Keywords: Nd:YAG capsulotomy; Macula; OCT; Macular volume; Macular thickness

Introduction

Uncomplicated cataract surgery with intra ocular lens (IOL) implantation cannot guarantee definitive and stable solution for permanent improving of visual acuity (VA). VA can decrease after certain period. Impairment of vision as a late result after cataract surgery can be due to various reasons (Cystoid macular edema (CME)- Irvine-Gass syndrome, retinal detachment, uveitis, TLS - toxic lens syndrome). One of the most frequent results of cataract surgery with IOL implantation is posterior capsule opacification (PCO)-secondary cataract.

Surgical method requires irrigation/aspiration (I/A) system to “clean” posterior capsule. This method is chosen when Echogenic pears are present on the posterior capsule. Removing of cell aggregations from the posterior capsule will not get rid the patient of the problem completely because cells from periphery are able to return to the centre. Non invasive method is an alternative to surgical procedure Nd:YAG laser capsulotomy. One of the most frequent reasons of cataract surgery with IOL capsulotomy is posterior capsule opacification (PCO)-secondary cataract.

Nd:YAG capsulotomy is to remove the secondary cataract by opening (by transfixion) the posterior capsule in centre. Energy pulses with wavelength of 1064 nm and flashes with duration of nanoseconds create a shockwaves effect (acoustic gradient) as well as a short thermic effect in place of focus. Because of acoustic wave is the posterior lens capsule opened by photo disruption of the tissue [1-3]. This effect is called noninvasive trauma with photochemical and ionising effect. The result is opening in the centre of posterior capsule with diameter cca 4 mm. The acoustic energy from the capsule is transmitted with vitreous to the retina trough adhered vitreous cortex. Energy from YAG laser capsulotomy can damage retina [4] tissue by thermal photocogulation and especially has influence on central part of retina by changing foveal minimal thickness (FMT) [1,5]. Turkish authors report a paper of long term follow up after Nd:YAG capsulotomy without significant changes of foveal thickness [6].

With use of optical coherent tomography (OCT) we are able to measure FMT of the retina, visualize retinal layers, compare dynamic changes in macular region in time. The objective is to evaluate the influence of Nd:YAG laser energy on the central macula region-especially fovea and the impact on best corrected visual acuity (BCVA) and intra ocular pressure (IOP).

Methods

Our prospective study group included 36 patients, 17 male and 19 female (40 eyes) in average age 78.2 ±13 years with secondary cataract after uncomplicated cataract surgery. Group was treated with Nd:YAG capsulotomy. Inclusion criteria were slit lamp confirmed findings of fibrotic PCO, without presence of other pathological processes in the eye. Examination and procedure were performed on outpatient basis. Patient with dilated pupil were treated by Nd:YAG laser capsulotomy with “X” shaped opening of the posterior capsule. 10– 20 pulses were used to create 4 mm opening. After treatment patients administer Diclophenacum natricum eye drops QID for 3 weeks. 30 minutes after treatment stenopeic BCVA and IOP were examined. FMT and macular volume (MV) in 6 mm diameter were analysed with OCT (Stratus III, D300, Carl Zeiss Meditec, Germany).
Carl Zeiss Meditec, USA). All patients were examined in the same day after Nd:YAG laser capsulotomy and one month after the procedure.

Data were statistically analysed with Students T test. Parameter p<0.05 was considered as significant.

OCT data before Nd:YAG capsulotomy were in the study not included because of low quality of acquired image signal due to PCO.

Results

Average BCVA immediately after Nd:YAG laser capsulotomy was 0.71 (median 0.50). One month after procedure was 0.80 (median 0.67). FMT immediately after treatment was 197.63 ± 10 µm, (median 189 µm), one month after procedure 189.63 ± 11 µm, (median 184 µm). Average IOP was 15.41 ± 2.5 torr (median 15 torr) and 15.72 ± 3 torr (median 16 torr) one month after. Average MV after treatment in 6 mm diameter was 6.53 ± 0.5 mm³ (median 6.53 mm³), after month 6.51 ± 0.44 mm³ (median 6.51 mm³). Used average energy for Nd:YAG capsulotomy was 72.35 ± 47.04 mJ , (median 62.53 mJ) (Table 1.)

Discussion

36 patients (40 eyes) with secondary cataract, after uncomplicated cataract surgery was included in this study. The question to answer was if laser energy used by Nd:YAG capsulotomy causes changes on posterior pole, especially in macula and foveola. Best corrected stenopeic visual acuity immediately after treatment was 0.71 ± 0.3, one month after procedure was 0.80 ± 0.2. BCVA one month after Nd:YAG capsulectomy shows significant improvement (p=0.011). Significant changes in BCVA are due to stenopeic measurement of BCVA at the day one and tyndallisation of PCO particles in anterior chamber. IOP was with no significant difference (15.41 ± 2.5 torr and 15.72 ± 3 torr, p=0.496). Average minimal foveal thickness in OCT imaging in day after procedure was 197.63 ±10 µm and decreased one month after treatment to 189.63 ± 11 µm. Macular volume values in day one were 6.53 ± 0.5 mm³ and one month after 6.51 ± 0.44 mm³ in average. Used average Ng:YAG energy was 72.35 mJ ± 47.04. OCT examination of the posterior pole in day one and one month later showed decrease of average FMT and average MV without statistically significant values in both parameters (p=0.141, p<0.817). BCVA changes did not correlate with changes in FMT and MV. Comparing our results with literature we came to similar results published in medical journals. Total average energy, number of laser shots or mean energy per shot did not affect the foveal thickness or macular volume [6].

Conclusions

Nd:YAG capsulotomy is safe method for treatment of posterior capsule opacification. Foveal minimal thickness and macular volume are sensitive indicators that may correlate with BCVA. Nonsignificant changes in FMT and MV do not correlate with BCVA. In one month follow up in our study were no complications like retinal detachment, CME or increase of IOP in patients [7,8]. Patients continue follow up in our outpatients department.

References


Table 1: Results after Nd:YAG laser capsulotomy (N=40).

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<th>Average BCVA (Snellen)</th>
<th>Average IOP (torr)</th>
<th>Average MFT (µm)</th>
<th>Average MV (mm³)</th>
<th>After procedure</th>
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<th>Student’s t test</th>
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BCVA: Best Corrected Visual Acuity; IOP: Intra Ocular Pressure; MFT: Minimal Foveal Thickness; MV: Macular Volume