

PREOPERATIVE DIAGNOSIS: ,Open angle glaucoma
OX,POSTOPERATIVE DIAGNOSIS:, Open angle glaucoma
OX,PROCEDURE:, Ahmed valve model S2 implant with
pericardial reinforcement XXX eye,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 Ocuflax and Ocular. (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. A speculum was
placed on the eyelids and microscope was brought into
position. A #7-0 Vicryl suture was passed through the
superotemporal limbus and traction suture was placed at the
superotemporal limbus and the eye was rotated infranasally
so as to expose the superotemporal conjunctiva. At this point,
smooth forceps and Westcott scissors were used to create a
100-degree superotemporal conjunctival peritomy,
approximately 2 mm posterior to the superotemporal limbus.
This was then dissected anteriorly to the limbus edge and

then posteriorly. Steven scissors were then dissected in a superotemporal quadrant between the superior and lateral rectus muscles to provide good exposure. At this point, we primed the Ahmed valve with a #27 gauge cannula using BSS and it was noted to be patent. We then placed Ahmed valve in the superotemporal subconjunctival recess underneath the subtenon space and this was pushed posteriorly. We then measured with calipers so that it was positioned 9 mm posterior to the limbus. The Ahmed valve was then tacked down with #8-0 nylon suture through both fenestrations. We then applied light cautery to the superotemporal episcleral bed. We placed a paracentesis at the temporal position and inflated the anterior chamber with a small amount of Healon. We then used a #23 gauge needle and entered the superotemporal sclera, approximately 1 mm posterior to the limbus into the anterior chamber away from iris and away from cornea. We then trimmed the tube, beveled up in a 30 degree fashion with Vannas scissors, and introduced the tube through the #23 gauge tract into the anterior chamber so that approximately 2-3 mm of tube was extending into the anterior chamber. We burped some of the Healon out of the anterior chamber and filled it with BSS and we felt that the tube was in good position away from the lens, away from the cornea, and away from the iris. We then tacked down the tubes to the sclera with #8-0 Vicryl suture in a figure-of-eight fashion. The pericardium was soaked in gentamicin. We then folded the pericardium 1x1 cm piece onto itself and then placed it over the tube and this was tacked down in all four quadrants to the

sclera with #8-0 nylon suture. At this point, we then re-approximated the conjunctiva to its original position and we closed it with an #8-0 Vicryl suture on a TG needle in a running fashion with interrupted locking bites. We then removed the traction suture. At the end of the case, the pupil was round, the chamber was deep, the tube appeared to be well positioned. The remaining portion of the Healon was burped out of the anterior chamber with BSS and the pressure was felt to be adequate. The speculum was removed. Ocuflax and Maxitrol ointment were placed over the eye. Then, an eye patch and shield were placed over the eye. The patient was awakened and taken to the recovery room in stable condition.