

Sir,

Migration of seton into the anterior chamber

Eye (2002) 16, 85–86. DOI: 10.1038/sj/EYE/6700013

Seton, derived from the Latin word *seta*,¹ meaning bristle. The concept of a seton to maintain patency of internal filtering ostium by keeping the edges permanently separated has been attempted in many forms. Materials ranging from horsehair to metals (titanium) to polyethylene have been utilised.² Since it was first introduced as a modern surgical device in 1969 by Molteno,³ glaucoma drainage implants are known to cause several complications.⁴ We report an unusual case of migration of 'seton', which was a modified long tube version used as glaucoma drainage implant, into the anterior chamber.

Case report

In December 2000, a 76-year-old gentleman presented to our institute with complaints of sudden onset of redness and blurring in the right eye for 3 days. The patient was operated in the pseudophakic right eye for trabeculectomy two and a half years back, followed by insertion of 'Molteno-type tube implantation' 1 year later in July 1999 in another clinic as documented in the referral note. At presentation the patient was on latanoprost eyedrops 0.005% at bedtime in both eyes and levobunolol 0.5% eyedrops twice daily only in the right eye.

On examination at our institute, his visual acuity was 20/40 OD and 20/20 OS. The right eye showed conjunctival and ciliary congestion, a diffuse conjunctival filtering bleb at the 12 o'clock position, trace epithelial with stromal corneal edema, Descemet's folds localised to the areas of stromal edema with pigment dispersion on the corneal endothelium. The anterior chamber was deep with 2+ cells and 1+ flare, and a hollow tube lying horizontally in the AC inferiorly (Figure 1a and b), which was mobile with eye movements causing endothelial touch. The iris showed areas of atrophy and a patent iridectomy at 12 o'clock with presence of posterior chamber intraocular lens. The intraocular pressure was 20 mmHg in both the eyes. Gonioscopy of the right eye revealed an open angle with a sclerostomy at the 12 o'clock position and a patent internal ostium. Optic disc evaluation using 78 D lens showed a cup to disc ratio of 0.7:1 with notching and pallor of the inferior neuroretinal rim.

In view of the anterior chamber inflammation and mobility of the tube, we decided to explant the tube to prevent corneal decompensation. Explantation of the

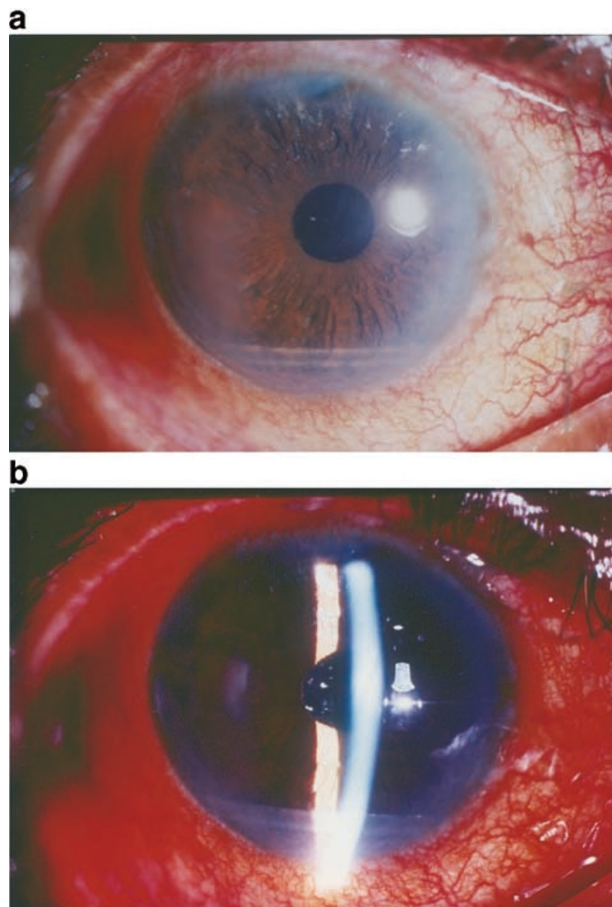


Figure 1 (a) Clinical photograph of the right eye in diffuse illumination showing seton in the anterior chamber. (b) Clinical photograph of the right eye showing the seton in slit illumination.

tube was performed through a 3.2-mm clear corneal self-sealing incision holding it with a McPherson forceps. The tube was 7 mm in length, with a lumen and had a bevelled edge at one end (Figure 2a). Postoperatively at 6 weeks the iritis subsided and the corneal edema cleared (Figure 2b). His antiglaucoma medications were continued.

