General Principles of Glaucoma Management

Wallace L.M. Alward, M.D.
Professor Emeritus
Department of Ophthalmology
University of Iowa Carver College of Medicine
Conflicts

- I have no commercial interest in anything that I will discuss in this talk
- I am on the Data and Safety Monitoring Committee for InnFocus Vision
Iowa Glaucoma Curriculum

- 50 lectures
- Covers all of glaucoma
- curriculum.iowaglaucoma.org
- gonioscopy.org
Referral Practice for 34 years

The University of Iowa Hospitals and Clinics
Referral Practice for 34 years

• Most of my patients have been managed elsewhere before coming to see me
• Most of my referring doctors are excellent
• But there are some practice patterns that really bother me
General Principles of Glaucoma Management

• These are some “rules” that I teach my residents and fellows
General Principles of Glaucoma Management

• These are some “rules” that I teach my residents and fellows
• Much of it is personal opinion
General Principles of Glaucoma Management

- These are some “rules” that I teach my residents and fellows
- Much of it is personal opinion
- A bit of a rant
Make Sure That The Patient Needs to Be Treated
Make Sure That The Patient Needs to Be Treated

- No one will have the courage to discontinue the medications that you start.
Make Sure That The Patient Needs to Be Treated

• No one will have the courage to discontinue the medications that you start
• Be certain that the patient has active disease that needs treatment
Make Sure That The Patient Needs to Be Treated

- No one will have the courage to discontinue the medications that you start
- Be certain that the patient has active disease that needs treatment
- If in doubt, follow for progression
Make Sure That The Patient Needs to Be Treated

• No one will have the courage to discontinue the medications that you start
• Be certain that the patient has active disease that needs treatment
• If in doubt, follow for progression
“overall we can conclude that there is a modest penalty for delaying treatment in OHT subjects. This penalty is minimal for low-risk patients…”

Normal Tension Glaucoma

• My two rules
Normal Tension Glaucoma

• My two rules
  – Be slow to begin treatment
Normal Tension Glaucoma

• My two rules
  – Be slow to begin treatment
  – Be appropriately aggressive
Make Sure That The Patient Needs to Be Treated

• Also, make sure that the patient has enough vision to fight for
Make Sure That The Patient Needs to Be Treated

• Also, make sure that the patient has enough vision to fight for

• If OD is healthy and OS has HM vision on four agents, the patient may wonder whether it is worthwhile to treat the eye
Make Sure That The Patient Needs to Be Treated

• The patch test
Consider the Pace of Damage & The Patient’s Longevity
Normal

Blind

Based on teachings of George L. Spaeth, M.D.
Based on teachings of George L. Spaeth, M.D.
Based on teachings of George L. Spaeth, M.D.
Based on teachings of George L. Spaeth, M.D.
Based on teachings of George L. Spaeth, M.D.
Based on teachings of George L. Spaeth, M.D.
Rate of Progression: \(-7.0 \pm 1.2\%\)/year (95% confidence)

Slope significant at \(P < 0.1\%

First chosen baseline test not used in order to correct for marked learning effects.
Set a Target Pressure
Set a Target Pressure

• “the IOP at which the rate of ganglion cell loss is no greater than the age-related loss”
  – Richard Brubaker, MD
Set a Target Pressure

• Some people balk at this
Set a Target Pressure

• Some people balk at this

• But we do this every time we see a patient anyway
Set a Target Pressure

- Some people balk at this

- But we do this every time we see a patient anyway

- Writing it down saves us having to process this information every visit
Set a Target Pressure

• Not $\leq 21$ mmHg
Set a Target Pressure

• Not $\leq 21$ mmHg

• The American Academy of Ophthalmology suggests 20% IOP reduction
Set a Target Pressure

- Not $\leq 21$ mmHg

- The American Academy of Ophthalmology suggests 20% IOP reduction

- The Collaborative Normal Tension Treatment Study used 30%
Set a Target Pressure

• Based on:
  – severity of damage
  – height of IOP where damage occurred
  – longevity
  – CCT
  – family history
Set a Target Pressure

- 60-year-old
- No family history
- CCT 580µ
- C/D 0.3
- IOP 38 mmHg
Set a Target Pressure

- 60-year-old
- No family history
- CCT 580µ
- C/D 0.3
- IOP 38 mmHg
- Target 28 mmHg
Set a Target Pressure

- 60-year-old
- + Family history
- CCT 480μ
- C/D 0.95
- IOP 13 mmHg
Set a Target Pressure

