

Glaucoma



Chats

Implants and Injectables for Glaucoma Treatment

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Transcript of teleconference with Dr. Nitasha Gupta, Glaucoma specialist in Westchester County, NY

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Please note: This Chat has been edited for clarity and brevity.

MS. SARAH DISANDRO: Hello, and welcome to today's Glaucoma Chat, "Implants and Injectables for Glaucoma Treatment." My name is Sarah DiSandro, and on behalf of BrightFocus Foundation, I'm pleased to be here with you today. Our Glaucoma Chats are a monthly program, in partnership with the American Glaucoma Society, designed to provide people living with glaucoma and their families and friends with support straight from the experts. All Glaucoma Chats presented by BrightFocus are also available to listen to as podcasts on YouTube, Spotify, iHeartRadio, Amazon Music, Apple Podcasts, and Pandora. BrightFocus Foundation's National Glaucoma Research Program is one of the world's leading nonprofit funders of glaucoma research and has supported more than \$51 million in scientific grants exploring the root causes, prevention strategies, and treatments to end this sight-stealing disease.

Now, I would like to introduce today's guest speaker. Dr. Nitasha Gupta

is a board-certified and fellowship-trained glaucoma specialist and cataract surgeon. She received her bachelor's and medical degrees from Northwestern University before completing a residency at the University of Chicago and a fellowship at the University of Wisconsin–Madison. In her final year of residency, Dr. Gupta served as chief resident and was recognized by the Department of Ophthalmology and Visual Sciences for her excellence in patient care. Welcome, Dr. Gupta.

NITASHA GUPTA: Hi, Sarah, thank you so much. It's a real pleasure to be here.

SARAH DISANDRO: Great. So, to kick things off today, it's important that we recognize that many people may not know where to even begin after they've been diagnosed with glaucoma. What's usually the first step in treating this condition?

NITASHA GUPTA: Yeah, that's a great question. Glaucoma is, I think, one of the most challenging conditions to be diagnosed with within the ophthalmology world, because it's something that you really feel like you have no control over. There's no diets, dietary changes, lifestyle modifications, or really anything that you can do to treat your own disease, and it's really up to taking medications and coming to appointments and things like that. So, it really feels like you're out of control. So, the way that I start a lot with the first diagnosis of glaucoma is really a conversation that centers around: What is this relationship going to be like? Glaucoma is lifelong, so the relationship between the physician and the patient has to be strong, and it has to have mutual trust, mutual respect going both ways. So, I usually start with: What is glaucoma? And I give a brief overview of what glaucoma is, how it affects someone's vision, and remind the patient—and if they have family members with them—that the goal of all of our treatments, all of our interventions, everything that we do is to maintain the sight that they have and to stop things in their tracks and really hope that things don't get worse. And then I kind of launch into this is how we treat glaucoma. And there are many, many different ways to treat glaucoma, and I think that we've touched about a lot of them in the past and we will touch upon various of them today. But I usually I start to outline the treatment options by saying that we have

eye drops—multiple different eye drops—and then we have in-office procedures, including lasers and sustained-release medication implants. And then if we're talking in the surgery world, we have minimally invasive surgeries and more invasive surgeries. And then I usually go so far as to say that most people, unfortunately, will need almost all of these interventions, and it's just a matter of figuring out what is the order in which it's going to be most appropriate for you. And that's kind of the key.

SARAH DISANDRO: Great, thank you. I really like what you said about the need to establish that relationship of trust with your physician. I also agree that's incredibly important. And so, we touched a little bit on eye drops and laser procedures. Now, what if eye drops or laser procedures, like selective laser trabeculoplasty or SLT, what if those aren't really working as initial treatments? What other options might our listeners want to explore?

NITASHA GUPTA: Yeah, I kind of heard two questions there, Sarah. One is: What is an initial approach or what is an appropriate initial approach to treatment?

SARAH DISANDRO: Right.

