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T Ong, W Nolan and J Jagger

Ophthalmology Department, Royal Free Hospital
London NW3, UK

Correspondence: T Ong
Tel: +44 77 60273918
Fax: +44 208 692 9111
E-mail: tuyen.ong@doctors.org.uk

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Sir,
Calcification of Aqua-Sense intraocular lenses

We read with interest the article by Izak and co-workers, reporting clinical and pathological features of hydrophilic acrylic intraocular lenses (IOLs) of three major designs explanted because of late postoperative opacification.¹

These authors analysed eight Aqua-Sense IOLs (Ophthalmic Innovations International, OII). Five of them had been explanted in South Africa, two in the UK, and one in Brazil. According to the paper, a total of 23 cases of postoperative opacification of the Aqua-Sense lenses were observed by Dr Troskie in South Africa, and the manufacturer of the Aqua-Sense lens has apparently reported 12 similar cases to the authors in a personal communication in September 2001.¹

In the University Hospital Aintree, Liverpool, UK, we have exchanged 25 opacified Aqua-Sense lenses between August 2001 and July 2003. The initial Aqua-Sense IOL implantations were performed in the year 2000 and early 2001. We summarised our experience with the exchange of these lenses in a paper that we submitted recently for consideration of publication in the *Journal of Cataract and Refractive Surgery*.

A further nine Aqua-Sense lenses developed severe late opacification but have not been exchanged so far for various reasons, bringing the total number of opacified Aqua-Sense lenses observed in our department to 34. Thus, the overall number of opacified Aqua-Sense lenses might be higher than suggested in the article and we are wondering whether other colleagues have exchanged or observed opacified Aqua-Sense lenses.

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E Dagres, MA Khan, GM Kyle and D Clark

Department of Ophthalmology, University Hospital
Aintree, Liverpool, UK

Correspondence: E Dagres
Tel: +44 7811 405836
Fax: +44 1515 294283
E-mail: edagres@yahoo.com

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Sir,
Bilateral, multiple choroidal effusions after vomiting

Choroidal effusions occur secondary to local changes such as hypotony, surgery, or inflammation. Primary uveal effusion may also occur with nanophthalmos or scleral abnormalities.¹ Acute choroidal effusion has been described in association with local or systemic predisposing factors.^{2–6} We present a patient with acute, bilateral choroidal effusions related to an episode of vomiting alone.

A 64-year-old man presented with a 2-day history of painless visual loss in the left eye noticed the morning after an episode of vomiting. Other than type II diabetes mellitus, his past medical and ocular histories were unremarkable. Visual acuity with low myopic correction was 6/6 in the right eye and 6/36 in the left. Examination of the ocular adnexae, anterior segments, and intraocular pressure was normal. Dilated fundal examination revealed multiple, shallow choroidal effusions in the

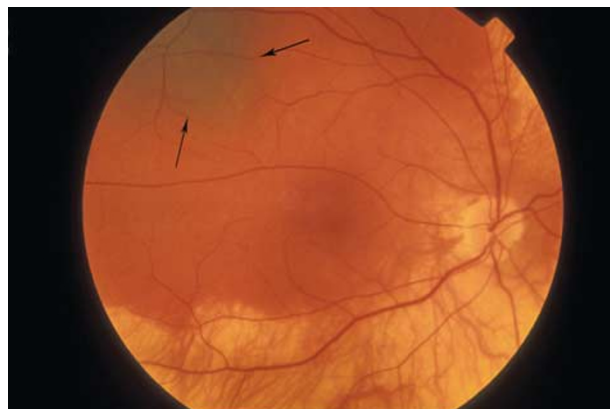


Figure 1 Small choroidal effusion affecting the posterior pole of the right eye.



Figure 2 Larger choroidal effusions seen at the posterior pole of the more symptomatic left eye.

posterior pole and anterior to the equator of both eyes (Figures 1 and 2), involving the fovea in the left. There was no vitritis, retinitis, or vasculitis. B-mode ultrasonography confirmed shallow choroidal detachments with low internal reflectivity and no scleral thickening. Axial lengths (measured at presentation) were within normal limits (24 mm). A CT scan of the globes, fluorescein and indocyanine green angiography were unremarkable. Without treatment, his visual symptoms and signs resolved over 2 months and his corrected acuity returned to 6/6.

Acute choroidal detachments secondary to haemorrhage or effusion have been described previously. Many of these patients had known risk factors including impaired episcleral venous outflow, topical glaucoma therapy, prior ocular surgery, high myopia, or systemic anticoagulation.²⁻⁶ To our knowledge, there are only two published reports of acute choroidal detachment precipitated by Valsalva manoeuvre without other risk factors. Hammam and Madhavan⁷ described an acute rise in intraocular pressure following unilateral

choroidal haemorrhage precipitated by straining during a bowel movement. Suan *et al*⁸ reported bilateral choroidal effusions occurring 3 days after prolonged vomiting. In our patient, lack of pain, low internal reflectivity, and the multifocal, bilateral nature point towards this being choroidal effusion rather than haemorrhage. Choroidal effusion can occur due to reduced trans-scleral movement of fluid, which may be secondary to scleral abnormality or, as in this case after Valsalva manoeuvre, raised intrathoracic pressure can increase back pressure in the venous drainage system.

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FM Cuthbertson and M McKibbin

Department of Ophthalmology
St James's University Hospital
Beckett Street
Leeds LS9 7TF, UK

Correspondence: F Cuthbertson
Tel: +44 113 206 6429
Email: fcuthbertson@hotmail.com

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