



## Long Term Visual Outcomes of Glaucoma Patients Following a Single Episode of Transscleral Cyclodiode Laser Treatment

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## Long Term Visual Outcomes of Glaucoma Patients Following a Single Episode of Transscleral Cyclodiode Laser Treatment

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**Objectives:** To investigate the efficacy of a single cyclodiode laser photocoagulation treatment for refractory glaucoma and its effect on visual outcome in patients with good visual potential as well as to evaluate possible predictive factors in establishing optimal treatment parameters.

**Design:** Retrospective observational study

**Setting:** Tertiary referral centre

**Participants:** The notes of 87 patients with refractory glaucoma who underwent cyclodiode photocoagulation as a first surgical intervention over a 7-year period.

**Main outcome measures:** Maintenance of intraocular pressure reduction, number of medications and visual acuity outcomes post-treatment.

**Results:** The mean intraocular pressure (IOP) after a single treatment decreased from 39.5 +/-1.3 mmHg to 17.8 +/-1.5 mmHg after a 6-week follow-up period (P<0.0001). This reduction in IOP was maintained over a 3-year period. Here 61.5% of the patients were able to reduce the number of medications used, with mean reduction from 2.6 to 1.5 medications (P<0.05). Mean initial visual field loss prior to treatment was 8.74dB and at 6 months post-treatment was measured at 9.06dB (P>0.05) suggesting no significant overall change. The visual acuity remained unchanged or improved for 83.6% of the patients (P>0.05) with relatively good visual potential (average vision preoperatively was 0.57 logMAR). Hypotony occurred in 5.3% of the patients. No patients required enucleation or evisceration.

**Conclusion:** A single session of cyclodiode laser therapy was sufficient to achieve IOP reduction in the majority of the patients with refractory glaucoma. The majority were able to maintain the IOP reduction over a 3-year period without the need for a

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3 further surgical intervention. Additionally, over 80% of the patients in our study were  
4 able to maintain their baseline visual acuity. These results support the view that a  
5 single cyclodiode treatment can be sufficient in achieving long term IOP control and  
6 may be considered in eyes with relatively good visual potential.  
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### 11 **Introduction:**

12 Transscleral diode laser cyclophotocoagulation (cyclodiode) has been established as a  
13 relatively safe and effective intervention for glaucoma.<sup>1-6</sup> Cyclodiode is often used in  
14 refractory glaucoma, where alternative surgical approaches, such as antiproliferative  
15 augmented trabeculectomy and tube shunt surgery, may sometimes be judged less  
16 appropriate, for example in eyes with poor visual potential. Additionally, cyclodiode  
17 has been shown to be safer than other cyclodestructive procedures, such as Nd:YAG  
18 laser cyclophotocoagulation and cyclocryotherapy, which present a greater risk of  
19 hypotony and phthisis resulting from excessive ciliary body ablation.<sup>7-9</sup> However, the  
20 outcome of cyclodiode therapy is unpredictable and multiple treatments may be  
21 required to achieve long term intraocular control.<sup>10-11</sup>  
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38 Currently there is no general consensus for an optimum treatment protocol for  
39 cyclodiode. Data for outcomes following cyclodiode laser vary considerably in the  
40 literature.<sup>12</sup> Parameters such as total delivered energy per eye, number of laser  
41 applications per treatment, pulse power, pulse duration and proportion of  
42 circumference treated have been analysed with varying results.<sup>13-17</sup> Furthermore,  
43 cyclodiode therapy has often been reserved for eyes with poor vision due to reports  
44 that it can lead to decrease in visual acuity.<sup>18</sup>  
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55 The purpose of this study was to evaluate the long-term safety and efficacy of a single  
56 episode of transscleral diode laser cyclophotocoagulation for raised intraocular  
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3 pressure in patients with good visual potential at a UK tertiary glaucoma referral  
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5 centre. Additionally, we aim to identify possible predictive factors that could establish  
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7 optimal treatment parameters by investigating the relation between laser energy  
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9 delivered and degrees treated to the long-term maintenance in IOP reduction.  
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### 11 12 13 **Methods:**

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15 The departmental electronic medical record system (Medisoft Ophthalmology,  
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17 Medisoft Ltd Leeds UK) and operating theatre log books were examined for the  
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19 period 09/2004 to 06/2011 to identify patients who had undergone cyclodiode  
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21 treatment as a first surgical intervention.  
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27 All patients were assessed for their response to treatment and those who did not  
28  
29 achieve the target IOP reduction were taken as treatment failures. The patients who  
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31 required either repeat cyclodiode or alternative treatments for IOP control during the  
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33 follow up period were also considered as treatment failures from the time of the  
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35 additional surgical intervention. They were not further assessed for maintenance of  
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37 post-operative IOP as any additional surgical interventions would interfere with the  
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39 interpretation of the IOP maintenance data.  
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45 Cyclophotocoagulation was performed in the Operating Theatre under subtenon,  
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47 peribulbar or general anaesthesia using a standard treatment protocol. A lid speculum  
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49 was placed to achieve adequate exposure for probe placement all around the limbus  
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51 and a squint hook was used to rotate the globe to achieve exposure in those with  
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53 narrow palpebral apertures. All treatments were performed using Oculight Sx  
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55 semiconductor diode 810nm laser and the contact G Probe™ (IRIS Medical  
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3 Instruments, Inc.). Standard settings were 1500ms duration and 1500mW power. The  
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5 energy levels were not routinely titrated for ‘pops’ and the power settings were left at  
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7 1500mW. Transillumination was performed for ciliary body identification. Usually 10  
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9 applications were applied per quadrant for 180 to 360°, with the applications spaced  
10  
11 approximately one-half width of the probe tip apart. The 3 and 9 o’clock positions  
12  
13 were avoided to spare the long ciliary nerves. Postoperative steroid drops were used  
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15 for 4 weeks. Glaucoma medications were continued after cyclodiode treatment and  
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17 adjusted later as required.  
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23 Success was defined as an intraocular pressure (IOP) of 6–21 mmHg at the last  
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25 follow-up visit without the need for oral acetazolamide and an IOP reduction of at  
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27 least 30% compared with pre-treatment. Hypotony was defined as an IOP of 5 mmHg  
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29 or less. The laser energy used was classified as either low energy (median value 45  
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31 +/- 11.47 J, range 22.5-67.5J) or high energy (median value 90 +/- 13.42 J, range  
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33 67.5-130J). The follow up period in IOP measurements was 3 years. Visual acuity  
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35 (VA) prior to treatment was assessed for all patients using LogMAR scale. Visual  
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37 field testing was performed with the Humphrey Visual Field Analyser™ using the  
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39 SITA 24-2 threshold programme. Mean deviation of visual field sensitivity loss in  
40  
41 decibels (MD) was taken as our surrogate measure of visual field loss.  
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47 Data was analysed using Microsoft Excel™ and where appropriate a Student’s t-test  
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49 was used to calculate p-values. R<sup>2</sup> values were derived from linear regression analyses  
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51 using the same programme. Kaplan-Meier ‘survival’ analysis was done using  
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53 GraphPad Prism 5.0™. Approval for the audit was granted by the Cambridge  
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University Hospitals NHS Foundation Trust Ethics Committee. The tenets of the Declaration of Helsinki were observed.

## Results:

From our records, we were able to identify 104 patients who underwent cyclodiode therapy as a first surgical treatment modality in the period from 09/2004 to 06/2011 at Addenbrooke's Hospital, Cambridge. Of these, complete medical records were available for 87 patients with follow up data available for up to 3 years. Preoperative patient data is summarised in **Table 1**.

**Table 1.** Baseline demographics and clinical parameters

	Category	Cases (n=87)
Mean age, yrs		66.3
Sex (n (%))	Male	49 (56.3%)
	Female	38 (43.7%)
Preoperative VA, mean		0.57 LogMAR
IOP (mmHg), mean (SD)		39.5 +/- 1.3 mmHg
Mean number of glaucoma medications		2.6
Glaucoma type (n (%))	Primary open angle glaucoma (POAG)	33 (37.9%)
	Primary angle closure glaucoma (PACG)	6 (6.9%)
	Neovascular glaucoma	25 (28.7%)
	Uveitic glaucoma	5 (5.7%)
	Secondary open angle glaucoma (SOAG)- Other	18 (20.8%)

### Change in Intraocular Pressure (Fig.1A)

Mean intraocular pressure (IOP) decreased significantly from 39.5 mmHg (SE 1.26) before cyclodiode therapy to 17.8 mmHg (SE 1.51) at 6 weeks post-treatment, an observable reduction of 45.1 % ( $P < 0.0001$ ). There was a mild linear correlation between preoperative IOP and observed IOP reduction ( $R^2 = 0.32$ ).

### Safety and Efficacy of Cyclodiode Treatment (Fig.1B)

An IOP reduction greater than 30% of initial IOP was achieved at 6 weeks in 67.7 % of the patients, while hypotony occurred in only 5 cases or 5.3% of patients ( $p < 0.05$ ).

None of the patients experienced post-treatment uveitis or required further treatment or enucleation for pain symptoms. The data for the patients who developed hypotony such as initial diagnosis, treatment settings, IOP measurements and VA outcome is summarised in **Table 2**.

**Table 2.** Details of hypotony patients

	Diagnosis	Energy used	Degrees treated	Peak IOP (mmHg)	Postop IOP (mmHg)	Hypotony duration	Last IOP (mmHg)	Preop VA (LogMAR)	Last VA (LogMAR)
PT1	Neovascular	90J	180	58	2	6 months	10	0.78	PL
PT2	Neovascular	90J	360	41	4	6 months	32	PL	NPL
PT3	Neovascular	120J	360	40	2	6 months	9	0.6	HM
PT4	SOAG(other)	120J	360	26	3	6 months	8	1.0	CF
PT5	SOAG(other)	120J	360	48	2	-	3	HM	HM

### Long term maintenance of IOP reduction after a single cyclodiode treatment

(Fig.1C)

The IOP reduction was maintained long term over the period of 3 years in the majority of our patients. Measurements were taken pre-operatively ( $39.5 \pm 1.3$  mmHg) as well as post-operatively at 6 weeks ( $17.8 \pm 1.5$  mmHg) and 6 months ( $19.6 \pm 1.5$  mmHg) for all patients. Patients who required additional procedures in that eye post-treatment were excluded from further analysis from the time point of additional intervention as it would artificially lower their IOP measurements. The follow-up measurements at 1 year (18.9 mmHg), 2 year (22.1 mmHg) and 3 years (21.7 mmHg) were all after a single cyclodiode treatment.

### **Kaplan-Meier analysis of IOP reduction ‘survival’ following a single cyclodiode treatment (Fig.2)**

Success was defined as an intraocular pressure (IOP) of 6–21 mmHg at the last follow up visit without the need for oral acetazolamide and an IOP reduction of at least 30% compared with preoperatively. The proportion of patients to maintain the desired IOP reduction after a single cyclodiode treatment without the need for further IOP lowering intervention in our study was 67.7% at 6 weeks post-operatively, 66.2% at 6 months, 63% at 1 year, 61.2% at 2 years and 61.2% at 3 years. Of the patients who responded to treatment at 6 weeks, 90.4% were able to maintain the IOP reduction over a period of 3 years.

### **Cyclodiode effect on glaucoma medications (Fig.3A)**

A significant proportion of the patients (61.5%) were able to decrease the number of medications they are taking for IOP control following cyclodiode. A decrease of 2 medications or more was achieved by 34.6% of patients, while 26.9% of patients decreased their medication by one. Overall, the average number of medications decreased from 2.6 before cyclodiode treatment to 1.5 medications after cyclodiode treatment ( $P < 0.05$ ).

### **Change in visual acuity (Fig.3B)**

A single episode of cyclodiode treatment had no significant effect on visual acuity (VA). Mean VA measurements changed from 0.5720 Log MAR units before cyclodiode therapy to 0.5408 Log MAR units post treatment, which was not statistically significant ( $P > 0.05$ ). The data analysis was performed on 47 patients (54.1%), who had clearly annotated numerical values for their VA measurements both



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3 preoperatively and postoperatively. The boxed numerals in the graph represent the  
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5 number of values at the same point.  
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### 9 10 **Change in visual fields (Fig.3C)**

11 The average visual field sensitivity remained almost unchanged with an average MD  
12 value of -8.74 dB pre-treatment compared to MD value of -9.05 dB at 6 months post-  
13 treatment, which was not statistically significant ( $P>0.05$ ). The data analysis was  
14 performed on 36 patients (41.3%), who had clearly annotated numerical values for  
15 their visual fields measurements both pre-operatively and post-operatively.  
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### 25 **Effect of laser energy on IOP reduction (Fig.4A)**

26 Of the patients that received high energy treatment (90J), 80.3% obtained pressure  
27 reduction of  $>30\%$  of initial IOP compared with 56.8% in the patients that received  
28 low energy treatment (45J).  
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### 36 **Effect of laser energy on visual acuity (Fig.4B)**

37 Of the patients that received high energy treatment (90J), 18.6% noted improvement  
38 of the equivalent of at least 1 Snellen line compared with 6.7% in the patients that  
39 received low energy treatment.  
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### 47 **Effect of degrees treated on IOP reduction (Fig.4C)**

48 Of the patients that underwent 360 degrees treatment, 71.4% obtained pressure  
49 reduction greater than 30% of initial IOP compared with 55% of the patients that  
50 underwent 180 degree treatment.  
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### Effect of degrees treated on visual acuity (Fig.4D)

Of the patients that underwent 360 degrees treatment, 20.9% noted improvement of the equivalent of at least 1 Snellen line compared with 5.5% of the patients underwent 180 degree treatment.