NITASHA GUPTA: And I always offer eye drops and laser first line. So, we have about four or five different eye drops available, but the problem with eye drops is that they have side effects. Now, they have preservatives, they make your eyes red. They can also cause, sometimes, systemic side effects. You can get fatigue, dizziness, brain fog, low heart rate. All of the drops are not necessarily benign. Thankfully, our interventions have really evolved and become a lot safer. So, SLT, selective laser trabeculoplasty, which you mentioned, is, in my opinion, a great option for first-line treatment. It is very safe. It is repeatable. It's done right in the office. There's no downtime. The eye can feel irritated for a couple of days, but there's really no restrictions, no downtime. And like anything with glaucoma, there's about a 75 percent success rate, and that's typically what I quote for anything that we're doing, even if it's an eye drop. A lot of people think that eye drops are, kind of, the safer way or, "Yeah, I'll just

use an eye drop because that's easy. It's going to work. Simple, safe, let's sign me up for that." But what I sometimes try to remind people is you have to remember to take that eye drop every day, and then you get side effects. Your eyes get red. They get dry from all the preservatives—that also affects your vision. And if anything, that affects your quality of life more than the actual glaucoma does.

So, I encourage patients to maybe ask about laser and some of our listeners to ask your doctor about laser if you haven't already had it and just to consider that as much as a drop may seem like it's the safer option off the bat, a lot of times it may not be the best option for you. So, I usually start with offering drops and laser first line, and I'd say I end up doing like 50/50, because I do kind of leave it up to the patient to decide how they want to start. The nice thing about laser is it can be repeated. So even if it doesn't work at the very first time as much as you'd want it to, there's more and more evidence that we're finding out and is being presented at conferences and everything that show that repeat lasers actually are more effective, and just because you didn't respond well the first time doesn't mean you can't try it a second time.

So, depending on the person, I'll try repeating laser again, but then I might go into some of the other in-office options that we have. One of them being a sustained-release medication device called Durysta®. That is done in the office. It is the same active ingredient as Lumigan®, and I'm sure a lot of our listeners are familiar with Lumigan. It's a very, very, very commonly used first-line drop. It's my first-line drop, typically, and instead of taking it every day, it comes as an extended-release implant, which is biodegradable. It's injected right in the office, takes literally 30 seconds, is painless, and dissolves directly into the eye, releasing the medication into the eye directly where it needs to be. It's really safe, it's covered by most insurance plans, and it can really take you off drops. That's one way that I like to start.

SARAH DISANDRO: Right, that's great. That's very interesting. So, you covered some of those advantages of the sustained-release treatments. Are there any downsides people should be aware of or know about regarding sustained release?

NITASHA GUPTA: I'll answer that question in terms of the whole minimally invasive phase. So, the Durysta implant, which I just mentioned, is done in the office. That one lasts 6 to 12 months in my opinion, from what I've seen. I think some of the studies do show an effect of Durysta up to 18 months, and I think even up to 24 months. I, personally, to be completely honest, have not necessarily seen that, so I typically will quote more like 6 to 12 months. But the nice thing is that it's done right in the office. There is another extended-release delivery device, which—I'm actually in surgery today, and I actually just put a couple in—is called the iDose®. That one lasts 3 years. So because it lasts longer, we do like to do it in the operating room, just make sure it's really positioned properly, safely in the most sterile environment. That contains travoprost, which is, again, a very, very commonly used first-line eye drop, and it is slowly released over 3 years in a very controlled fashion. So, that's another one of the extended-release drops. And I think that those work very well and are very comparable to the minimally invasive glaucoma space, which is a nice bridge towards some of the invasive surgeries that our listeners may have unfortunately experienced, like trabeculectomies and tube shunt surgeries.

In general, you had asked me, Sarah, about the downsides to some of these sustained-release treatments. In general, I say for the minimally invasive space and the Durysta and iDose implants, it just may not work. That is honestly, in my opinion, the biggest downside. I think from a procedure standpoint, it's extremely safe. The risk of infection is quite low. I think the trials for Durysta, which is the one in the office, had a zero percent risk of infection. I know the iDose data also has a zero percent risk of reported infections in the studies at least. So, it is extremely safe. Surgically, we have a very sterile protocol that we follow, including Betadine washes, really doing everything that we can to ensure sterility and lack of infection. So, I really don't believe infection is a risk. And beyond that, it is surgery, so in theory, yes, there is a chance that something unexpected could happen. The implant could be positioned in a slightly different way if we're talking about the iDose and has to be repositioned. But for the most part, any surgeon who's trained in this, any glaucoma specialist ... it is fairly straightforward, and I literally tell my patients that the biggest risk is that it may not work and that we have to revisit the next plan and what's the next thing that we're going to do.