- 60-year-old
- + Family history
- CCT 480µ
- C/D 0.95
- IOP 13 mmHg
- Target 8 mmHg
Set a Target Pressure

• The target can move
Set a Target Pressure

- Patient at target IOP of 18 mmHg
Set a Target Pressure

- Patient at target IOP of 18 mmHg
- Presents with new disc hemorrhage or new field loss
Set a Target Pressure

• Patient at target IOP of 18 mmHg
• Presents with new disc hemorrhage or new field loss
• Reset the target lower
Set a Target Pressure

• Patient at target IOP of 18 mmHg
• Presents with new disc hemorrhage or new field loss
• Reset the target lower
• In the record make a note as to why the target is so low: “In 2016 new disc hemorrhage at IOP of 18 mmHg, target reset to 13 mmHg.”
Set a Target Pressure

- Targets are general goals – if the IOP is 1 or 2 mmHg over target, but everything else is stable one is not obligated to change therapy
Set a Target Pressure

• Acting on an IOP above target also depends on the magnitude of the next step
Set a Target Pressure

• Acting on an IOP above target also depends on the magnitude of the next step
• If the next step is another drop or trabeculoplasty then it would be easy to act on an IOP over target
Set a Target Pressure

- Acting on an IOP above target also depends on the magnitude of the next step.
- If the next step is another drop or trabeculoplasty then it would be easy to act on an IOP over target.
- But if the next step was a second tube-shunt or CPC we might be more conservative.
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<thead>
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<th>Comments</th>
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<tbody>
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<td>Ocular Surgery (with date)</td>
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<tr>
<td>Maximum IOP (mmHg)</td>
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<td>Target IOP (mmHg)</td>
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<td>Venlafaxine</td>
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<td>Timolol - fatigue</td>
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<td>OS</td>
<td>Trabeculodomy MMC 04/26/18</td>
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Set a Target Pressure

Really??!
Consider Lifestyle
Consider Lifestyle

• One may be on many drops in a day
  – latanoprost qhs
  – timolol bid
  – brimonidine tid
  – dorzolamide tid
Consider Lifestyle

• One may be on many drops in a day
  – latanoprost qhs
  – timolol bid
  – brimonidine tid
  – dorzolamide tid

• 9 drops a day
Consider Lifestyle

• One may be on many drops in a day
  – latanoprost qhs
  – timolol bid
  – brimonidine tid
  – dorzolamide tid
• 9 drops a day
• With 3 – 5 minutes of NLD occlusion = 27 – 45 min
Consider Lifestyle

• An argument for combination agents
Consider Lifestyle

• An argument for combination agents

• For busy people tid is much more difficult than bid
Consider Systemic Health
Consider Systemic Health

• Most of the agents that we use are systemically pretty safe
Consider Systemic Health

• Most of the agents that we use are systemically pretty safe

• Beware $\beta$-adrenergic antagonists in patients with asthma, bradycardia, etc.
Consider Systemic Medications
Consider Systemic Medications

• Oral carbonic anhydrase inhibitors in patients on thiazide diuretics can cause severe hypokalemia
Consider Systemic Medications

- Oral carbonic anhydrase inhibitors in patients on thiazide diuretics can cause severe hypokalemia.
- Topical $\beta$-adrenergic antagonists in patients on verapamil or quinidine can cause profound bradycardia.
Consider Systemic Medications

• Oral carbonic anhydrase inhibitors in patients on thiazide diuretics can cause severe hypokalemia.

• Topical $\beta$-adrenergic antagonists in patients on verapamil or quinidine can cause profound bradycardia.

• If a patient is on an oral $\beta$-adrenergic antagonist adding a topical agent another may not add much.
Consider Cost
Consider Cost

- Patient on “maximum medical therapy”
  - prostaglandin analog
  - $\beta$-adrenergic antagonist
  - $\alpha$-adrenergic agonist
  - topical carbonic anhydrase inhibitor
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<tr>
<th>Drug</th>
<th>Size (ml)</th>
<th>Generic Cost ($)</th>
<th>Name Brand Cost ($)</th>
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Source GoodRx.com October 6, 2021 for Iowa City, Iowa
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<td>227</td>
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<td><strong>Total</strong></td>
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An 18-fold difference

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* Using branded brinzolamide instead would be $342 and bring the total to $983 (25x)

Source GoodRx.com October 6, 2021 for Iowa City, Iowa
Samples – My Bias
Be Realistic
Be Realistic
Be Realistic

• Is the change that you are instituting likely to bring the patient to the target pressure?
Be Realistic

• Is the change that you are instituting likely to bring the patient to the target pressure?

