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**Outcomes of transconjuctival, sutureless 27 gauge vitrectomy for stage 4 retinopathy of prematurity**

1. Shah PK *et al.* 27 G vitrectomy for ROP
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**Abstract**

***AIM***

To report initial experience of lens sparing vitrectomy for stage 4 retinopathy of prematurity using 27 gauge (G) system.

***METHODS***

Retrospective case series involving 9 eyes of 5 babies with active stage 4 ROP, who underwent 27 G lens sparing vitrectomy. Surgery was done using 27 G valved cannulas and sclerotomies were made 1.5 mm from limbus. Bilateral sequential vitrectomy was done in eight eyes.

***RESULTS***

At one year follow up, anatomical outcome was favourable in all 9 eyes (100%). High speed cutting and smaller sclerotomies were helpful in reducing the intra and post-operative complications.

***CONCLUSION***

27 gauge vitrectomy is well suited for stage 4 ROP surgeries.

**Key words:** 27 gauge; Retinopathy of prematurity; Vitrectomy

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**Core tip**: It was a retrospective study of 9 eyes of 5 children with active stage 4 retinopathy of prematurity, which underwent 27 gauge micro incision vitrectomy surgeries with excellent outcomes.

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**INTRODUCTION**

Pars plana vitrectomy was first described by Machemer *et al*[1] in 1971 when he used the 17 gauge (G) system, where the incisions were > 1 mm in size. Later O'Malley and Heintz[2] introduced the 20 G system where the incisions became 0.9 mm in size. Although this remained the standard of care for almost three decades, the disadvantage was that apart from relatively bulky instruments, it needed conjunctival dissection followed by applications of sutures. A big change was seen when 23 and 25 G small-gauge instrumentation was introduced[3,4].With thinner instrumentation the incision became smaller, to 0.5 mm and trans-conjunctival entry with sutureless closure became a possibility. This is extremely beneficial in the small eyes of premature neonates[5]. Advent of 27 G vitrectomy with only 0.4 mm incisions has led to a new beginning of transconjuctival microincision vitrectomy surgery (MIVS) in retinopathy of prematurity (ROP). Oshima *et al*[6] in 2010 was the first to describe safety and feasibility of 27 gauge MIVS system with excellent visual and anatomical outcomes in adults. However its use in ROP is still not established, although Yonekawa *et al*[7] have reported 25 and 27 G hybrid vitrectomy in complex surgeries including ROP.

The purpose of this study is to describe our initial experience in using 27 G trocar and cannula system in pediatric eyes with Stage 4 ROP.

**MATERIALS AND METHODS**

This is a retrospective non-comparative case series of 9 eyes of 5 babies. All eyes were with stage 4 ROP. Four babies had bilateral disease and both eyes were operated sequentially under same general anesthesia[8]. Care was taken to rescrub and reperp the surgical field of second eye as done for any new case. The entire team rescrubbed and a new set of surgical instruments were used for each eye. Written informed consent was taken from their parents for the procedure. Ethics committee approval was taken for this study. The study was conducted between January 2015 to December 2015. Patients records were reviewed and the data collected were date of birth, gestational age, birth weight, post conceptional age, post natal age and intra and post-operative status of each eye.

All surgeries were performed under general anesthesia by a single surgeon. All surgeries were performed using the Constellation Vision System with Vitrectomy 27 G Total Plus Vitrectomy Pak system (Alcon Laboratories, Texas, United States). Valved 27 G cannulas were used. The intraocular portions of the 27 G cannula were shortened similar to what has been described by Babu *et al*[9]. We took a 42 silicon band, which has a width of 4 mm and a thickness of 1.25 mm. The band was divided at 2 mm and again cut in the center to get 2 small pieces of 2 mm x 2 mm each. The trocar and cannula were passed through these pieces till the hub with the help of a toothed forceps. Cannulas were inserted at inferotemporal, superotemporal and superonasal quadrants, 1.5 mm away from the limbus (Figure 1). The conjunctiva and Tenon’s capsule were displaced over the sclera to avoid communication between conjunctival and scleral entry sites.

Trocar cannulas were inserted with a “straight in” (perpendicular to the sclera) or angled (less than 90 degrees to the sclera) approach in a 1-step procedure. First a core vitrectomy is performed using a cutting of 5000 cuts per minute and a suction of 150 mmHg in core mode. Peripheral vitrectomy is done using 7500 cuts per minute with the same suction in shave mode of the machine. After the vitrectomy, partial fluid air exchange was done, the cannulas were removed and sclerotomies were left sutureless after thorough examination for any leakage. Babies were examined on post-operative days 1, 14 and after one month.

