BLUE FIN VISION®

PATIENT INFORMATION

YAG Laser Peripheral Iridotomy

Treatment to protect an eye at risk of angle closure

To achieve the immeasurable, you must measure everything.

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Contents

> **How to use this leaflet**
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> This leaflet is written to be read before your appointment, so that you arrive already familiar with why a laser peripheral iridotomy may have been recommended, what the treatment can and cannot achieve, its alternatives, its risks and its costs.
>
> It forms part of your informed consent alongside the assessment and discussion you will have with your consultant surgeon and the consent form you sign. No document replaces that conversation.

About This Leaflet

This leaflet is for patients who have been told that the drainage angle inside one or both eyes is narrow, or who have already experienced angle closure, and for whom a laser peripheral iridotomy, usually shortened to PI, is being considered.

A peripheral iridotomy is a short outpatient laser procedure. It creates a microscopic opening in the coloured iris, providing another route for fluid to move from behind the iris to the front of the eye. This can reduce the tendency of the iris to obstruct the eye's natural drainage angle.

The treatment is straightforward. The decision to perform it is more important than the laser itself.

Not everybody with narrow drainage angles needs treatment. Contemporary evidence shows that many people with uncomplicated narrow angles have a low risk of ever developing acute angle closure or glaucoma, and observation is entirely appropriate for some patients.[3]

> **At Blue Fin Vision®**
>
> Your named Blue Fin Vision® consultant ophthalmic surgeon assesses your eye, decides with you whether treatment is appropriate, obtains your consent and performs your laser personally.
>
> We do not perform a peripheral iridotomy simply because an angle looks narrow. An assessment that ends in a recommendation not to treat is a successful assessment.

The General Medical Council requires that the person performing your treatment is the person who obtains your consent, and that you are given the information you need to decide.[1]

What Does a Narrow Angle Mean?

The front of your eye continuously produces a clear fluid called aqueous humour. This fluid normally passes through the pupil and leaves the eye through a drainage system in the angle between the cornea, the clear window at the front of the eye, and the iris, the coloured part of the eye.

In some eyes this drainage angle is unusually narrow. A narrow angle does not itself mean that you have glaucoma. In most people with narrow angles alone the pressure remains normal and glaucoma never develops. The problem arises only if the iris moves forward far enough to obstruct the drainage angle.

Acute angle closure

If the angle closes suddenly, pressure inside the eye can rise rapidly. Symptoms can include severe aching pain in or around the eye, blurred or misty vision, coloured halos around lights, a red eye, headache, and nausea or vomiting. This requires urgent assessment, because sustained very high pressure can permanently damage vision.[2]

Chronic angle closure

The drainage angle can also close gradually and without dramatic symptoms. Repeated or prolonged closure can damage the drainage system, raise the pressure and eventually damage the optic nerve. This is angle-closure glaucoma.

Unlike the symptoms of an acute attack, glaucoma damage is irreversible. The purpose of assessment is therefore to identify the eyes in which intervention is worthwhile before preventable damage occurs.

Do I Need Treatment?

This is the most important question in this leaflet. Having a narrow angle does not automatically mean that you need a peripheral iridotomy.

A large randomised trial of preventative laser in eyes with narrow angles found that the absolute risk of an angle-closure event over six years was low, and that a very large number of eyes would need to be treated to prevent one event.[3] National guidance therefore does not recommend preventative laser routinely for everybody with narrow angles.[4]

Treatment is more likely to be recommended if

- You have already had an episode of acute or intermittent angle closure.
- Your eye pressure is elevated because the angle is closing.
- Parts of the angle are already closing or have become permanently adherent.
- There is evidence of angle-closure glaucoma.
- Your anatomy places you at particularly high risk, for example if you are very long-sighted.
- You have only one functioning eye, or a strong family history increases concern.
- You require repeated pupil dilation, or medication increases the likelihood of angle closure.
- Access to emergency ophthalmic care would be difficult if an acute attack occurred.