• If a patient with advanced glaucoma has an IOP of 30 mmHg on three agents, adding a fourth is not likely to bring the IOP into the low teens
Be Realistic

• Don’t shuffle within a class
Be Realistic

• The case of Mr. J.D.
  – 50 yo
  – primary congenital glaucoma
  – monocular
  – his remaining right eye has had several surgeries
I last saw on July 8, 1999. Pressure in the right eye was 24, but has been fluctuating between 24 and 44. He is currently using the following medications in the right eye: 0.06% Phospholine iodide q 8h, Iopodine qid, 0.05% Timoptic XE bid, 6% Pilocarpine qid, Xalatan q hs, Trusopt tid, Voltaren tid, Muro 128 gtts tid, Alphagan bid, and 2-250mg tablets q 8h po.
Be Realistic

I last saw [Patient Name] on July 8, 1999. Pressure in the right eye was 24, but has been fluctuating between 24 and 44. He is currently using the following medications in the right eye: 0.06% Phospholine iodide q 8h, Iopodine qid, 0.05% Timoptic XE bid, 6% Pilocarpine qid, Xalatan q hs, Trusopt tid, Voltaren tid, Muro 128 gtts tid, Alphagan bid, and 2-250mg tablets q 8h po.

- 19 drops a day
Be Realistic

I last saw on July 8, 1999. Pressure in the right eye was 24, but has been fluctuating between 24 and 44. He is currently using the following medications in the right eye: .06% Phospholine iodide q 8h, Iopidine qid, .05% Timoptic XE bid, 6% Pilocarpine qid, Xalatan q hs, Trusopt tid, Voltaren tid, Muro 128 gtts tid, Alphagan bid, and 2-250mg tablets q 8h po.

• 19 drops a day
• 3 – 5 minutes of eyelid closure = 57 – 95 minutes a day
Be Realistic

19 drops a day
3 – 5 minutes of eyelid closure = 57 – 95 minutes a day
Cost!!
Teach Nasolacrimal Duct Occlusion

• Increases the amount of medication entering the eye
Teach Nasolacrimal Duct Occlusion

- Increases the amount of medication entering the eye
- Decreases the amount of medication entering the systemic circulation by 2/3
Teach Nasolacrimal Duct Occlusion
Teach Proper Spacing

• Leave at least 5 - 10 minutes between drops
Teach Proper Spacing

• Leave at least 5 - 10 minutes between drops

• Spread drops out through the day
Teach Proper Spacing

• Leave at least 5 - 10 minutes between drops

• Spread drops out through the day

• Do not adjust sleep habits to take medications
Give Written Instructions
Your Instructions

Glaucoma Medications

This section will review your glaucoma medications. If you have any questions regarding what is written please contact the Glaucoma Service At (319) ...

Timolol (Timoptic) yellow cap, use one drop in right eye every morning

Travaprost (Travatan Z) aqua bottle, use one drop in right eye every evening

Brinzolamide (Azopt) orange cap, use one drop in right eye twice a day

Guidelines for Medications

Only 1 drop is needed – it is enough even if some runs out of your eye.
Gently close the eyes after each drop for 3 to 5 minutes. This allows more medicine to get into your eye and less into your bloodstream.
Wait at least 10 minutes between different drops.
Please bring all of your eye medications with you for each visit
Do not run out of your medication!

Twice a day means every twelve hours.
Three times a day is as close to every eight hours as possible.
Four times a day is first and last thing in the day with the waking hours divided as evenly as possible. (for example - breakfast, lunch, supper, bedtime).
You should not change your sleep regimen for your drops.
Have Patients Bring Their Medications
Watch the Patient Administer their Drops
Warn of Potential Side Effects
Warn of Potential Side Effects

• These will be less concerning if they are not surprising
Warn of Potential Side Effects

• These will be less concerning if they are not surprising
• Burning with dorzolamide
Warn of Potential Side Effects

• These will be less concerning if they are not surprising
• Burning with dorzolamide
• Tingling and funny taste with oral CAIs
Warn of Potential Side Effects

• These will be less concerning if they are not surprising
• Burning with dorzolamide
• Tingling and funny taste with oral CAIs
• Lash growth with prostaglandin analogs
Learn & Use Generic Names
Learn & Use Generic Names

