Visual outcome and efficacy of conjunctival autograft, harvested from the body of pterygium in pterygium excision

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Purpose: To evaluate the efficacy of conjunctival autograft after the pterygium excision with fibrin adhesive using conjunctiva over the pterygium.

Patients and methods: This prospective study included 25 eyes of 25 patients with a mean age of 40±10 years, who underwent the pterygium excision with conjunctival autograft derived from the body of the pterygium and attached using fibrin glue. The mean follow-up period was 6 months. On all postoperative visits, changes in uncorrected visual acuity, corrected distance visual acuity, astigmatism, complications, and the evidence of recurrence were recorded.

Results: At the end of the mean follow-up, uncorrected visual acuity and corrected distance visual acuity improved by one or two lines in all eyes treated. Mean astigmatism reduced significantly from a preoperative value from 2.308D to 1.248D postoperatively ($P<0.026$). Minor postoperative complications such as congestion, chemosis, and subconjunctival hemorrhage were seen, which resolved with time. No major sight-threatening or graft-related complications were detected. There was no evidence of recurrence during a follow-up period of 6 months.

Conclusion: Self-conjunctival autograft following the pterygium excision appears to be a feasible, safe, and effective alternative method for management of pterygium. It also preserves the superior conjunctiva for future surgeries. However, longer follow-up is required to study the long-term outcomes, especially the incidence of recurrence.

Keywords: Pterygium, self-conjunctival graft, body, autograft

Introduction
Pterygium, a word derived from “pterygion” (ancient Greek for a wing) is a wing-shaped, fibro-vascular overgrowth arising from subconjunctival tissue extending across the limbus onto the cornea. It is a degenerative condition of the subconjunctival tissue, which proliferates as a vascularized granulation tissue to invade the cornea, destroying superficial layers of stroma and Bowman’s membrane.¹

Several theories have been proposed to explain the pathogenesis of the pterygium such as inflammatory theory (Kamel), neoplastic theory (McReynolds and Schreiter), degenerative theory (Fuchs and Schoinger), and immunologic theory. The most accepted theory in pathogenesis is Kamel’s inflammatory theory. Various methods of surgical management of pterygia are excision, avulsion, and excision with primary closure, transplantation of the head of the pterygium, conjunctival autograft, limbal conjunctival autograft, and amniotic membrane graft. The pterygium surgery with conjunctival autograft remains the gold standard with less incidence of recurrence after its initial description in 1985.¹ Recurrence rates consistently reported are in the range of 5%–10%.² The recent technique is to use tissue fibrin glue for anchoring the graft to the bed.
The favored site to harvest the autograft is superotemporal because this location in an oblique quadrant will avoid inadvertent injury to extraocular muscle, while its position under the upper lid will aid with patient comfort and healing of the donor site.

However, in this study, we report outcomes with a novel technique of the pterygium management using conjunctival autograft harvested from the body of the pterygium. We also discuss our experience regarding the patient acceptability, visual results, and potential complications in a 6-month follow-up period with this new technique.

**Patients and methods**

The study was approved by the institutional review board of Nethradhama Superspeciality Eye Hospital, Bangalore and adhered to the tenets of the Declaration of Helsinki. Informed consent was obtained from all the patients participating in the study.

In the above review of literature, the sample size for similar studies was as low as 20 and as high as 88 eyes. In view of 6-month follow-up required in this study and an average pterygium surgeries of eleven per month in the hospital set up the sample size was selected as 25 eyes.

A total of 25 eyes of 25 patients with the primary pterygium diagnosed on slit-lamp were selected for the study. However, recurrent pterygia, ocular surface disorders, severe dry eye, and the patients already on antimetabolites were excluded from the study.

A detailed preoperative clinical examination was conducted on all patients which included recording of uncorrected visual acuity (UCVA) and corrected distance visual acuity (CDVA) using Snellen’s test charts and LogMAR, slit-lamp examination, keratometry readings using Orbscan II (Technolas, Munich, Germany), dry eye assessment using Schirmer’s 1 and 2 tests, dilated fundus examination with pupillary dilatation using 90D and indirect ophthalmoscopy was done. B-scan ultrasonography was performed whenever the fundus details were not clearly visible.

The pterygium was classified into three types depending on the extent of corneal involvement:

- **Type 1**: extends less than 2 mm on the cornea
- **Type 2**: involves up to 4 mm on the cornea
- **Type 3**: encroaches onto more than 4 mm of the cornea and involves the visual axis.