SARAH DISANDRO: All right, great. Thank you for that. You mentioned earlier, and I know that our listeners have probably received recommendations from their eye doctors regarding something called a tube shunt. Now, in simple terms, what is a tube shunt and how does it help people with glaucoma?

NITASHA GUPTA: Tube shunts are a group of surgeries. There are three or four—don't quote me on that—different devices that are available on the market. And it basically involves a tube that's made out of medical grade silicone which is inserted into the front of the eye, close to the iris—which is the colored part of the eye—and then that tube is attached to a part of the overall device that we call the plate. And the plate is secured to the white of the eye—that's called the sclera. So basically, you have this external device which is secured to the actual wall of the eye, to the actual eyeball, and has literally a tube that extends into the front of the eye. The idea being the fluid in the front of the eye, which is kind of the culprit in glaucoma and we want to try to redirect the fluid and manage that better, can flow through the tube and then kind of leave the eye through the plates over the actual eyeball, and that way we bypass the natural drain of the eye and the natural anatomical parts, which just unfortunately do not work as well as glaucoma advances. So that, in a nutshell, is what a tube shunt is, and it's used to reduce pressure quickly. So, say somebody's pressure is going up very quickly, they've been stable in the teens and then it's trending up to the 20s, it's even going up to the 30s. A tube shunt is probably the fastest way to lower your pressure. Definitely surgically drops also can sometimes take some time, so it's probably the fastest way to lower pressure. In terms of vision, a lot of times our goal is not necessarily to make your vision better, it's more to stop the disease; that's the downside, again, to glaucoma. So, the tube shunt helps to treat the pressure, and hopefully, then that will stabilize the disease in the long run.

SARAH DISANDRO: Right, great. Thank you for that explanation. Are there any risks related to this particular treatment—to tube shunts—that our listeners should be aware of?

NITASHA GUPTA: Yeah, the tube shunts and trabeculectomy surgeries are more of the invasive glaucoma surgeries that until maybe 10 years

ago were really the only surgical options that we had. So, they are great. They work, and they are effective. They lower pressure, and there is still very much a role for tube shunts in glaucoma surgery. Risks and side effects: Because they are more invasive, they do take a little bit longer—the actual surgery itself—and so there is a slightly higher risk of infection compared to the more minimally invasive surgeries. And specifically, with tube shunts, you are putting in a piece of hardware in the eye. You are actually physically putting a device that's made out of plastic and silicone, so there is a risk of erosion or exposure of the tube through the tissues. Normally when we place the tube shunt, we cover it with tissues and we make sure it's nicely insulated, covered, and protected. But over time, just through wear and tear, aging changes that can happen to the tissues of the eye. And we kind of tuck it under the eyelid, so sometimes also friction from eyelid movement can cause the tissues that cover the tube shunt to become a little bit fragile. And if they become too fragile, it can actually start to cause the tube to be exposed. That's probably the biggest risk that I would tell people about for tube shunts, because if that were to happen, we do like to fix that. It is another trip back to the operating room, but we do like to fix that fairly quickly because that can be an infection risk, just to have an exposed tube present in your eye. That's probably the biggest risk I would say.

SARAH DISANDRO: Yeah, got it. Thank you for that. For our listeners who might be concerned about their long-term eye health, how might newer implants or injectable treatments affect their vision over many years?

NITASHA GUPTA: Yeah, that's a great question, Sarah. I kind of have two answers for that. So, in terms of their vision over many years, definitely stabilizing your pressure early in the safest ways—you can just halt the disease as early as we can. That is number one. And then you don't even have to worry about vision loss or any vision loss that may have already occurred. The goal is to keep it where it is and not let it get any worse. We are learning more and more that drops are a very imperfect way to treat glaucoma. Again, you have to remember to take them. They have side effects. They have a co-pay. There's literal cost associated with it. There's a lot of challenges with drops. And then if we take those kind of personal, human aspects out of the equation and strictly look at it medically, you

have to take drops multiple times a day. So, why? Clearly, they're wearing off, and that's why you have to keep replenishing that drop. So, if you think about what's happening to your eye pressure during that time, you take your drop, your eye pressure goes down, but then you have to take it again, sometimes 12 hours later, sometimes 8 hours later, sometimes 24 hours later. But what's happening to your pressure right before you have to take that next drop? It does go up a little bit, right? So, you get these mini fluctuations in eye pressure that in the long run are probably not good for the optic nerve and for progression of disease. And I think as we have more options—and honestly, as we have safer options—I think we're learning more and more that even these microfluctuations in pressure are not good for progression long-term. So, introducing sustained-release medication implants, introducing minimally invasive glaucoma surgery, and introducing non-drop options—laser even, very simple procedure in the office—can really minimize progression in the long run. So, that's vision over many years.