Observation may be the better choice

If your angles are narrow but your pressure is normal, your optic nerves are healthy and there are no additional features suggesting significant risk, monitoring may expose you to less risk than treating an eye that may never develop a problem.

> **Observation is not nothing**
> If we recommend observation, that does not mean nothing is being done. It means the balance of benefit and risk currently favours measurement and surveillance rather than intervention, and we will tell you what is measured, how often, and which symptoms require urgent assessment.

What a Peripheral Iridotomy Does

In many narrow-angle eyes, pressure behind the iris causes it to bow slightly forwards. This is called pupillary block.

The peripheral iridotomy creates a microscopic opening through the outer part of the iris. Fluid can then pass directly through that opening, equalising the pressure on either side of the iris and allowing it to fall backwards. The drainage angle can consequently become wider.

The opening is deliberately positioned towards the edge of the iris and is usually hidden beneath the upper eyelid. It is generally not visible to somebody looking at you.

What the laser does not do

- It does not remove your natural lens.
- It does not guarantee that your drainage angle will become completely open.
- It does not reverse glaucoma damage that has already occurred.
- It does not guarantee that you will never need pressure-lowering drops, further laser or surgery.

Its purpose is much more specific: to remove or reduce the pupillary-block component of angle closure.

How We Assess Your Risk

The decision to perform a peripheral iridotomy follows the anatomy of your eye, not simply a label of narrow angles.

Your Blue Fin Vision® assessment may include the following.

- Measurement of the pressure inside each eye.
- Examination of the drainage angle.
- Anterior segment imaging to document the configuration of the angle.
- Examination of your natural lens.
- Assessment of the optic nerve, with OCT imaging where appropriate.
- Visual field testing where glaucoma is suspected or established.

We also consider your prescription, age, symptoms, previous episodes, medication, family history, and whether another treatment would address the underlying anatomy more effectively.

Why the natural lens matters

The natural lens becomes thicker and moves forward with age, and in some eyes it is an important reason why the drainage angle has become narrow. A peripheral iridotomy is therefore not always the final answer.

For some patients, particularly those with cataract or established angle-closure disease, removing the natural lens opens the drainage angle more effectively than laser alone. A randomised trial comparing early lens extraction with laser iridotomy in primary angle-closure glaucoma found better outcomes in the lens extraction group.[5]

> **Why this matters at Blue Fin Vision®**
> Because laser treatment, cataract surgery and lens replacement are all performed within the same practice, the recommendation can follow your eye rather than the procedure we happen to offer. A practice that offers only one of these has fewer options available when the anatomy calls for another.

Your Alternatives

Observation

For many people with uncomplicated narrow angles, observation is entirely reasonable. This normally means regular measurement of your eye pressure, assessment for glaucoma, and repeat examination of the drainage angle when appropriate.

Lens surgery

Removing the natural lens creates more space at the front of the eye and can substantially widen the drainage angle. If you already have a cataract, significant visual symptoms or established angle-closure disease, lens surgery may offer greater benefit than an iridotomy alone.[5] It is, however, an operation inside the eye and carries a different risk profile from a short outpatient laser procedure. The advantages and disadvantages are discussed individually.

Doing nothing without monitoring

This is different from observation. If your eye has been identified as being at significant risk, simply ignoring that risk is not recommended. If you choose not to have laser, we will explain what monitoring is appropriate and which symptoms require urgent assessment.

On The Day

A peripheral iridotomy is performed in the clinic using a laser attached to a slit lamp microscope. There is no theatre, no incision and no injection into the eye. You are seated upright throughout.

