CyPass Micro-Stent
Charting the New Course for MIGS

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MIGS: A NEW ERA IN GLAUCOMA SURGERY

Microinvasive glaucoma surgery (MIGS) is ushering in a new era in glaucoma surgery. These devices are designed to effectively lower IOP, avoid a filtration bleb, and be implanted in conjunction with cataract surgery.

The CyPass Micro-Stent from Alcon (Figure) represents the next wave of innovation in the MIGS implant category. Its intuitive, straightforward implantation procedure, coupled with the positive results from the COMPASS pivotal trial, means the CyPass Micro-Stent is positioned to provide a valuable new treatment option for patients undergoing cataract surgery who suffer from mild to moderate open-angle glaucoma.

The CyPass Micro-Stent is placed in the supraciliary space to take advantage of the uveoscleral outflow and avoid the trabecular meshwork and Schlemm’s canal. The supraciliary space provides a viable outflow pathway that is based on a negative pressure gradient compared to the anterior chamber. Its ab interno approach allows for surgery that spares the conjunctiva, which means future filtration surgery (if needed) can remain an option for patients.

As you will read in these pages, the data from the COMPASS pivotal trial show the CyPass Micro-Stent can significantly lower and stabilize IOP while providing an alternative surgical option to conventional glaucoma surgery. It is an exciting time to be an anterior segment surgeon, and MIGS is driving that excitement for cataract and glaucoma surgeons alike.

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CHARTING THE NEW COURSE FOR MIGS

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CyPass® Micro-Stent — the next wave in micro-invasive glaucoma surgery.

Get on board today.

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CHARTING THE NEW COURSE FOR MIGS
SEE WHAT'S ON THE HORIZON

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CyPass® Micro-Stent
IMPORT TANT PRODUCT INFORMATION

CAUTION: FEDERAL (USA) LAW RESTRICTS THIS DEVICE TO SALE BY OR ON THE ORDER OF A PHYSICIAN.

INDICATION: The CyPass Micro-Stent is indicated for use in conjunction with cataract surgery for the reduction of intraocular pressure (IOP) in adult patients with mild to moderate primary open-angle glaucoma (POAG).

CONTRAINDICATIONS: Use of the CyPass Micro-Stent is contraindicated in the following circumstances or conditions: (1) in eyes with angle-closure glaucoma; and (2) in eyes with traumatic, malignant, uveitic, or neovascular glaucoma or discernible congenital anomalies of the anterior chamber angle.

MRI INFORMATION: The CyPass Micro-Stent is magnetic resonance (MR) Safe: the implant is constructed of polyimide material, a non-conducting, non-metallic, non-magnetic polymer that poses no known hazards in all magnetic resonance imaging environments.

WARNINGS: Gonioscopy should be performed prior to surgery to exclude peripheral anterior synechiae (PAS), rubeosis, and other angle abnormalities or conditions that would prohibit adequate visualization of the angle that could lead to improper placement of the stent and pose a hazard.

PRECAUTIONS: The surgeon should monitor the patient postoperatively for proper maintenance of intraocular pressure. The safety and effectiveness of the CyPass Micro-Stent has not been established as an alternative to the primary treatment of glaucoma with medications, in patients 21 years or younger, in eyes with significant prior trauma, chronic inflammation, eyes with an abnormal anterior segment, eyes with chronic inflammation, eyes with glaucoma associated with vascular disorders, pseudophakic eyes with glaucoma, eyes with uveitic glaucoma, eyes with pseudoexfoliative or pigmentary glaucoma, eyes with other secondary open-angle glaucomas, eyes that have undergone prior incisional glaucoma surgery or cilioablati ve procedures, eyes with laser trabeculoplasty performed ≤ 3 months prior to the surgical screening visit, eyes with unmedicated IOP less than 21 mmHg or greater than 33 mmHg, eyes with medicated IOP greater than 25 mmHg, in the setting of complicated cataract surgery with iatrogenic injury to the anterior or posterior segment, and when implantation is without concomitant cataract surgery with IOL implantation for visually significant cataract. The safety and effectiveness of use of more than a single CyPass Micro-Stent has not been established.