**Surgical technique**

All the patients were operated by a single, experienced corneal surgeon (VB) under topical anesthesia using an operating microscope. Proparacaine 0.5% (Sunways India Pvt Ltd., Mumbai, India), eye drops were instilled in the eye twice at an interval of 10 minutes before surgery and intraoperatively as required.

After instillation of topical anesthesia, the conjunctival tissue over the body of the pterygium was marked using a marker. It was then isolated from the underlying degenerative tissue using blunt dissection. Using anatraumatic conjunctival forceps and Vannas scissors, the conjunctiva was carefully dissected and isolated from subconjunctival tissue (Figure 1).

In addition, care was taken to prevent buttonholing during dissection. The dissected graft was flipped over the cornea.

The pterygium was excised in a circular fashion similar to performing a capsulorhexis. Blunt and sharp dissection was performed to separate the pterygium from underlying sclera and surrounding conjunctiva. The body of the pterygium, along with underlying tenons was excised using Westcott scissors. The wound bed was smoothened by scraping and bleeding vessels cauterized using wet field cautery. The harvested graft was then placed over the bare scleral bed, while maintaining the orientation that is epithelium side up and limbal edge toward limbus. In addition, care was taken to prevent the graft from rolling over.

Fibrin glue (Tisseel fibrin sealant Baxter AG, Vienna, Austria) was used to attach the autograft in place. The mixing of the component was done as per the manufacturer’s instructions.
Statistical analysis

The data were collected and tabulated using Microsoft Excel and Word. Descriptive analysis and analysis of variance statistical analysis were carried out in this study. The results of continuous measurements were presented on mean ± standard deviation (SD) and results of categorical measurements were presented in number (%). Significance was assessed at 5% level of significance. Student’s t-test (two-tailed, dependent) was used to find the significance of study parameters on a continuous scale within each group.

Results

A total of 25 eyes of 25 patients underwent the pterygium excision with this new technique. Mean age was 40±10 years. The number of eyes classified preoperatively as grade 1, 2, or 3 were 10, 11, and 4 eyes.

There were no intraoperative complications encountered. The procedure was well tolerated and the patients did not report any significant subjective complaints of excessive pain, irritation, or discomfort both intra as well as postoperatively.

Changes in keratometry

A significant flattening in mean simulated keratometry (sim K) was observed over time. A significant reduction in mean sim K was seen from a preoperative value of 2.308±2.25 SD to 1.248±0.99 SD at 1 month postoperatively, which was statistically significant (P-value <0.026). Keratometry remained stable and no significant changes in sim K observed between 1 month and subsequent follow-up visits (Table 1).

Changes in visual acuity

The UCVA improved in all the three types of pterygium. In type 2, the preoperative mean was 0.350±0.20 SD, which significantly improved to 0.20±0.14 SD at 1-month postoperation (P-value =0.005).

Similarly, in type 3 preoperative mean improved from 0.53±0.18 SD to 0.275±0.05 SD on 1 month postoperatively. The results were also statistically significant.

Table 1 Simulated (sim) K readings

<table>
<thead>
<tr>
<th>sim K values</th>
<th>Mean</th>
<th>N</th>
<th>Standard deviation</th>
<th>t-value</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative</td>
<td>2.308</td>
<td>25</td>
<td>2.25</td>
<td>2.370</td>
<td>&lt;0.026**</td>
</tr>
<tr>
<td>Postoperative 1 month</td>
<td>1.248</td>
<td>25</td>
<td>0.99</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: **P<0.05 significant.
Abbreviation: K, keratometry.
Postoperative complications

No major complications were observed. Minor complications like congestion of 21 eyes (84%) on day 1, chemosis in five eyes (20%) on day 1 and subconjunctival hemorrhage in six eyes (24%). Discomfort was experienced in 13 eyes (52%), foreign body sensation in eight eyes (32%) and tearing in four eyes (16%) on postoperative day 1. All these subjective complaints that improved in due course of time and all patients were symptomatically comfortable by 2 weeks (Table 5) shows complications after surgery (Table 6).

There was no incidence of graft dislocation, infection, necrosis, or other graft-related complications during the follow-up period of 6 months (Table 5). Slit-lamp examinations showed clear cornea with well-apposed graft during the follow-up period of 6 months (Table 5). Slit-lamp examinations showed clear cornea with well-apposed graft during the follow-up period of 6 months (Table 5). No major complications were observed. Minor complications like congestion of 21 eyes (84%) on day 1, chemosis in five eyes (20%) on day 1 and subconjunctival hemorrhage in six eyes (24%). Discomfort was experienced in 13 eyes (52%), foreign body sensation in eight eyes (32%) and tearing in four eyes (16%) on postoperative day 1. All these subjective complaints that improved in due course of time and all patients were symptomatically comfortable by 2 weeks (Table 5) shows complications after surgery (Table 6).

