

MIGS: YES, IT'S RELEVANT



The popularity of microinvasive glaucoma surgery (MIGS) has skyrocketed over the past few years, with excitement on a range of fronts, from glaucoma surgeons to the ophthalmic industry. A number of devices are available, each with its own advantages and disadvantages. The question many cataract and refractive surgeons are probably

asking, though, is this: **How is MIGS relevant to us?**

No, the publishers of *CRST Europe* have not become confused in featuring MIGS as a cover focus. The reality is that cataract surgeons are very well positioned to adopt and introduce MIGS procedures in their practices. Consider the number of patients who have cataracts and are also taking glaucoma medications. As Kuldev Singh, MD, MPH, points out in his article in this issue, cataract surgery alone reduces IOP, and IOP can be reliably reduced further by introducing a MIGS procedure at the same time as cataract surgery.

Pushing the thought process further, if cataract surgeons performed MIGS or other glaucoma procedures to control IOP at the time of cataract surgery, a glaucoma patient might more readily be considered a candidate for premium lenses, with fewer concerns about developing IOP issues, reduction in contrast sensitivity (which would affect the lens performance), and visual field damage. Cataract surgeons also have a great advantage in that they are adept at using both hands within the eye. Therefore, the learning curve for MIGS is potentially truncated. With that said, however, the learning curve must not be underestimated.

I confess, I have over the past year started to perform MIGS. For me, the most difficult part of the procedure was perfecting the technique of performing intraocular gonioscopy and operating on the angle at the same time. My first piece of advice to those who wish to start doing MIGS is to practice intraoperative gonioscopy on patients at the end of a case using some of the pearls offered by Shakeel Shareef, MD, in this issue and from manufacturers' online courses and videos available on Eyetube and YouTube. Initially I found it challenging to operate with the microscope at a significant angle and my arms outstretched, trying to hold a gonioscope steady with my left hand and operating on the angle with my right. As I became less clumsy, there was a great sense of accomplishment getting that Hydrus Microstent (Ivantis) into the canal of Schlemm or unroofing the trabecular meshwork using the Kahook Dual Blade (New World Medical). Even more gratifying was seeing patients at 3 months after surgery who were off all glaucoma medications—I have been lucky—and reporting their joy at being freed from the shackles of the drops.



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There is no question that MIGS is here to stay, and with so many devices out there, it is not easy deciding which to adopt. Intuitively, improving the anatomy by restoring or enhancing natural outflow through the canal of Schlemm seemed like the right thing to be doing—thus my personal choice for starting with the two techniques I mentioned previously. I am, however, also looking forward to trying other devices in due course. As with everything else, in the end I will undoubtedly gravitate to just one or two techniques.

I have absolutely no desire to adopt glaucoma as a subspecialty, and I plan to continue sending those low-tension glaucoma patients and very advanced cases to my glaucoma colleagues. However, I also believe that the vast bulk of glaucoma patients are amenable to MIGS, and after my own excellent early experience, I believe all glaucoma patients undergoing cataract surgery should be offered the option of MIGS.

So, no, we at *CRST Europe* have not grown confused over the summer; the inclusion of MIGS as a cover focus is intended. We have no doubt that the largest volume of MIGS procedures in the future will be performed by cataract surgeons. ■

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