Clinical benefits for the monitoring and modulating of subconjunctival tissue following glaucoma filtration surgery

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Abstract

Glaucoma filtration surgery (GFS) can be defined as an attempt to lower intraocular pressure (IOP) by the surgical formation of an artificial drainage pathway from the anterior chamber to the subconjunctival space. Surgical techniques and devices to create the drainage pathway have been continuously improved since the first attempts almost 180 years ago. Filtering procedures, such as trabeculectomy or drainage implant surgery have been used extensively in the treatment of glaucoma. Glaucoma affects >60 million people worldwide and is the second most common cause of irreversible blindness. A minimally invasive surgical technique including a bioengineered microfistula tube, a sophisticated implanter, and an ab-interno surgical procedure was developed by our team. Such minimally invasive surgery without surgical damage to the conjunctiva will significantly reduce the inflammatory reaction and scarring process and provide more optimal surgical outcomes. It also creates an opportunity to clinically investigate the question of the consequences of the presence of aqueous humor in the subconjunctival tissue. Our patents were licensed to a startup company (AqueSys), to commercially develop the technology and AqueSys has recently been acquired by Allergan. Commercialization also creates new opportunities for scientific research to further improve surgical outcomes. An important topic has arisen related to the monitoring and modulation of the subconjunctival tissue after GFS. We would also like to examine the conjunctiva to select the most suitable surgical site before implantation. We believe that the answer to such questions could be critical for improving the outcomes of our procedure, and indeed all other GFS procedures. We describe three avenues of research that need to be addressed whilst the clinical use of this technique is expanding. The purpose of such research is to gain the best outcomes for each patient treated with our newly developed techniques.

Introduction

Glaucoma affects >60 million people worldwide and is the second most common cause of irreversible blindness [1]. The main modifiable risk factor for optic nerve damage in primary open-angle glaucoma is increased intraocular pressure (IOP), thought to be primarily due to decreased outflow of aqueous humour through the trabecular meshwork and Schlemm’s canal [2-5]. Surgical approaches to glaucoma treatment hope to achieve a permanent reduction in the outflow resistance and restore normal IOP with minimal complications. Many types of glaucoma surgery have been developed since the first attempts almost 180 years ago [6]. Filtering procedures, such as trabeculectomy, or drainage implant surgery, has been used extensively in treatment of glaucoma. Minimally invasive glaucoma surgery could be beneficial for reducing surgical injury, local inflammation and scar formation. However, there are several different procedures which have been used for minimally invasive glaucoma surgery. Each procedure has certain advantages and some disadvantages. It is very important to study the longevity of any glaucoma surgery’s outcome. Recently, the different types of minimally invasive glaucoma surgery have been followed clinically [7-10]. Our aim was to develop a safer and more effective surgical procedure. We hoped to overcome any potential causes of the failure of glaucoma surgery and obtain the best surgical outcome for every patient. A minimally invasive surgical technique including bioengineered microfistula, sophisticated implanter and ab-interno surgical procedure was developed by our team [10,11]. Our patents (AU#721915, PCT/AU97/00811, US patent #6544249) were licensed to a startup company (AqueSys), to commercially develop the technology and AqueSys has recently been acquired by Allergan. It is very likely that our technique will be used worldwide. Such minimally invasive surgery without surgical damage to the conjunctiva could significantly reduce inflammatory reaction and scarring process and provide optimum surgical outcomes. It minimizes conjunctival disturbance and maximizes the ability to visualize the evolution of subconjunctival tissue changes post-operatively. In addition, it creates an opportunity to investigate the consequences of aqueous humor presence in the subconjunctival tissue. We have demonstrated that the conjunctiva and its lymphatics play a critical role in GFS outcomes [11]. Some glaucoma patients may have had long term local drug applications and previous glaucoma surgery. It is important to develop techniques to examine the conjunctiva and its lymphatics before the surgery, and to monitor and modulate subconjunctival tissue properties following GFS. We believe that the answer to such questions could be critical for further improving the outcomes of GFS.

