characteristics of an arthritis presenting before the age of 16, lasting for at least 6 weeks in which no defined cause can be found. The systemic form of JIA is characterised by arthritis and quotidian (swinging) pyrexia accompanied by one or more features. These include an evanescent erythematous rash; hepatomegaly or splenomegaly; serositis (eg pericarditis) and lymphadenopathy. A subgroup without persistent arthritis is recognised, where a single episode is followed by remission for at least 2 years. Uveitis is not a feature and ANA testing is negative.

The main differential diagnosis in this case was acute rheumatic fever or poststreptococcal reactive arthritis, although the latter is unusual in childhood.[6] The polyarthritis, pericarditis, and raised antistreptococcal antibody levels were initially suggestive. However, the pattern of fever, failure to respond to adequate doses of aspirin, and persistence of inflammation in individual joints were not typical. The raised antistreptococcal antibody levels may have indicated coexistent recent streptococcal infection, but have also been reported in JIA and have been used to monitor treatment.[7] Preseptal cellulitis has not, to our knowledge, been previously reported in association with JIA.

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Sir,

Iatrogenic retinal tear and vitreous haemorrhage with Rycroft cannula during phacoemulsification cataract surgery

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We report the case of a 75-year-old patient who suffered an unusual complication during routine phacoemulsification cataract surgery under peribulbar block.

Case report

Towards the end of routine phacoemulsification cataract surgery after insertion of the intraocular lens implant, the anterior chamber was irrigated using balanced salt solution loaded in a 2 ml non-luer lock polypropylene syringe (Becton Dickinson, ref 300185) with a 27G Rycroft cannula (Steriseal, ref 1273A) attached. During the injection, the cannula became disinserted from the syringe with sufficient force to pass behind the lens implant, through the posterior lens capsule and vitreous and into the inferotemporal retina.

The result was an immediate vitreous haemorrhage. At this point, the cannula was retrieved and the eye closed. A B scan revealed vitreous and subretinal haemorrhage with probable retinal tear.

Six days later the patient underwent vitrectomy, and at the time of surgery an inferotemporal retinal detachment and accompanying tear, presumably caused by the

Rycroft cannula 6 days previous, was noted; this was repaired with vitrectomy cryotherapy and gas tamponade. At the most recent follow-up (1 month following the original injury), visual acuity was 6/60 and the retina remains flat with some thin subretinal haemorrhage.

Comment

It is the responsibility of the surgeon to check that cannulae/needles are appropriate for the task in hand and well secured before use. It is expected that the scrub nurse also follows the above procedure. Despite adherence to these recommendations, an accident occurred. While not belittling the importance of the above, we believe that safety in the operating theatre could be improved if only syringes with a luer lock are used while performing intraocular surgery. We recognise that if not appropriately fitted, cannulae can still detach from the luer lock system.

This case has been reported to the Medical Devices Agency.

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Sir,

Spontaneous suprachoroidal haemorrhage following a valsalva manoeuvre

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Suprachoroidal haemorrhage is the accumulation of blood within the suprachoroidal space, which is a potential space situated between the choroid and the sclera.[1] It has been reported to occur in all types of intraocular procedures.[2] Sudden hypotony is thought to be responsible for the haemorrhage.[2]

We describe a patient who developed a small SCH apparently induced by a valsalva manoeuvre.

Case report

A 65-year-old gentleman presented to the eye casualty, after straining severely during a bowel movement. He felt a sudden 'popping' in his right eye followed by pain and reduced vision in the right eye.

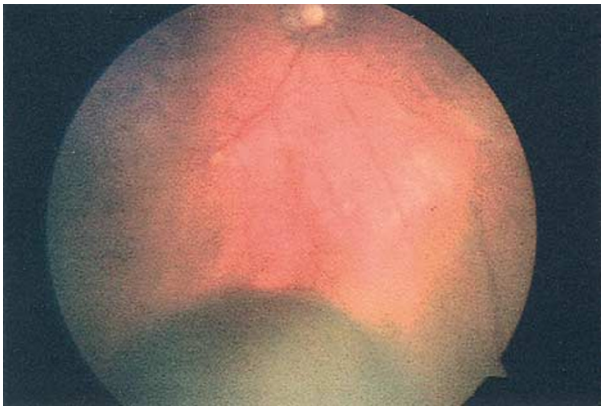

Figure 1

There was no past or family history of eye disorders. He was known to be asthmatic and had recently developed a well-differentiated prostatic cancer that was being treated with Indoramin (a selective alpha-blocker). There was no history of bleeding disorder; routine coagulation screening test results were normal.

On examination, the best corrected visual acuity was 6/24 in his right eye and 6/5 in his left eye. Intraocular pressures were 38 mmHg on the right and 12 mmHg on the left. There was epithelial oedema affecting the lower half of the right cornea. The anterior chambers were deep and clear and both angles were open. Fundus examination of the left eye revealed an elevated, dark-brown choroidal mass, approximately five disc diameters in size, located in the inferior half of the fundus (Figure 1). A contact ultrasonographic examination of the right eye confirmed the presence of a choroidal lesion 4 mm in thickness (Figure 2).

An intravenous acetazolamide 500 mg stat dose was given and the right intraocular pressure came down to 16 mmHg.

One week later his right cornea cleared and the right visual acuity had improved to 6/5. The swelling had reduced considerably and it had disappeared by the end of the second week. Ultrasound revealed total resolution of the choroidal haemorrhage. We suggest that he suffered small choroidal haemorrhage caused by valsalva manoeuvre, and this resulted in a sudden increase in intraocular pressure and subsequent corneal oedema.

Comment

A valsalva manoeuvre results in a rapid rise in intrathoracic or intra-abdominal pressure against closed glottis. As a result of the absence of valves in the venous system, this pressure is transmitted to the eye causing