- Eat and drink normally and take your usual medication unless specifically instructed otherwise.
- Your vision and eye pressure are checked.
- Drops are placed into the eye before treatment. These usually include a pressure-lowering drop and pilocarpine, which makes the pupil smaller and stretches the peripheral iris.
- Pilocarpine can temporarily cause brow ache or headache and may make your vision darker or more blurred. These effects wear off.
- Anaesthetic drops numb the surface of the eye, and a small contact lens is rested gently on it to focus the laser.
- You will see a bright light and hear clicking from the laser. Most patients feel little or nothing, although some notice a brief flicking or stinging sensation.
- The laser itself usually takes only a few minutes.

A YAG laser is generally used. In a thick or heavily pigmented iris, another laser may be used first to thin the iris before the opening is completed with the YAG. This is a recognised technique.[6]

One eye or both

Where both eyes require treatment, they can often be treated during the same visit. Your surgeon will decide with you whether that is appropriate for your eyes.

After Your Treatment

Your eye pressure is checked before you leave. This is one of the most important measurements of the day, because pressure can rise temporarily after an iridotomy.

- You will normally use anti-inflammatory eye drops for a short period afterwards.
- Continue any existing glaucoma medication unless your surgeon specifically tells you otherwise.
- Your vision may be blurred for several hours because of the drops and the bright examination light, so you should not drive yourself home.

At your follow-up we check that the iridotomy is open, measure your eye pressure, examine whether the drainage angle has widened as expected, and establish whether anything further is required.

Risks and Side Effects

Peripheral iridotomy is generally a low-risk procedure, but it is not risk free.

Temporary rise in eye pressure

Pressure can rise during the hours after treatment. This is why pressure-lowering medication is given around the time of the procedure and why your pressure is measured afterwards. Most rises are temporary and are treated with drops or tablets if necessary.

Inflammation

Mild inflammation inside the eye is expected and is treated with anti-inflammatory drops. More significant inflammation is uncommon.

Bleeding

A small amount of bleeding from the iris can occur while the opening is being created. This usually stops during the procedure and may cause temporary mistiness of vision. Please tell us about any anticoagulant or antiplatelet medication you take, and do not stop prescribed medication unless specifically advised to do so.

Lines, glare or ghosting

Some patients notice a new line, shadow, glare or ghost image after an iridotomy. A randomised study of preventative laser found that new visual symptoms were reported more often in treated eyes than untreated ones.[7] These symptoms often improve with time but occasionally persist, and evidence on whether the position of the opening affects them is conflicting. We therefore regard this as a genuine risk rather than dismissing it as trivial.

The opening may close or be incomplete

Occasionally the opening is not large enough, or later becomes less patent, and additional laser is required. Where Blue Fin Vision® performed the original iridotomy, further laser to complete or enlarge that opening carries no additional treatment fee.

Serious complications

Significant damage to other structures in the eye is uncommon. Serious loss of vision, or the need for urgent surgery following a peripheral iridotomy, is very rare.

If The Angle Remains Narrow

An open iridotomy does not necessarily mean that the drainage angle becomes completely normal. That is an important distinction.

The laser removes the pupillary-block component of angle closure. Some eyes have additional anatomical reasons for remaining narrow, including the size and position of the natural lens. If your angle remains significantly compromised after treatment, we reassess rather than assuming the problem has been solved.

Depending on the findings, the next step may be continued observation, pressure-lowering medication, further laser in selected circumstances, cataract or lens surgery, or glaucoma treatment where established disease is present.

> **What follow-up is for**
> The purpose of follow-up is not simply to prove that an opening exists. It is to establish what that opening has achieved.

Warning Signs

Contact Blue Fin Vision® immediately, or attend an eye casualty department, if you develop any of the following.

- Severe or increasing pain in or around the eye.
- Worsening redness.
- Persistent misty or markedly reduced vision.
- Increasingly prominent halos around lights.
- Headache associated with eye pain, or nausea and vomiting with eye symptoms.

> **If you have not yet been treated**
> If you have been told your angles are narrow and have not yet had treatment, the combination of eye pain, blurred vision, halos, redness, headache, nausea or vomiting may indicate acute angle closure. This requires urgent assessment on the same day and should not wait for a routine appointment.

