



The Role of Selective Laser Trabeculoplasty in the Management of Primary Open-angle Glaucoma

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Authors' contribution s

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript. Authors AT performed data analysis. Author YSAS introduced the study concept. Author EJL collected the data, author YOD was responsible for redaction of the manuscript. Author YA also contributed to data collection. Authors MY and AO supervised and directed the work. All authors read and approved the final manuscript.

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ABSTRACT

Aim: underlining the benefits of the Selective laser trabeculoplasty (SLT) in the management of glaucoma

Study: Selective laser trabeculoplasty (SLT) is a Laser used to treat open-angle glaucoma. A prospective, monocentric study was carried out over a period of 8 months. 34 eyes which benefited from a session of SLT. The intra ocular pression (IOP) was measured just before the laser, on the

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7th day, then at one month, at the 3rd and finally at the 6th month. Success was defined as a decrease in IOP at 6 months \geq 20% from baseline. As result, the mean pressure drop was 1.7mmHg, 3.15mmHg, 4.49mmHg and 5.97mmHg at day 7, month 1, month 3 and month 6 respectively. The success rate was 61.7%. Factors for a good response to SLT in our series included the absence of diabetes and, high baseline IOP. Other factors such as age, sex, race, hypertension, myopia, central corneal thickness, and the number of hypotonising eye drops used do not seem to be correlated with the success of SLT.

Keywords: Primary open-angle glaucoma; selective laser trabeculoplasty; efficacy; safety; success factors.

1. INTRODUCTION

Glaucoma is a progressive optic neuropathy characterised by functional impairment of the visual field and structural damage to the optic fibers [1]. It is the second most common cause of blindness after cataracts [2]. Glaucoma can be treated by lowering intraocular pressure through medical, physical or surgical treatment. Selective laser trabeculoplasty is an increasingly popular physical treatment. This study aims to underline the benefits of the Selective laser trabeculoplasty (SLT) in the management of glaucoma.

2. MATERIALS AND METHODS

This was a prospective study carried out over an 8-month period from March 2022 to October 2022.

We included in our study patients older than 20 years, with suspected primary open-angle glaucoma (POAG) according to the following criteria: high baseline IOP, and/or open iridocorneal angle: Shaffer \geq 3, optic disc changes, suggestive visual field alteration and/or suggestive involvement on papillary and ganglion cell OCT. Patients newly diagnosed with, or already being followed up for POAG on mono-, bi-, tri- or quadri-therapy. We have obtained the consent of all our patients.

We excluded patients with secondary glaucoma pseudoexfoliative (PEx), pigmentary, cortisone-induced, post-traumatic, post-surgical, etc.), patients with a narrow iridocorneal angle (Shaffer $<$ 3), patients who had previously undergone physical treatment or filtering surgery, changes in hypotonising treatment during the study unless the treatment was reduced.

Before the SLT was performed, we recorded the following for each patient: Epidemiological data such as age, sex, ethnicity, pathological history;

Clinical data, i.e. visual acuity, IOP using the Goldmann tonometer, gonioscopy, central corneal thickness; Therapeutic data: treatments previously instituted and those in progress, tolerance to usual treatment; Changes in IOP during the study.

The laser used was an Nd-Yag Q-Switch, LIGHTLas 2. Thirty minutes before the procedure, patients were instilled with Pilocarpine and Apraclonidine. The laser was performed by the same operator using a Latina glass under topical anesthesia. Fifty non-adjointing impacts were performed in a single session between 3 and 9 o'clock. We began with an energy of 0.5 mJ and progressively increased it until achieving a minimum formation of cavitation bubbles upon impact. Both eyes were treated successively during the same session. In addition to the usual hypotonising eye drops, the patients received a non-steroidal anti-inflammatory eye drop of 3 drops per day for 07 days. They were reviewed after 7 days, then at one month, three months and finally at six months.