ADVERSE EVENTS: In a randomized, multicenter clinical trial comparing cataract surgery with the CyPass Micro-Stent to cataract surgery alone, the most common postoperative adverse events included: BCVA loss of 10 or more letters at 3 months after surgery (8.8% for the CyPass Micro-Stent vs. 15.3% for cataract surgery only); anterior chamber cell and flare requiring steroid treatment 30 or more days after surgery (8.6% vs. 3.8%); worsening of visual field mean deviation by 2.5 or more decibels (6.7% vs. 9.9%); IOP increase of 10 or more mmHg 30 or more days after surgery (4.3% vs. 2.3%); and corneal edema 30 or more days after surgery, or severe in nature (3.5% vs. 1.5%).

ATTENTION: PLEASE REFER TO THE INSTRUCTIONS FOR A COMPLETE LIST OF CONTRAINDICATIONS, WARNINGS, PRECAUTIONS, AND ADVERSE EVENTS.
WHY MIGS MATTERS

During the past few years, there has been a changing paradigm in how we handle our patients with combined cataract and glaucoma.

BY NATHAN RADCLIFFE, MD

As our aging population puts more demand on limited resources, it makes sense for several reasons that more ophthalmic surgical procedures are going to be combined. First, almost one-fifth of patients undergoing cataract surgery also have a diagnosis of mild to moderate glaucoma.1 As treating physicians we often worry that our older patients will have trouble with adherence to glaucoma medication regimens, especially when the number of medications increases. Perhaps, more importantly, many patients on topical glaucoma medications continue to have disease progression, and go on to require traditional incision surgery.

During the past few years, there has been a changing paradigm in how we handle our patients with combined cataract and glaucoma. In the past, anterior segment surgeons would almost exclusively perform cataract surgery as a standalone procedure (and upon rare occasions combine phacoemulsification with trabeculectomy for those with advanced glaucoma), and we know phacoemulsification alone can reduce IOP.2 Now we have begun revisiting the issue as a direct result of newer glaucoma devices. We have seen a dramatic increase in the number of combination surgeries with these microinvasive glaucoma surgery (MIGS) devices, especially since the data show these MIGS devices to be generally safe. I am particularly enthusiastic about these devices as we now have a relatively simple surgical means to address mild to moderate glaucoma that brings with it a substantial IOP-lowering effect.

For this discussion, I define mild to moderate glaucoma as including optic nerve damage coupled with the IOP and a number of topical medications. Delineating these patients can be difficult. Some patients have reasonably advanced nerve findings, but fairly low pressures that can be managed with only one drop; I would classify this group as having moderate glaucoma. Another patient may be on three topical medications but still have a healthy optic nerve, and some of us would consider that patient to have only early or mild glaucoma. These are all patients who could benefit from a MIGS procedure.

ADDING MIGS INTO PRACTICE PATTERNS

In the United States, we have had access commercially to MIGS devices since 2012, and in my view, that has created a rapid, dramatic, and positive evolution in glaucoma surgery safety. Across the United States, cataract and glaucoma surgeons have become adept at angle surgery, opening up many new treatment options for glaucoma patients with cataracts.

This new era of angle surgeries has evolved to include many types of incisional trabecular excision, revision, and bypass—including goniotomy, ab interno trabeculotomy, and viscocanalostomy. These additional options have allowed a new generation of angle surgeons to operate on patients with different diagnoses, indications, and health care insurers—regardless of the patient’s lens status.

With greater experience in angle surgery, we have also seen the limitations of the microbypass trabecular approach. We have begun to hypothesize that patients who have had glaucoma for a long time may have distal outflow pathway disease or atrophy that limits the benefit of removing resistance at the level of the meshwork. To summarize, the first 5 years of the MIGS era, we have rapidly gained new tools and techniques to safely perform glaucoma surgery, but at the same time have struggled with the limitations of this approach.

