PREOPERATIVE DIAGNOSIS:, Open angle glaucoma OX,POSTOPERATIVE DIAGNOSIS:, Open angle glaucoma OX,PROCEDURE:, Trabeculectomy with mitomycin C, XXX eye 0.3 c per mg times three minutes.,INDICATIONS: ,This is a XX-year-old (wo)man with glaucoma in the OX eye, uncontrolled by maximum tolerated medical therapy.,PROCEDURE: ,The risks and benefits of glaucoma surgery were discussed at length with the patient including bleeding, infection, reoperation, retinal detachment, diplopia, ptosis, loss of vision, and loss of the eye, corneal hemorrhage hypotony, elevated pressure, worsening of glaucoma, and corneal edema. Informed consent was obtained. Patient received several sets of drops in his/her XXX eye including Ocuflox, Ocular, and pilocarpine. (S)He was taken to the operating room where monitored anesthetic care was initiated. Retrobulbar anesthesia was then administered to the XXX eye using a 50:50 mixture of 2% plain lidocaine and 0.05% Marcaine. The XXX eye was then prepped and draped in the usual sterile ophthalmic fashion and the microscope was brought in position. A Lieberman lid speculum was used to provide exposure. Vannas scissors and smooth forceps were used to create a 6 mm limbal peritomy superiorly. This was dissected posteriorly with Vannas scissors to produce a fornix based conjunctival flap. Residual episcleral vessels were cauterized with Eraser-tip cautery. Sponges soaked in mitomycin C 0.3 mm per cc were then placed underneath the conjunctival flap and allowed to sit there for 3 minutes checked against the clock. Sponges were removed and area

was copiously irrigated with balanced salt solution. A Super blade was then used to fashion a partial thickness limbal based trapezoidal scleral flap. This was dissected anteriorly with a crescent blade to clear cornea. A temporal paracentesis was then made. Scleral flap was lifted and a Super blade was used to enter the anterior chamber. A Kelly-Descemet punch was used to remove a block of limbal tissue. DeWecker scissors were used to perform a surgical iridectomy. The iris was then carefully reposited back into place and the iridectomy was visible through the clear cornea. A scleral flap was then re- approximated back on the bed. One end of the scleral flap was closed with a #10-0 nylon suture in interrupted fashion and the knot was buried. The other end of the scleral flap was closed with #10-0 nylon suture in interrupted fashion and the knot was buried. The anterior chamber was then refilled with balanced salt solution and a small amount of fluid was noted to trickle out of the scleral flap with slow shallowing of the chamber. Therefore it was felt that another #10-0 nylon suture should be placed and it was therefore placed in interrupted fashion half way between each of the end sutures previously placed. The anterior chamber was then again refilled with balanced salt solution and it was noted that there was a small amount of fluid tricking out of the scleral flap and the pressure was felt to be adequate in the anterior chamber. Conjunctiva was then re-approximated to the limbus and closed with #9-0 Vicryl suture on a TG needle at each of the peritomy ends. Then a horizontal mattress style #9-0 Vicryl suture was placed at the

center of the conjunctival peritomy. The conjunctival peritomy was checked for any leaks and was noted to be watertight using Weck- cel sponge. The anterior chamber was inflated and there was noted that the superior bleb was well formed. At the end of the case, the pupil was round, the chamber was formed and the pressure was felt to be adequate. Speculum and drapes were carefully removed. Ocuflox and Maxitrol ointment were placed over the eye. Atropine was also placed over the eye. Then an eye patch and eye shield were placed over the eye. The patient was taken to the recovery room in good condition. There were no complications.