and is a temporizing measure until more definitive lensectomy, if indicated to improve visual function, can be performed. Lens extraction is usually indicated to restore vision and to reduce the risk of recurrent pupillary block and chronic angle closure development. See Table 5-3 for a list of conditions that can cause ectopia lentis.

Microspherophakia, a congenital disorder in which the lens has a spherical or globular shape, may cause ectopia lentis and subsequent pupillary block and PAC (Fig 5-6). Treatment with cyclopia may tighten the zonule, flatten the lens, and pull it posteriorly, breaking the pupillary block. Miotics may make the condition worse by increasing the pupillary block and by rotating the ciliary body forward, loosening the zonule and allowing the lens to become more globular. Microspherophakia is often familial and may occur as an isolated condition or as part of either Weil-Marchesani or Marfan syndrome. The most common form of acquired zonular insufficiency and crystalline lens subluxation occurs in the pseudoexfoliation syndrome (Fig 5-7).

**Aphakic or pseudophakic angle-closure glaucoma**

Pupillary block may occur in aphakic and pseudophakic eyes. An intact vitreous face can block the pupil and/or an iridotomy site in aphakic or pseudophakic eyes or in a phakic eye with a dislocated lens. Generally, the anterior chamber shallows and the iris shows considerable bombé configuration. Treatment with mydriatic and cycloplegic agents may restore the aqueous flow through the pupil but may also make performing a laser iridotomy difficult initially. Topical β-adrenergic antagonists, α1-adrenergic agonists, carbonic anhydrase inhibitors, and hyperosmotic agents can be effective in reducing IOP prior to performing an iridotomy. One or more laser iridotomies may be required.
Pupillary block may also occur with anterior chamber intraocular lenses. Pupillary block develops with apposition of the iris, vitreous face, and/or lens optic. The lens haptic or vitreous may obstruct the iridectomy site or the pupil, and the peripheral iris bows forward around the anterior chamber intraocular lens to occlude the angle. The central chamber remains deep relative to the peripheral chamber in this instance, because the