With the arrival of CyPass Micro-Stent from Alcon (Figure), a much-needed new outflow option has arrived—
this device is designed to provide the maximum uveoscleral outflow into the supraciliary space. Implantation leverages the same primary incision as phacoemulsification surgery. In my opinion, the CyPass Micro-Stent is an ideal option for mild to moderate primary open-angle glaucoma patients. Finally, it is possible that the CyPass Micro-Stent will allow for more future surgical combination options that we have yet to conceive.

**DIFFERENTIATING THE MIGS DEVICES**

The trabecular microbypass device is designed to enhance outflow through Schlemm’s canal and the collector channels. What we have learned is that some of its success is dependent upon the patient having intact traditional outflow. It is possible this device can be effective in patients who have lost some of that outflow during the course of their disease. One of my frustrations with using this approach or others like it that aim to improve the trabecular outflow is that we, as clinicians, are unable to differentiate which of our patients has an intact flow system from those who do not. It has been trial by error, so to speak. While these devices will not damage the optic nerve or cause the disease to progress if they are ineffective, they will not address the patient’s IOP.

The CyPass Micro-Stent is the first MIGS device to leverage an entirely new outflow pathway. The ab interno approach is not trying to fix something that has been deemed broken, like the trabecular outflow pathway. Instead, this device takes the aqueous to sneak it through a new door—the supraciliary space. It has been suggested that the negative pressure gradient between the suprachoroidal space and the anterior chamber may be a desirable avenue to direct aqueous. Others have shown clinically that using the uveoscleral route can result in substantial IOP reduction, and some currently available topical therapies are designed to increase uveoscleral outflow.

**CYPASS IMPLANTATION**

I have found there to be a relatively short learning curve with the CyPass Micro-Stent implantation procedure. Using a gonio lens, the ophthalmologist inserts the CyPass Micro-Stent into the anterior chamber through the same incisions as were used for the phaco portion of the surgery. Placement of the device is guided by the eye’s anatomy; it will be inserted into the supraciliary space.

In my opinion, this will become a go-to recommended procedure for patients with concurrent cataract and mild to moderate glaucoma. I look forward to using this device for years to come.

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INCORPORATING MIGS INTO COMPREHENSIVE OPHTHALMIC CARE

MIGS devices were developed to address the gap between topical medications and conventional glaucoma surgery.

BY STEVEN D. VOLD, MD

As many as one-fifth of the people undergoing cataract surgery are likely to have concomitant glaucoma, but combining glaucoma and cataract surgery is often an overlooked means to streamline patient care because of the risks associated with conventional glaucoma surgery.

Microinvasive glaucoma surgery (MIGS) devices were developed to address the gap between topical medications and conventional glaucoma surgery, with the hope that efficacy would approach that of trabeculectomy or shunts but without the major complications associated with those more invasive glaucoma surgical procedures.

I believe that in today’s environment, comprehensive ophthalmologists giving the best care to their patients need to incorporate MIGS devices into their surgical strategies. I found the CyPass Micro-Stent from Alcon (Figure) an extremely valuable device because it is intuitive to implant and because the data behind its approval are overwhelmingly positive.

The CyPass Micro-Stent is a fenestrated microstent made of biocompatible polyimide material that measures 6.35 mm long, with 300-μm and 510-μm internal and external diameters. This MIGS device is designed to increase aqueous outflow from the anterior chamber into the supraciliary space via the uveoscleral pathway.

With the CyPass Micro-Stent procedure, surgeons are performing blebless surgery, eliminating any potential for bleb-related complications down the road. The CyPass Micro-Stent takes advantage of uveoscleral outflow, much like topical prostaglandins do. Leveraging this outflow pathway is one of the greatest advantages of this device compared with other MIGS devices.

