PREOPERATIVE DIAGNOSES,1. Uncontrolled open angle glaucoma, left eye.,2. Conjunctival scarring, left eye.,POSTOPERATIVE DIAGNOSES,1. Uncontrolled open angle glaucoma, left eye.,2. Conjunctival scarring, left eye.,PROCEDURES: , Short flap trabeculectomy with lysis of conjunctival scarring, tenonectomy, peripheral iridectomy, paracentesis, watertight conjunctival closure, and 0.5 mg/mL mitomycin x2 minutes, left eye.,ANESTHESIA: ,Retrobulbar block with monitored anesthesia care.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS:, Negligible.,DESCRIPTION OF PROCEDURE:, The patient was brought to the operating suite where the Anesthesia team established a peripheral IV as well as monitoring lines. In the preoperative area, the patient received pilocarpine drops. The patient received IV propofol and once somnolent from this, a retrobulbar block was administered consisting of 2% Xylocaine plain. Approximately 3 mL were given. The operative eye then underwent a Betadine prep with respect to the face, lids, lashes, and eye. During the draping process, care was taken to isolate the lashes. A screw type speculum was inserted to maintain patency of lids. A 6-0 Vicryl suture was placed through the superior cornea, and the eye was reflected downward to expose the superior conjunctiva. A peritomy was performed approximately 8 to 10 mm posterior to the limbus and this flap was dissected forward to the cornea. All Tenons were removed from the overlying sclera and the area was treated with wet-field cautery to achieve hemostasis. A 2 mm x 3 mm scleral flap was then outlined

with a Micro-Sharp blade. This was approximately one-half scleral depth in thickness. A crescent blade was then used to dissect forward the clear cornea. Hemostasis was again achieved with wet-field cautery. A Weck-Cel sponge tip soaked in mitomycin was then placed under the conjunctival and tenon flap and left there for two minutes. The site was then profusely irrigated with balanced salt solution. A paracentesis wound was made temporarily and then the Micro-Sharp blade was used to enter the anterior chamber at the anterior most margin of the trabeculectomy bed. A Kelly-Descemet punch was then inserted, and a trabeculectomy was performed. Iris was withdrawn through the trabeculectomy site and a peripheral iridectomy was performed using Vannas scissors and 0.12 forceps. The iris was then repositioned into the eye and the anterior chamber was inflated with BSS. The scleral flap was sutured in place with two 10-0 nylon sutures with knots trimmed, rotated, and buried. The overlying conjunctiva was then closed with a running 8-0 Vicryl suture on a BV needle. BSS was irrigated in the anterior chamber and the blood was noted to elevate nicely without leakage. Antibiotic and steroid drops were placed in the eye as was homatropine 5%. The antibiotic consisted of Vigamox and the steroid was Econopred Plus. A patch and shield were placed over the eye after the drape was removed. The patient was taken to the recovery room in good condition. She will be seen in followup in the office tomorrow.