Aqueous flow and glaucoma

Aqueous humor does not normally contact the subconjunctival tissue. The normal aqueous outflow pathways consist of an intraocular part, exit routes by which aqueous humor leaves the eye, and the return route to the systemic circulation. The major components are the ocular...
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immuno privileged system, phagocytic function of the trabecular meshwork, and a fully endothelium lined drainage system. These components play the key roles in the maintenance of stable aqueous flow under normal conditions [11]. The steady-state IOP is developed due to the balance between aqueous production and the resistance to aqueous humor outflow. Elevated IOP in open angle glaucoma is predominantly due to increased outflow resistance. It is generally accepted that in the normal and glaucomatous eye, most of the outflow resistance lies across and within the trabecular meshwork, perhaps in the cribriform region adjacent to the inner wall of Schlemm’s canal [12]. It is also known that in glaucoma disease states the aqueous humor quality is altered with greater oxidative stress capacity [13].

Subconjunctival microenvironments and the conjunctival bleb

GFS allows altered and unfiltered aqueous humor to come into intimate contact with subconjunctival tissue. Aqueous humor in the subconjunctival tissue after GFS unavoidably alters the subconjunctival microenvironment.

It is predictable that a substantial amount of aqueous humor enters into subconjunctival tissue after GFS. Assuming aqueous production by the ciliary epithelium is ~2 µL per minute, the volume of aqueous entering into the subconjunctival tissue after GFS could be as much as 3 mL per day. No doubt that there must be adequate pathways and mechanisms to allow aqueous humor to be removed from the bleb following GFS. To our knowledge, the role of the conjunctiva in the outcomes of GFS has not been systematically reviewed and many critical questions remain unanswered.

Naturally, the pooling of aqueous humor beneath the conjunctiva and/or Tenon’s capsule forms a filtering bleb that has been considered a cornerstone of IOP control after GFS [14-19]. Often the bleb appears to be an unstable tissue [20]. Bleb-related complications can be serious and the surgeon has little control over the final appearance of the filtering bleb after surgery [21]. Such complications require very careful management to avoid loss of vision.

It is very important to understand the bleb both structurally and functionally. Aqueous humor enters the subconjunctival tissue and joins the interstitial fluid. Cells and tissue around newly formed pathways are continuously bathed in aqueous humor. Ideally aqueous humor should be removed sooner rather than later. Clinical evidence shows that changes in the number of inflammatory cells and fibroblasts occur in the conjunctiva of eyes at increased risk of GFS failure [22-27] and it is possible that this may influence the wound healing process following surgery. The failure of trabeculectomy is most commonly associated with a fibrotic response at the wound site in the subconjunctival tissue [28]. However, the mechanisms by which aqueous humor drains from the bleb after GFS have not been fully elucidated [29-33]. There is very limited knowledge of the pathways and mechanisms draining the aqueous humor from the bleb.

Without surgical damage to the conjunctiva, we can obtain more reliable information of the conjunctival bleb after microfistula implantation. Figure 1 shows an example from our experimental studies which illustrates detailed and dynamic information from the subconjunctival bleb after GFS, providing clues to the mystery of how aqueous humor enters and drains from the subconjunctival tissue [11]. A video was recorded after fluorescein dye injection into the anterior chamber in a rabbit with a functional bleb after microfistula implantation. A sequence of video frames shows the spread of fluorescein staining from the anterior chamber. A thin line of fluorescein dye appeared under the conjunctival tissue linking with the scleral channel, which appeared after fluorescein injection into the anterior chamber. This thin-line of fluorescein then enlarged and showed a very uneven structure (yellow arrowhead) which is very likely to be initial lymphatics. The fluorescein staining in this line gradually extended in length and area (Panels E to I). More drainage vessels are seen and some of them had a lymphatic appearance (brownish and bent arrow, Panel C to I). In later phases the small vessels are seen along with more extensive filling and increased numbers. The staining within the bleb also increases with time. Panel J shows a magnified view of Panel I. A conjunctival bleb along with a scleral channel (black arrows) and a number of drainage vessels are seen. Some of the drainage vessels appeared even and regular with small calibre and their orientations and appearance are similar to the normal conjunctival and episcleral veins. Other drainage vessels are uneven with larger calibre and their orientations and appearance are similar to normal conjunctival lymphatic vessels (brownish bent arrows). (Modified from Yu, et al.) [11].

