Sir,

Bilateral endophthalmitis due to self-mutilation
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Self-inflicted injury to the eyes is a rare but devastating phenomenon. There are several cases of self-inflicted ocular injuries reported especially among psychotic patients but similar injuries have also been reported in patients with obsessive/compulsive neuroses, drug-induced psychosis, organic mental states including epilepsy, encephalitis, diabetes with renal vascular and infective complications.[1]

Self-mutilation is rarely encountered by ophthalmologists but one must be very suspicious to avoid misdiagnosis when dealing with psychotic patients, especially schizophrenics. Here we report a schizophrenic patient who was misdiagnosed as bilateral panuveitis initially, but in fact had bilateral endophthalmitis due to self-mutilation.

Case report

A 32-year-old schizophrenic woman suffering from visual loss and pain in both eyes was referred to our clinic with diagnosis of bilateral panuveitis, and topical corticosteroid and cyloplegic drops had been initiated by the referring ophthalmologist. The left eye has perception of light vision and the right eye has no perception of light. There were no pupil reactions in either eye. Mild anterior chamber reaction, fibrinoid membrane formation, cataract, and posterior synechias were present bilaterally, and there were dense vitreous membranes and opacities in both eyes. Careful biomicroscopic evaluation revealed conjunctival laceration and scleral perforation 10–12 mm posterior to the limbus at the six o'clock position bilaterally. There was no visible uveal tissue prolapsus in both eyes (Figure 1).

Although she had denied initially, after psychiatric consultation she accepted that she had perforated her eyes with a sewing (crochet) needle: right eye 5 weeks and left eye 3 weeks ago. She attributed this self-violation act to the shame of her sexual hallucinations. Ultrasonography disclosed total retinal detachmet in her right eye, while there were dense vitreous membranes and opacities bilaterally. Neurologic evaluation revealed normal findings and psychiatric consultation confirmed the diagnosis of schizophrenia and antipsychotic medical therapy initiated.

Considering the fact that there was no light perception in the left eye, we decided to operate the right eye first. Under general anaesthesia, pars plana vitrectomy and membrane pealing was performed but we could not achieve to reattach the retina because of severe retinal atrophy and dense subretinal fibrosis. The patient and her family refused operation of the second eye.

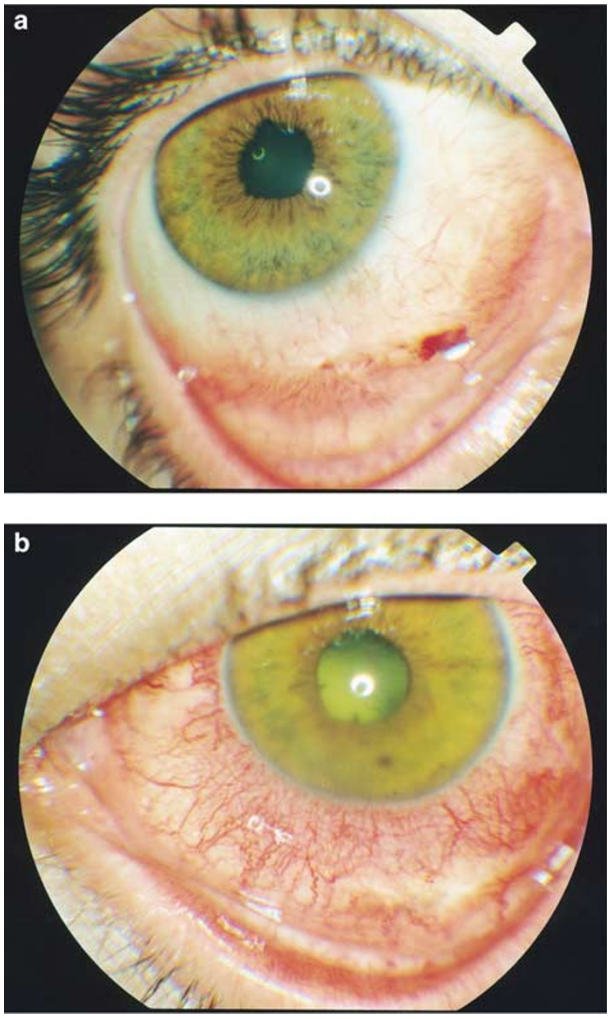

Figure 1 Bilateral posterior synechias, keratic precipitates, vitreous membranes, and inferiorly located scar tissues secondary to scleral perforations: (a) right eye; (b) left eye of the patient.