Comment

The era of true seton has passed. Modern implants have been termed as glaucoma drainage implants⁵ as they shunt the aqueous from the anterior chamber through a tube into an explant located 8–12 mm posterior to limbus on the sclera.

The medical report of the patient documented that insertion of a 'Molteno-type tube implantation' was performed. We thought that the tube in the anterior chamber was probably the detached long tube portion of the Molteno implant. However there was no

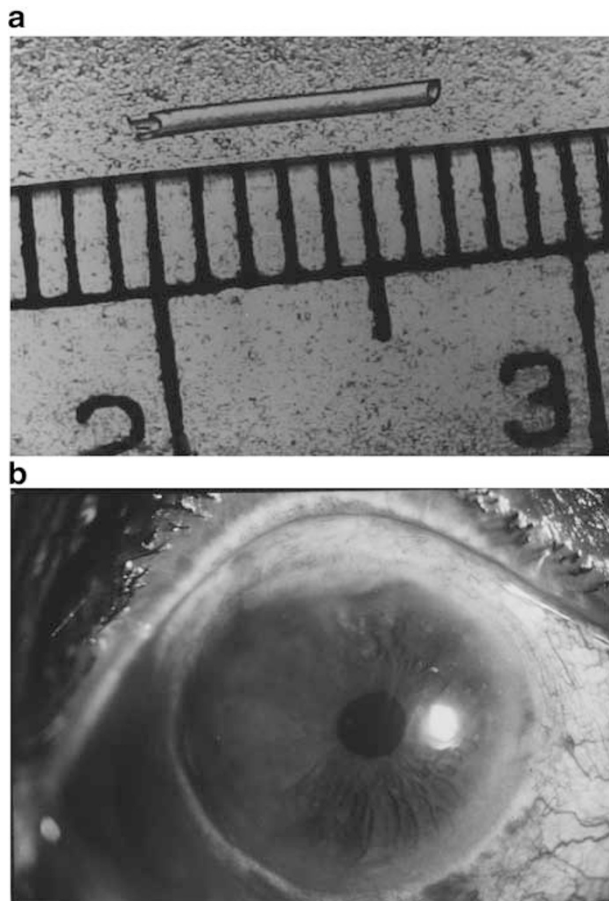


Figure 2 (a) Clinical photograph of the seton with a lumen and a bevelled edge. (b) Clinical photograph of the right eye in diffuse illumination on first postoperative day.

evidence of a retained episcleral plate either clinically or on ultrasound B-scan.⁶ Hence we concluded that only a hollow tube was used by the previous surgeon as a glaucoma drainage device and this 'seton' had migrated into the anterior chamber in the absence of an anchor.

As the intraocular pressure was 20 mmHg on two medications, we were not sure whether the high intraocular pressure was pre-existing or secondary to anterior chamber inflammation. So we explanted the seton through a self-sealing clear corneal incision eliminating the possibility of bleb compromise and also leaving the adjacent conjunctiva untouched in anticipation of future filtering surgery if intraocular pressure continued to remain uncontrolled in the postoperative period.

Migration of the seton tube out of the AC, or implant erosion⁴ are the known reported complications. To the knowledge of the authors, migration of the seton tube into the AC has not been reported. Another interesting feature of the case is the removal of the

seton through a self-sealing clear corneal incision eliminating the possibility of bleb compromise.

Acknowledgements

This study was supported by the Hyderabad Eye Research Foundation, Hyderabad, India. The authors have no proprietary interest in any of the methods or techniques used in this study.

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Progressive ophthalmoplegia in arthrogryposis multiplex congenita

Eye (2002) **16**, 86–88. DOI: 10.1038/sj/EYE/6700014

Arthrogryposis multiplex congenita (AMC) is a syndrome characterised by multiple joint deformities present at birth.^{1–3} Although there have been several reported ophthalmic associations with this syndrome^{4–9} however, progression of ocular motility disorder in this condition is not well documented. We report a case of