


A.V. Sánchez Ferreiro∗, L. Muñoz Bellido
Servicio de Oftalmología, Hospital del Bierzo, León, Spain

∗Corresponding author.
E-mail address: vanesaferreiro1980@yahoo.es (A.V. Sánchez Ferreiro).

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Ex-PRESS® implant protected sclerostomy

Esclerostomía protegida con implante Ex-PRESS®

Dear Sir,

Even though at present there are multiple options for surgically treating glaucoma, innovations continue to appear with the aim of improving the efficiency and predictability of penetrating surgery. Within the group of new devices for implants, Ex-PRESS® (Alcon Laboratories, Inc., 6201 South Freeway, Fort Worth, TX, USA), developed in 1998 (Optonol LTD, Kansas City, MO, USA), has recently changed its design as well as modified its implantation technique with the aim of improving biocompatibility1 as well as efficacy and predictability. Ex-PRESS is a valveless filtration device and accordingly allows two-way free flow which deviates the aqueous humor from the anterior chamber to the subconjunctival space once implanted under a scleral flap.2

The diversity of techniques—and modifications thereof—and devices gives rise to confusion amongst users regarding the name and exact characteristics of each. This is repeatedly observed in presentations and some publications. For instance, the same procedure has been named as trabeculectomy with implant, glaucoma surgery with a small drainage device or deep sclerectomy modified with Ex-PRESS implant.3

In summary, it can be said that initially the surgical protocol for the Ex-PRESS implant is similar to a classic trabeculectomy (Cairns, 1968) in the execution of the conjunctival flap, the superficial scleral flap and the addition or not of antimetabolites, with the exception that a portion of the trabeculum is not removed; instead, a perforation is made at the level of the sclerocorneal limbus (esclerostomía; Mackenzie, 1830) and iridectomy is avoided as it facilitates information and hyphema. The fact that the implant is placed under a scleral flap prevents complications including mobilization, conjunctival erosion, Seidel, endophthalmitis, etc. (PROTECTED). The final placement of the drainage device (Ex-PRESS IMPLANT) aims at maintaining the sclerostomy permeability4 (Fig. 1).

In accordance with the above and endeavoring to maintain clarity as regards concepts, we consider that the most

Fig. 1 – Phakic patient 2 weeks after a “protected sclerostomy with Ex-PRESS® implant”. (A) Correct implant location, maintaining the anterior chamber. (B) Absence of inflammatory signs. (C) Absence of Seidel. (D) Formation of filtration bleb.

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adequate definition for describing the above-mentioned technique is “protected sclerostomy with Ex-PRESS® implant.”

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J.A. Abreu a, c, J. Moreno b, J.J. Aguilar a
a Unidad de Glaucoma, Servicio de Oftalmología, Hospital Universitario de Canarias, Tenerife, Spain
b Unidad de Glaucoma, Servicio de Oftalmología, Clínica Universitaria de Navarra, Pamplona, Spain
* Corresponding author.
E-mail address: jaabreureyes@gmail.com (J.A. Abreu).

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**Tacrolimus in the treatment of atopic kerato-conjunctivitis**

**Tracolimús en el tratamiento de la queratoconjunctivitis atópica**

Dear Sir,

Atopia affects about 5–20% of the general population. Atopic keratoconjunctivitis appears in approximately 20–40% of individuals with this disease. Apart from this entity, other common ocular events in this context are allergic conjunctivitis, giant papillary conjunctivitis and vernal keratoconjunctivitis.¹

In what concerns atopic keratoconjunctivitis, ocular involvement can range from superficial keratitis punctata to cicatrizaton defects, corneal thinning, keratoconus, formation of simblepharon and in advanced stages could even cause significant visual acuity reduction to the extent of causing blindness.²

In general, treatment is based on the application of anti-inflammatory or mastocyte-stabilizing eyedrops such as antihistaminics and corticosteroids. However, the chronic course of the disease limits the use of the latter. In some cases this therapeutic approach is not enough and calls for the adoption of other therapeutic options such as immunomodulators like cyclosporine A or surgical treatment.

Atopia can be defined as a particular sensitivity which in some families leads to the development of hypersensitivity to environmental substances which involve epithelia, skin and mucosa. Individuals with atopia frequently exhibit environmental allergy, allergic asthma, rhinitis, atypical dermatitis or eczema. Less common are allergies to food, urticaria and hereditary angioedema. Immunoglobulin E (IGE) is the mediator of these excessive responses. Hypersensitivity reactions I and IV are responsible for inflammatory changes in the conjunctiva and cornea which occur in atopic keratoconjunctivitis.

Tacrolimus is an immunosuppressant macrolide produced by the fermentation of Streptomyces tsukubaensis, originally from Japan. This drug is highly efficient to prevent post-transplant rejection in patients resistant to steroids and cyclosporine. In this regard, tacrolimus is between 10 and 100 times more powerful than the latter.¹²

At present, tacrolimus cream is available in 2 approved concentrations (0.1 and 0.3%) by the Food and Drug Administration for skin use in the treatment of atopic dermatitis.

There are several studies about tacrolimus, as described below.

Attas-Fox et al.¹³: this study assessed the usefulness of tacrolimus at 0.03% applied to the conjunctival sac for treating refractory allergic conjunctivitis. The results demonstrated highly significant improvements in all the evaluated categories, with only one patient suspending treatment.

Kymionis et al.¹⁴: this study described one case of giant papillary conjunctivitis. Six months later no relapses or side effects were found. Other studies on the use of tacrolimus

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