Devices designed for trabecular bypass have access to more limited “real estate” versus those designed for implantation into the supraciliary space. As glaucoma progresses, it remains unknown how functional the distal collector channels remain and if they will remain open over the long term.

COMPASS STUDY DETAILS

The COMPASS trial was a pivotal, multicenter, randomized clinical trial conducted to support US Food and Drug Administration approval of supraciliary microstenting for the surgical treatment of primary open-angle glaucoma. There were a total of 505 eyes enrolled in a 3:1 ratio to the CyPass (n = 374) or phacoemulsification alone (n = 131; the control group) and all eyes were followed for 2 years. Two key inclusion criteria: the screening visit medicated IOP had to be 25 mm Hg or less, or subjects had to have an unmedicated IOP between 21 and 33 mm Hg. Screening and baseline characteristics were balanced between the two groups, and there were more whites (83.6%) and women (53%) enrolled.

Some of the additional strengths of this study included a washout to baseline at year 1 and then also at year 2—meaning we were able to assess the full potential of the device on its own to lower IOP. More than 95% of the enrolled subjects completed the entire follow-up.

In COMPASS, the primary efficacy outcome measure was

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the proportion of eyes with unmedicated diurnal IOP reduction of 20% or greater at 24 months from unmedicated baseline IOP. The primary effectiveness endpoint was met, with 72.5% in the CyPass Micro-Stent group and 58.0% in the control group achieving a clinically significant decrease in unmedicated mean diurnal IOP from baseline to 24 months; this between-group difference was statistically significant ($P= .0030$).

To me, that reinforces a combined CyPass Micro-Stent-cataract surgery is substantially better at controlling IOP than cataract surgery alone, even years later. The mean reduction in unmedicated mean diurnal IOP from baseline to 24 months (a secondary endpoint) was 7.0±4.5 mm Hg in the CyPass Micro-Stent group compared to 5.3±4.0 mm Hg in the control group ($P < .0001$). Moreover, 61.2% of the CyPass Micro-Stent group (compared to 43.5% of the control group) had an unmedicated diurnal IOP between 6 and 18 mm Hg at 24 months ($P = .0005$).

**SAFETY DATA FROM COMPASS**

The primary safety outcome measure of this pivotal trial was the frequency and nature of any oculocutaneous adverse events (AEs) that occurred through 24 months. A secondary safety-related outcome was the proportion of patients with BCVA of 20/40 or better at 24 months.

Because the COMPASS trial was only evaluating the safety of the CyPass Micro-Stent device, any AE that occurred intraoperatively during cataract surgery itself warranted exclusion from the study before CyPass Micro-Stent implantation could occur. Ten patients in the CyPass Micro-Stent group (2.7%) experienced hyphema during the procedure; this was not considered a serious intraoperative AE, and it resolved within the first 2 weeks in all cases.

In addition, 11 subjects (2.9%) in the CyPass group developed hypotony within the first month of implantation, all of which resolved without incident (Table).

**INTUITIVE IMPLANTATION**

Cataract surgeons will find the CyPass Micro-Stent implantation to be an intuitive procedure. The device’s proximal rings are easily discerned under the gonio lens, which helps to guide the device into position and probably accounts for the short learning curve.

There are some pearls to implantation, however. I like to hyperinflate the anterior chamber a bit, which allows surgeons to enter from a little steeper approach. This also helps avoid areas of dialysis and helps me avoid the corneal endothelium, allowing the device to be placed right into the supraciliary space.

When sliding the guide wire into the supraciliary space, I recommend getting as radial as possible to the globe and having the device perpendicular to the iris plane.

Then, tap the end of the CyPass device so the distal end is visualized between the pigmented trabecular meshwork and Schwalbe’s line. Likewise, ensure the device is not placed too posteriorly, to avoid peripheral anterior synechiae. Then remove the ophthalmic viscosurgical device. It is really a very straightforward procedure.

