OMNI IN A REAL-WORLD CLINICAL SETTING

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Our practice is a collaborative optometry and ophthalmology referral-based clinic with a specific focus on ambulatory surgical procedures. We treat many patients with various stages of glaucoma who also need cataract surgery. In all cases, patient education is our first line of treatment.

CASCADE OF EVENTS CAUSED BY PROSTAGLANDINS

When we speak with our glaucoma patients who need cataract surgery, we discuss different treatment pathways available to them based on the severity of both pathologies. We discuss prescription eye drops, laser surgery, and traditional surgical intervention to manage their IOP. Even before MIGS, our practice was using endoscopic cyclophotocoagulation combined with cataract surgery. When stenting procedures came along and truly defined MIGS, we started using this technology.

When the OMNI Surgical System (Sight Sciences) was introduced, it ushered in a new era, allowing us to address all three potential points of resistance within the conventional outflow pathway and to safely and effectively combine cataract surgery with an IOP-lowering procedure without having to place a stent in the trabecular meshwork (Figure). This technology not only gave us the ability to effectively lower IOP with a titratable procedure at the time of cataract surgery but also to effectively lower IOP in pseudophakes and other standalone cases as well.

We know that anytime we can reduce dependence on IOP-lowering drops, the better it is for the patient. Compliance is a significant obstacle in successfully treating patients with glaucoma. Additionally, the medications are costly to the patient, and we know that most, if not all, topical drops can exacerbate ocular surface disease. This is a tremendous issue. These are cascading events that lead to poor treatment quality and quality of life for the patient. If we can remove these factors from the treatment decision tree, then we have a significantly higher chance of treating these patients successfully. This is a substantial benefit of using the OMNI.

PATIENT SELECTION AND EDUCATION

When patients hear there is a strong chance of reducing or completely removing their dependency on prescription eye drops to control IOP, they are elated.

We start educating patients as early as possible. Any of our cataract patients that are ocular hypertensive or previously treated with laser, as well as glaucoma patients that are currently being treated with medicated eye drops, are great candidates for the OMNI procedure. Additionally, pseudophakic patients experiencing compliance issues with drops are also strong candidates. This group of patients now have a safe, effective procedure option before making the jump to a higher risk, labor-intensive filtering procedure.

Key communication points we relay to our patients about OMNI are simple. We explain that we can take an extra minute or 2 while already in the OR for cataract surgery to address their glaucoma and then explain how OMNI works. In the instance of a pseudophakic patient or a standalone case, we explain the procedure is similar to having cataract surgery.

OMNI POSTOPERATIVE & OUTCOMES

Once the OMNI procedure is complete, the postoperative examinations aren't much different than what you would do for a standard cataract postoperative visit. Our follow-up intervals are typically 1 day and 1 week. Depending on the results after week 1, we will follow up at week 3 or 1 month. For optometrists conducting postoperative examinations, managing OMNI patients is very straightforward. You want to focus on a safe regimen of taking patients off IOP-lowering drops, monitor for pressure spikes, and take note of any inflammation or hyphema.

After surgery, we prescribe a topical steroid to be used for approximately 1 month. This helps mitigate any inflammation or scarring in the angle. Depending on their past treatment for pressure, I typically continue the IOP-lowering drops until the patient is tapered off the topical steroid, in case of a steroid response or pressure spike. Hyphema is not an issue we've experienced in our patients. I typically describe this condition as a micro-hyphema and do not conduct any additional postoperative treatments. In my experience with OMNI, any micro-hyphema usually resolves within the first week.

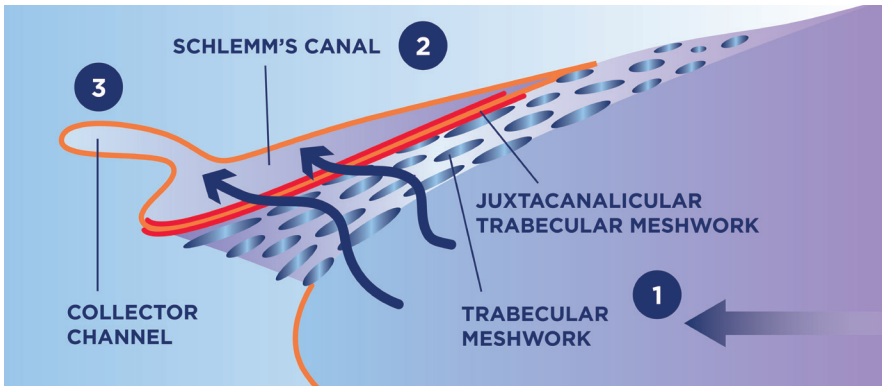

Figure. The OMNI allows surgeons to address all three potential points of resistance within the conventional outflow pathway.

DEMONSTRATIVE ADVANTAGES IN A CLINICAL SETTING

In our practice, we've utilized the OMNI Surgical System with many of our glaucoma patients. To demonstrate the advantages this technology offers, one particular case stands out. A longtime patient of ours initially presented with elevated IOP in the presence of nerve fiber layer and optic nerve changes, as well as a positive family history. His untreated IOP ranged from 26 to 28 mm Hg. He was 59 years old at the time of diagnosis and underwent selective laser trabeculoplasty (SLT) as his initial treatment, controlling his pressure well for many years. When he became a patient, IOP-lowering drops and SLT were the standard of care for his severity of glaucoma. Over 7 years and two SLT procedures, our patient's IOP needed better control, so he was prescribed prostaglandin drops, which stabilized his pressure. For a few years his pressure was stable as long as he remained compliant with his medications. In time, his pressure began to rise again, and additional drops were prescribed to reach our target IOP.

Last year, the patient presented with slightly elevated IOP, while taking both a beta-blocker/carbonic anhydrase inhibitor combination along with his prostaglandin analogue. Now, at age 71, his visual acuity has begun to decrease along with his advancing cataract changes. In discussing his treatment options, I educated him about our experience with OMNI, and the patient decided to proceed with the phacoemulsification procedure combined with OMNI.

At the same time as inserting a toric IOL, we conducted an ab interno 360° canal viscodilation and a 180° trabeculotomy with OMNI targeting all three potential points of resistance in the conventional outflow pathway. Postoperatively, we decided to discontinue the use of his IOP-lowering medication but prescribed a topical steroid to address any inflammation or pressure spikes. After being off all IOP-lowering medications for 1 week, the patient's pressure was 27 mm Hg. From this point, I decided to put him back on only one medication to reach our target IOP goal. This is a reduction of two medicines, and we continue to maintain his target IOP. During his most recent visit, his pressure was controlled at 14 mm Hg, which is where we want it. The patient was thrilled to reduce his drops from three to one, and with his new premium IOL, he is very happy.

CONCLUSION

The arrival of the OMNI Surgical System represents an exciting time in the treatment of glaucoma for patients. Being able to offer patients an effective, ab interno approach to lower IOP and reduce or eliminate dependency on drops adds tremendous value to our practice. Also, optometrists who are given therapeutic privileges to address glaucoma can now consider MIGS as an option. Having the opportunity to discuss OMNI with patients adds a safe and effective treatment option in the decision tree and surgical paradigm. ■

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