The success criteria was a reduction in IOP \geq 20% compared with the initial IOP at the 6th month. The statistical study was carried out using SPSS version 23 software. Given the size of the sample, the non-parametric Wilcoxon and Mann Whitney tests, as well as the Chi-square test and Fisher's exact test were used to compare the different variables. A value of $p < 0.05$ was considered statistically significant. This case series has been reported in line with the PROCESS Guideline [3].

3. RESULTS

34 eyes from 17 patients were included in our study, 13 men and 4 women, giving a sex ratio of 3 men to 1 woman. The mean age was 65.64 years, with extremes between 46 and 84 years. Two patients were melanodermic, a percentage

of 11.8%. The medical histories is shown in Fig. 1.

Mean visual acuity was 8.05/10. Patients with a visual acuity of less than 2/10 accounted for 5.88%, while those with a visual acuity of >7/10 accounted for 64.7%. Overall visual acuity remained stable; the only decreases in visual acuity recorded were linked to cataracts in 2 patients, which were unrelated to SLT. The central corneal thickness was 504.02± µm. 77% of patients had a central corneal thickness (CCT) less than 520µm. The average CCT in the

Moroccan population is 528 +/- 30 µm. On gonioscopy, the mean Shaffer classification was 3.7. Twelve percent of patients had never received local hypotonising treatment, 12% on monotherapy, 41% on dual therapy, 23% on triple therapy and 12% on quadritherapy.

We defined the degree of tolerance as a function of the number of adverse events experienced by patients undergoing treatment. 77% of patients had adverse reactions to the drops (Fig. 5) and were on adjuvant therapy.

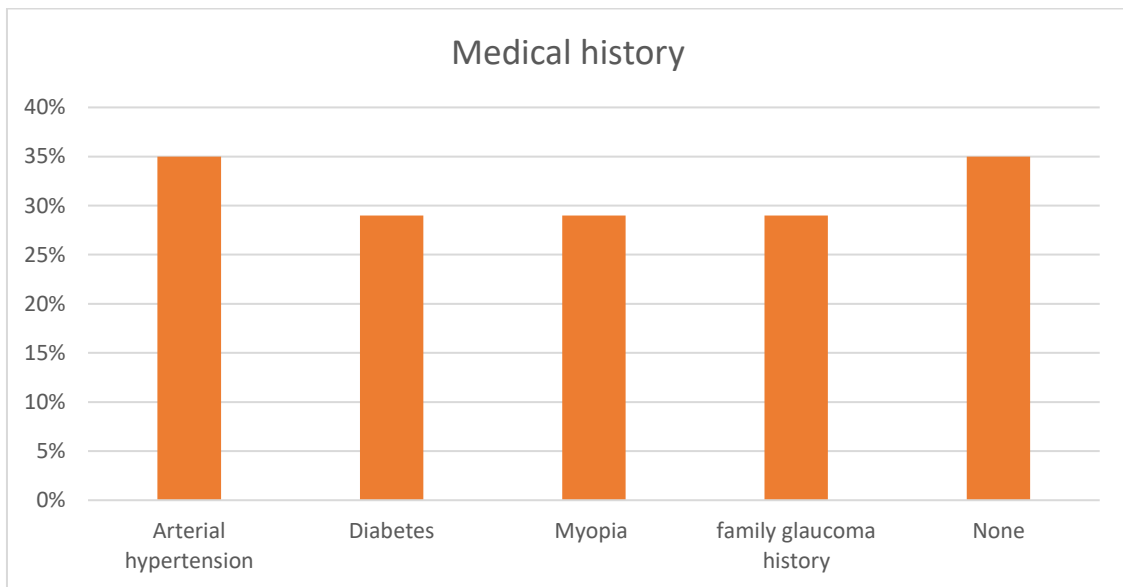


Fig. 1. Among the patient’s medical histories : 35.3% had hypertension, 29.4% diabetes, 29.4% moderate myopia, 29.4% a family history of first-degree glaucoma and 35.3% no pathological history. It should be noted that some patients had several associated disease