**RESULTS**

Nine eyes of 4 babies were operated during the study period. Mean gestational age of these babies were 29.2 wk (range 28-31 wk). Mean birth weight 1177 g (range 950-1850 g). Mean post conceptional age at the time of surgery was 39 wk (range 36-43 wk) and the mean post natal age was 9.6 weeks (range 6-12 wk). Out of 9 eyes, 7 eyes had stage 4a and 2 eyes with 4b disease. Two eyes of case 1 had ROP in zone 1 while the rest of the eyes were in zone 2. 8 eyes of 4 cases had undergone laser prior to vitrectomy (Table 1). Two eyes of case 1 underwent vitrectomy along with intravitreal injection of Ranibizumab as this case had excessive vascularity. At four month follow up, anatomical success was seen in all 10 eyes (100%) (Figure 2). We did not encounter any post-operative hypotony in any of our cases. No other complications were noted in the follow up period. At averge follow-up of 12 mo, all eyes showed stable regressed ROP.

**DISCUSSION**

Introduction of 27 G vitrectomy had major concerns with like reduced endoillumination, instrument fragility and reduced flow rate during surgery[10]. Oshima *et al*[6] in his study describes the various steps taken to improvise the MIVS. This study done in 2010 with 31 adult eyes undergoing vitreoretinal surgeries for epiretinal membrane, macular hole, vitreous hemorrhage, focal tractional retinal detachment and vitreomacular traction also analyzed the duty cycles of cutter, infusion and aspiration rates and the clinical outcome of 27 gauge MIVS. Brighter light sources such as xenon and mercury vapour bulb were used to increase the endoillumination. The smaller gauge did increase the fragility of the cutter during vitrectomy and to avoid this, the shaft of the cutter was reduced from 32 mm to 25 mm, which gives a good rigidity similar to that of a conventional 25 G vitrectomy.

High cutting rates of 27 gauge vitrectomy was proved to be a major advantage as it reduced the risk of iatrogenic damage to the retinal surface and intraoperative retinal tears by preventing uncut vitreous fibers entering the cutter port. Clinically and experimentally it has been proved that high cutting rates reduces retinal traction and thereby the retinal breaks[11,12].

Post operative complications seen with 23 gauge and 25 gauge like poor wound sealing causing leakage, hypotony and endophthalmitis[13-15] were serious concerns, but 1 step insertion technique in 27 G vitrectomy surgeries avoided these problems. Opening and closing procedures are simplified with 1 step insertion technique, consequently shortening the total operative time. Similarly, Rizzo and associates[16] in 2012 described 27 G vitrectomy in 16 patients and had a good clinical outcome. Additional surgical indications included were rhegmatogenous retinal detachment and tractional retinal detachment. No intraoperative and postoperative complications were encountered and no cases were converted to 23 or 25 G system.

A retrospective case series of 95 adult eyes by Khan *et al*[17] has been extremely valuable as it includes large sample size of 27 G MIVS operated till date. This study evaluated the change in visual acuity, post operative intraocular pressure (IOP) and the mean operative time by diagnosis. They reported an initial fall in IOP over the first week, and started increasing after day 30. A recently published study of cases with 20, 23 and 25 gauge showed decrease in baseline IOP for over a period of 3 mo and gradual regain[18]. Thus they concluded that IOP regains faster to the baseline value in MIVS.

Our study 27 gauge MIVS in pediatric eyes is the first of its kind and has not been reported till date. The problem of bending of the shaft is minimal as the plus system has a small cuff of metal supporting the base and ROP vitrectomy just needs just a good core vitrectomy with keeping the instruments more perpendicular compared to adults where base shaving may be required. None of our case had hypotony in the post operative period as compared to 5% in a study by Khan *et al*[17]. However our sample size is much smaller compared to their study. Singh *et al*[19] showed that the different gauge vitrectomy systems are equally effective and safe. All of our cases were sutureless and at the end of the surgery none developed any wound leak, which is seen in about 0%-7.1% cases of 23 and 25-gauge vitrectomy[20-22]. No sclerotomy related retinal tears were noted while with 23 and 25 gauge vitrectomy 0%-3.1% have been reported.[22-25]

In one case during vitrectomy, the cannula came out along with the vitrectomy cutter, this could have been avoided by carefully removing the cutter. This could be more common in 27 G system compared to 25 G, as Alcon 27 G cannulas are valved and hence get snuggly attached to the instruments. In four babies bilateral simultaneous vitrectomy was performed as all these babies had bilateral acute disease. The anatomical outcome was 100% in our study which is better than previously reported ROP vitrectomies with larger gauges[8,26-28].

