haemorrhage have been described with anticoagulation.[6] One case controlled retrospective study of 50 patients with ARMD showed an odds ratio of 11.6 that a patient with a massive intraorbital haemorrhage would also be on anticoagulants (warfarin or aspirin). In another study, the antiplatelet odds ratio (aspirin) was smaller at 2.1.[7]

Whether these risks can be extrapolated to myopic eyes is unknown. This rare case illustrates how high myopia associated with choroidal vasculature fragility exacerbated by hypertension could cause spontaneous haemorrhage. This was further aggravated by the presence of aspirin in this patient.

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Sir,

Closure of cyclodialysis cleft using diode laser

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Cyclodialysis clefts are a result of disinsertion of the ciliary body from the scleral spur. These can be caused traumatically, commonly following blunt injury, or iatrogenically following anterior chamber surgery. The consequence of this is a communication between the anterior chamber and the suprachoroidal space with a newly created path for aqueous drainage. As a result, the eye becomes hypotonus with choroidal effusions, macular folds and decreased visual acuity.

Identification of the cleft can be difficult using the slit-lamp gonioscope because of a shallow anterior chamber and a collapsed drainage angle. If the anterior chamber is deepened using viscoelastic, then the cleft can often be seen clearly.

Treatment of this condition aims to restore normal intraocular pressure, resolve choroidal effusions and as a consequence, restore visual function.

Medical management is based on the apposition of the ciliary body against the scleral spur and promotion of adherence by scar formation. This is enhanced by strong mydriasis for up to 6 weeks, anterior chamber inflammation and minimal use of steroid medications.

Several surgical methods have been employed in management of cyclodialysis clefts. These include invasive methods such as vitrectomy, cryotherapy and gas tamponade,[1] scleral buckle,[2] diathermy,[3] suturing[4] and endolaser.[5] Noninvasive methods have also been employed including trans-scleral YAG or diode laser.[6,7]

We describe two cases of successful cyclodialysis cleft closure using trans-scleral diode laser.

Case reports

Patient A is an 81-year-old lady who was diagnosed with primary open-angle glaucoma in 1997 and started on topical antihypertensive therapy. In view of inadequate intraocular pressure (IOP) control and progressing disease, right trabeculectomy was performed shortly followed by left trabeculectomy. IOPs were stabilised at 12 mmHg in both eyes. After 2 years, the patient underwent left cataract extraction (phacoemulsification and posterior chamber IOL). At 2 months following this, the patient presented with decreased visual acuity (VA) (6/24) and IOP of 0 mmHg with large choroidal effusions. A cyclodialysis cleft was identified in the inferotemporal aspect and closure was achieved using transcleral diode laser (21, 1.5 s burns at a power of 2000 mW) to the cleft under direct endoscopic visualisation through a corneal paracentesis. IOP

stabilised at approx. 12 mmHg with regression of choroidal effusions 2 weeks following the procedure and VA remained at 6/24. Unfortunately, the patient then emigrated and died shortly afterward.

Patient B is an 81-year-old man with right-sided Eale's disease who suffered recurrent vitreous haemorrhage between 1948 and 1994. During this time, he also suffered from chronic uveitis with frequent exacerbations. In the 1970s he was diagnosed with bilateral acute angle closure glaucoma and treated with bilateral peripheral iridotomy; VA at that time was R 6/9 and L 6/6. IOP was poorly controlled and glaucomatous field damage occurred. In 1985, right and left trabeculectomies were performed. IOP was controlled in the mid-teens in both sides. By 1995, VA deteriorated to count fingers in the left side with significant glaucoma damage and cataract. In 1998, left extracapsular cataract extraction with intraocular lens implant was performed. This improved the vision to 6/36. In 2001, the patient developed left bacterial keratitis with hypopyon and VA of 6/60. A number of weeks later, the patient presented with hand movement vision both sides, a hypotonus (3 mmHg) left eye and large choroidal effusions. A cyclodialysis cleft was identified at the 10 O'clock position and treated with transcleral diode laser (16, I s bums at 2000 mW). At latest follow-up (6 months post-treatment), VA was 6/18—with an IOP of 12 in the left eye, no choroidal effusions, no identifiable cleft and a quiet anterior chamber. Unfortunately, fields were very constricted because of glaucomatous damage.

Both patients had their mydriatics stopped before the treatment was performed. Two parallel rows of confluent transcleral diode laser burns were applied consecutively in one session at the conjunctival limbus in the area overlying the cyclodialysis cleft. Post-procedure discomfort and inflammation were controlled with the minimum dose of topical steroid drops.

Comment

Cyclodialysis clefts can be a difficult problem to identify and can cause significant visual loss. Several treatment modalities have emerged. We have described a minimally invasive method that can be performed under local anaesthetic without distress to the patient, limited theoretical complications and good efficacy. We recommend the use of transcleral diode laser in the first-line surgical treatment of cyclodialysis clefts.

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Sir,

Lipogranuloma of the nasolacrimal system, an iatrogenic and preventable entity.

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Congenital nasolacrimal duct obstruction is a common problem. It affects approximately 6% of infants,[1] and 90% resolve spontaneously by 1 year. However, some children require syringing and probing. After the probe has entered the lacrimal punctum, the remainder of the probing procedure is blind. This can give rise to inadvertent formation of a false passage and the procedure has a recognised failure rate. Failure may occur because of the anatomical level of the obstruction, the severity of the obstruction, or technical difficulty. The formation of a false passage may occur in 15% of the cases, even in experienced hands.[2]

Some authors routinely irrigate the lacrimal system with antibiotic and steroid after probing.[3] We would like to highlight the dangers of such a practice by illustrating three cases referred to us with complications after irrigating such ointments through unsuspected false passages.