### Discussion:

The results of this retrospective analysis are supportive of a single cyclodiode treatment being effective in management of refractory glaucoma. Although this is a retrospective rather than a prospective study, we aimed to avoid selection bias by including all patients either as success or failure of treatment. The patients who required additional surgical interventions were taken as failure from the time of additional intervention.

Our data show that 67.7% of the patients achieved an IOP reduction greater than 30% of presenting IOP at 6 weeks and 61.5% could reduce the number of medications by at least 1. Hypotony appears to be related to the type of glaucoma (with neovascular glaucoma associated with worse outcome) as well as to the number of degrees treated and total energy used. Indeed, the patients with neovascular glaucoma in our cohort were almost 4 times more likely to develop hypotony compared to any other types of glaucoma.

In our patients, the mean intraocular pressure (IOP) decreased significantly from 39.5 mmHg (SE 1.26) before cyclodiode therapy to 17.8 mmHg (SE 1.51) at 6 weeks post-treatment, an observable reduction of 45.1 % ( $P<0.05$ ). The results of the linear regression analysis indicate that there might be some predictive value in determining

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3 IOP reduction based on initial IOP measurements such as the greatest reduction in  
4 IOP is likely to be seen in patients with the highest IOP at the time of treatment ( $R^2 =$   
5 0.32). A similar relationship was reported by Vernon et al., where eyes with IOP  
6 greater than 30 mmHg were more likely to exhibit a pressure drop greater than 30%  
7 of initial IOP.<sup>19</sup>  
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16 The IOP reduction was maintained long term in 61.2% of all patients in our study  
17 after a single cyclodiode treatment. Of the patients who responded to treatment at 6  
18 weeks, 90.4% were able to maintain the IOP reduction over a period of 3 years.  
19  
20 Similar sustainability of the mean IOP reduction postoperatively is also reported by  
21 Bloom et al. and Kosoko et al., although in both these studies the follow up was  
22 considerably shorter, the average time being less than 2 years.<sup>18,20</sup> The results from  
23 our patient cohort suggest that a single session of cyclodiode therapy could potentially  
24 be a viable initial treatment modality for maintaining a longer term IOP control in  
25 patients with refractory glaucoma.  
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39 In our study, of the patients that received high energy treatment (90J), 80.3% obtained  
40 an IOP reduction of greater than 30% of the initial IOP compared with 56.8% in the  
41 patients receiving low energy treatment (45J). This is consistent with a meta-analysis  
42 by Iliev et al., where comparing different laser protocols from different studies  
43 suggested that the use of a low energy protocol potentially could result in the lowest  
44 IOP reduction, the highest postoperative IOP and the highest retreatment rate  
45 overall.<sup>17</sup> We also observed similar relationship when patients were assessed in regard  
46 to the degrees treated rather than energy used. Here, of the patients that underwent  
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3 360 degrees treatment, 71.4% obtained pressure reduction greater than 30% of initial  
4 IOP compared with 55% of the patients that underwent 180 degrees treatment.  
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10 Hypotony was the most common long-term complication in our study (5.3%), which  
11 is in accordance with other published reports.<sup>14</sup> In our cohort, the incidence of  
12 hypotony was much more likely with an eye with neovascular glaucoma (**Table 2**).  
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14 Murphy et al. also found a higher risk of hypotony in eyes with neovascular  
15 glaucoma, particularly if preoperative IOP was high and energy level used was  
16 greater.<sup>14</sup> This correlation between hypotony and higher energy used in cyclodiode is  
17 also observed in several other studies.<sup>12</sup> However, univariate regression analysis done  
18 by Murphy et al. shows that very high pre-treatment IOP alone, possibly causing  
19 ciliary body ischaemia, could be responsible for the high incidence of hypotony in the  
20 patients receiving high-energy treatment in their study.<sup>14</sup>  
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34 Additionally, in a retrospective analysis of 209 eyes by Bloom et al., a very low  
35 incidence of hypotony (1%) was observed with a high energy protocol when the mean  
36 energy used was 90J.<sup>18</sup> Furthermore, Iliev et al. report in their study that eyes  
37 developing hypotony had not received higher energies compared with eyes that  
38 maintained normal IOP.<sup>17</sup> Therefore, the intention to reduce hypotony risk by using a  
39 lower laser power and fewer applications per treatment should be weighed against the  
40 possibility for a lower efficacy of the cyclodiode treatment.  
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52 Visual acuity (VA) remained unchanged for the majority of our patients who  
53 underwent cyclodiode treatment (69.9%). In our study 16.4% reported deterioration in  
54 VA of 1 Snellen line, while 13.7% of the patients reported an improvement in VA of  
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3 1 Snellen line after 6 weeks. The latter probably resulted either from resolution of  
4 preoperative corneal oedema or inter-observer variation in visual acuity testing.  
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6 Similar results are also reported in a study by Murphy et al., where the VA remained  
7 the same in 74.6% of the patients at 6 months following cyclodiode treatment.<sup>14</sup> In  
8  
9 our study most patients with difficult to manage glaucoma retained their good VA in  
10 the long-term following cyclodiode treatment. The proportion losing two Snellen lines  
11 is actually better than that reported after trabeculectomy or tube surgery.<sup>21</sup> These  
12 results suggest a possible role for the use of transscleral cyclodiode treatment in eyes  
13 with relatively good visual potential, however, further controlled prospective studies  
14 would be required to better define this role.  
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27 This study is the first to measure the mean deviation (MD) values for the patients both  
28 pre-operatively and post-operatively in order to provide a more objective assessment  
29 of glaucoma related visual loss. The MD values in our patients remained virtually  
30 unchanged after cyclodiode treatment from -8.74dB preoperatively to -9.05 dB  
31 postoperatively. Previously it has been reported that the most frequent cause of visual  
32 loss was further progression of glaucoma, which was an attributable cause in over half  
33 of the cases.<sup>22</sup> The peri-operative visual field assessment presented in this study  
34 suggests that the maintenance of VA observed in the majority of the patients  
35 following cyclodiode treatment could be due to a good postoperative IOP control.  
36 There are no previous retrospective or prospective studies evaluating visual field  
37 measurements peri-operatively in patients undergoing cyclodiode treatment and this  
38 most likely reflects the difficulties associated with performing the tests in patients  
39 with poor VA. Our study therefore is the first to provide a standardised measurable  
40 evidence of maintenance of patients' visual fields as a marker of glaucoma  
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3 progression following a single cyclodiode treatment. Our study's main limitations are  
4  
5 its retrospective nature and the absence of a control group to distinguish the adverse  
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7 effects of the treatment from the natural history of the underlying disease.  
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12 The results of this study suggest that the IOP reduction after cyclodiode treatment  
13  
14 could potentially prevent further deterioration in the glaucoma patients' vision.  
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16 Currently, according to the UK National Cyclodiode Survey Study only 60% of  
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18 practitioners would perform cyclodiode procedure in the presence of good visual  
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20 acuity.<sup>12</sup> Until recently, cyclodiode treatment has been associated with subsequent  
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22 loss of VA in significant percentage of the patients.<sup>18,23,24</sup> However, cyclodiode use in  
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24 eyes with useful vision has already been proposed in several studies.<sup>19,22-25</sup>  
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26 Furthermore, the risk of VA loss in patients after multiple cyclodiode treatments does  
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28 not appear to be any greater than that after any other surgical modality used for  
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30 treating patients with glaucoma as reported in a study by Rotchford et al.<sup>24</sup>  
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37 In our study, the better outcome in visual acuity was most pronounced in the high  
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39 energy group, probably due to the more effective IOP control. Of the patients that  
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41 received high energy treatment (90J), 18.6% noted improvement of at least 1 Snellen  
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43 line compared with 6.7% in the patients that received low energy treatment (45J).  
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45 Similar results are observed when patients were assessed in regard to the degrees  
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47 treated. Here, of the patients that underwent 360 degrees treatment, 20.9% noted  
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49 improvement of the equivalent of at least 1 Snellen line compared with 5.5% of the  
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51 patients underwent 180 degrees treatment.  
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3 In conclusion, conventional diode cyclophotocoagulation is a safe and effective  
4 treatment for refractory glaucoma characterised by low incidence of complications.  
5 IOP pressure can be effectively reduced in patients with glaucoma after a single  
6 cyclodiode treatment without adverse effects on VA over a 3 year period in majority  
7 of the patients. Hypotony is the main risk of treatment and might be limited by  
8 reducing the laser energy applied to less than 90J, particularly for patients with  
9 neovascular glaucoma.  
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### 20 21 **Figure and Table Legends**

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24 **Figure 1 (A)** Change in Intraocular Pressure following a single Cyclodiode treatment  
25 **(B)** Safety and Efficacy of Cyclodiode Treatment **(C)** IOP reduction was maintained  
26 long-term over the period of 3 years after single treatment  
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33 **Figure 2** Kaplan-Meier analysis for cumulative proportion of success in IOP control  
34 after a single Cyclodiode treatment. Survival was defined as sustained IOP drop of at  
35 least 30% compared with pre-treatment or sustained intraocular pressure (IOP) of 6–  
36 21 mmHg without the need for additional IOP lowering medications or further  
37 surgical interventions.  
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46 **Figure 3 (A)** Cyclodiode effect on antiglaucoma medications **(B)** Preoperative and  
47 postoperative visual acuity measurements in LogMAR units after a single Cyclodiode  
48 treatment **(C)** Preoperative and postoperative visual field loss taken from MD values  
49 **(dB)** on the HVF analyser after a single Cyclodiode treatment  
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3 **Figure 4 (A)** Effect of laser energy on IOP reduction **(B)** Effect of laser energy on  
4 visual acuity (VA) **(C)** Effect of degrees treated on IOP reduction **(D)** Effect of  
5 degrees treated on visual acuity (VA)  
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12 **Table 1** Baseline demographics of the patients and clinical parameters including  
13 diagnostic features, pre-operative IOP and visual acuity assessments.  
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19 **Table 2** Details of the patients who developed hypotony including diagnostic and  
20 treatment features, peri-operative IOP assessments and duration of hypotony  
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### References

1. Hennis HL, Stewart WC. Semiconductor diode laser transscleral cyclophotocoagulation in patients with glaucoma. *Am J Ophthalmol* 1992;**113**:81–5.
2. Hawkins TA, Stewart WC. One-year results of semiconductor transscleral cyclophotocoagulation in patients with glaucoma. *Arch Ophthalmol* 1993;**111**:488–91.
3. Brancato R, Carassa RG, Bettin P. Contact transscleral cyclophotocoagulation with diode laser in refractory glaucoma. *Eur J Ophthalmol* 1995;**5**:32–9.
4. Threlkeld AB, Johnson MH. Contact transscleral diode cyclophotocoagulation for refractory glaucoma. *J Glaucoma* 1999;**8**:3–7.
5. Egbert PR, Fiadoyor S, Budenz DL. Diode laser transscleral cyclophotocoagulation as a primary surgical treatment for primary open angle glaucoma. *Arch Ophthalmol* 2001;**119**:345–50.
6. Mistlberger A, Liebmann JM, Tschiderer H. Diode laser transscleral cyclophotocoagulation for refractory glaucoma. *J Glaucoma* 2001;**10**:288–93.
7. Benson MT, Nelson ME. Cyclocryotherapy: a review of cases over a 10-year period. *Br J Ophthalmol* 1990;**74**:103–5.
8. Schuman JS, Bellows AR, Shingleton BJ. Contact transscleral Nd:YAG laser cyclophotocoagulation. *Ophthalmology* 1992;**99**:1089–94.