**COMBINATIONS THAT WORK**

The positive outcomes from the COMPASS pivotal trial, coupled with straightforward implantation of the CyPass Micro-Stent, have made this MIGS device an excellent option for patients with concomitant cataract and primary open-angle glaucoma.
The majority of cataract surgeons are comprehensive ophthalmologists who also treat and observe glaucoma patients. However, many refer these same patients to a glaucoma specialist when a trabeculectomy or other incisional glaucoma surgical procedure becomes necessary. One reason undoubtedly relates to the complexity of both the surgery and the postoperative management. Full-thickness filtering surgery is often considered more of a therapeutic “last resort” due to the patient’s visual field loss or escalating IOP despite maximal medical treatment and after laser treatments have also failed. These patients tend to have advanced disease and maximum medical therapy is failing. Clinicians would welcome surgical options that are safe, less invasive and will significantly reduce IOP.

MICROINVASIVE GLAUCOMA SURGERY

Microinvasive glaucoma surgery—MIGS—is often touted by glaucoma specialists as a category of procedures that can address the sizable therapeutic gap between nonsurgical treatments and full thickness filtering surgery. The latter entails a broad gamut of potential minor and major complications, from induced astigmatism and bleb-related dry eye, to hypotony, bleb infection, and suprachoroidal hemorrhage. As a result, surgical intervention is often delayed and deferred despite suboptimal IOP control or patient compliance. Blebless MIGS procedures, such as trabecular or suprachoroidal stents, can be initiated much earlier in the glaucomatous disease process, and are promising new options.

The first MIGS device approved in the United States was a trabecular microbypass stent, and with the approval, a new category and an important new role for the cataract surgeon were born: performing a low-risk adjunct procedure during phacoemulsification that can improve the clinical management of coexisting glaucoma.

Earlier this year, the US Food and Drug Administration approved the CyPass Micro-Stent from Alcon, to treat patients with mild to moderate primary open-angle glaucoma in conjunction with cataract surgery. This approval was based on the recently published COMPASS study—the largest MIGS study to date—that enrolled more than 500 patients and has 2 years of follow-up. A large majority of patients—73% — achieved a significant decrease in IOP of 20% or greater. Plus, 61% of the CyPass Micro-Stent study group achieved their target IOP at the 2-year follow-up, without medication.

MIGS AND THE CATARACT SURGEON

Why should adjunct MIGS technology appeal to cataract surgeons? One important reason is the projected growth in the number of patients with both cataract and glaucoma over the next several decades. It is already estimated that more than 20% of cataract patients have comorbid glaucoma. MIGS represents an opportunity to improve glaucoma treatment by taking advantage of the intraocular surgical access already afforded by the cataract procedure.

For cataract surgeons, the most significant barrier to performing a combined phaco-trabeculectomy is probably the risk of intra- and postoperative complications, some of which can result in visual loss. MIGS procedures avoid or reduce the risk of bleb complications that can occur with conventional glaucoma surgery. By sparing the conjunctiva, these MIGS surgeries should not diminish the later prognosis for a successful trabeculectomy,

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should the patient need one. Finally, because the same phaco incision is used, MIGS procedures can be done efficiently, and they should not compromise visual rehabilitation or refractive outcomes. This is in contrast to the early postoperative IOP variability encountered with astigmatism-inducing trabeculectomies. For example, I would be more likely to implant a toric IOL in combination with a MIGS procedure, but not in combination with a trabeculectomy.

Another advantage of MIGS procedures is the potential for reduction in the number of glaucoma medications. Of subjects who were responders (e.g., 24-month unmedicated mean diurnal IOP was reduced by ≥20% as compared with baseline in the absence of IOP-affecting surgery during the study), 93% of subjects in the CyPass group (251/271) and 72.4% of subjects in the control group (55/74) were not using ocular hypotensive medication at 24 months.\(^5\)

Performing MIGS procedures should be well within the typical cataract surgeon’s skillset. As with all intraocular microsurgery, proper visualization is critical and there is certainly a learning curve to using intraoperative gonioscopy. I highly recommend the Vold “floating” gonio lens that independently applanates the cornea without increasing pressure from the fixation ring.