But I also think there's an advantage to your vision every day in the short term, because—I kind of feel like I sound like a broken record—but drops have side effects and drops have preservatives. And if I go out into my waiting room, I know exactly who's there to see me and I know exactly who's there to see one of my colleagues who only does cataract surgery. Their eyes look very different. So, if we can minimize ... and they're just still red, they look dry, they're swollen sometimes. It's all the preservative from the drops. So, I'm not saying that drops are bad, I'm not saying throw them in the garbage. There's a role for drops. There is 100 percent a role for drops, but if we can minimize that role and if we can reduce the number of bottles that somebody has, if we can reduce how many drops are actually going on the surface of the eye, I actually think your vision improves because you just don't have so much crap, honestly, going on the eye, so much preservative, and you don't have as much dry eye. And I think your vision is clearer. The quality of your vision just has to improve. So, I think there's also that advantage in your everyday life.

SARAH DISANDRO: Yeah, this is just so interesting, and it sounds like such an exciting time for glaucoma treatment, truly.

NITASHA GUPTA: Yeah, it really is. We call it the interventional glaucoma revolution right now.

SARAH DISANDRO: Oh, really?

NITASHA GUPTA: Yeah, there's a really big push towards doing interventions sooner rather than later, and it all has to do with innovation. So, we have so many options now. They're so much safer than they were before. The surgeries are straightforward, safe, and effective. So, it's a great time to see what the options are out there.

SARAH DISANDRO: Fantastic, that's great. So, we also receive a lot of questions about what's coming next in glaucoma care. Could you share some promising new treatments being developed that might change how we manage glaucoma in the coming years?

NITASHA GUPTA: Yes, this is probably the subject for three more Chats to come, honestly. But in a nutshell, at least what I am familiar with ... and I by no means do active research or design or anything like that, but from what I know, there's a big push towards a couple of major things. One is definitely the sustained medication delivery. So, we have two fantastic options right now—Durysta in the office, iDose in the operating room. And then there's also some research going into seeing artificial lens implants that we put in at the time of cataract surgery. Can we put something along with that that will slowly release medication into the eye as well? There's different modes of how to put medication directly into the eye in this slow elution, sustained-release delivery system approach.

And then a lot of what we do is focused on what we call the trabecular meshwork, which is one part of the eye. That is the number one pathway for how pressure is regulated in the eye, but there's also a secondary pathway. So, that one has typically not really been utilized until now, and so there's more focus on utilizing that secondary pathway. It's called the uveoscleral pathway. So, there is a newer surgery that's looking into that. It's called outflow—I do that one, as well. There's been research in the pipeline using this pathway for quite a while, and I think that it's just a matter of finessing it and giving us options so that way we can tackle pressure control through both natural pathways. That's another one. And I

think there's some research into looking at different applications for laser. So, the way that we currently use SLT, for example, right now, is we have a standard protocol for settings. Typically, on average, it lasts about 2 to 3 years, and then we can repeat it. But what if we were to adapt those settings and maybe introduce it yearly as opposed to every 2 or 3 years? And just seeing if we can use the safe options that we have now and make them more accessible for everybody. So, that's what I'm aware of at least coming.

SARAH DISANDRO: Great, great. That's really exciting. So, we've received several listener questions. I'm going to start to shift over to questions from our listeners here on the Chat. Our first question that came from a listener is: Can you use these glaucoma options if you also have age-related macular degeneration?