Costs

Peripheral iridotomy is a medically indicated treatment, and private medical insurance commonly provides cover, subject to your policy terms and prior authorisation. The fees below apply if you are paying for yourself.

Item	Fee
Consultation and diagnostic assessment	£325
YAG peripheral iridotomy, one eye	£750
YAG peripheral iridotomy, both eyes	£1,200

What your laser fee includes

- Treatment by a Blue Fin Vision® consultant ophthalmic surgeon.
- All laser treatment required to create the planned iridotomy.
- Eye pressure measurement after treatment, and post-treatment medication.
- Routine follow-up relating to the iridotomy.
- Further laser to complete or enlarge an iridotomy we have created, where clinically required.

Treatment of a separate condition identified during your assessment is not included, and is discussed and quoted separately before anything proceeds.

> **Iridotomy within another Blue Fin Vision® pathway**
> Where a peripheral iridotomy is clinically required as part of another planned Blue Fin Vision® treatment, the applicable pathway and its quotation take precedence over the fees above.

You will receive a written quotation confirming your exact total before you commit.

Questions Worth Asking

You are entitled to clear answers to these questions, from us or from any provider you are considering.

- Why are my angles narrow, and is pupillary block the main reason?
- Do I actually need treatment, or could my eyes safely be monitored?
- What is my individual risk if I do nothing?
- Has my eye pressure already been affected, and is there any evidence of glaucoma?
- Would lens surgery address my anatomy more effectively?
- What will you measure before and after the laser?
- What happens if my angle remains narrow despite a successful iridotomy?
- What visual symptoms can the iridotomy itself cause?
- What happens, and what does it cost, if the opening needs further treatment?

> **Taking your time**
> Unless you are experiencing acute angle closure, or there is another clinical reason for urgency, you should have time to understand your options and make your decision. Blue Fin Vision® does not use time-limited pricing or pressure of any kind. If assessment shows that treatment is unnecessary, not performing the laser is the correct outcome.

Where We Operate

Blue Fin Vision® works across the sites below. Governance, protocols and measurement pathways do not vary by postcode. Availability of laser treatment varies by site, and we will confirm where your appointment is held when it is arranged.

Site	Address
The Harley Street Eye Centre	22A Harley Street, London W1G 9BP
Weymouth Street Hospital	42-46 Weymouth Street, London W1G 6NP
Phoenix Hospital Chelmsford	Essex Healthcare Park, West Hanningfield Road, Chelmsford CM2 8HN
One Hatfield Hospital	3 Hatfield Avenue, Hatfield, Hertfordshire AL10 9UA
Chase Lodge Hospital	Page Street, Mill Hill, London NW7 2ED
London Eye Diagnostic Centre	25 Harley Street, London W1G 9QW. Insured patients
Abbey Wood Hospital	The Cottage, Bostall Hill, Abbey Wood, London SE2 0GD. Blue Fin Vision® services starting soon

Further information about our structure of care is published at **bluefinvision.com/advantage**.

Your Surgical Team

Blue Fin Vision® is a consultant-led practice. Your assessment, your laser treatment and your follow-up are performed by a named Blue Fin Vision® consultant ophthalmic surgeon, who is the person who obtains your consent and remains responsible for your care. This document is authored and clinically governed by our Medical Director.

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Mr Mfazo Hove is a Consultant Ophthalmic Surgeon with experience spanning more than 57 000 procedures. He completed 6.5 years of specialist training at Moorfields Eye Hospital and served as a consultant at the Western Eye Hospital, Imperial College Healthcare NHS Trust, from 2017 to 2022. He has published six consecutive years of outcome data through the National Ophthalmology Database, with a posterior capsule rupture rate in cataract and lens surgery of approximately 0.2 per cent.

Document control

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Contact Blue Fin Vision®

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