Figure 1. Sequence of video frames (Panels A to I) after injection of fluorescein into the anterior chamber of a rabbit 6 months after microfistula implantation.

Initially a thin line of fluorescein dye appears under the conjunctival tissue directly linking with the scleral channel (Panel A, yellow arrowhead). This thin-line of fluorescein then enlarges and shows a very uneven structure (yellow arrowhead) which is very likely to be initial lymphatics. The fluorescein staining in this line gradually extended in length and area (Panels E to I). More drainage vessels are seen and some of them had a lymphatic appearance (brownish and bent arrow, Panel C to I). In later phases the small vessels are seen along with more extensive filling and increased numbers. The staining within the bleb also increases with time. Panel J shows a magnified view of Panel I. A conjunctival bleb along with a scleral channel (black arrows) and a number of drainage vessels are seen. Some of the drainage vessels appeared even and regular with small calibre and their orientations and appearance are similar to the normal conjunctival and episcleral veins. Other drainage vessels are uneven with larger calibre and their orientations and appearance are similar to normal conjunctival lymphatic vessels (brownish bent arrows). (Modified from Yu, et al.) [11].
more extensive filling and increased numbers, and also enlarged with time within the bleb. Now we know that in addition to diffused aqueous humor the bleb also contains a number of initial lymphatics and that these vessels drain aqueous humour forming an important part of the “active” drainage pathways. These “active” drainage pathways appear to play an important role in removal of aqueous fluid from the subconjunctival tissue, although diffusion from the bleb may still be a factor. A conjunctival bleb along with a scleral channel and a number of drainage vessels were apparent. Some of the vessels appeared even and regular with small calibre and their orientations and appearance are similar to the normal conjunctival and episcleral veins. Drainage lymphatics are uneven with larger calibre and their orientation and appearance were similar to normal conjunctival lymphatic vessels.

We have demonstrated the role of lymphatics in drainage of fluid from subconjunctival tissue. Trypan blue was injected into the subconjunctival tissue to create interstitial tissue fluid which was then drained through the lymphatics using a technique similar to that previously described [34,35]. A tiny amount of sterile trypan blue was injected using a 32-gauge needle to form a small subconjunctival blister just below the conjunctival epithelium. The pool of trypan blue was observed in order to evaluate if it remained stagnant, meaning lack of lymphatic drainage, or if it spread away from the blister forming distinct branch-like tributaries indicating the existence of lymphatic drainage. The distribution and appearance of normal conjunctival lymphatics in the monkey are shown in Figure 2. After sufficient injection of trypan blue to create a blister in the subconjunctival space the dye rapidly appeared in the most favourable lymphatic channels. The dye then spread throughout the lymphatic vascular tree to reach the major collecting lymphatics (2B). Some backfilling of the smaller initial lymphatics was also evident (2F). Only a small blister of trypan blue was required in the monkey.

Furthermore, we have also demonstrated the conjunctival lymphatics distribution in rabbits and monkeys. We identified that both initial and collecting lymphatics are present in the conjunctiva using the enzyme histochemistry, immunohistochemistry and isolated lymphatics. These initial lymphatics are generally similar to those in other organs. Interstitial tissue fluid, solutes, cells and particulate matter from the conjunctival tissue enter the initial lymphatics. Initial lymphatics have also been termed terminal lymphatics or lymphatic capillaries. These are the most distal structures in the lymphatic system. They vary in size and shape, and are typically blind-ended tubes with variable anastomoses with other initial or collecting lymphatics. Initial lymphatics have very thin walls comprised of non-fenestrated endothelial cells, incomplete basement membrane, and are devoid of muscle cells or pericytes.