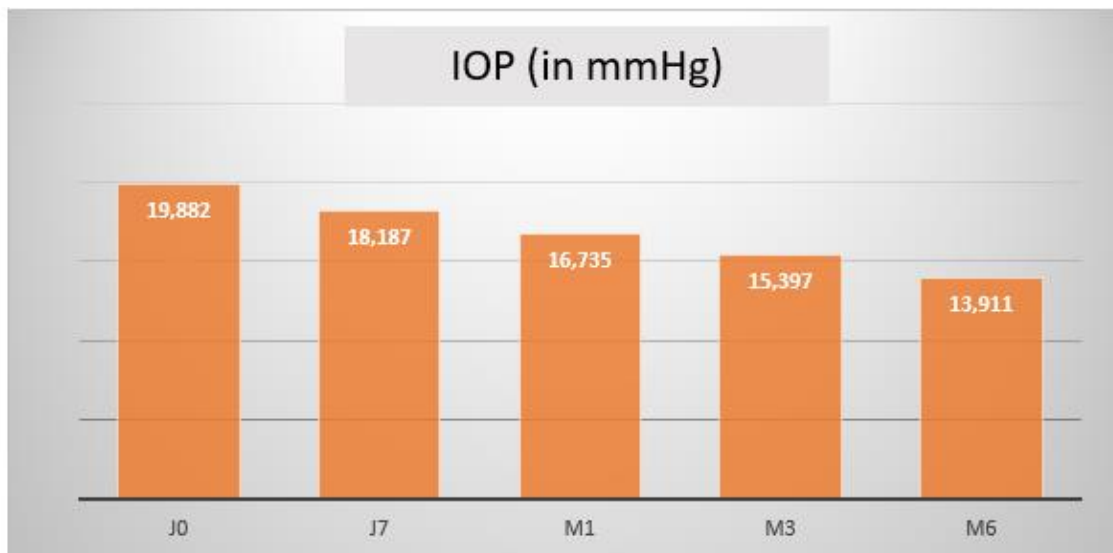


Fig. 2. Evolutionary profile of IOP in patients treated with SLT

In our study, the mean IOP of the 34 eyes treated just before SLT was 19.88 mmHg. Follow-up of our patients showed a progressive reduction in IOP (Fig. 2), with the following results: On day 7 post-SLT: the mean reduction was : 9.47% (i.e. 1.7 mmHg), At the 1st month: the average reduction was 16.93% (i.e. 3.15 mmHg), At the 3rd month: an average reduction of 23.57% (i.e. 4.49 mmHg), At the 6th month, an average reduction of 30.80% (i.e. 5.97 mmHg). The success rate was 61.7%.

In our study we looked for factors that might influence response to SLT. We found no correlation between age or gender and response to SLT. The Pearson correlation coefficient was low ($R= 0.14$) and not significant ($p=0.43$). We have the impression that melanodermic patients respond better to SLT (35% versus 25% on average). However, this is not significant given the small number of melanoderm cases (12%). The SLT laser appears to be more effective in non-diabetic patients than in diabetic patients ($p=0.02$). Our figures give the impression that non-hypertensive patients respond better to the SLT laser than hypertensive patients, although these results are not statistically significant ($p=0.13$). We found no significant difference in

response to SLT between myopic and non-myopic patients ($p=0.25$). There was a very weak negative correlation between the age of the glaucoma and the response to SLT, i.e. the older the glaucoma, the less responsive it was to the laser, although this was not statistically significant, Pearson's coefficient = -0.08 ($p= 0.65$). There is a strong correlation between initial IOP and the extent of the pressure reduction obtained after SLT. The Pearson correlation coefficient in our study was $r =0.85$ ($p<0.001$). This means that the higher the initial IOP, the greater the drop expected after SLT (Fig. 3). We did not find a statistically significant correlation between CCT and response to SLT in our study.