I have also found educating cataract patients with glaucoma about the MIGS option to be easy and straightforward. If there is a potential upside without significant risk, side effects, additional out-of-pocket cost, or delay in visual recovery, then patients have been quick to accept my recommendation for an adjunct MIGS procedure when they undergo cataract surgery.

Finally, new MIGS technologies portend a promising future for ophthalmologists and their glaucoma patients. My experience with implanting the supraciliary stent is that it may be more intuitive to implant compared with some other devices. It is very easy for the surgeon to confirm proper anatomic placement. This, combined with the encouraging COMPASS pivotal trial data,\(^3\) should spark major interest in this device, and even greater overall enthusiasm for MIGS.

Cataract surgery has a long history of great safety and efficacy. Although traditional glaucoma surgery has shown to be fairly efficacious, short and long-term risks have limited its broad utility. Safety concerns and high postoperative management intensity are some of the reasons why cataract surgeons opt not to perform combined procedures on patients with both cataract and primary open-angle glaucoma. We are now aware that cataract surgery alone can reduce IOP. Historically, we have treated mild to moderate glaucoma with topical drugs, but patient adherence can be challenging, sufficient IOP lowering may not always be achieved via one medication, and these medications may be deleterious to the ocular surface.

For patients with advanced disease who are above IOP target and on maximum topical therapy, trabeculectomy and tube shunts have been our historical surgical techniques for good reason with their potent IOP lowering, and both surgeon and patient alike are willing to take the potential serious risks to prevent glaucomatous vision loss in these cases. But what about for the patient who does not need an aggressive IOP lowering, but is medicated or with borderline IOP control with mild to moderate disease—especially when going to cataract surgery?

Clinicians have been clamoring for microinvasive glaucoma surgical (MIGS) procedures that match the safety we have come to expect with our phaco procedures, that deliver significant IOP lowering efficacy to a physiological range, and that could be compatible with phacoemulsification.

**MIGS TODAY**

As an investigator for these MIGS procedures, I can state there are numerous advantages over traditional glaucoma surgeries, including a promising safety profile and reduced trauma. However, traditional bleb surgery still holds the gold standard in terms of IOP lowering.

The CyPass Micro-Stent from Alcon (Figure) has been designed for implantation into the supraciliary space, is a conjunctiva-sparing device, and is meant for cataract patients with mild to moderate primary open-angle glaucoma.

The entire field of MIGS is in its infancy, and we are still learning about the safety and efficacy of these devices over the long term. The COMPASS pivotal trial data is, to date, the largest pivotal MIGS randomized controlled glaucoma surgical trial completed to date, and we will continue to analyze its data for years to come.

**COMPASS PIVOTAL TRIAL DATA**

We recently published results from the 2-year COMPASS pivotal trial that evaluated the CyPass Micro-Stent device implantation for the treatment of glaucoma in conjunction with patients undergoing phacoemulsification. Those results composed the basis of the Food and Drug Administration’s approval.

This study enrolled 505 eyes (505 subjects); 374 eyes (74.1%) received both phacoemulsification and CyPass Micro-Stent implantation (the “CyPass group”) and 131 eyes (25.9%) received phacoemulsification alone (the “control group”). Of those, 480 eyes (95%) completed the full 2-year follow-up. The study showed 73% of the CyPass group and 58% of the control group achieved at least a 20% reduction in unmedicated diurnal IOP at 24 months ($P = .002$).
Furthermore, what was even more impressive to me was that 61.2% of the CyPass group maintained an unmedicated diurnal IOP between 6 and 18 mm Hg at 24 months, compared with 43.5% in the control group.

SAFETY PROFILE

There were few safety issues reported in the COMPASS pivotal trial data. It is noteworthy that the overall complication rate in the combined phaco/CyPass group was not substantially different from complication rates reported in modern cataract surgery in patients with or without glaucoma (See Table on page 10).