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3 9. Ulbig MW, McHugh DA, McNaught AI. Clinical comparison of semiconductor  
4 diode versus neodymium:YAG non-contact cyclophotocoagulation. *Br J Ophthalmol*  
5 1995;**79**:569–74.  
6  
7  
8 10. Pucci V, Tappainer F, Borin S. et al Longterm follow up after transscleral diode  
9 laser photocoagulation in refractory glaucoma. *Ophthalmologica* 2003; **217**:279–283.  
10  
11 11. Grueb M, Rohrbach J M, Bartz-Schmidt K U. et al Transscleral diode laser  
12 cyclophotocoagulation as primary and secondary surgical treatment in primary open  
13 angle and pseudoexfoliative glaucoma: Long term clinical outcomes. *Graefes Arch*  
14 *Clin Exp Ophthalmol* 2006; **244**:1293–1299.  
15 12. P Agrawal, S Dulku, W Nolan and V Sung. The UK National Cyclodiode Laser  
16 Survey. *Eye* 2011; **25**:168–173  
17  
18 13. Walland MJ. Diode laser cyclophotocoagulation: longer term follow up of a  
19 standardized treatment protocol. *Clin Exp Ophthalmol* 2000; **28**:263–7.  
20  
21 14. Murphy CC, Burnett CAM, Spry PDG, Broadway DC, Diamond JP. A two centre  
22 study of the dose-response relation for transscleral diode laser cyclophotocoagulation  
23 in refractory glaucoma. *Br J Ophthalmol* 2003; **87**:1252–1257  
24  
25 15. Chang SH, Chen YC, Li CY. Contact diode laser transscleral  
26 cyclophotocoagulation for refractory glaucoma: comparison of two treatment  
27 protocols. *Can J Ophthalmol* 2004; **39**:511–6.  
28  
29 16. Nouredin BN, Zein W, Haddad C. Diode laser transcleral cyclophotocoagulation  
30 for refractory glaucoma: a 1 year follow-up of patients treated using an aggressive  
31 protocol. *Eye* 2006; **20**:329–35.  
32  
33 17. Iliev ME, Gerber S. Long-term outcome of trans-scleral diode laser  
34 cyclophotocoagulation in refractory glaucoma. *Br J Ophthalmol* 2007; **91**:1631–1635.  
35  
36 18. Bloom PA, Tsai JC, Sharma K, Miller MH, Rice NS, Hitchings RA. Cyclodiode  
37 trans-scleral diode laser cyclophotocoagulation in the treatment of advanced  
38 refractory glaucoma. *Ophthalmology* 1997; **104**:1508–1520.  
39  
40 19. Vernon SA, Koppens JM, Menon GJ, Negi AK. Diode laser cycloablation in adult  
41 glaucoma: long-term results of a standard protocol and review of current literature.  
42 *Clin Exp Ophthalmol* 2006; **34**:411-20.  
43  
44 20. Kosoko O, Gaasterland DE, Pollack IP. Long-term outcome of initial ciliary  
45 ablation with contact diode laser transscleral cyclophotocoagulation for severe  
46 glaucoma. The diode laser ciliary ablation study group. *Ophthalmology* 1996;  
47 **103**:1294–302.  
48  
49 21. Gedde SJ, Schiffman JC, Feuer WJ, Herndon LW, Brandt JD, Budenz DL.  
50 Treatment outcomes in the tube versus trabeculectomy study after one year of follow-  
51 up. *Am J Ophthalmol* 2007; **143**(1):9-22.  
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3 22. Rotchford AP, Jayasawal R, Madhusudhan S, Ho S, King AJ, Vernon SA.  
4 Transscleral diode laser cycloablation in patients with good vision *Br J Ophthalmol*  
5 2010; **94**:1180-1183  
6  
7 23. Youn J, Cox TA, Allingham RR. Factors associated with visual acuity loss after  
8 noncontact transscleral Nd:YAG cyclophotocoagulation. *J Glaucoma* 1996; **5**:390-94.  
9  
10 24. Wilensky JT, Kammer J. Long-term visual outcome of transscleral laser  
11 cyclotherapy in eyes with ambulatory vision. *Ophthalmology* 2004; **111**:1389-92.  
12  
13 25. Ansari E, Gandhewar J. Long-term efficacy and visual acuity following  
14 transscleral diode laser photocoagulation in cases of refractory and non-refractory  
15 glaucoma. *Eye* 2007; **21**:936-40.  
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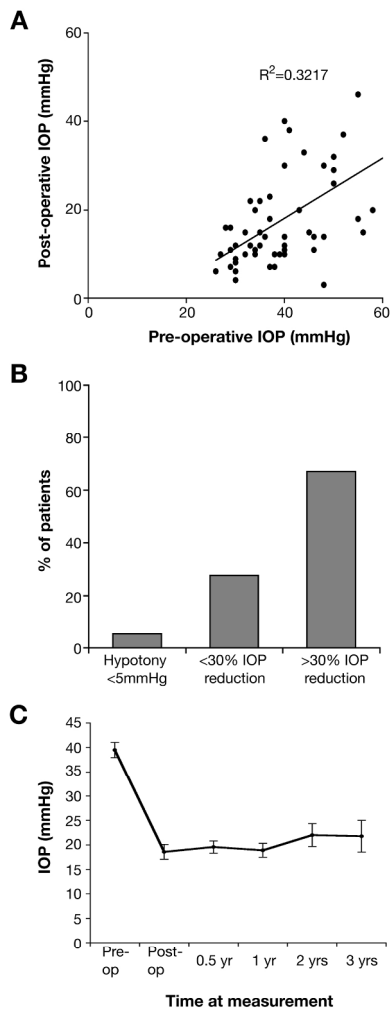
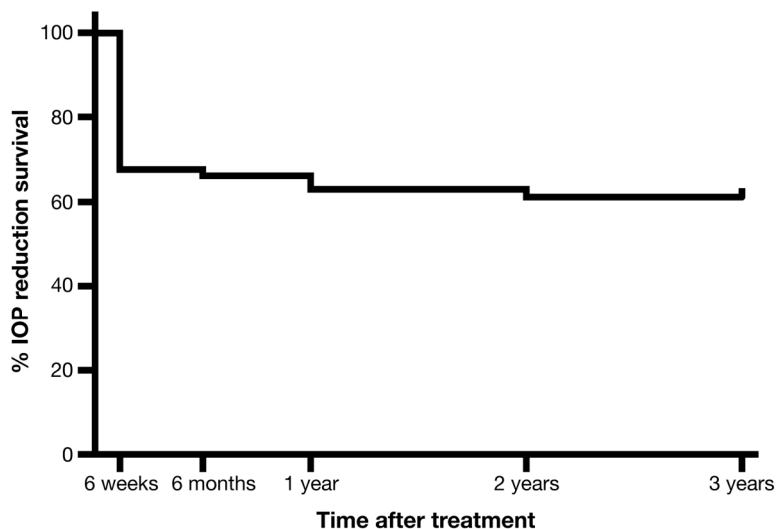


Figure 1

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**Figure 2**

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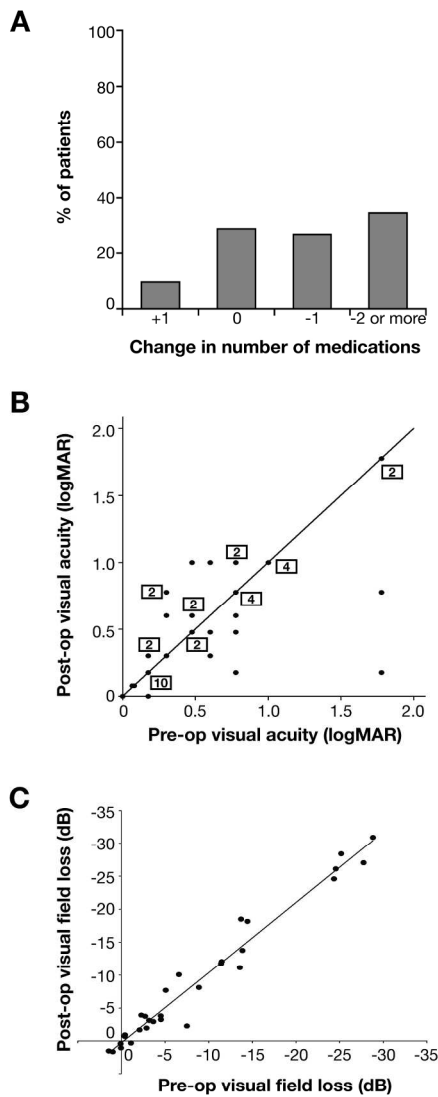


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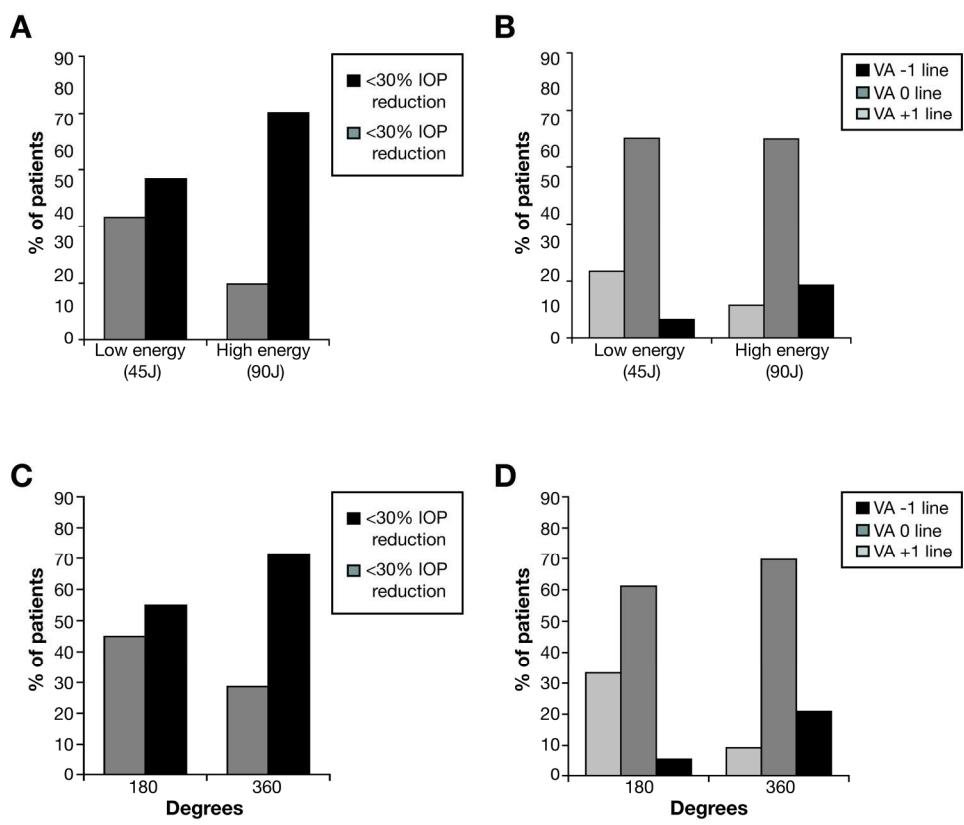


Figure 4

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## A Retrospective Analysis of Long Term Outcomes Following a Single Episode of Transscleral Cyclodiode Laser Treatment in Glaucoma Patients

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# A Retrospective Analysis of Long Term Outcomes Following a Single Episode of Transscleral Cyclodiode Laser Treatment in Glaucoma Patients

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**Objectives:** To investigate the efficacy of a single cyclodiode laser photocoagulation treatment for refractory glaucoma and its effect on visual outcome in patients with good visual potential as well as to evaluate possible predictive factors in establishing optimal treatment parameters.

**Design:** Retrospective observational study

**Setting:** Tertiary referral centre

**Participants:** The notes of 87 patients with refractory glaucoma who underwent cyclodiode photocoagulation as a first surgical intervention over a 7-year period.

**Main outcome measures:** Maintenance of intraocular pressure reduction, number of medications and visual acuity outcomes post-treatment.

**Results:** The mean intraocular pressure (IOP) after a single treatment decreased from 39.5 +/-1.3 mmHg to 17.8 +/-1.5 mmHg after a 6-week follow-up period (P<0.0001). This reduction in IOP was maintained over a 3-year period. Here 61.5% of the patients were able to reduce the number of medications used, with mean reduction from 2.6 to 1.5 medications (P<0.05). Mean initial visual field loss prior to treatment was 8.74dB and at 6 months post-treatment was measured at 9.06dB (P>0.05) suggesting no significant overall change. The visual acuity remained unchanged or improved for 83.6% of the patients (P>0.05) with relatively good visual potential (average vision preoperatively was 0.57 logMAR). Hypotony occurred in 5.3% of the patients. No patients required enucleation or evisceration.