We have developed a minimally invasive glaucoma surgery along with bioengineered microfistula and ab-interno approach which can significantly improve glaucoma surgical outcomes. We have also enhanced our knowledge from detailed experimental investigations of drainage mechanisms of aqueous humor in the subconjunctival tissue. We would like to translate our research discoveries of aqueous humor drainage mechanisms in the subconjunctival tissue for clinical diagnosis and further treatment by developing non-invasive and label-free imaging techniques to monitor each patient’s conjunctival lymphatics before the operation and the conjunctival bleb after GFS. It can be expected that GFS success rate will be significantly increased if such techniques can be employed. Furthermore, if we could develop new therapeutics to modulate the function of conjunctival lymphatics, we could potentially fine tune lymphatic and hence bleb drainage to more effectively remove the aqueous humor from subconjunctival tissue. It is unavoidable that some glaucoma patients have had long term pharmacological treatments with eye drops containing various substances and/or previous surgical procedures before our procedure, which tend to increase the risk of GFS failure. We would like to share our concepts and preliminary work to improve the monitoring and modulation of subconjunctival tissue and lymphatics after GFS so as to improve the predictability of GFS outcomes.

**Clinical monitoring of the subconjunctival microenvironment**

Unlike blood, lymph flow is colorless and the lymphatic vessel wall is very thin. We do not visualize lymphatics in the conjunctiva in normal conditions. Although we use fluorescence and trypan blue dyes to illustrate the presence of conjunctival lymphatics and their roles in the drainage aqueous humor from subconjunctival tissue experimentally, these dyes should be avoided clinically.

Fortunately, non-invasive and label-free techniques, such as optical coherence tomography (OCT) and confocal laser scanning ophthalmoscope (CLSO) have been widely used in the ophthalmology [10,36]. Using CLSO and the Heidelberg Rostock Cornea Module technique we have successful imaged optical sections of conjunctival

![Figure 2. Normal conjunctival lymphatics in the monkey demonstrated by subconjunctival trypan blue injection.](image-url)
bleb (Figure 3). From these sections, we are able to visualize the structure of the subconjunctival tissue and filtration bleb at a microscopic level. But we cannot identify exactly which structure is representing the lymphatics. Advances in OCT techniques may help to identify the lymphatics. The development of OCT has revolutionized ophthalmology by providing a rapid, simple, and non-invasive method to assess retinal structure at the microscopic level [37]. Recently, the development of OCT-angiography (OCT-A) has opened up exciting new avenues for label-free 3D clinical imaging of retinal capillaries, as demonstrated in studies using either commercially available or custom-built systems [38-43]. The OCT-A has successfully obtained retinal capillary and microvasculature images using signals from moving red blood cells. An interesting question is whether we can utilize specific features of the conjunctival lymphatics to identify it clinically. Conjunctival lymphatics have a specific pattern and distribution as we have described [11,44,45]. Figure 4 illustrates the conjunctival lymphatics which consists of lymphatic capillaries and pre-collectors. The conjunctiva has relatively dense lymphatic network. The blind-ended tubes at the initial lymphatics and collecting lymphatics have a larger and more uneven caliber located in the deeper layer. The conjunctival lymphatics have relatively large size and irregular shape which is distinctly different compared to blood vessels. In addition, initial lymphatics are located under conjunctival epithelium. It may be possible to use OCT techniques to image the conjunctival lymphatics identified by an interconnected large lumen network and the characteristics described above without the presence of moving red blood cells. Label-free optic lymphangiography has been reported by an auto segmentation method applied to OCT to visualize skin lymphatic vessels [46].