In the COMPASS study, 11 eyes in the CyPass group (2.9%) had transient hypotony, and all cases resolved in the first 2 weeks. I do not worry about numerical hypotony without anatomical or structural complications with these ab-interno procedures (as opposed to hypotony in a trabeculectomy with risk of sudden decompression and anatomical complications). The transient hypotony we noticed in the CyPass group did not occur as a result of incisonal leakage or chamber instability. In my hands, hypotony with this device is a nonissue and can be managed conservatively.

Hyphema can be a concern with glaucoma surgery—and has been reported to occur in up to 25% of eyes undergoing trabeculectomy, and in even higher rates in eyes undergoing trabecular meshwork ablation. That being said, most of those cases resolved without sequelae. In the COMPASS pivotal trial, hyphema occurred in 2.7% of those implanted with the CyPass Micro-Stent, was transient, and was not considered an issue postoperatively.

Although there were ocular adverse events associated with the CyPass Micro-Stent, the majority were transient as discussed and did not negatively affect visual outcomes. More than 98% of the overall study subjects had 20/40 or better at 24 months. It is important that surgeons consider the risk/reward/effort ratio in selecting the appropriate procedure for the individual patient.

STRAIGHTFORWARD IMPLANTATION

Surgeons who are comfortable with phacoemulsification should find a relatively short learning curve with CyPass Micro-Stent implantation. Visualization is needed, and can be readily achieved with the use of a gonio lens, and acetylcholine chloride (10 mg/mL) is administered after phacoemulsification is completed to optimize gonioscopic visualization. It is crucial that the patient’s head be turned correctly, the appropriate gonio lens be used, and the right pressure be maintained on the eye to ensure a good view.

The implantation technique itself is quite straightforward. The CyPass Micro-Stent is implanted through the corneal incision into the anterior chamber and advanced towards the scleral spur.

My advice is to aim just below the scleral spur. It is intuitive to place the guide wire in the vicinity of the iris root and simply push forward. That will direct the implant to the supraciliary space. The guide wire dissects the ciliary body to create a direct passage into the space.

I hold the guide wire horizontally first (which I call the sidewinder technique) and then rotate the applier so the guide wire follows the curve of the sclera. Once it is implanted, remove the ophthalmic viscosurgical device through traditional I/A, and treat the patient according to standard postoperative cataract regimens. I prefer to hold glaucoma medications immediately after surgery, but watch for steroid response in the first few weeks postoperatively and treat medically as needed. Technique-wise, this truly is a most intuitive MIGS procedure to perform.

As the number of patients with mild to moderate glaucoma continues to increase, procedures like MIGS are going to become more commonplace—and the CyPass Micro-Stent is a welcome addition to our armamentarium. Widespread experience will determine what role and where the CyPass Micro-Stent fits in our treatment options.

MIGS devices have helped ophthalmologists improve our understanding of aqueous outflow, which has led to the development of more effective technologies and techniques, including the CyPass Micro-Stent from Alcon.

As we have discussed here and in the COMPASS pivotal trial, the CyPass Micro-Stent “demonstrated sustained 24-month efficacy benefit over phacoemulsification across several outcomes.”\(^1\) It is clear that combining CyPass Micro-Stent and cataract surgery offers ophthalmologists a means to effectively lower IOP compared to cataract surgery alone while maintaining a safety profile. MIGS offers an excellent alternative to traditional glaucoma filtration surgery due to its low complication rate, while maintaining an acceptable safety profile.

The CyPass Micro-Stent provides an attractive benefit-to-risk ratio for patients with mild to moderate glaucoma who are undergoing cataract surgery. It is these factors that will make the CyPass Micro-Stent a valuable choice for this group of patients.


**CONCLUSION**

**CYPASS MICRO-STENT: A PROMISING FUTURE**

Steven D. Vold, MD

See page 6 for Important Product Information.