

ILM peeling in stage 1 macular hole

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I have been systematically removing the ILM for epiretinal membrane since 1987. So, when stage 1 macular hole surgery started, I naturally did the same thing for this kind of surgery too. The disappointing De Bustros study conclusions confused me since his results were completely different from mine. I then decided to carry on using my technique. 93 stage 1 macular holes have been operated since 1991 by core vitrectomy, localized posterior hyaloid removal using forceps and subsequent systematic ILM removal. All of them had previously undergone full thickness macular hole surgery on the fellow eye. They represent 8.5 percent of total operated MH. With a mean follow-up of 48 months, 3 eyes only developed a subsequent macular hole. Interestingly, we observed 2 cases of stage 1 recurrence after 3 and 17 months postop; they were successfully reoperated. Regarding functional results we have a mean improvement of 1.5 LogMAR lines. Preoperatively 26 patients had less than 20/50 and 12 patients more than 20/32. Postoperatively, only 2 patients remained under 20/50 while 43 recovered more than 20/32. Two retinal detachments were observed; they were treated successfully. On the 83 phakic patients, 43 had subsequent cataract surgery during follow-up period. Many reasons can be given for not operating stage 1 macular hole: - First, only 40% of stage 1 macular holes seem to develop spontaneously a full thickness macular hole. - Second, stage 2 macular holes have good surgical results. As far as I am concerned, I only had 1 failure on 214 stage 2 cases and mean improvement in those cases is 3.4 logMAR lines which means twice as much as in stage 1. - At least De Bustros study showed that posterior hyaloid removal did not prove a benefit as far as numbers of subsequent full thickness macular hole and functional results are concerned. The recommendation not to perform any longer a posterior hyaloid removal in stage 1 macular hole was certainly accurate. But, our study shows that if you remove the ILM, you may then significantly decrease the evolution to a full thickness macular hole. Furthermore, when we compare the final visual acuity of these operated stage 1 macular holes to the ones of our patients operated for later stages, we observe that the risk for the patients not to reach 20/50 is significantly higher for these the more advanced stages: 4 times more for stage 2 to 8 times more for stage 4. Waiting that stage 1 macular hole to develop into a full thickness macular hole before carrying out the operation may lead the patient to a less favorable final functional result. So, should we really remove the ILM in stage 1 macular hole? It is difficult to answer under the light of this retrospective, pilot, non-randomized study. Moreover, there are many other things to consider: such as the status of the fellow eye, patient's anxiety or the surgeon's ability to perform this surgery with a minimum of complications. As far as I am concerned I think that we must explain the different risks and advantages linked to the two different possibilities - to operate or to wait - in order to allow the patient to make his own choice.