



COMPLICATIONS AFTER FISTILIZING ANTIGLAUCOMA SURGERY AND METHOD OF TREATMENT (CLINICAL CASE)

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Article history:	Abstract:
<p>Received: December 30th 2023 Accepted: February 23rd 2024</p>	<p>According to the World Health organization, the number of patients with glaucoma in the world ranges from 60.5 to 105 million people, and in the next 10 years it may increase by another 10 million [1].</p> <p>The main tasks in the treatment of glaucoma are: reducing and normalizing elevated intraocular pressure, creating conditions for the most favorable microcirculation in the optic nerve, removing the phenomena and consequences of its hypoxia, improving nutrition and tissue metabolism in it [2]. This is achieved through therapeutic and surgical means. The choice of the type of surgical intervention should be determined by the effectiveness and minimum of possible complications. One of the main criteria for making a decision about the operation is the lack of stabilization of the glaucoma process [3, 4]. Surgical treatment of glaucoma is a rather complicated and risky approach, and complications after such operations are not uncommon.</p>

Keywords: Glaucoma, Glaucoma process

MATERIAL AND METHOD. Our studies were carried out in two patients who were being treated at RSSPMCMG from 2020 to 2022. The average follow-up period for patients was 6 months. Patient S.Kh. born in 1943 was admitted to the RSSPMCEM with complaints of decreased vision, fog in both eyes, more in the right.

Patient A.I., born in 1949 He was admitted to the RSSPMCEM with complaints of decreased vision in the right eye, noted a decrease in vision for 3-4 years.

RESULTS AND DISCUSSION. In the first case, after a second operation, Vis OD=0.07, IOP=19,0 mm rt. art. OD - The suture and wound are normal, the filtration cushion is flat, the cornea is slightly swollen, p / chamber 3.0, the pupil is dilated to 6.0 mm, pigment deposits are on the p / lens capsule, the lens is sclerotic, with ch. bottom pink reflex. The patient was discharged home, examination

after 1 day Vis OD=0.1 n/a: B-scan: Single opacities in the vitreous body. The retina is adjacent. Inspection after 1 month, after 3 months, after 6 months. Vis OD=0.1sph (-) 1.0=0.3. IOP b/c=18.0 mm. rt. In the second case, the problem was corrected on the operating table during the first operation. Therefore, in our opinion, this did not affect the indicators of visual acuity. Vis=0.1; IOP measured by IHD=15.0 mm. rt. Art. The patient was discharged home. Inspection after 2 days, after 1 week. after 1 month, after 3 months, after 6 months Vis=0.1/0.7; IOP 17.0/19.0 mm. rt. Art. According to literature data, such cases occur in world practice. We have experience in solving such problems. In the presence of external filtration after antiglaucoma surgery, under local anesthesia, the edges of the conjunctival wound are refreshed and interrupted sutures are applied. The entire area of anti-glaucoma surgery and



nearby areas with sutures to the own conjunctiva at a distance of 4-5 mm from the area of anti-glaucoma surgery. In another case, the said goal is achieved by the fact that it includes the separation of the conjunctival flap together with the filtration pad, blocking the scleral fistula and strengthening the thinned conjunctiva.

When separating the conjunctival flap, the boundaries of the intervention zone are expanded to an unchanged fibrous process of the conjunctival tissues. And they form a subconjunctival pocket in them, then block the scleral fistula and episclerally cover the entire area of intervention with a film of biocompatible material, the edges of which are fixed in the subconjunctival pocket, after which the conjunctiva is sutured. In our case, under local anesthesia, the rough side of the alloplant was attached to the flap and fixed in four segments with 4 knotted sutures. Thus, we closed the tissue defect of the flap in the area of the fistula. The size of the alloplant is cut out 2-3 mm larger than the scleral flap. The excess alloplant is attached to the sclera with two interrupted sutures. Continuous suture on the conjunctiva.

CONCLUSIONS. To prevent such cases with high intraocular pressure and pronounced congestion, at the time of the incision must be taken into account. When separating the upper flap, it is necessary to take 2/3 parts of the sclera thickness. Avoid cutting out an excessively thin layer of sclera. Avoid excessive burns of blood vessels when stopping bleeding, after which there is a thinning of the sclera.

REFERENCES:

1. Ташпулатова А. З., Бузруков Б. Т., Закирходжаева Д. А. Вторичная глаукома при синдроме Марфана //РМЖ. Клиническая офтальмология. – 2012. – Т. 13. – №. 4. – С. 126-127.

2. Alimova D. D., Amonov S. E. The morphological characteristic of the mucous membrane at polypous rhinosinuitis //International Journal of Pharmaceutical Research (09752366). – 2020. – Т. 12. – №. 3.
3. Султанова Д. Д., Камалов З. С. Цитокиновый статус у детей с хроническими риносинуситами в зависимости от их этиологии //Оториноларингология. Восточная Европа. – 2015. – №. 1. – С. 38-45.
4. Султанова Д. Д., Миртаджиева З. Д. Микробиологический спектр возбудителей хронических риносинуситов у детей //Молодой ученый. – 2017. – №. 16. – С. 81-82.