There was no incidence of graft dislocation, infection, necrosis, or other graft-related complications during the follow-up period of 6 months (Table 5). Slit-lamp examinations showed clear cornea with well-apposed graft during the follow-up period of 6 months (Table 5). None of the eyes showed any evidence of recurrence of the pterygium at the end of the follow-up period.

Discussion

Till date, the pterygium remains to be an enigma for the ophthalmic world. Although extensive studies on the pterygium have unraveled the etiopathogenesis of this benign looking entity, the attempts to get rid of it have proved futile. Furthermore, the phenomenon of recurrence with its devastating effect on vision has seriously questioned the utility of simple excision as a mode of management of pterygium. Various researchers have reported a recurrence rate anywhere ranging from 30% to 80%. The existence of multiple adjuvant therapies for the pterygium in the present era, substantiate the fact that there is no single satisfactory and universally acceptable treatment modality for treating it.

This study was contemplated with the objective to study the results of the pterygium excision with self-conjunctival autograft of the pterygium using fibrin glue in the surgical management of pterygium. Since the pathology in the pterygium is subconjunctival degeneration, while the overlying conjunctiva being healthy, it may be unnecessary to sacrifice the healthy conjunctiva which itself may be utilized to cover the bare sclera after the excision of pterygium, instead of harvesting conjunctival tissue from another site. It has been found the conjunctival deficiency or scarring in the superior or superotemporal part due to the earlier pterygium surgery.

Table 2 UCVA in type 2 pterygium

<table>
<thead>
<tr>
<th>UCVA LogMAR in type 2</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>t-value</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative</td>
<td>0.350</td>
<td>0.2062</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postoperative 1 month</td>
<td>0.200</td>
<td>0.1483</td>
<td>3.563</td>
<td>0.005**</td>
</tr>
<tr>
<td>Postoperative 3 months</td>
<td>0.220</td>
<td>0.1398</td>
<td>3.794</td>
<td>0.004**</td>
</tr>
<tr>
<td>Postoperative 6 months</td>
<td>0.182</td>
<td>0.1357</td>
<td>4.032</td>
<td>0.002**</td>
</tr>
</tbody>
</table>

Note: **Indicates statistical significance.
Abbreviation: UCVA, uncorrected visual acuity.

Table 3 UCVA in type 3 pterygium

<table>
<thead>
<tr>
<th>UCVA LogMAR in type 3</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>t-value</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative</td>
<td>0.538</td>
<td>0.188</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postoperative 1 month</td>
<td>0.350</td>
<td>0.251</td>
<td>1.349</td>
<td>0.270</td>
</tr>
<tr>
<td>Postoperative 3 months</td>
<td>0.275</td>
<td>0.050</td>
<td>3.516</td>
<td>0.039**</td>
</tr>
<tr>
<td>Postoperative 6 months</td>
<td>0.225</td>
<td>0.095</td>
<td>4.753</td>
<td>0.018**</td>
</tr>
</tbody>
</table>

Note: **Indicates statistical significance.
Abbreviation: UCVA, uncorrected visual acuity.

Table 4 Best-corrected visual acuity (BCVA)

<table>
<thead>
<tr>
<th>BCVA LogMAR in type 2</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>t-value</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative</td>
<td>0.109</td>
<td>0.157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postoperative 1 month</td>
<td>0.018</td>
<td>0.075</td>
<td>2.469</td>
<td>0.033**</td>
</tr>
<tr>
<td>Postoperative 3 months</td>
<td>0.036</td>
<td>0.067</td>
<td>2.390</td>
<td>0.038**</td>
</tr>
<tr>
<td>Postoperative 6 months</td>
<td>0.036</td>
<td>0.067</td>
<td>2.390</td>
<td>0.038**</td>
</tr>
</tbody>
</table>

Note: **Indicates statistical significance.

