



# Punctoplasty combined with lacrimal stenting versus lacrimal stenting for punctal stenosis

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## To the Editor:

We read with interest the article by Goldberg et al. [1] regarding lacrimal stenting alone versus Kelly punch punctoplasty (KPP) combined with stenting for the treatment of simple punctal stenosis. Both techniques involve the use of a Mini Monoka (MM) silicon stent (FCI Ophthalmics, France Chirurgie Instrumentation, Paris, France) kept in-situ for one month to maintain patency of the punctum in the early post-operative period. The authors concluded that simple punctal dilation with MM stent insertion is effective in relieving symptoms of punctal stenosis and that KPP with MM stent conferred no additional benefits [1]. While we agree that punctal dilation with MM without punctoplasty has the advantage of being performed as an office procedure, the value of punctoplasty combined with lacrimal stenting—in group 2 of this study—for simple punctal stenosis is unclear. The latter approach may, however, be suitable in selected patients including cicatrising peri-punctal disease, internal punctal stenosis, or canalicular stricture.

Comparable results have been shown between punctal dilation with stenting and 3 snip punctoplasty without stenting, highlighting that stenting is not essential in the latter. Other non-comparative studies of surgical punctoplasty without stenting also show high anatomical and functional success rates of up to over 90% [2–4]. Not only does stent placement require an interim clinic review—with inherent costs—for stent removal before the evaluation of symptomatic improvement can be carried out, but it may carry risks including stent retention [5], migration [6], granuloma formation [7], infection, and biofilm formation [8], and potential trauma to the canalicular system with creation of a false

passage. Furthermore, the design of a MM stent relies on the plug component to anchor the stent into the punctum; division of the ampulla as is performed in a surgical punctoplasty potentially renders the stent unstable, and may therefore increase the risk of stent prolapse or migration.

Punctoplasty combined with stenting may have the potential advantage of reducing the rate of early restenosis caused by reunion and scarring of the punctum during the healing phase. However, the current study [1] reports a ‘redo’ rate of 4% (1 in 24) in combined KPP and stenting group, presumably due to restenosis, which is not dissimilar to previously reported restenosis rate after KPP alone (~3%).

While MM certainly has well-established indications in lacrimal surgery, routine stenting probably does not offer additional value to punctoplasty in cases of simple acquired punctal stenosis. Combined punctoplasty and stenting is perhaps more advantageous for cases with puncto-canalicular stenosis. A less invasive approach for such cases may also be one-snip punctoplasty (without ampullectomy) combined with canalicular stenting that would address the associated canalicular stenosis simultaneously, with minimal disruption of the punctal and ampullar anatomy thus promoting stent stability, although cases of severe stenosis or peri-punctal scarring may still benefit from ampullectomy.

## Compliance with ethical standards

**Conflict of interest** The authors declare that they have no conflict of interest.

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