The SLT is not without complications, but these are not very frequent. Laser tolerance in our study was generally good, with the only complication being a moderate rise in IOP, which we recorded on day 7 in 5 patients (29.4%). The average rise was 2.7 mmHg. It subsequently subsided without any change in the hypotonising treatment. Other complications such as inflammatory reactions, hyphaema and macular oedema were not found during follow-up.

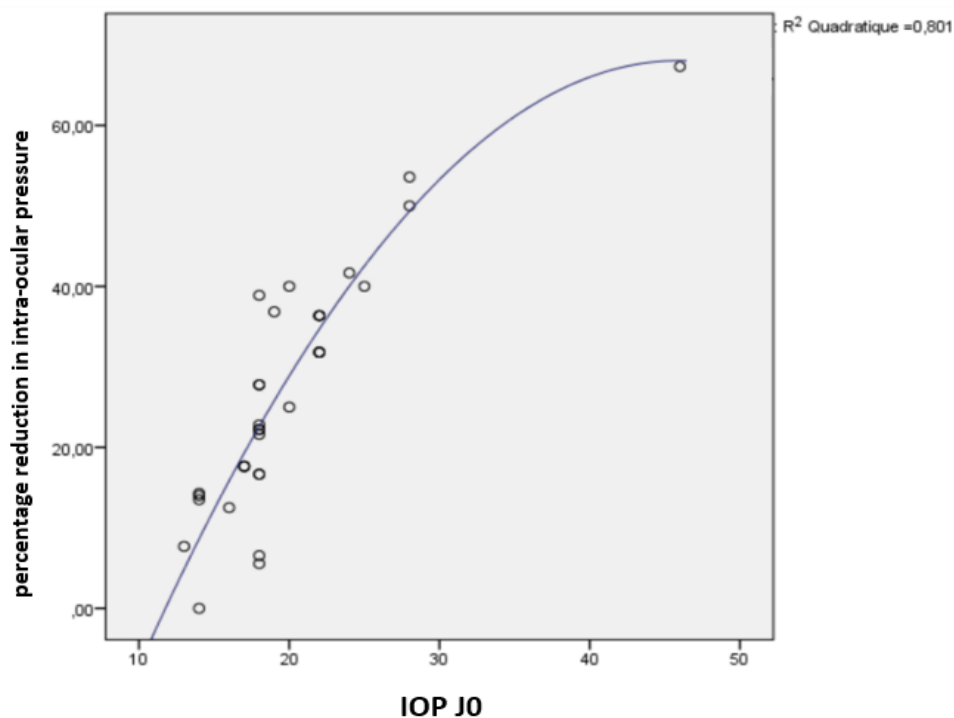


Fig. 3. Correlation between pressure reduction at the 6th month after SLT and initial IOP

Table 1. Comparison of our results with those in the literature

Authors	Population	Protocol SLT	Initial IOP	Follow-up period	IOP reduction	Success criteria	Success rate
Latina and al 1998 [4]	53 eyes POAG	SLT on 180° Nasal	24.6	6,5 months	4.6 (18%)	Average IOP reduction \geq 3mm Hg	70%
Realini and al 2008 [20]	256 eyes POAG	SLT on 360°	21.2 \pm 4,7	8 years	6	IOP reduction	71%
Bonnel and al 2017 [35]	106 eyes POAG or OHT	SLT on 180°	19,4 \pm 3,6 mmHg	12 months	4	Average IOP reduction \geq 20%	68%
Diallo and al 2021 [36]	35 eyes POAG	SLT on 180° inf	20,1	4 months	NC	Average IOP reduction \geq 20%	43,3%
Lee and al 2015 [37]	83 eyes NPG	SLT on 180°	16.1 \pm 2.2	6 months	4,7 \pm 1,8 (29,7%)	Average IOP reduction \geq 30%	56,6%
Our study	34 eyes POAG	SLT on 180°inf.	19,88	6 months	30,8%	Average IOP reduction >20%	61,7%



Fig. 4. Success rate of SLT over time (percentage) according to medium- and long-term studies

4. DISCUSSION

Since the first publication on SLT in 1998 by Latina and al [4], several studies have increasingly demonstrated the efficacy of selective laser trabeculoplasty in the treatment of open-angle glaucoma. In many recent studies, the success rate of SLT was favourable (59.7% to 89%) [5-11] However, other studies have reported disappointing results, with a failure rate of 68-74% [12].