**Modulation of conjunctival lymphatic capillaries**

The outcomes of GFS can be further improved if conjunctival lymphatic capillaries could be functionally modulated. Aqueous humor after GFS will continuously enter subconjunctival tissue joining interstitial fluid. Lymph vessels are required for carrying that fluid, interstitial proteins, peptides, and cells to the lymph nodes and back to the blood circulation (Figure 4). Initial lymphatic vessels (also called lymphatic capillaries) are present in the conjunctiva in human, rabbits and primates [11,44]. An important result from our experimental work is that lymphatic capillaries are very close to the aqueous exit point outside of the sclera in the functional bleb [11]. We still do not know whether these lymphatic capillaries were pre-existing or newly formed by an amoeboid migration of endothelial cells from initial lymphatic vessels or lymphangiogenesis. The endothelial cells in the initial lymphatics are able to undertake amoeboid migration and even phagocytosis [47]. Lymphatic capillaries consist of a single layer of overlapping and interdigitated endothelial cells. These overlapped endothelial cells are joined by the junctional protein VE-cadherin. The abluminal part of the initial lymphatics is connected to the elastic fibers in the surrounding ECM via so-called anchoring filaments, consisting of collagen VII, a connection made via the transmembrane integrin and focal adhesion kinase [47-48]. Such a structure has been described as flaps and initial valves allowing one-way passage of cells, fluid, and protein.

Whether “pre-lymphatic channels” with low resistance pathways exist in the normal subconjunctival tissue, as found in the skin and muscle is another interesting question. Interestingly, the integrated effect of spontaneous motion could induce volumetric contraction of the entire initial lymphatics. To change lymphatic lumen volume of a collapsed lymphatic requires tensile tissue stress. A distended lymphatic requires compressive tissue stress to reduce lymphatic volume. The ‘tissue pump’ and initial lymphatics enable lymph formation and transport. The overlapping junctions may thus constitute a valve system that prevents retrograde flow from the lymphatic capillary back into the interstitium. There are complex mechanisms involved the removing the aqueous humor from subconjunctival tissues by the initial lymphatics. Knowledge of these mechanisms will help us to improve this draining process.

**Modulation of conjunctival lymphatic pre-collectors**

We have demonstrated that collecting lymphatics are present in the conjunctiva. The lymphatic valve can be seen histologically in a flat-mount of a human conjunctiva stained with 3'-nucleotidase and also in an in vivo monkey after GFS and in an isolated perfused preparation [11,44]. These luminal unidirectional valves are closely spaced creating...
segmented collecting lymphatics. These segments in the collecting vessel form a lymphangion. Segmentation, unidirectional valves and muscular wall are important features of lymphatics. The function of the lymphangion has an intrinsic contractile mechanism and undergoes rhythmic, phasic constrictions to propel the lymph centrally. An isolated perfused conjunctival lymphatic vessel system has been established in our group using methods previously used on isolated retinal arterioles and veins [49-55]. To determine the performance of the collecting lymphatics, we dissected, cannulated and perfused the collecting lymphatics from fresh conjunctiva and studied them. As the importance of the lymphatic system in the human body becomes increasingly evident, novel research effort will drive the need for improved models to study lymphatic biology. Using this preparation, possible modulations of collecting lymphatics by chemicals, drugs and other factors could also be tested. Hopefully, we can find effective compounds which could modulate the function of the conjunctival lymphatic pre-collectors after GFS if required.

Summary

Translation research is one of the most important aspects of medical research. Our team is focusing on some common and critical questions and needs in the field of ophthalmology. We need to carefully consider our hypotheses, take optimum approaches and perform the appropriate experimental studies. There are exciting opportunities to discover the answers to key questions as the clinical data from the expanding use of this novel GFS approach becomes available. A collaborative approach with industry partners may well provide the most efficient way forward. Translation of new discoveries into clinical practice is not the end of the process. Feedback from clinical use would provide the best pathway to optimizing devices and techniques to produce the optimum outcome for each and every patient. This process (Figure 5) could be long term with many challenges. Therefore, we should consider new questions and challenges raised in clinical applications. We will continue our efforts to answer these new questions and challenges. We propose to collaborate with experts in OCT and lymphatic fields to develop the techniques required to further improve surgical outcomes in GFS.

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