**Conclusion:** A single session of cyclodiode laser therapy was associated with significant IOP reduction in the majority of the patients with refractory glaucoma. The



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3 majority were able to maintain the IOP reduction over a 3-year period without the  
4 need for a further surgical intervention. Additionally, over 80% of the patients in our  
5 study were able to maintain their baseline visual acuity. These results support the  
6 view that a single cyclodiode treatment can be sufficient in achieving long term IOP  
7 control and may be considered in eyes with relatively good visual potential.  
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### 10 11 12 **Introduction:**

13 Transscleral diode laser cyclophotocoagulation (cyclodiode) has been established as a  
14 relatively safe and effective intervention for glaucoma.<sup>1-6</sup> Cyclodiode is often used in  
15 refractory glaucoma, where alternative surgical approaches, such as antiproliferative  
16 augmented trabeculectomy and tube shunt surgery, may sometimes be judged less  
17 appropriate, for example in eyes with poor visual potential. Additionally, cyclodiode  
18 has been shown to be safer than other cyclodestructive procedures, such as Nd:YAG  
19 laser cyclophotocoagulation and cyclocryotherapy, which present a greater risk of  
20 hypotony and phthisis resulting from excessive ciliary body ablation.<sup>7-9</sup> However, the  
21 outcome of cyclodiode therapy is unpredictable and multiple treatments may be  
22 required to achieve long term intraocular control.<sup>10-11</sup>  
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40 Currently there is no general consensus for an optimum treatment protocol for  
41 cyclodiode. Data for outcomes following cyclodiode laser vary considerably in the  
42 literature.<sup>12</sup> Parameters such as total delivered energy per eye, number of laser  
43 applications per treatment, pulse power, pulse duration and proportion of  
44 circumference treated have been analysed with varying results.<sup>13-17</sup> Furthermore,  
45 cyclodiode therapy has often been reserved for eyes with poor vision due to reports  
46 that it can lead to decrease in visual acuity.<sup>18</sup>  
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3 The purpose of this study was to evaluate the long-term safety and efficacy of a single  
4 episode of transscleral diode laser cyclophotocoagulation for raised intraocular  
5 pressure in patients with good visual potential at a UK tertiary glaucoma referral  
6 centre. The retrospective nature of the study design reflected the need to analyse  
7 multiple clinical variables and evaluate different types of outcomes as well as their  
8 progression over several years. Additionally, such a study could facilitate the  
9 identification predictive factors for optimal treatment parameters by investigating the  
10 relation of laser energy delivered and degrees treated to the long-term maintenance in  
11 IOP reduction.  
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### 25 **Methods:**

26 The departmental electronic medical record system (Medisoft Ophthalmology,  
27 Medisoft Ltd Leeds UK) and operating theatre log books were examined for the  
28 period 09/2004 to 06/2011 to identify patients who had undergone cyclodiode  
29 treatment as a first surgical intervention.  
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39 All patients were assessed for their response to treatment and those who did not  
40 achieve the target IOP reduction were taken as treatment failures. The patients who  
41 required either repeat cyclodiode or alternative treatments for IOP control during the  
42 follow up period were also considered as treatment failures from the time of the  
43 additional surgical intervention. They were not further assessed for maintenance of  
44 post-operative IOP as any additional surgical interventions would interfere with the  
45 interpretation of the IOP maintenance data.  
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3 Cyclophotocoagulation was performed in the Operating Theatre under subtenon,  
4 peribulbar or general anaesthesia using a standard treatment protocol. A lid speculum  
5 was placed to achieve adequate exposure for probe placement all around the limbus  
6 and a squint hook was used to rotate the globe to achieve exposure in those with  
7 narrow palpebral apertures. All treatments were performed using Oculight Sx  
8 semiconductor diode 810nm laser and the contact G Probe™ (IRIS Medical  
9 Instruments, Inc.). Standard settings were 1500ms duration and 1500mW power. The  
10 energy levels were not routinely titrated for ‘pops’ and the power settings were left at  
11 1500mW. Transillumination was performed for ciliary body identification. Usually 10  
12 applications were applied per quadrant for 180 to 360°, with the applications spaced  
13 approximately one-half width of the probe tip apart. The 3 and 9 o’clock positions  
14 were avoided to spare the long ciliary nerves. Postoperative steroid drops were used  
15 for 4 weeks. Glaucoma medications were continued after cyclodiode treatment and  
16 adjusted later as required.  
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36 Success was defined as an intraocular pressure (IOP) of 6–21 mmHg at the last  
37 follow-up visit without the need for oral acetazolamide and an IOP reduction of at  
38 least 30% compared with pre-treatment. Hypotony was defined as an IOP of 5 mmHg  
39 or less. The laser energy used was classified as either low energy (median value 45  
40 +/- 11.47 J, range 22.5-67.5J) or high energy (median value 90 +/- 13.42 J, range  
41 67.5-130J). The follow up period in IOP measurements was 3 years. Visual acuity  
42 (VA) prior to treatment was assessed for all patients using LogMAR scale. Visual  
43 field testing was performed with the Humphrey Visual Field Analyser™ using the  
44 SITA 24-2 threshold programme. Mean deviation of visual field sensitivity loss in  
45 decibels (MD) was taken as our surrogate measure of visual field loss.  
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Data was analysed using Microsoft Excel™ and where appropriate a Student's t-test was used to calculate p-values. R<sup>2</sup> values were derived from linear regression analyses using the same programme. Kaplan-Meier 'survival' analysis was done using GraphPad Prism 5.0™. Approval for the audit was granted by the Cambridge University Hospitals NHS Foundation Trust Ethics Committee. The tenets of the Declaration of Helsinki were observed.

## Results:

From our records, we were able to identify 104 patients who underwent cyclodiode therapy as a first surgical treatment modality in the period from 09/2004 to 06/2011 at Addenbrooke's Hospital, Cambridge. Of these, complete medical records were available for 87 patients with follow up data available for up to 3 years. Preoperative patient data is summarised in **Table 1**.

**Table 1.** Baseline demographics and clinical parameters

	Category	Cases (n=87)
Mean age, yrs		66.3
Sex (n (%))	Male	49 (56.3%)
	Female	38 (43.7%)
Preoperative VA, mean		0.57 LogMAR
IOP (mmHg), mean (SD)		39.5 +/- 1.3 mmHg
Mean number of glaucoma medications		2.6
Glaucoma type (n (%))	Primary open angle glaucoma (POAG)	33 (37.9%)
	Primary angle closure glaucoma (PACG)	6 (6.9%)
	Neovascular glaucoma	25 (28.7%)
	Uveitic glaucoma	5 (5.7%)
	Secondary open angle glaucoma (SOAG)- Other	18 (20.8%)

### Change in Intraocular Pressure (Fig.1A)

Mean intraocular pressure (IOP) decreased significantly from 39.5 mmHg (SE 1.26) before cyclodiode therapy to 17.8 mmHg (SE 1.51) at 6 weeks post-treatment, an observable reduction of 45.1 % ( $P < 0.0001$ ). There was a mild linear correlation between preoperative IOP and observed IOP reduction ( $R^2 = 0.32$ ).

### Safety and Efficacy of Cyclodiode Treatment (Fig.1B)

An IOP reduction greater than 30% of initial IOP was achieved at 6 weeks in 67.7 % of the patients, while hypotony occurred in only 5 cases or 5.3% of patients ( $p < 0.05$ ). None of the patients experienced post-treatment uveitis or required further treatment or enucleation for pain symptoms. The data for the patients who developed hypotony such as initial diagnosis, treatment settings, IOP measurements and VA outcome is summarised in **Table 2**.

**Table 2.** Details of hypotony patients

	Diagnosis	Energy used	Degrees treated	Peak IOP (mmHg)	Postop IOP (mmHg)	Hypotony duration	Last IOP (mmHg)	Preop VA (LogMAR)	Last VA (LogMAR)
PT1	Neovascular	90J	180	58	2	6 months	10	0.78	PL
PT2	Neovascular	90J	360	41	4	6 months	32	PL	NPL
PT3	Neovascular	120J	360	40	2	6 months	9	0.6	HM
PT4	SOAG(other)	120J	360	26	3	6 months	8	1.0	CF
PT5	SOAG(other)	120J	360	48	2	-	3	HM	HM

### Long term maintenance of IOP reduction after a single cyclodiode treatment

(Fig.1C)

The IOP reduction was maintained long term over the period of 3 years in the majority of our patients. Measurements were taken pre-operatively (39.5 $\pm$ 1.3 mmHg) as well as post-operatively at 6 weeks (17.8 $\pm$ 1.5 mmHg) and 6 months

(19.6±1.5 mmHg) for all patients. Patients who required additional procedures in that eye post-treatment were excluded from further analysis from the time point of additional intervention as it would artificially lower their IOP measurements. The follow-up measurements at 1 year (18.9 mmHg), 2 year (22.1 mmHg) and 3 years (21.7 mmHg) were all after a single cyclodiode treatment.

### **Kaplan-Meier analysis of IOP reduction ‘survival’ following a single cyclodiode treatment (Fig.2)**

Success was defined as an intraocular pressure (IOP) of 6–21 mmHg at the last follow up visit without the need for oral acetazolamide and an IOP reduction of at least 30% compared with preoperatively. The proportion of patients to maintain the desired IOP reduction after a single cyclodiode treatment without the need for further IOP lowering intervention in our study was 67.7% at 6 weeks post-operatively, 66.2% at 6 months, 63% at 1 year, 61.2% at 2 years and 61.2% at 3 years. Of the patients who responded to treatment at 6 weeks, 90.4% were able to maintain the IOP reduction over a period of 3 years.

### **Cyclodiode effect on glaucoma medications (Fig.3A)**

A significant proportion of the patients (61.5%) were able to decrease the number of medications they are taking for IOP control following cyclodiode. A decrease of 2 medications or more was achieved by 34.6% of patients, while 26.9% of patients decreased their medication by one. Overall, the average number of medications decreased from 2.6 before cyclodiode treatment to 1.5 medications after cyclodiode treatment ( $P<0.05$ ).

**Change in visual acuity (Fig.3B)**

A single episode of cyclodiode treatment had no significant effect on visual acuity (VA). Mean VA measurements changed from 0.5720 Log MAR units before cyclodiode therapy to 0.5408 Log MAR units post treatment, which was not statistically significant ( $P>0.05$ ). The data analysis was performed on 47 patients (54.1%), who had clearly annotated numerical values for their VA measurements both preoperatively and postoperatively. The boxed numerals in the graph represent the number of values at the same point.

**Change in visual fields (Fig.3C)**

The average visual field sensitivity remained almost unchanged with an average MD value of -8.74 dB pre-treatment compared to MD value of -9.05 dB at 6 months post-treatment, which was not statistically significant ( $P>0.05$ ). The data analysis was performed on 36 patients (41.3%), who had clearly annotated numerical values for their visual fields measurements both pre-operatively and post-operatively.

**Effect of laser energy on IOP reduction (Fig.4A)**

Of the patients that received high energy treatment (90J), 80.3% obtained pressure reduction of  $>30\%$  of initial IOP compared with 56.8% in the patients that received low energy treatment (45J).

**Effect of laser energy on visual acuity (Fig.4B)**

Of the patients that received high energy treatment (90J), 18.6% noted improvement of the equivalent of at least 1 Snellen line compared with 6.7% in the patients that received low energy treatment.

**Effect of degrees treated on IOP reduction (Fig.4C)**

Of the patients that underwent 360 degrees treatment, 71.4% obtained pressure reduction greater than 30% of initial IOP compared with 55% of the patients that underwent 180 degree treatment.

**Effect of degrees treated on visual acuity (Fig.4D)**

Of the patients that underwent 360 degrees treatment, 20.9% noted improvement of the equivalent of at least 1 Snellen line compared with 5.5% of the patients underwent 180 degree treatment.

**Discussion:**

The results of this retrospective analysis are supportive of a single cyclodiode treatment being effective in management of refractory glaucoma. Although this is a retrospective rather than a prospective study, we aimed to avoid selection bias by including all patients either as success or failure of treatment. The patients who required additional surgical interventions were taken as failure from the time of additional intervention.