• It is especially important to know what is in the combination medications
Recognize That Patients May Not be Adherent With Their Regimens
Recognize That Patients May Not be Adherent With Their Regimens


Recognize That Patients May Not be Adherent With Their Regimens

- For bid timolol only 83% of doses were taken
Recognize That Patients May Not be Adherent With Their Regimens

- For bid timolol only 83% of doses were taken

- 47% of patients missed an entire day of timolol in a month
We Are Not Great at Recognizing Who is Adherent

• Compliance was best on the day that the patient visited the ophthalmologist’s office (p<0.0001)
We Are Not Great at Recognizing Who is Adherent

• Compliance was best on the day that the patient visited the ophthalmologist’s office (p<0.0001)
Patients Cannot be Forced to be Adherent

• Simply admonishing the patient at each visit doesn’t help
Patients Cannot be Forced to be Adherent

• I hate seeing this over and over in referred charts:

“Stressed compliance”
However, Adherence Can Be Enhanced

- Teach the patient about their disease
However, Adherence Can Be Enhanced

- Teach the patient about their disease
- Simplify the regimen
However, Adherence Can Be Enhanced

• Teach the patient about their disease

• Simplify the regimen

• A strong doctor : patient relationship helps
Don’t Avoid Surgery
Don’t Avoid Surgery
My Recent Treatment Algorithm

- Prostaglandin analog (latanoprost qhs)
- Add $\beta$-adrenergic antagonist (timolol qAM)
- Switch timolol to timolol/dorzolamide bid
- Either trabeculoplasty or brimonidine
- Trabeculectomy
- Glaucoma drainage device
LiGHT Trial

- 718 patients with OHT or early glaucoma
- Randomized to SLT or drops

LiGHT Trial

- At 36 months
  - No difference in quality of life
  - 74.2% of SLT patients drop-free
  - IOP at target in 93.0% of SLT and 91.3% of drops
  - Surgery required in 0 SLT patients vs. 11 eye drop patients
  - Lower cost in the UK medical system

My Current Treatment Algorithm

- Selective laser trabeculoplasty
- Prostaglandin analog (latanoprost qhs)
- Add $\beta$-adrenergic antagonist (timolol qAM)
- Switch timolol to timolol/dorzolamide bid
- Brimonidine? Rho Kinase Inhibitors? MIGs?
- Trabeculectomy
- Glaucoma drainage device
My Current Treatment Algorithm

- Selective laser trabeculoplasty
- Prostaglandin analog (latanoprost qhs)
- Add $\beta$-adrenergic antagonist (timolol qAM)
- Switch timolol to timolol/dorzolamide bid
- Brimonidine? Rho Kinase Inhibitors? MIGs?
- **Trabeculectomy**
- Glaucoma drainage device
Why I like Trabeculectomy

- Recent patient
- Had glaucoma progressing at normal IOPs
- Underwent trabeculectomy with mitomycin C
- Referred back for cataract surgery 11 years later
- IOP 4 mmHg OU on no medications
**03-19-2002 SITA-Standard**

GHT: Outside normal limits

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**Fovea:** 35 dB

**FL:** 1/16

**FN:** 0%

**FP:** 1%

**MD:** -2.09 dB P < 5%

**PSD:** 5.87 dB P < 0.5%

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**08-15-2013 SITA-Standard**

GHT: Outside normal limits

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**Fovea:** 32 dB

**FL:** 3/17

**FN:** 1%

**FP:** 4%

**MD:** -2.25 dB P < 5%

**PSD:** 4.13 dB P < 0.5%
03-19-2002  SITA-Standard  GHT: Outside normal limits

Fovea: 34 dB  FL: 0/15  FN: 0%  FP: 1%
MD: -2.25 dB  P < 5%  PSD: 3.20 dB  P < 1%

08-15-2013  SITA-Standard  GHT: Outside normal limits

Fovea: 35 dB  FL: 1/14  FN: 7%  FP: 7%
MD: -0.58 dB  PSD: 2.82 dB  P < 2%

20/30  4.2 mm  20/30
Key Rules

• Make sure the patient needs treatment
• Consider the pace of the disease & longevity
• Set a target pressure
• Be realistic
• Give written instructions
• Recognize non-adherence
Key Rules

• Make sure the patient needs treatment
• Consider the pace of the disease & longevity
• **Set a target pressure**
• **Be realistic**
• Give written instructions
• Recognize non-adherence
A similar version of this talk is available at:
curriculum.iowaglaucoma.org

Chapter 34
Thank You