Limitation of our study is small sample size. Thus to summarize, 27-gauge system could be favourable for pediatric cases, since this technique has a favorable wound sealing structure with few postoperative complications and better surgical outcomes. However studies with a larger sample size are needed to substantiate this.

**ARTICLE HIGHLIGHTS**

***Research background***

Retinopathy of prematurity (ROP) vitrectomy is challenging due to the altered and more compact structures in a pediatric eye. Hence there is a need to invent smaller vitrectomy instruments to make the outcome of this surgery better. 27 gauge vitrectomy being the smallest gauge available commercially could have the most benefit in pediatric age group.

***Research motivation***

27 gauge instruments are smaller in size and has capability of high speed cutting, which is ideal for pediatric eyes. Hence this study was conducted to see the feasibility of this instrument in ROP surgery.

***Research objectives***

The main research objective was to assess the feasibility of 27 gauge vitrectomy for ROP and to see if the ease of surgery and surgical outcomes could be bettered.

***Research methods***

27 gauge vitrectomy has been reported mainly in adult eyes. Very few studies has explored its use in pediatric age group and especially in ROP. This is one of the few studies which has tried 27 gauge vitrectomy exclusively in stage 4 ROP.

***Research results***

The results of this study show that sutureless, trans conjuctival 27 gauge vitrectomy has good anatomical outcome in stage 4 ROP.

***Research conclusions***

27 gauge vitrectomy is beneficial for pediatric eyes. It is safe and effective. This study shows that smaller gauge instruments are most suitable for lens sparing vitrectomy in ROP where the surgical space in very limited with the ever looming danger of damaging the lens anteriorly and the retinal posteriorly. Even with the limited surgical space, it become easier to maneuver with 27 gauge instruments without damaging the critical structures.

***Research perspectives***

Thus in the future, 27 gauge vitrectomy has the potential to become the standard of care for all ROP related lens sparing vitrectomies.

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**Figure 1** **Intraoperative picture of left eye.** The three sclerotomies 1.5 mm from limbus are labeled as 1 (infero temporal port), 2 (supero temporal port) and 3 (supero nasal port) of 27 gauge vitrectomy system. The white solid arrow shows the infusion tube through which balanced salt solution flows and maintains in intra ocular pressure. The black arrow shows the trocar handle inserting the last supero nasal port. The white outline arrow shows the tip of corneal forceps.



**Figure 2 Anatomical success was seen in all 10 eyes at 4 mo follow-up.** A: Preoperative picture of left eyes showing stage 4 A ROP with partial retinal detachment (black arrows), optic disc is shown by the think white arrow and fovea with the thin white arrow; B: Post-operative picture of same eye showing settled retinal detachment with residual fibrous tissue (black arrows), The optic disc and fovea are shown by the thick and thin white arrows respectively.

**Table 1 Baseline characteristics and final outcome of the cases**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Case No** | **GA****(wk)** | **BW (gm)** | **PCA****(wk)** | **Eye** | **Zone** | **Stage** | **Preoperative****laser** | **Intraoperative****Anti-****VEGF** | **Final outcome** |
| 1 | 30 | 1100 | 36 | RE | 1 | 4a  | Y | Y | F |
|  |  |  |  | LE | 1 | 4a  | Y | Y | F |
| 2 | 31 | 950 | 43 | RE | 2 | 4a  | Y | N | F |
|  |  |  |  | LE | 2 | 4a  | Y | N | F |
| 3 | 28 | 1000 | 37 | RE | 2 | 4b | Y | N | F |
|  |  |  |  | LE | 2 | 4a | Y | N | F |
| 4 | 28 | 1850 | 38 | RE | 2 | 4a | Y | N | F |
|  |  |  |  | LE | 2 | 4a | Y | N | F |
| 5 | 29 | 985 | 41 | RE | 2 | 4b | N | N | F |

GA: Gestational age; BW: Birth weight; PCA: Post conceptional age; RE: Right eye; LE: Left eye; F: Favourable.