Our data show that 67.7% of the patients achieved an IOP reduction greater than 30% of presenting IOP at 6 weeks and 61.5% could reduce the number of medications by at least 1. Hypotony appears to be related to the type of glaucoma (with neovascular glaucoma associated with worse outcome) as well as to the number of degrees treated and total energy used. Indeed, the patients with neovascular glaucoma in our cohort



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3 were almost 4 times more likely to develop hypotony compared to any other types of  
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10 In our patients, the mean intraocular pressure (IOP) decreased significantly from 39.5  
11 mmHg (SE 1.26) before cyclodiode therapy to 17.8 mmHg (SE 1.51) at 6 weeks post-  
12 treatment, an observable reduction of 45.1 % (P<0.05). The results of the linear  
13 regression analysis indicate that there might be some predictive value in determining  
14 IOP reduction based on initial IOP measurements such as the greatest reduction in  
15 IOP is likely to be seen in patients with the highest IOP at the time of treatment ( $R^2 =$   
16 0.32). A similar relationship was reported by Vernon et al., where eyes with IOP  
17 greater than 30 mmHg were more likely to exhibit a pressure drop greater than 30%  
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32 The IOP reduction was maintained long term in 61.2% of all patients in our study  
33 after a single cyclodiode treatment. Of the patients who responded to treatment at 6  
34 weeks, 90.4% were able to maintain the IOP reduction over a period of 3 years.  
35 Similar sustainability of the mean IOP reduction postoperatively is also reported by  
36 Bloom et al. and Kosoko et al., although in both these studies the follow up was  
37 considerably shorter, the average time being less than 2 years.<sup>18,20</sup> The results from  
38 our patient cohort suggest that a single session of cyclodiode therapy could potentially  
39 be a viable initial treatment modality for maintaining a longer term IOP control in  
40 patients with refractory glaucoma.  
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54 In our study, of the patients that received high energy treatment (90J), 80.3% obtained  
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3 patients receiving low energy treatment (45J). This is consistent with a meta-analysis  
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5 by Iliev et al., where comparing different laser protocols from different studies  
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7 suggested that the use of a low energy protocol potentially could result in the lowest  
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9 IOP reduction, the highest postoperative IOP and the highest retreatment rate  
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11 overall.<sup>17</sup> We also observed similar relationship when patients were assessed in regard  
12  
13 to the degrees treated rather than energy used. Here, of the patients that underwent  
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15 360 degrees treatment, 71.4% obtained pressure reduction greater than 30% of initial  
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17 IOP compared with 55% of the patients that underwent 180 degrees treatment.  
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22 Hypotony was the most common long-term complication in our study (5.3%), which  
23  
24 is in accordance with other published reports.<sup>14</sup> In our cohort, the incidence of  
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26 hypotony was much more likely with an eye with neovascular glaucoma (**Table 2**).  
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28 Murphy et al. also found a higher risk of hypotony in eyes with neovascular  
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30 glaucoma, particularly if preoperative IOP was high and energy level used was  
31  
32 greater.<sup>14</sup> This correlation between hypotony and higher energy used in cyclodiode is  
33  
34 also observed in several other studies.<sup>12</sup> However, univariate regression analysis done  
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36 by Murphy et al. shows that very high pre-treatment IOP alone, possibly causing  
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38 ciliary body ischaemia, could be responsible for the high incidence of hypotony in the  
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40 patients receiving high-energy treatment in their study.<sup>14</sup>  
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48 Additionally, in a retrospective analysis of 209 eyes by Bloom et al., a very low  
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50 incidence of hypotony (1%) was observed with a high energy protocol when the mean  
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52 energy used was 90J.<sup>18</sup> Furthermore, Iliev et al. report in their study that eyes  
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54 developing hypotony had not received higher energies compared with eyes that  
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56 maintained normal IOP.<sup>17</sup> Therefore, the intention to reduce hypotony risk by using a  
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3 lower laser power and fewer applications per treatment should be weighed against the  
4 possibility for a lower efficacy of the cyclodiode treatment.  
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10 Visual acuity (VA) remained unchanged for the majority of our patients who  
11 underwent cyclodiode treatment (69.9%). In our study 16.4% reported deterioration in  
12 VA of 1 Snellen line, while 13.7% of the patients reported an improvement in VA of  
13 1 Snellen line after 6 weeks. The latter probably resulted either from resolution of  
14 preoperative corneal oedema or inter-observer variation in visual acuity testing.  
15  
16 Similar results are also reported in a study by Murphy et al., where the VA remained  
17 the same in 74.6% of the patients at 6 months following cyclodiode treatment.<sup>14</sup> In  
18 our study most patients with difficult to manage glaucoma retained their good VA in  
19 the long-term following cyclodiode treatment. The proportion losing two Snellen lines  
20 is actually better than that reported after trabeculectomy or tube surgery.<sup>21</sup> These  
21 results suggest a possible role for the use of transscleral cyclodiode treatment in eyes  
22 with relatively good visual potential, however, further controlled prospective studies  
23 would be required to better define this role.  
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40 This study is the first to measure the mean deviation (MD) values for the patients both  
41 pre-operatively and post-operatively in order to provide a more objective assessment  
42 of glaucoma related visual loss. The MD values in our patients remained virtually  
43 unchanged after cyclodiode treatment from -8.74dB preoperatively to -9.05 dB  
44 postoperatively. Previously it has been reported that the most frequent cause of visual  
45 loss was further progression of glaucoma, which was an attributable cause in over half  
46 of the cases.<sup>22</sup> The peri-operative visual field assessment presented in this study  
47 suggests that the maintenance of VA observed in the majority of the patients  
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3 following cyclodiode treatment could be due to a good postoperative IOP control.  
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5 There are no previous retrospective or prospective studies evaluating visual field  
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7 measurements peri-operatively in patients undergoing cyclodiode treatment and this  
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9 most likely reflects the difficulties associated with performing the tests in patients  
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11 with poor VA. Our study therefore is the first to provide a standardised measurable  
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13 evidence of maintenance of patients' visual fields as a marker of glaucoma  
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15 progression following a single cyclodiode treatment. Our study's main limitations are  
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17 its retrospective nature and the absence of a control group to distinguish the adverse  
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19 effects of the treatment from the natural history of the underlying disease.  
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25 The results of this study suggest that the IOP reduction after cyclodiode treatment  
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27 could potentially prevent further deterioration in the glaucoma patients' vision.  
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29 Currently, according to the UK National Cyclodiode Survey Study only 60% of  
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31 practitioners would perform cyclodiode procedure in the presence of good visual  
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33 acuity.<sup>12</sup> Until recently, cyclodiode treatment has been associated with subsequent  
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35 loss of VA in significant percentage of the patients.<sup>18,23,24</sup> However, cyclodiode use in  
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37 eyes with useful vision has already been proposed in several studies.<sup>19,22-25</sup>  
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39 Furthermore, the risk of VA loss in patients after multiple cyclodiode treatments does  
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41 not appear to be any greater than that after any other surgical modality used for  
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43 treating patients with glaucoma as reported in a study by Rotchford et al.<sup>24</sup>  
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49 In our study, the better outcome in visual acuity was most pronounced in the high  
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51 energy group, probably due to the more effective IOP control. Of the patients that  
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53 received high energy treatment (90J), 18.6% noted improvement of at least 1 Snellen  
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55 line compared with 6.7% in the patients that received low energy treatment (45J).  
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3 Similar results are observed when patients were assessed in regard to the degrees  
4 treated. Here, of the patients that underwent 360 degrees treatment, 20.9% noted  
5 improvement of the equivalent of at least 1 Snellen line compared with 5.5% of the  
6 patients underwent 180 degrees treatment.  
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14 In conclusion, conventional diode cyclophotocoagulation is characterised by low  
15 incidence of complications and therefore appears to be a safe and effective treatment  
16 for refractory glaucoma. In our study the IOP pressure was effectively reduced in  
17 glaucoma patients after a single cyclodiode treatment without adverse effects on VA  
18 in the majority of the patients over a 3 year period. Hypotony seems to be the main  
19 risk of treatment and could be limited by reducing the laser energy applied to less than  
20 90J, particularly in the patients with neovascular glaucoma.  
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### 32 **Figure and Table Legends**

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35 **Figure 1** (A) Change in Intraocular Pressure following a single Cyclodiode treatment  
36 (B) Safety and Efficacy of Cyclodiode Treatment (C) IOP reduction was maintained  
37 long-term over the period of 3 years after single treatment  
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44 **Figure 2** Kaplan-Meier analysis for cumulative proportion of success in IOP control  
45 after a single Cyclodiode treatment. Survival was defined as sustained IOP drop of at  
46 least 30% compared with pre-treatment or sustained intraocular pressure (IOP) of 6–  
47 21 mmHg without the need for additional IOP lowering medications or further  
48 surgical interventions.  
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3 **Figure 3 (A)** Cyclodiode effect on antiglaucoma medications **(B)** Preoperative and  
4 postoperative visual acuity measurements in LogMAR units after a single Cyclodiode  
5 treatment **(C)** Preoperative and postoperative visual field loss taken from MD values  
6 (dB) on the HVF analyser after a single Cyclodiode treatment  
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14 **Figure 4 (A)** Effect of laser energy on IOP reduction **(B)** Effect of laser energy on  
15 visual acuity (VA) **(C)** Effect of degrees treated on IOP reduction **(D)** Effect of  
16 degrees treated on visual acuity (VA)  
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23 **Table 1** Baseline demographics of the patients and clinical parameters including  
24 diagnostic features, pre-operative IOP and visual acuity assessments.  
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30 **Table 2** Details of the patients who developed hypotony including diagnostic and  
31 treatment features, peri-operative IOP assessments and duration of hypotony  
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## References

1. Hennis HL, Stewart WC. Semiconductor diode laser transscleral cyclophotocoagulation in patients with glaucoma. *Am J Ophthalmol* 1992;**113**:81–5.
2. Hawkins TA, Stewart WC. One-year results of semiconductor transscleral cyclophotocoagulation in patients with glaucoma. *Arch Ophthalmol* 1993;**111**:488–91.
3. Brancato R, Carassa RG, Bettin P. Contact transscleral cyclophotocoagulation with diode laser in refractory glaucoma. *Eur J Ophthalmol* 1995;**5**:32–9.
4. Threlkeld AB, Johnson MH. Contact transscleral diode cyclophotocoagulation for refractory glaucoma. *J Glaucoma* 1999;**8**:3–7.
5. Egbert PR, Fiadoyor S, Budenz DL. Diode laser transscleral cyclophotocoagulation as a primary surgical treatment for primary open angle glaucoma. *Arch Ophthalmol* 2001;**119**:345–50.

- 1  
2  
3 6.Mistlberger A, Liebmann JM, Tschiderer H. Diode laser transscleral  
4 cyclophotocoagulation for refractory glaucoma. *J Glaucoma* 2001;**10**:288–93.
- 5  
6 7. Benson MT, Nelson ME. Cyclocryotherapy: a review of cases over a 10-year  
7 period. *Br J Ophthalmol* 1990;**74**:103–5.
- 8  
9 8.Schuman JS, Bellows AR, Shingleton BJ. Contact transscleral Nd:YAG laser  
10 cyclophotocoagulation. *Ophthalmology* 1992;**99**:1089–94.
- 11  
12 9. Ulbig MW, McHugh DA, McNaught AI. Clinical comparison of semiconductor  
13 diode versus neodymium:YAG non-contact cyclophotocoagulation. *Br J Ophthalmol*  
14 1995;**79**:569–74.
- 15  
16 10. Pucci V, Tappainer F, Borin S. et al Longterm follow up after transscleral diode  
17 laser photocoagulation in refractory glaucoma. *Ophthalmologica* 2003; **217**:279–283.
- 18  
19 11. Grueb M, Rohrbach J M, Bartz et al Transscleral diode laser  
20 cyclophotocoagulation as primary and secondary surgical treatment in primary open  
21 angle and pseudoexfoliative glaucoma: Long term clinical outcomes. *Graefes Arch*  
22 *Clin Exp Ophthalmol* 2006; **244**:1293–1299.
- 23  
24 12. P Agrawal, S Dulku, W Nolan and V Sung. The UK National Cyclodiode Laser  
25 Survey. *Eye* 2011; **25**:168–173
- 26  
27 13. Walland MJ. Diode laser cyclophotocoagulation: longer term follow up of a  
28 standardized treatment protocol. *Clin Exp Ophthalmol* 2000; **28**:263–7.
- 29  
30 14. Murphy CC, Burnett CAM, Spry PDG, et al. A two centre study of the dose-  
31 response relation for transscleral diode laser cyclophotocoagulation in refractory  
32 glaucoma. *Br J Ophthalmol* 2003; **87**:1252–1257
- 33  
34 15. Chang SH, Chen YC, Li CY. Contact diode laser transscleral  
35 cyclophotocoagulation for refractory glaucoma: comparison of two treatment  
36 protocols. *Can J Ophthalmol* 2004; **39**:511–6.
- 37  
38 16. Nouredin BN, Zein W, Haddad C. Diode laser transcleral cyclophotocoagulation  
39 for refractory glaucoma: a 1 year follow-up of patients treated using an aggressive  
40 protocol. *Eye* 2006; **20**:329–35.
- 41  
42 17.Iliev ME, Gerber S. Long-term outcome of trans-scleral diode laser  
43 cyclophotocoagulation in refractory glaucoma. *Br J Ophthalmol* 2007; **91**:1631–1635.
- 44  
45 18. Bloom PA, Tsai JC, Sharma K, et al. Cyclodiode trans-scleral diode laser  
46 cyclophotocoagulation in the treatment of advanced refractory glaucoma.  
47 *Ophthalmology* 1997; **104**:1508–1520.
- 48  
49 19. Vernon SA, Koppens JM, Menon GJ, et al. Diode laser cycloablation in adult  
50 glaucoma:long-term results of a standard protocol and review of current literature.  
51 *Clin Exp Ophthalmol* 2006; **34**:411-20.
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2  
3 20. Kosoko O, Gaasterland DE, Pollack IP. Long-term outcome of initial ciliary  
4 ablation with contact diode laser transscleral cyclophotocoagulation for severe  
5 glaucoma. The diode laser ciliary ablation study group. *Ophthalmology* 1996;  
6 **103**:1294–302.  
7  
8  
9 21. Gedde SJ, Schiffman JC, Feuer WJ, et al. Treatment outcomes in the tube versus  
10 trabeculectomy study after one year of follow-up. *Am J Ophthalmol* 2007; **143**(1):9-  
11 22.  
12  
13 22. Rotchford AP, Jayasawal R, Madhusudhan S, et al. Transscleral diode laser  
14 cycloablation in patients with good vision *Br J Ophthalmol* 2010; **94**:1180-1183  
15  
16 23. Youn J, Cox TA, Allingham RR. Factors associated with visual acuity loss after  
17 noncontact transscleral Nd:YAG cyclophotocoagulation. *J Glaucoma* 1996; **5**:390-94.  
18  
19 24. Wilensky JT, Kammer J. Long-term visual outcome of transscleral laser  
20 cyclotherapy in eyes with ambulatory vision. *Ophthalmology* 2004; **111**:1389-92.  
21  
22 25. Ansari E, Gandhewar J. Long-term efficacy and visual acuity following  
23 transscleral diode laser photocoagulation in cases of refractory and non-refractory  
24 glaucoma. *Eye* 2007; **21**:936-40.  
25  
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# A Retrospective Analysis of Long Term Outcomes Following a Single Episode of Transscleral Cyclodiode Laser Treatment in Glaucoma Patients

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**Objectives:** To investigate the efficacy of a single cyclodiode laser photocoagulation treatment for refractory glaucoma and its effect on visual outcome in patients with good visual potential as well as to evaluate possible predictive factors in establishing optimal treatment parameters.