NITASHA GUPTA: Yes, absolutely. So, they are two completely separate entities, and I work with retina specialists, as well, so I actually share a lot of patients with them, and they have both glaucoma and macular degeneration. And we also know that if somebody's getting injections for macular degeneration, sometimes there can be an effect on the pressure, and you have to watch that closely anyway. Sometimes you can actually get a secondary pressure elevation due to multiple retinal injections, so I actually encourage the listeners to keep an eye on their pressure, as well. But in my opinion, yes, nothing is off-limits with any other diagnosis of macular degeneration.

SARAH DISANDRO: Okay, great. Another question we received: Are there stitches involved with these procedures? Are they biodegradable, or must they be removed? Basically, this is a three-part question. Are there stitches involved with the procedures? Are they biodegradable? And also, if they are biodegradable, how long does it take for them to dissolve?

NITASHA GUPTA: So, stitches is a little bit of a surgeon preference, but in general, most cataract surgeries do not require sutures, and most of the minimally invasive glaucoma surgeries do not require stitches, including the Durysta and iDose. Trabeculectomy surgeries and tube shunt surgeries do usually require some stitches. Again, it's a little bit of surgeon preference. I have some colleagues I know who are using other

techniques to secure the plate and close the tissues that may not rely on stitches as much, but the answer is yes and no for a lot of this, because some of them are dissolvable, some of them don't dissolve. If they don't dissolve, you don't necessarily have to remove them, actually, as long as they remain taut and tight and are not causing any kind of issues for the patient in terms of foreign body sensation, you can leave those in. If they do need to be removed, it can be done right in the office. The dissolvable ones typically take about 6 to 8 weeks to dissolve.

SARAH DISANDRO: Okay, great. And then another question that we received: Which procedure has the longest track record of long-term success?

NITASHA GUPTA: Oh, so that's a loaded question. So, anything glaucoma, I would say there's about a 25 percent to 30 percent failure rate. And the truth is glaucoma is very difficult to control and very difficult to treat. Myself, as a cataract surgeon and a glaucoma surgeon, my conversations about cataract surgery are very different than glaucoma surgery. Cataract surgery, you know what to expect. I can tell you how long it is—it's going last forever, etc., etc. With glaucoma surgery, this is what we're going try, and if we can get 2 or 3 years out of this, fantastic. We are most likely going to have to do something again, and that is just the nature of the disease. Actually, when I was in fellowship, my mentor told me that the happiest glaucoma surgeon moves every 5 years.

SARAH DISANDRO: Oh, wow.

NITASHA GUPTA: And it's because when you move every 5 years, you don't see your failures, and you don't see when the surgery that you just did failed and the pressure starts to go up. But to actually get to your question, I think that the longest track record for success is probably a tube shunt or a traditional trabeculectomy procedure. That is the mainstay of glaucoma surgery. It's been around for probably 30, 50 years at this point. Tube shunts we know work. Trabeculectomies we know work. They lower pressure. The problem with invasive glaucoma, as well with any surgery, is scarring, and trabeculectomy surgeries are particularly prone to scarring, and tube shunt surgeries, over time, they just stop working as well, and we know that. So, it's a tricky question, but I'd probably say the

highest track record, long-term success, trabeculectomy and tube shunt surgeries.

SARAH DISANDRO: Got it, got it. And another question just came in, and it's: Are these procedures helpful if your vision has severely declined? So, if you already have severe vision loss, are these procedures helpful?

NITASHA GUPTA: That's a really good question. I think the short answer is yes, because anything that lowers pressure is good, right? And it's helpful. So, the short answer is yes. The longer answer, and unfortunately I do have this a lot, and this goes back to how we first started, Sarah, with, "What is your relationship with your surgeon and with your doctor?" Because if you have significant vision loss to the point where you can maybe only make out motions or shadows or counting fingers, and you don't quite make it to the eye chart, if we're talking that degree of vision loss, then yes, there's still vision to preserve, and it's important vision, and it's worth protecting and saving and maintaining. But is it worth putting a tube shunt in for that and taking the risk of a longer surgery and that risk of exposure and some of those things that go along with a tube shunt surgery, or do we try a minimally invasive surgery? Do we try a slightly more aggressive laser to get the pressure down and treat glaucoma? We're not giving up on treatment, but it's kind of a cost-benefit ratio to how aggressive we want the surgical intervention to be for the gain and the preservation of vision. So, that's a very tricky question.

SARAH DISANDRO: Right, right. Those are all such important things to consider, very, very important things to consider. Thank you. Another question that we just got in, a very specific question: Can the XEN® Gel Stent procedure be done multiple times over many years?

