



Rich



Poor



Rich

- * Regular review
- * Monitoring
- * Action if change observed

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- * Medical therapy
- * Laser therapy
- * Surgical therapy

Aims:

- Preserve adequate vision for life
- Lower intraocular pressure

Options:

- No therapy
- Medical treatment
- Laser
- Surgery

How to choose the best options

- Risks and benefits need to be balanced
- Consider efficacy, tolerability, quality of life, cost and compliance
- Consider complications of surgery
- Decision should be evidence-based individualised to patient's needs

Before prescribing any new eye drop for glaucoma:

- General medical history
- Drug history
- History of topical allergy
- Find out if the patient can use eye drops (memory and dexterity, carers)

Guidelines for new prescriptions

- Start only one drug regardless of presenting IOP in COAG
- Show the patients how to put the drops in
- Check IOP again within 3 months

How eye drops work:

- Reduce aqueous production (CAI's, α and β receptors)
- Increase outflow through the trabecular meshwork (cholinergics)
- Increase uveoscleral flow by increasing permeability ciliary muscle (PG agonists)

All drugs licensed to treat glaucoma are licensed as IOP lowering agents

IOP lowered by 20-35%

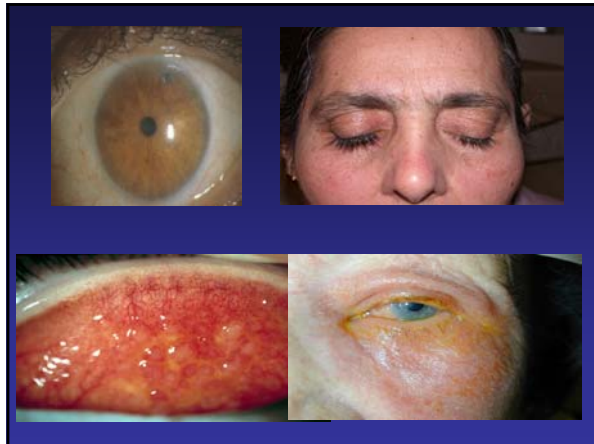
Approx 5 - 7 mmHg on average

Pharmacology of drugs for IOP lowering:

- Prostaglandin agonists
- Beta receptor antagonists
- Alpha 2 receptor agonists
- Carbonic anhydrase inhibitors
- Cholinergic agonists
- *Sympathomimetics*
- *Alpha and beta receptor antagonists (guanethidine)*
- *Anticholinesterases (phospholine iodide)*

Systemic Drugs lowering IOP

- Carbonic anhydrase inhibitors
- β antagonists
- Calcium channel antagonists
- Osmotic agents: mannitol, glycerol



Trabeculoplasty

40-50 burns 50 microns size
to anterior trabecular meshwork

Iridoplasty

20-24 burns 500 microns size
Treat extreme peripheral iris

Iridotomy

peripherally at 12 o'clock

Cyclodiode

40-60 burns retroillumination

Trabeculectomy