**Design:** Retrospective observational study

**Setting:** Tertiary referral centre

**Participants:** The notes of 87 patients with refractory glaucoma who underwent cyclodiode photocoagulation as a first surgical intervention over a 7-year period.

**Main outcome measures:** Maintenance of intraocular pressure reduction, number of medications and visual acuity outcomes post-treatment.

**Results:** The mean intraocular pressure (IOP) after a single treatment decreased from 39.5 +/-1.3 mmHg to 17.8 +/-1.5 mmHg after a 6-week follow-up period (P<0.0001). This reduction in IOP was maintained over a 3-year period. Here 61.5% of the patients were able to reduce the number of medications used, with mean reduction from 2.6 to 1.5 medications (P<0.05). Mean initial visual field loss prior to treatment was 8.74dB and at 6 months post-treatment was measured at 9.06dB (P>0.05) suggesting no significant overall change. The visual acuity remained unchanged or improved for 83.6% of the patients (P>0.05) with relatively good visual potential (average vision preoperatively was 0.57 logMAR). Hypotony occurred in 5.3% of the patients. No patients required enucleation or evisceration.

**Conclusion:** A single session of cyclodiode laser therapy was associated with significant IOP reduction in the majority of the patients with refractory

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3 **glaucoma.** The majority were able to maintain the IOP reduction over a 3-year period  
4 without the need for a further surgical intervention. Additionally, over 80% of the  
5 patients in our study were able to maintain their baseline visual acuity. These results  
6 support the view that a single cyclodiode treatment can be sufficient in achieving long  
7 term IOP control and may be considered in eyes with relatively good visual potential.  
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### 10 11 12 13 **Introduction:**

14 Transscleral diode laser cyclophotocoagulation (cyclodiode) has been established as a  
15 relatively safe and effective intervention for glaucoma.<sup>1-6</sup> Cyclodiode is often used in  
16 refractory glaucoma, where alternative surgical approaches, such as antiproliferative  
17 augmented trabeculectomy and tube shunt surgery, may sometimes be judged less  
18 appropriate, for example in eyes with poor visual potential. Additionally, cyclodiode  
19 has been shown to be safer than other cyclodestructive procedures, such as Nd:YAG  
20 laser cyclophotocoagulation and cyclocryotherapy, which present a greater risk of  
21 hypotony and phthisis resulting from excessive ciliary body ablation.<sup>7-9</sup> However, the  
22 outcome of cyclodiode therapy is unpredictable and multiple treatments may be  
23 required to achieve long term intraocular control.<sup>10-11</sup>  
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40 Currently there is no general consensus for an optimum treatment protocol for  
41 cyclodiode. Data for outcomes following cyclodiode laser vary considerably in the  
42 literature.<sup>12</sup> Parameters such as total delivered energy per eye, number of laser  
43 applications per treatment, pulse power, pulse duration and proportion of  
44 circumference treated have been analysed with varying results.<sup>13-17</sup> Furthermore,  
45 cyclodiode therapy has often been reserved for eyes with poor vision due to reports  
46 that it can lead to decrease in visual acuity.<sup>18</sup>  
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3 The purpose of this study was to evaluate the long-term safety and efficacy of a single  
4 episode of transscleral diode laser cyclophotocoagulation for raised intraocular  
5 pressure in patients with good visual potential at a UK tertiary glaucoma referral  
6 centre. **The retrospective nature of the study design reflected the need to analyse  
7 multiple clinical variables and evaluate different types of outcomes as well as  
8 their progression over several years. Additionally, such a study could facilitate  
9 the identification predictive factors for optimal treatment parameters by  
10 investigating the relation of laser energy delivered and degrees treated to the  
11 long-term maintenance in IOP reduction.**  
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### 25 **Methods:**

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27 The departmental electronic medical record system (Medisoft Ophthalmology,  
28 Medisoft Ltd Leeds UK) and operating theatre log books were examined for the  
29 period 09/2004 to 06/2011 to identify patients who had undergone cyclodiode  
30 treatment as a first surgical intervention.  
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39 All patients were assessed for their response to treatment and those who did not  
40 achieve the target IOP reduction were taken as treatment failures. The patients who  
41 required either repeat cyclodiode or alternative treatments for IOP control during the  
42 follow up period were also considered as treatment failures from the time of the  
43 additional surgical intervention. They were not further assessed for maintenance of  
44 post-operative IOP as any additional surgical interventions would interfere with the  
45 interpretation of the IOP maintenance data.  
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3 Cyclophotocoagulation was performed in the Operating Theatre under subtenon,  
4 peribulbar or general anaesthesia using a standard treatment protocol. A lid speculum  
5 was placed to achieve adequate exposure for probe placement all around the limbus  
6 and a squint hook was used to rotate the globe to achieve exposure in those with  
7 narrow palpebral apertures. All treatments were performed using Oculight Sx  
8 semiconductor diode 810nm laser and the contact G Probe™ (IRIS Medical  
9 Instruments, Inc.). Standard settings were 1500ms duration and 1500mW power. The  
10 energy levels were not routinely titrated for ‘pops’ and the power settings were left at  
11 1500mW. Transillumination was performed for ciliary body identification. Usually 10  
12 applications were applied per quadrant for 180 to 360°, with the applications spaced  
13 approximately one-half width of the probe tip apart. The 3 and 9 o’clock positions  
14 were avoided to spare the long ciliary nerves. Postoperative steroid drops were used  
15 for 4 weeks. Glaucoma medications were continued after cyclodiode treatment and  
16 adjusted later as required.  
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36 Success was defined as an intraocular pressure (IOP) of 6–21 mmHg at the last  
37 follow-up visit without the need for oral acetazolamide and an IOP reduction of at  
38 least 30% compared with pre-treatment. Hypotony was defined as an IOP of 5 mmHg  
39 or less. The laser energy used was classified as either low energy (median value 45  
40 +/- 11.47 J, range 22.5-67.5J) or high energy (median value 90 +/- 13.42 J, range  
41 67.5-130J). The follow up period in IOP measurements was 3 years. Visual acuity  
42 (VA) prior to treatment was assessed for all patients using LogMAR scale. Visual  
43 field testing was performed with the Humphrey Visual Field Analyser™ using the  
44 SITA 24-2 threshold programme. Mean deviation of visual field sensitivity loss in  
45 decibels (MD) was taken as our surrogate measure of visual field loss.  
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Data was analysed using Microsoft Excel<sup>TM</sup> and where appropriate a Student's t-test was used to calculate p-values. R<sup>2</sup> values were derived from linear regression analyses using the same programme. Kaplan-Meier 'survival' analysis was done using GraphPad Prism 5.0<sup>TM</sup>. Approval for the audit was granted by the Cambridge University Hospitals NHS Foundation Trust Ethics Committee. The tenets of the Declaration of Helsinki were observed.

## Results:

From our records, we were able to identify 104 patients who underwent cyclodiode therapy as a first surgical treatment modality in the period from 09/2004 to 06/2011 at Addenbrooke's Hospital, Cambridge. Of these, complete medical records were available for 87 patients with follow up data available for up to 3 years. Preoperative patient data is summarised in **Table 1**.

**Table 1.** Baseline demographics and clinical parameters

	Category	Cases (n=87)
Mean age, yrs		66.3
Sex (n (%))	Male	49 (56.3%)
	Female	38 (43.7%)
Preoperative VA, mean		0.57 LogMAR
IOP (mmHg), mean (SD)		39.5 +/- 1.3 mmHg
Mean number of glaucoma medications		2.6
Glaucoma type (n (%))	Primary open angle glaucoma (POAG)	33 (37.9%)
	Primary angle closure glaucoma (PACG)	6 (6.9%)
	Neovascular glaucoma	25 (28.7%)
	Uveitic glaucoma	5 (5.7%)
	Secondary open angle glaucoma (SOAG)- Other	18 (20.8%)

### Change in Intraocular Pressure (Fig.1A)

Mean intraocular pressure (IOP) decreased significantly from 39.5 mmHg (SE 1.26) before cyclodiode therapy to 17.8 mmHg (SE 1.51) at 6 weeks post-treatment, an observable reduction of 45.1 % ( $P < 0.0001$ ). There was a mild linear correlation between preoperative IOP and observed IOP reduction ( $R^2 = 0.32$ ).

### Safety and Efficacy of Cyclodiode Treatment (Fig.1B)

An IOP reduction greater than 30% of initial IOP was achieved at 6 weeks in 67.7 % of the patients, while hypotony occurred in only 5 cases or 5.3% of patients ( $p < 0.05$ ). None of the patients experienced post-treatment uveitis or required further treatment or enucleation for pain symptoms. The data for the patients who developed hypotony such as initial diagnosis, treatment settings, IOP measurements and VA outcome is summarised in **Table 2**.

**Table 2.** Details of hypotony patients

	Diagnosis	Energy used	Degrees treated	Peak IOP (mmHg)	Postop IOP (mmHg)	Hypotony duration	Last IOP (mmHg)	Preop VA (LogMAR)	Last VA (LogMAR)
PT1	Neovascular	90J	180	58	2	6 months	10	0.78	PL
PT2	Neovascular	90J	360	41	4	6 months	32	PL	NPL
PT3	Neovascular	120J	360	40	2	6 months	9	0.6	HM
PT4	SOAG(other)	120J	360	26	3	6 months	8	1.0	CF
PT5	SOAG(other)	120J	360	48	2	-	3	HM	HM

### Long term maintenance of IOP reduction after a single cyclodiode treatment

(Fig.1C)

The IOP reduction was maintained long term over the period of 3 years in the majority of our patients. Measurements were taken pre-operatively (39.5+/-1.3 mmHg) as well as post-operatively at 6 weeks (17.8+/-1.5 mmHg) and 6 months

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3 (19.6±1.5 mmHg) for all patients. Patients who required additional procedures in  
4 that eye post-treatment were excluded from further analysis from the time point of  
5 additional intervention as it would artificially lower their IOP measurements The  
6 follow-up measurements at 1 year (18.9 mmHg), 2 year (22.1 mmHg) and 3 years  
7 (21.7 mmHg) were all after a single cyclodiode treatment.  
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### 10 11 12 **Kaplan-Meier analysis of IOP reduction ‘survival’ following a single cyclodiode** 13 **treatment (Fig.2)** 14

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16 Success was defined as an intraocular pressure (IOP) of 6–21 mmHg at the last follow  
17 up visit without the need for oral acetazolamide and an IOP reduction of at least 30%  
18 compared with preoperatively. The proportion of patients to maintain the desired IOP  
19 reduction after a single cyclodiode treatment without the need for further IOP  
20 lowering intervention in our study was 67.7% at 6 weeks post-operatively, 66.2% at 6  
21 months, 63% at 1 year, 61.2% at 2 years and 61.2% at 3 years. Of the patients who  
22 responded to treatment at 6 weeks, 90.4% were able to maintain the IOP reduction  
23 over a period of 3 years.  
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### 40 41 **Cyclodiode effect on glaucoma medications (Fig.3A)** 42

43 A significant proportion of the patients (61.5%) were able to decrease the number of  
44 medications they are taking for IOP control following cyclodiode. A decrease of 2  
45 medications or more was achieved by 34.6% of patients, while 26.9% of patients  
46 decreased their medication by one. Overall, the average number of medications  
47 decreased from 2.6 before cyclodiode treatment to 1.5 medications after cyclodiode  
48 treatment (P<0.05).  
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**Change in visual acuity (Fig.3B)**

A single episode of cyclodiode treatment had no significant effect on visual acuity (VA). Mean VA measurements changed from 0.5720 Log MAR units before cyclodiode therapy to 0.5408 Log MAR units post treatment, which was not statistically significant ( $P>0.05$ ). The data analysis was performed on 47 patients (54.1%), who had clearly annotated numerical values for their VA measurements both preoperatively and postoperatively. The boxed numerals in the graph represent the number of values at the same point.