We noted an overall progressive reduction in IOP after SLT which was remarkable from day 7, with a success rate of 61.7% at 6 months. This success rate is comparable to that of certain studies, and is summarised in Table 1.

Our study does not allow us to follow up our patients in the long term. A recent meta-analysis [13] identified 35 studies, including eight randomised controlled trials evaluating IOP reduction 12 months or more after SLT. These studies included patients with ocular hypertonia, POAG and other types of secondary open-angle glaucoma. SLT resulted in IOP reductions ranging from 6.9% to 35.9% of IOP. The mean IOP reduction after SLT is reported to be 21.8% at 6 months [14-16], 16.9-30% at 12 months [14,17-19], 7.7-27.8% at 2 years [14, 20], 24.5-25.1% at 3 years [14, 20], 23.1-29.3% at 4 years

[14,20], 22.6-32.1% at 5 years [14,20], and 22.8% at 6 years [14]. Based on the commonly adopted success criteria of a 20% reduction in IOP from baseline, the effect of SLT diminishes over time [21]. Fig. 4 summarises these results.

We studied the factors predictive of the efficacy of SLT in order to determine the optimal indication for treatment. We found no significant relationship between SLT response and age or gender. Our results are in line with some studies in which age and sex do not appear to be predictive factors of SLT success [22-24]. However, Chavez et al. found that the association between female gender and a good response to SLT was statistically significant ($p=0.02$) [11]. We found that non-diabetic subjects responded better to the SLT laser than diabetic subjects ($P=0.02$). This could be explained by the fact that diabetes alters tissue structure and therefore results in an insufficient response to the SLT laser. Melanoderm subjects seemed to respond better to SLT, with a mean reduction in IOP of 35% compared with 25% in favour of melanoderm subjects. These results may be compared with the study of Seck in Dakar, involving 69 eyes of melanoderma patients, which showed that SLT was effective in around 90% of eyes, and led to prostaglandins being stopped in 60% of patients [25]. In black subjects, glaucoma often occurs earlier, progresses rapidly and is difficult to treat.