NITASHA GUPTA: Again, yes and no. So, the short answer is yes. If there is tissue available, if there's space available, if it worked before, absolutely. I, myself, have gone—and probably within a year, though I wouldn't say it was many years—and I did put a second XEN Gel Stent in next to the first one. I left the first one in, and I put a second one in, but I'd say I did that within the year. Everything for glaucoma surgery revolves around scarring and what does the tissue look like, because we rely on the physical tissues to support the surgeries that we do. If there's scarring or the tissues are

not strong enough, that can limit what some of your options are.

SARAH DISANDRO: Right, okay. And then I think we just have one more question right now, and that is: What do you think of the iStent infinite®—this is three stents—so, the iStent infinite to slow down mild to moderate glaucoma?

NITASHA GUPTA: I think it is a great option because it is approved for all stages of glaucoma—mild, moderate, severe—and it is straightforward. It can be done with cataract surgery, it can be done with other glaucoma surgeries, and it can be done alone as well. I think the key is, like with anything, and kind of like I've said a couple of times, it really comes down to your surgeon, what they are comfortable with, and the results that they have had. So, I have had people come to me, and they'll say specifically, "What do you think about X, Y, or Z?" And I'll say, "It works well. I have colleagues who do that routinely. In my hands, I haven't necessarily gotten the results that I wanted, so it's not necessarily my first choice," for example. So, I think that more than looking at each surgery individually, you have to look at who's performing it, their comfort level, and how happy have they been with their results.

SARAH DISANDRO: Right.

NITASHA GUPTA: But I have done the iStent infinite standalone and in combination with cataract surgery for all stages of disease. And the main thing to remember with glaucoma, and I had somebody call me out on this in the office the other day when I was talking about laser, and they said, "Well, after 2 years, you have to repeat it, so it only lasts 2 years." I'm like, but that's 2 years. Two years that you haven't had to use drops, 2 years that your pressure has been controlled, and what's the alternative? Taking drops every single day. So, I think one thing you'll find if you talk to a lot of glaucoma specialists is they're not looking for a cure, they're not looking for a slam dunk, they're looking for something that's going to buy you time. And if we can get a year off the drops, if we can get 2 years of reduced drops, that's a win in our book.

SARAH DISANDRO: That's great. Yeah, absolutely. Well, that's all the time we have for questions today. Thank you. Thank you so much, Dr. Gupta.

Thank you for taking time out of your busy schedule and your surgeries and everything that you've had going on today. So, thank you so much for being here and for the invaluable insights you shared with us today. Dr. Gupta, before we close, do you have any final words of advice for our listeners?

NITASHA GUPTA: Glaucoma is tough, but it is manageable. There's a lot of exciting new innovation out there, and we are really trying our best to come up with effective, safe options for treatment. So, it's an exciting time to be in this world right now.

SARAH DISANDRO: Wonderful, thank you. Thank you, Dr. Gupta. To our audience, we'll be taking a short break for the month of June, so our next Glaucoma Chat will be on Wednesday, July 9, where we'll explore exciting new research in the field. Thanks again for joining, and this concludes today's Glaucoma Chat. Take care.

Useful Resources and Key Terms

BrightFocus Foundation: (800) 437-2423 or visit us at BrightFocus.org. Available resources include—

- [Glaucoma Chats Archive](#)
- [Research funded by National Glaucoma Research](#)
- [Overview of Glaucoma](#)
- [Treatments for Glaucoma](#)
- [Resources for Glaucoma](#)
- [Expert Advice for Glaucoma](#)
- [Tube Shunt Drainage Devices for Glaucoma](#)
- [Exploring the Benefits and Limitations of Minimally Invasive Glaucoma Surgeries](#)

Helpful treatment options or resources mentioned during the Chat include—

- [Durysta®](#), a drug delivery implant system
- [Lumigan®](#), eye drops used to treat high eye pressure
- [iDose®](#), a sustained-release medication implant containing travoprost
- Tube shunt, a class of surgical glaucoma treatments to help drain the eye
- [XEN® Gel Stent](#), an implant designed to lower eye pressure
- uveoscleral outflow surgery, which involves using the uveoscleral pathway to drain fluid from the eye