**Change in visual fields (Fig.3C)**

The average visual field sensitivity remained almost unchanged with an average MD value of -8.74 dB pre-treatment compared to MD value of -9.05 dB at 6 months post-treatment, which was not statistically significant ( $P>0.05$ ). The data analysis was performed on 36 patients (41.3%), who had clearly annotated numerical values for their visual fields measurements both pre-operatively and post-operatively.

**Effect of laser energy on IOP reduction (Fig.4A)**

Of the patients that received high energy treatment (90J), 80.3% obtained pressure reduction of  $>30\%$  of initial IOP compared with 56.8% in the patients that received low energy treatment (45J).

**Effect of laser energy on visual acuity (Fig.4B)**

Of the patients that received high energy treatment (90J), 18.6% noted improvement of the equivalent of at least 1 Snellen line compared with 6.7% in the patients that received low energy treatment.



**Effect of degrees treated on IOP reduction (Fig.4C)**

Of the patients that underwent 360 degrees treatment, 71.4% obtained pressure reduction greater than 30% of initial IOP compared with 55% of the patients that underwent 180 degree treatment.

**Effect of degrees treated on visual acuity (Fig.4D)**

Of the patients that underwent 360 degrees treatment, 20.9% noted improvement of the equivalent of at least 1 Snellen line compared with 5.5% of the patients underwent 180 degree treatment.

**Discussion:**

The results of this retrospective analysis are supportive of a single cyclodiode treatment being effective in management of refractory glaucoma. Although this is a retrospective rather than a prospective study, we aimed to avoid selection bias by including all patients either as success or failure of treatment. The patients who required additional surgical interventions were taken as failure from the time of additional intervention.

Our data show that 67.7% of the patients achieved an IOP reduction greater than 30% of presenting IOP at 6 weeks and 61.5% could reduce the number of medications by at least 1. Hypotony appears to be related to the type of glaucoma (with neovascular glaucoma associated with worse outcome) as well as to the number of degrees treated and total energy used. Indeed, the patients with neovascular glaucoma in our cohort

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3 were almost 4 times more likely to develop hypotony compared to any other types of  
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5 glaucoma.  
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10 In our patients, the mean intraocular pressure (IOP) decreased significantly from 39.5  
11 mmHg (SE 1.26) before cyclodiode therapy to 17.8 mmHg (SE 1.51) at 6 weeks post-  
12 treatment, an observable reduction of 45.1 % (P<0.05). The results of the linear  
13 regression analysis indicate that there might be some predictive value in determining  
14 IOP reduction based on initial IOP measurements such as the greatest reduction in  
15 IOP is likely to be seen in patients with the highest IOP at the time of treatment ( $R^2 =$   
16 0.32). A similar relationship was reported by Vernon et al., where eyes with IOP  
17 greater than 30 mmHg were more likely to exhibit a pressure drop greater than 30%  
18 of initial IOP.<sup>19</sup>  
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32 The IOP reduction was maintained long term in 61.2% of all patients in our study  
33 after a single cyclodiode treatment. Of the patients who responded to treatment at 6  
34 weeks, 90.4% were able to maintain the IOP reduction over a period of 3 years.  
35 Similar sustainability of the mean IOP reduction postoperatively is also reported by  
36 Bloom et al. and Kosoko et al., although in both these studies the follow up was  
37 considerably shorter, the average time being less than 2 years.<sup>18,20</sup> The results from  
38 our patient cohort suggest that a single session of cyclodiode therapy could potentially  
39 be a viable initial treatment modality for maintaining a longer term IOP control in  
40 patients with refractory glaucoma.  
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54 In our study, of the patients that received high energy treatment (90J), 80.3% obtained  
55 an IOP reduction of greater than 30% of the initial IOP compared with 56.8% in the  
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3 patients receiving low energy treatment (45J). This is consistent with a meta-analysis  
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5 by Iliev et al., where comparing different laser protocols from different studies  
6  
7 suggested that the use of a low energy protocol potentially could result in the lowest  
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9 IOP reduction, the highest postoperative IOP and the highest retreatment rate  
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11 overall.<sup>17</sup> We also observed similar relationship when patients were assessed in regard  
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13 to the degrees treated rather than energy used. Here, of the patients that underwent  
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15 360 degrees treatment, 71.4% obtained pressure reduction greater than 30% of initial  
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17 IOP compared with 55% of the patients that underwent 180 degrees treatment.  
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22 Hypotony was the most common long-term complication in our study (5.3%), which  
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24 is in accordance with other published reports.<sup>14</sup> In our cohort, the incidence of  
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26 hypotony was much more likely with an eye with neovascular glaucoma (**Table 2**).  
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28 Murphy et al. also found a higher risk of hypotony in eyes with neovascular  
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30 glaucoma, particularly if preoperative IOP was high and energy level used was  
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32 greater.<sup>14</sup> This correlation between hypotony and higher energy used in cyclodiode is  
33  
34 also observed in several other studies.<sup>12</sup> However, univariate regression analysis done  
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36 by Murphy et al. shows that very high pre-treatment IOP alone, possibly causing  
37  
38 ciliary body ischaemia, could be responsible for the high incidence of hypotony in the  
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40 patients receiving high-energy treatment in their study.<sup>14</sup>  
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47 Additionally, in a retrospective analysis of 209 eyes by Bloom et al., a very low  
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49 incidence of hypotony (1%) was observed with a high energy protocol when the mean  
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51 energy used was 90J.<sup>18</sup> Furthermore, Iliev et al. report in their study that eyes  
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53 developing hypotony had not received higher energies compared with eyes that  
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55 maintained normal IOP.<sup>17</sup> Therefore, the intention to reduce hypotony risk by using a  
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3 lower laser power and fewer applications per treatment should be weighed against the  
4 possibility for a lower efficacy of the cyclodiode treatment.  
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10 Visual acuity (VA) remained unchanged for the majority of our patients who  
11 underwent cyclodiode treatment (69.9%). In our study 16.4% reported deterioration in  
12 VA of 1 Snellen line, while 13.7% of the patients reported an improvement in VA of  
13 1 Snellen line after 6 weeks. The latter probably resulted either from resolution of  
14 preoperative corneal oedema or inter-observer variation in visual acuity testing.  
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16 Similar results are also reported in a study by Murphy et al., where the VA remained  
17 the same in 74.6% of the patients at 6 months following cyclodiode treatment.<sup>14</sup> In  
18 our study most patients with difficult to manage glaucoma retained their good VA in  
19 the long-term following cyclodiode treatment. The proportion losing two Snellen lines  
20 is actually better than that reported after trabeculectomy or tube surgery.<sup>21</sup> These  
21 results suggest a possible role for the use of transscleral cyclodiode treatment in eyes  
22 with relatively good visual potential, however, further controlled prospective studies  
23 would be required to better define this role.  
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40 This study is the first to measure the mean deviation (MD) values for the patients both  
41 pre-operatively and post-operatively in order to provide a more objective assessment  
42 of glaucoma related visual loss. The MD values in our patients remained virtually  
43 unchanged after cyclodiode treatment from -8.74dB preoperatively to -9.05 dB  
44 postoperatively. Previously it has been reported that the most frequent cause of visual  
45 loss was further progression of glaucoma, which was an attributable cause in over half  
46 of the cases.<sup>22</sup> The peri-operative visual field assessment presented in this study  
47 suggests that the maintenance of VA observed in the majority of the patients  
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3 following cyclodiode treatment could be due to a good postoperative IOP control.  
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5 There are no previous retrospective or prospective studies evaluating visual field  
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7 measurements peri-operatively in patients undergoing cyclodiode treatment and this  
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9 most likely reflects the difficulties associated with performing the tests in patients  
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11 with poor VA. Our study therefore is the first to provide a standardised measurable  
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13 evidence of maintenance of patients' visual fields as a marker of glaucoma  
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15 progression following a single cyclodiode treatment. Our study's main limitations are  
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17 its retrospective nature and the absence of a control group to distinguish the adverse  
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19 effects of the treatment from the natural history of the underlying disease.  
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26 The results of this study suggest that the IOP reduction after cyclodiode treatment  
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28 could potentially prevent further deterioration in the glaucoma patients' vision.  
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30 Currently, according to the UK National Cyclodiode Survey Study only 60% of  
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32 practitioners would perform cyclodiode procedure in the presence of good visual  
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34 acuity.<sup>12</sup> Until recently, cyclodiode treatment has been associated with subsequent  
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36 loss of VA in significant percentage of the patients.<sup>18,23,24</sup> However, cyclodiode use in  
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38 eyes with useful vision has already been proposed in several studies.<sup>19,22-25</sup>  
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40 Furthermore, the risk of VA loss in patients after multiple cyclodiode treatments does  
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42 not appear to be any greater than that after any other surgical modality used for  
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44 treating patients with glaucoma as reported in a study by Rotchford et al.<sup>24</sup>  
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50 In our study, the better outcome in visual acuity was most pronounced in the high  
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52 energy group, probably due to the more effective IOP control. Of the patients that  
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54 received high energy treatment (90J), 18.6% noted improvement of at least 1 Snellen  
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56 line compared with 6.7% in the patients that received low energy treatment (45J).  
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3 Similar results are observed when patients were assessed in regard to the degrees  
4 treated. Here, of the patients that underwent 360 degrees treatment, 20.9% noted  
5 improvement of the equivalent of at least 1 Snellen line compared with 5.5% of the  
6 patients underwent 180 degrees treatment.  
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14 **In conclusion, conventional diode cyclophotocoagulation is characterised by low**  
15 **incidence of complications and therefore appears to be a safe and effective**  
16 **treatment for refractory glaucoma. In our study the IOP pressure was effectively**  
17 **reduced in glaucoma patients after a single cyclodiode treatment without adverse**  
18 **effects on VA in the majority of the patients over a 3 year period. Hypotony**  
19 **seems to be the main risk of treatment and could be limited by reducing the laser**  
20 **energy applied to less than 90J, particularly in the patients with neovascular**  
21 **glaucoma.**  
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#### 34 **Figure and Table Legends**

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37 **Figure 1 (A)** Change in Intraocular Pressure following a single Cyclodiode treatment  
38 **(B)** Safety and Efficacy of Cyclodiode Treatment **(C)** IOP reduction was maintained  
39 long-term over the period of 3 years after single treatment  
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46 **Figure 2** Kaplan-Meier analysis for cumulative proportion of success in IOP control  
47 after a single Cyclodiode treatment. Survival was defined as sustained IOP drop of at  
48 least 30% compared with pre-treatment or sustained intraocular pressure (IOP) of 6–  
49 21 mmHg without the need for additional IOP lowering medications or further  
50 surgical interventions.  
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3 **Figure 3 (A)** Cyclodiode effect on antiglaucoma medications **(B)** Preoperative and  
4 postoperative visual acuity measurements in LogMAR units after a single Cyclodiode  
5 treatment **(C)** Preoperative and postoperative visual field loss taken from MD values  
6 (dB) on the HVF analyser after a single Cyclodiode treatment  
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14 **Figure 4 (A)** Effect of laser energy on IOP reduction **(B)** Effect of laser energy on  
15 visual acuity (VA) **(C)** Effect of degrees treated on IOP reduction **(D)** Effect of  
16 degrees treated on visual acuity (VA)  
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23 **Table 1** Baseline demographics of the patients and clinical parameters including  
24 diagnostic features, pre-operative IOP and visual acuity assessments.  
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30 **Table 2** Details of the patients who developed hypotony including diagnostic and  
31 treatment features, peri-operative IOP assessments and duration of hypotony  
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## References

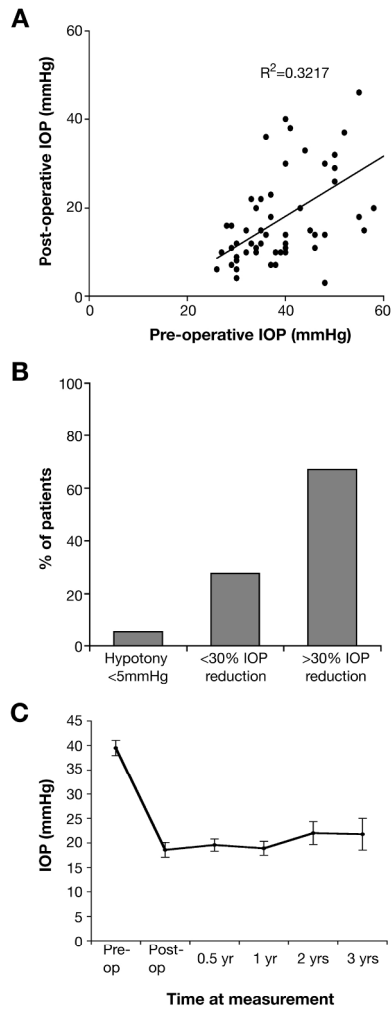
1. Hennis HL, Stewart WC. Semiconductor diode laser transscleral cyclophotocoagulation in patients with glaucoma. *Am J Ophthalmol* 1992;**113**:81–5.
2. Hawkins TA, Stewart WC. One-year results of semiconductor transscleral cyclophotocoagulation in patients with glaucoma. *Arch Ophthalmol* 1993;**111**:488–91.
3. Brancato R, Carassa RG, Bettin P. Contact transscleral cyclophotocoagulation with diode laser in refractory glaucoma. *Eur J Ophthalmol* 1995;**5**:32–9.
4. Threlkeld AB, Johnson MH. Contact transscleral diode cyclophotocoagulation for refractory glaucoma. *J Glaucoma* 1999;**8**:3–7.
5. Egbert PR, Fiadoyor S, Budenz DL. Diode laser transscleral cyclophotocoagulation as a primary surgical treatment for primary open angle glaucoma. *Arch Ophthalmol* 2001;**119**:345–50.