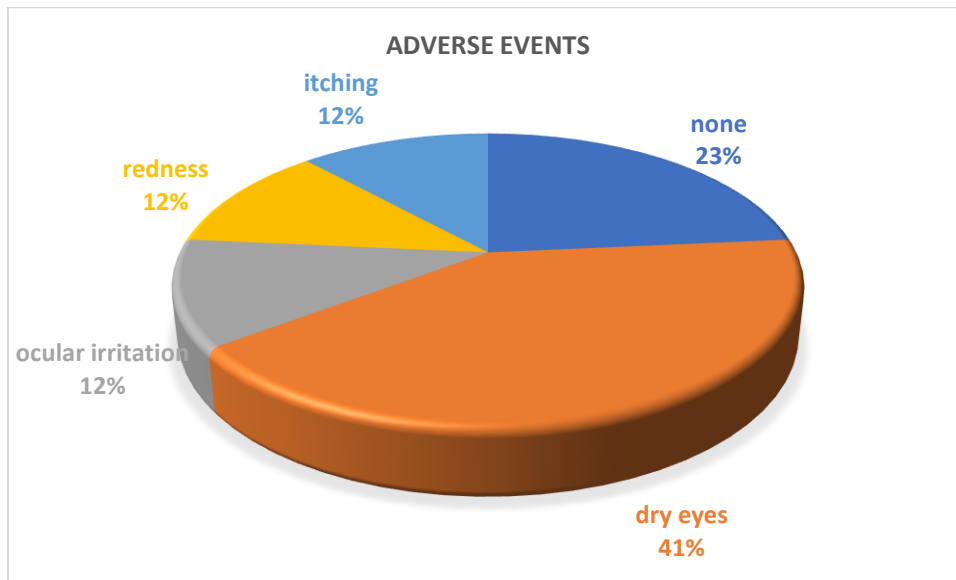


Fig. 5. Distribution of adverse reactions to eye drops in our patients

We found that there was no statistically significant association between arterial hypertension and a fall in IOP after SLT ($p=0.13$), as has been reported in the literature [23]. Our results do not allow us to demonstrate a relationship between response to SLT and the presence of myopia. As Tardif shows in his study, the presence of myopia does not seem to be a predictive factor for the success of a first SLT treatment [26]. There is a very weak negative correlation between the age of the glaucoma and the response to SLT.

In our series, the greatest pressure reduction was obtained among patients with high baseline IOP with Pearson's correlation coefficient in our study being $r = 0.85$ ($p < 0.001$). A recent study by Chang et al [27] reported that a higher baseline IOP was associated with a reduced risk of non-response (OR = 0.60, $P < 0.0001$ for an increase of 3 mm Hg). In the literature, the most important predictive factor found was a high baseline IOP [24,26,27]. This will allow us to propose SLT to patients with isolated ocular hypertonia (open angle) or associated with open angle glaucoma [28]. The mean of the central corneal thickness (CCT) found in our study is thin ($504\mu\text{m}$) and its correlation with the success of SLT is not statistically significant, as some authors have shown [11,12]. According to Shazly et al, the percentage reduction in IOP after SLT was significantly higher in eyes with an $\text{CCT} < 555\mu\text{m}$ for at least 30 months in patients with POAG and OHT ($p < 0.05$) [29].

The correlation between the fall in IOP and the number of eye drops hypotonating was not significant ($p=0.07$). These results can be compared with the study by Woo et al [15] who did not find a significant difference in the success rate according to the number of concomitant topical medications. In contrast, Lee et al [23] showed that the use of several topical medications, particularly carbonic anhydrase inhibitors, was associated with successful treatment with SLT. Bruen et al [22] found that pretreatment with prostaglandins was associated with a reduced IOP response. This is possible because SLT and prostaglandins are thought to share an almost common biological mechanism of action [30].

Hypotonating eye drops are a source of numerous side effects, with an increased frequency of dry eye, which was found in 40% of our patients. Local treatment must therefore generally be accompanied by adjuvant treatments, which increase the cost of patient care. According to our study, 52.94% of our patients were on artificial tears, and 11.8% were also on anti-allergy treatments. The LiGHT study [31] demonstrated that SLT on naïve eyes is effective for the treatment of POAG and OHT in first-line treatment, it offers superior pressure stability compared with drops, at lower cost and, above all, it enables control to be achieved in 74% of patients without drops for at least 3 years after SLT.

Complications associated with SLT are generally transient. In our study, the only complication

found was a transient rise in IOP on day 7 in 29% of our patients. IOP peaks can occur immediately after SLT. Increases of ≥ 5 mm Hg have been reported in up to 28% of eyes [32]. An association between IOP spikes has been observed in patients with a heavily pigmented trabeculum [33]. Anterior chamber inflammation is also common after SLT [34].

5. CONCLUSION

The literature shows that SLT is an effective means of lowering intraocular pressure. In most studies, the only factor that remains commonly correlated with a better success rate of SLT is the extent of the initial IOP elevation. Long-term studies show a decline in its effectiveness over time, but SLT offers the possibility of retreatment of the angle that has not been or has already been treated.

DISCLAIMER (ARTIFICIAL INTELLIGENCE)

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc) and text-to-image generators have been used during writing or editing of manuscripts.

CONSENT

As per international standards or university standards, patient(s) written consent has been collected and preserved by the author(s).

COMPETING INTERESTS

Author(s) have declared that no competing interests exist.

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