Table 5 Postoperative complaints and complications among subjects

<table>
<thead>
<tr>
<th>Day</th>
<th>Satisfactory</th>
<th>Conjunctival congestion</th>
<th>Conjunctival chemosis</th>
<th>Subconjunctival hemorrhage</th>
<th>Discomfort</th>
<th>Foreign body sensation</th>
<th>Tearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>21 (84%)</td>
<td>5 (20%)</td>
<td>6 (24%)</td>
<td>13 (52%)</td>
<td>8 (32%)</td>
<td>4 (16%)</td>
</tr>
<tr>
<td>15</td>
<td>16 (64%)</td>
<td>4 (16%)</td>
<td>1 (4%)</td>
<td>3 (12%)</td>
<td>8 (32%)</td>
<td>8 (32%)</td>
<td>4 (16%)</td>
</tr>
<tr>
<td>1 month</td>
<td>24 (96%)</td>
<td>1 (4%)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>3 months</td>
<td>25 (100%)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>6 months</td>
<td>25 (100%)</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Note: – Indicates no complaints or complications.
Table 6 Graft-related complications postoperatively

<table>
<thead>
<tr>
<th></th>
<th>Graft necrosis</th>
<th>Wound dehiscence</th>
<th>Conjunctival cyst</th>
<th>Tenon’s granuloma</th>
<th>Loose graft</th>
<th>Lost graft</th>
<th>Recurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Day 15</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>1 month</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>3 months</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>6 months</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: – indicates no complaints or complications.

poses a surgical challenge in subsequent glaucoma or other ocular procedures. Hence, this technique would also preserve the conjunctiva for surgeries such as glaucoma procedures, if the need arises in the future.

In this study, we observed a statistically significant reduction in overall mean astigmatism postoperatively by Orbscan, which indicates that as the type of the pterygium increases, the amount of astigmatism also increases in the same proportion. A similar observation was found by earlier researchers. They also found that the size of the pterygium was directly proportional to the amount of the astigmatism induced by it. Successful pterygium surgery reduced the pterygium induced refractive astigmatism and improved the visual acuity. They also suggested early surgical intervention reduces the mean induced corneal astigmatism.

We observed significant improvement in the UCVA after successful pterygium surgery that was significant in type 2 and type 3 pterygium. Though in type 1, there was an improvement in the UCVA, it was not statistically significant. Type 1 pterygium patients showed improvement in the UCVA postoperative 1 month and were constant till 6 months. These observations were similar to the study carried out by Maheshwari. Lindsay and Sullivan also found a similar significant correlation between successful pterygium surgery and improvement in visual acuity.

Allan et al compared preoperative unaided visual acuity with 3-month postoperative unaided visual acuity on Snellen’s chart in 93 eyes. They found unaided visual acuity was either unchanged or improved in 86 out of 93 cases, while seven eyes showed the decline in visual acuity on Snellen’s chart. The decline in visual acuity was not related to surgery but was either due to astigmatism, cataract, or retinal pathology.

This observation is also similar to our study. We compared preoperative unaided visual acuity with postoperative visual acuity and found that 16 cases (64%) reported improved visual acuity, eight cases (32%) showed unaltered visual acuity while one case (4%) showed deterioration in visual acuity. This decline was unrelated to the surgery, but it was because of progression of senile cataract.

We also studied the complication profile with this new technique, which was found to be favorable with only minor postoperative issues such as congestion, graft edema, subconjunctival hemorrhage etc. However, there were no graft-related or serious vision related complications, no graft inversion or dislocation was noticed. Also, there was no incidence of recurrence found at the end of mean follow-up of 6 months.

However, with the conventional technique of the pterygium excision with conjunctival autografting, some complications have been reported in literature. Allan et al in their study, encountered three cases of wound dehiscence, one case of conjunctival cyst and one case of Tenon’s granuloma. Similarly, Ma et al in a series of 80 eyes treated with the pterygium excision with conjunctival autografting had two cases of pyogenic granuloma and four cases of conjunctival inclusion cysts. All these complications were amenable to correction with minor surgical revision and did not have any sequelae.

Hence, our technique appears to be equally safer compared to the conventional technique in terms of postoperative complications.

**Conclusion**

The conjunctiva harvested from the body of the pterygium after dissecting it from underlying subconjunctival tissue may offer a simple and effective way to treat pterygium. This technique also has the added advantage as the superior conjunctiva is untouched and can be used for future surgeries if required. The recurrence rate is not expected to be any different from the conventional technique, since the only difference exists in the method and site of harvesting the conjunctiva while the rest of the procedure being essentially the same. However, longer follow-up is required to study the long-term safety, efficacy, complications, and the incidence of recurrence with this technique.
Disclosure
The authors report no conflicts of interest in this work.

References