Comment

Schizophrenia seems to be the most common feature in reported cases of self-inflicted ocular mutilation.[1,2] The most severe form of self-mutilation can be self-enucleation, and several factors are stressed in these cases: castration fears; failure to resolve oedipal conflicts; repressed homosexual impulses; severe guilt; self-punishment.[2] Since ego and eye are related, violence directed to the eye can also be a part of suicidal gesture.

Self-inflicted ocular mutilaton may be presented to the ophthalmologists in many different clinical pictures

including corneal laceration, scleral/corneal perforations, blunt orbital trauma, or even enucleation of the globe.[1–6] One may interpret the trauma and its cause more readily when the presentation is manifest, but sometimes, it can be quite difficult as in our case. Hardly visible perforations, patient's denial of the condition, and a long time interval between the perforation and admission to the doctor easily lead to misdiagnosis. Ophthalmologists must always keep the self-inflicted ocular mutilation in their mind when dealing with mentally disordered patients.

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Sir,

Exudative retinal detachment following central retinal vein occlusion

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Retinal vein occlusion can have a deleterious effect on vision, especially if ischaemic. Its complications include macular oedema, neovascularisation of iris and retina, neovascular glaucoma, and vitreous haemorrhage. We report two young patients who developed exudative retinal detachment following central retinal vein occlusion (CRVO). In both cases, the CRVO was ischaemic and led to severe visual loss.

Case reports

Case 1 A 39-year-old male presented elsewhere with sudden loss of vision in the right eye and was diagnosed with CRVO. Visual acuity was hand movements, there was an afferent pupillary defect, and marked retinal haemorrhages. Investigations revealed undiagnosed hypertension and gross obesity. After 3 months, the patient was referred to us with exudative retinal detachment in the right eye.

On examination, visual acuity was right eye hand movements and left eye 6/4. The right eye showed rubeosis iridis, relative afferent pupillary defect, intraocular pressure of 8 mmHg, and total retinal detachment associated with extensive retinal haemorrhages and exudation (Figure 1, left). No retinal breaks were identified. Examination of the left eye was unremarkable. Fluorescein angiography of the right eye revealed capillary nonperfusion, secondary telangiectasis, and staining of large retinal veins (Figure 1, right). There was also evidence of vascular leakage. The patient underwent multiple sessions of panretinal photocoagulation to the right eye which resulted in absorption of the subretinal fluid and exudation over 8 months and regression of the rubeosis iridis. However, visual acuity remained hand movements at 2 years of follow-up.

Case 2 A 29-year-old pilot presented with a 6-week history of blurred vision in the left eye. Visual acuity was right eye 6/5 and left eye 6/9. Examination of the left eye showed CRVO. Fluorescein angiography showed no ischaemia or macular oedema. Investigations revealed borderline raised protein C activity. The patient returned 1 week later with further reduction in the vision of the left eye to hand movements. There was an afferent pupillary defect and a marked increase in the number of retinal haemorrhages. Repeat fluorescein angiography showed capillary nonperfusion. The patient underwent panretinal photocoagulation and was started on oral steroids (prednisolone 60 mg/day). The steroids were tapered and stopped over a period of 7 weeks. The visual acuity remained hand movements. At 8 months from presentation, the patient developed rubeosis iridis and an exudative retinal detachment (Figure 2, left). Fluorescein angiography demonstrated capillary nonperfusion, secondary telangiectasis, and staining of the large retinal veins (Figure 2, right). Vascular leakage was noted at the later stages of the angiogram. The patient underwent further treatment with panretinal photocoagulation. Although the subretinal fluid