscoanalostomy and later canaloplasty.

Canaloplasty was first performed by Lewis et al. in 2007. This technique was designed to enhance the outflow of aqueous humor by dilating SC, establishing circumferential flow, and stretching out the trabecular meshwork. The effect on IOP reduction seemed to be correlated with suture tension, so many researchers tried to measure the distension of Schlemm’s canal created by the suture. Lewis et al. applied a grading system for suture tension measurement. After 2 years of follow-up, he observed that there was a 31% IOP reduction in the group with an evident post-operative distension, compared to 20% reduction in the group without such a one [10].

Bradao et al. used ultrasound biomicroscopy (UBM) and anterior segment optic coherence tomography (OCT) to measure Schlemm’s canal distension pre-operatively, 12 and 36 months post-operatively. The conclusion was that suture tension contributed to IOP reduction. Both equipments were equally efficient in the identification of the structures [11]. Another mechanism proposed as contributing to the reduction of IOP after canaloplasty is enhanced aqueous humor filtration across the sclera and conjunctiva. Mastropasqua et al. showed that conjunctival microcysts had a four-fold increase measured with confocal laser-scanning microscopy before and after the surgery [12].

The effect of canaloplasty on IOP is reported by many studies. Data reported by Lewis et al. show clear IOP reduction after canaloplasty in glaucoma patients [9], [10], [13]. Grieshaber et al. have also observed the reduction of IOP following canaloplasty but with lower complete success rates 3 years after surgery compared to 1 year after surgery [14], [15]. Comparative studies that investigate trabeculectomy versus canaloplasty show a greater reduction of IOP in patients who have undergone trabeculectomy, but higher complication rates [16], [17], [18].
Correct patient selection is the key to canaloplasty success [19]. Canaloplasty is mainly advised for open-angle glaucoma patients, including patients with pigmentary and pseudoexfoliative glaucoma, but also for angle-closure glaucoma patients who are undergoing or have previously undergone lensectomy. Canaloplasty is mainly indicated for patients with mild-to-moderate primary open-angle glaucoma and a low-to-mid-IOP target [20]. It is also indicated for patients with advanced glaucoma who is not good candidates for trabeculectomy [19]. Many surgeons prefer it for contact lens users due to the lack of the conjunctival bleb, which could be traumatized by the chronic friction of lens over the bleb. It is advised for the fellow eye in patients who have gone through serious complications in the other eye having undergone trabeculectomy. It is preferred for young patients, thinking to keep the list of other more aggressive techniques for later during life.

The safety profile is similar to the rates reported after classic non-penetrating glaucoma surgery [21]. The most common adverse effect reported by Lewis et al. is microhyphema in the first post-operative day (3.19 %), followed by IOP spikes, Descemet membrane detachment, hypotonia, choroidal effusion, and exposed suture. Iris prolapse has been reported by Shingleton et al. (1.9%), and one case of Bilateral Descemet membrane detachment has been reported by Palmiero et al. [22]. Few cases of Prolene suture erosion in the anterior chamber have also been reported.

Conclusions

Canaloplasty gives a satisfactory IOP reduction, with less intraoperative and post-operative complications compared to trabeculectomy, making it a preferred type of surgery for patients with a higher risk of complications. Ab externo canaloplasty has recently advanced toward ab interno canaloplasty, which eliminates the trauma to the conjunctiva. Further studies will be needed to evaluate the effectiveness of ab interno canaloplasty.

References


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