- 1  
2  
3 6.Mistlberger A, Liebmann JM, Tschiderer H. Diode laser transscleral  
4 cyclophotocoagulation for refractory glaucoma. *J Glaucoma* 2001;**10**:288–93.
- 5  
6  
7 7. Benson MT, Nelson ME. Cyclocryotherapy: a review of cases over a 10-year  
8 period. *Br J Ophthalmol* 1990;**74**:103–5.
- 9  
10  
11 8.Schuman JS, Bellows AR, Shingleton BJ. Contact transscleral Nd:YAG laser  
12 cyclophotocoagulation. *Ophthalmology* 1992;**99**:1089–94.
- 13  
14  
15 9. Ulbig MW, McHugh DA, McNaught AI. Clinical comparison of semiconductor  
16 diode versus neodymium:YAG non-contact cyclophotocoagulation. *Br J Ophthalmol*  
17 1995;**79**:569–74.
- 18  
19  
20 10. Pucci V, Tappainer F, Borin S. et al Longterm follow up after transscleral diode  
21 laser photocoagulation in refractory glaucoma. *Ophthalmologica* 2003; **217**:279–283.
- 22  
23  
24 11. Grueb M, Rohrbach J M, Bartz-Schmidt K U. et al Transscleral diode laser  
25 cyclophotocoagulation as primary and secondary surgical treatment in primary open  
26 angle and pseudoexfoliative glaucoma: Long term clinical outcomes. *Graefes Arch  
27 Clin Exp Ophthalmol* 2006; **244**:1293–1299.
- 28  
29  
30 12. P Agrawal, S Dulku, W Nolan and V Sung. The UK National Cyclodiode Laser  
31 Survey. *Eye* 2011; **25**:168–173
- 32  
33  
34 13. Walland MJ. Diode laser cyclophotocoagulation: longer term follow up of a  
35 standardized treatment protocol. *Clin Exp Ophthalmol* 2000; **28**:263–7.
- 36  
37  
38 14. Murphy CC, Burnett CAM, Spry PDG, Broadway DC, Diamond JP. A two centre  
39 study of the dose-response relation for transscleral diode laser cyclophotocoagulation  
40 in refractory glaucoma. *Br J Ophthalmol* 2003; **87**:1252–1257
- 41  
42  
43 15. Chang SH, Chen YC, Li CY. Contact diode laser transscleral  
44 cyclophotocoagulation for refractory glaucoma: comparison of two treatment  
45 protocols. *Can J Ophthalmol* 2004; **39**:511–6.
- 46  
47  
48 16. Nouredin BN, Zein W, Haddad C. Diode laser transcleral cyclophotocoagulation  
49 for refractory glaucoma: a 1 year follow-up of patients treated using an aggressive  
50 protocol. *Eye* 2006; **20**:329–35.
- 51  
52  
53 17.Iliev ME, Gerber S. Long-term outcome of trans-scleral diode laser  
54 cyclophotocoagulation in refractory glaucoma. *Br J Ophthalmol* 2007; **91**:1631–1635.
- 55  
56  
57 18. Bloom PA, Tsai JC, Sharma K, Miller MH, Rice NS, Hitchings RA. Cyclodiode  
58 trans-scleral diode laser cyclophotocoagulation in the treatment of advanced  
59 refractory glaucoma. *Ophthalmology* 1997; **104**:1508–1520.
- 60  
61  
62 19. Vernon SA, Koppens JM, Menon GJ, Negi AK. Diode laser cycloablation in adult  
63 glaucoma:long-term results of a standard protocol and review of current literature.  
64 *Clin Exp Ophthalmol* 2006; **34**:411-20.



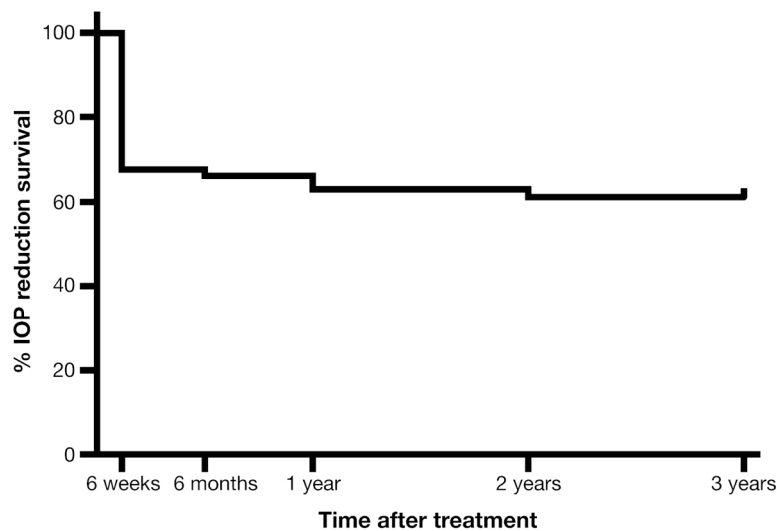
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2  
3 20. Kosoko O, Gaasterland DE, Pollack IP. Long-term outcome of initial ciliary  
4 ablation with contact diode laser transscleral cyclophotocoagulation for severe  
5 glaucoma. The diode laser ciliary ablation study group. *Ophthalmology* 1996;  
6 **103**:1294–302.  
7  
8  
9 21. Gedde SJ, Schiffman JC, Feuer WJ, Herndon LW, Brandt JD, Budenz DL.  
10 Treatment outcomes in the tube versus trabeculectomy study after one year of follow-  
11 up. *Am J Ophthalmol* 2007; **143**(1):9-22.  
12  
13 22. Rotchford AP, Jayasawal R, Madhusudhan S, Ho S, King AJ, Vernon SA.  
14 Transscleral diode laser cycloablation in patients with good vision *Br J Ophthalmol*  
15 2010; **94**:1180-1183  
16  
17 23. Youn J, Cox TA, Allingham RR. Factors associated with visual acuity loss after  
18 noncontact transscleral Nd:YAG cyclophotocoagulation. *J Glaucoma* 1996; **5**:390-94.  
19  
20 24. Wilensky JT, Kammer J. Long-term visual outcome of transscleral laser  
21 cyclotherapy in eyes with ambulatory vision. *Ophthalmology* 2004; **111**:1389-92.  
22  
23 25. Ansari E, Gandhewar J. Long-term efficacy and visual acuity following  
24 transscleral diode laser photocoagulation in cases of refractory and non-refractory  
25 glaucoma. *Eye* 2007; **21**:936-40.  
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**Figure 1**

Figure 1 (A) Change in Intraocular Pressure following a single Cyclodiode treatment (B) Safety and Efficacy of Cyclodiode Treatment (C) IOP reduction was maintained long-term over the period of 3 years after single treatment  
135x262mm (300 x 300 DPI)

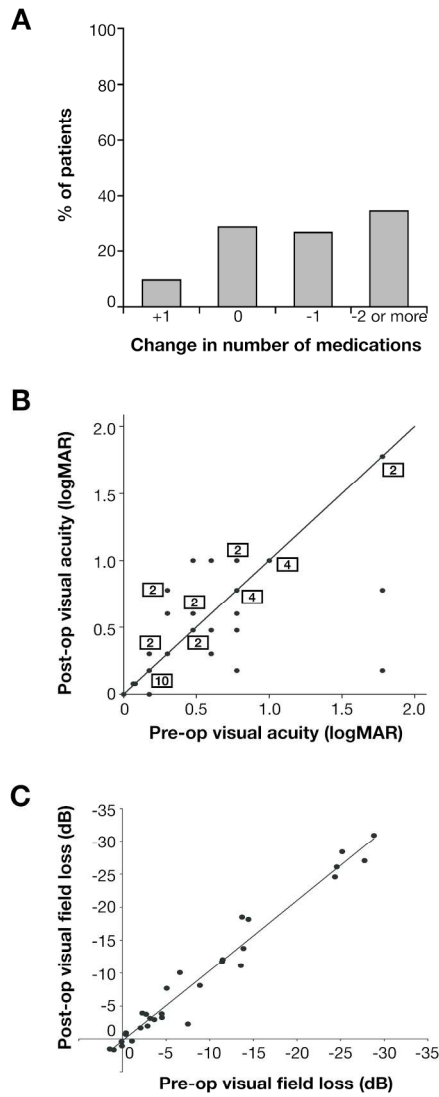


**Figure 2**

Figure 2 Kaplan-Meier analysis for cumulative proportion of success in IOP control after a single Cyclodiode treatment. Survival was defined as sustained IOP drop of at least 30% compared with pre-treatment or sustained intraocular pressure (IOP) of 6–21 mmHg without the need for additional IOP lowering medications or further surgical interventions.  
157x184mm (300 x 300 DPI)

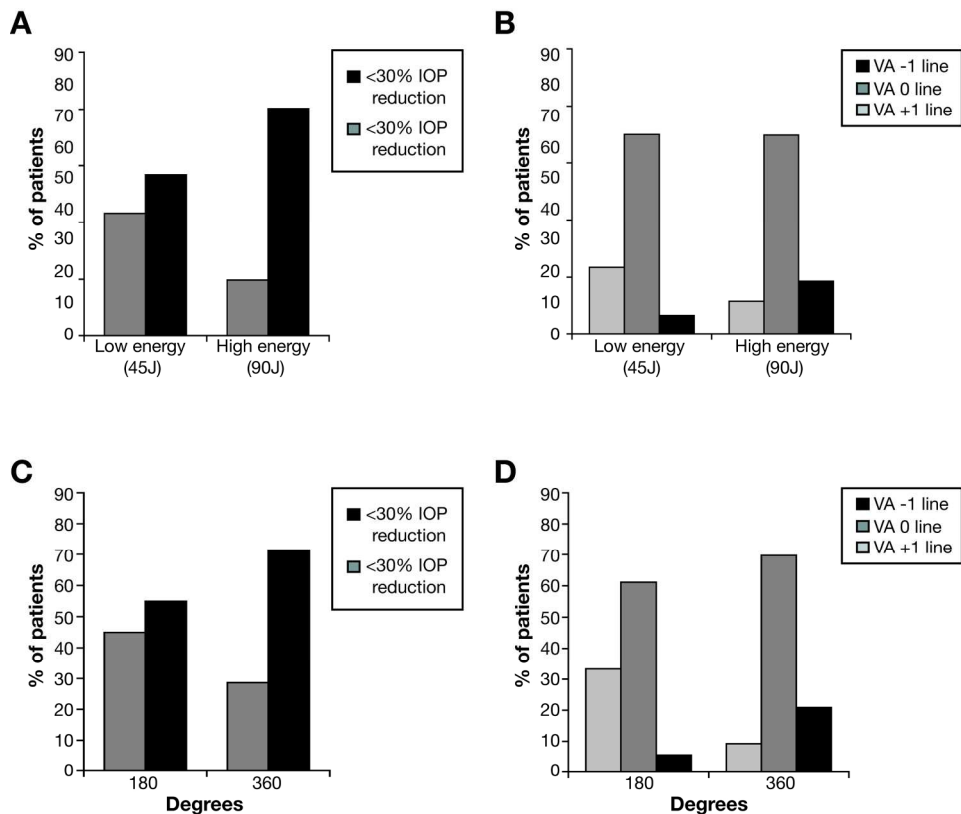
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**Figure 3**

Figure 3 (A) Cyclodiode effect on antiglaucoma medications (B) Preoperative and postoperative visual acuity measurements in LogMAR units after a single Cyclodiode treatment (C) Preoperative and postoperative visual field loss taken from MD values (dB) on the HVF analyser after a single Cyclodiode treatment 171x234mm (300 x 300 DPI)



**Figure 4**

Figure 4 (A) Effect of laser energy on IOP reduction (B) Effect of laser energy on visual acuity (VA) (C) Effect of degrees treated on IOP reduction (D) Effect of degrees treated on visual acuity (VA)  
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