

Fax: +44 2890330744  
E-mail: carolecooke322@ntlworld.com

At the time of writing this paper both authors were working at Altnagelvin Area Hospital, Derry.

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Sir,  
**Listing of cataract patients by optometrists**

We see in the *Short Notes from Council* (12 September 2003) that the College felt that 'medical intervention was vital in order to ensure that the diagnosis and indications for surgery were appropriate, at a stage *before the actual day of surgery*'.

At Peterborough, we have been running a one-stop cataract surgery project since September 1999 where patients are listed by trained optometrists. Patients have their surgery on the first day they come to the eye department, following a brief examination by the surgeon at the slit lamp after mydriasis.

We recently looked at the difference of rates of cancellation of surgery on the day for 'one-stoppers' and conventionally listed patients for the period January 2002–August 2003. This difference would be a broad measure of the appropriateness of listing of the one-stoppers.

Of roughly 600 one-stoppers, 67 (11%) were cancelled on the day. This compared with 153 (8%) of around 1800 conventionally booked patients cancelled on the day. This 3% difference equates to the loss of 18 surgical slots, but our theatre coordinators estimate that they refill 90% of slots with patients prepared to come in at short notice, or even with patients just listed during the same session by other surgeons in clinic. This comes as a surprise for the patient concerned, but is not compulsory and saves a theatre slot.

Thus, over the given period, without medical intervention before the day of surgery, we have lost about two operating slots, but saved 600 outpatient appointments.

AW Fitt, S Ramirez-Florez, TJ Rimmer and SJ Vardy

Department of Ophthalmology  
Peterborough District Hospital  
Thorpe Road, Peterborough, PE3 6DA, UK

Correspondence: TJ Rimmer  
Tel: +44 1733 874018

Fax: +44 1733 875281  
E-mail: timothy.rimmer@pbb-tr.nhs.uk

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Sir,  
**Successful combined cataract surgery and drainage of a needling-induced chronic ciliochoroidal detachment**

Needle revision is an accepted method of management for failed or poorly functioning trabeculectomy blebs.<sup>1–3</sup> We report a case of chronic ciliochoroidal effusion occurring after needle revision of failed trabeculectomy bleb in an only eye with poor vision due to cataract. The effusion failed to resolve with conservative management and required subsequent surgical intervention.

#### Case report

An 80-year-old-woman was referred to a glaucoma team for further management of her glaucoma. She was blind in her left eye from uncontrolled glaucoma. She had had an unaugmented fornix-based right trabeculectomy 8 years previously that had failed. The intraocular pressure (IOP) in the right eye was uncontrolled despite maximal tolerated medical therapy (Guttae Timoptol 0.25% b.d., Guttae Xalatan nocte, and Guttae Trusopt 2% bd).

At presentation she had a flat, scarred right trabeculectomy bleb, the IOP was 22 mmHg OD, and the optic disc was cupped with a vertical cup–disc ratio of 0.8. A right nuclear sclerotic cataract (grade 2+) was noted with almost 360° posterior synechiae. Angles were open with a patent sclerostomy. Snellen visual acuities were 6/36 OD and PL OS.

In order to maximise residual vision, a right phacoemulsification of cataract was planned. A target IOP was set at less than 15 mmHg and the option of combined cataract extraction and trabeculectomy was considered. Prior to any final decision with regards surgical procedure, it was decided to carry out a needle revision of the trabeculectomy bleb. If the bleb could be salvaged and satisfactory IOP control achieved, a combined procedure would be unnecessary.

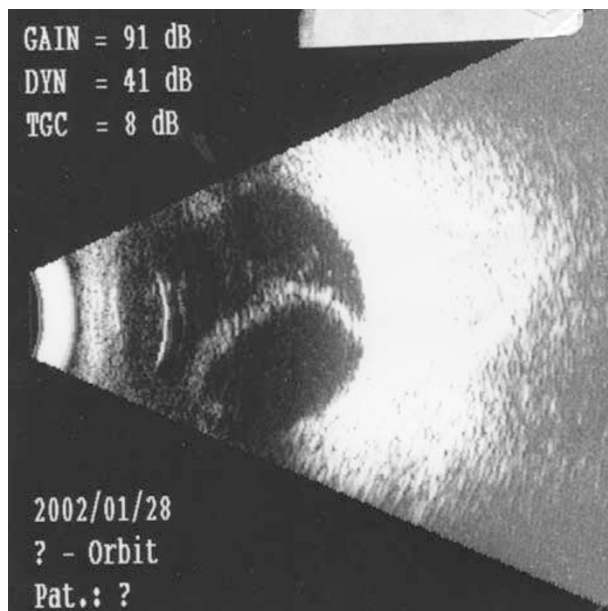
The patient underwent slit-lamp needling of trabeculectomy bleb with injection of 5-fluorouracil (5-FU). A good flow of aqueous was visualised with reformation of a bleb. At 1 week the bleb had once more flattened and the IOP was 26 mmHg. A further needling with 5-FU injection was undertaken. Postprocedure, the IOP was 6 mmHg with an elevated bleb. After 2 days, the IOP had risen to 12 mmHg and the anterior chamber was

shallow. The bleb remained formed with no evidence of leak. Biomicroscopy identified the presence of ciliochoroidal effusions, confirmed and delineated by B-scan (Figure 1). Visual acuity was reduced to 6/60.

It was elected to treat the ciliochoroidal effusions conservatively and over the subsequent 3 months the patient was observed closely with no active treatment. During this period, the anterior chamber was deep and the trabeculectomy bleb remained formed with the presence of numerous microcysts. The IOP was maintained at  $9 (\pm 2)$  mmHg. Visual acuity progressively deteriorated to hand motion. The ciliochoroidal effusions remained unchanged. It was felt that the visual loss was due to the progression of the cataract and the obstruction of the visual axis by the ciliochoroidal effusions.

The patient remained significantly visually disabled and surgical intervention was planned. In order to minimise the number of surgical episodes and maximise visual rehabilitation, it was decided to undertake drainage of the choroidal effusion combined with phacoemulsification of cataract.

Phacoemulsification of cataract was undertaken through a clear corneal superior section under local anaesthesia. The IOP was maintained during the procedure with Healon™ tamponade in the anterior chamber. An intraocular lens was placed in the capsular bag thereby facilitating fundal visualisation of choroidal drainage. The corneal section was temporarily secured with one suture while ciliochoroidal drainage was undertaken. A conjunctival incision was made and two oblique sclerotomies formed 6 mm posterior to the limbus



**Figure 1** Biomicroscopy identified the presence of ciliochoroidal effusions, confirmed and delineated by B-scan.

in the superonasal and superotemporal quadrants. Straw-coloured fluid was expressed by gentle pressure on the posterior lip of the sclerotomy with periodic reformation of the anterior chamber with balanced salt solution (BSS). The fundus was examined until the choroidal effusions had completely flattened. The sclerotomies were closed with 6/0 silk sutures and a firm pressure obtained by injection of BSS via the corneal paracentesis.

The following day visual acuity was 6/12 (pin hole) and the IOP was 13 mmHg. There were no choroidal effusions and the bleb was formed.

At 6-month follow-up, the visual acuity was 6/9 unaided and the IOP was 14 mmHg on no treatment. No ciliochoroidal effusions were present and a draining filtration bleb was noted.

### Comment

Slit-lamp needling of failed trabeculectomy blebs with adjunctive 5-FU injection has been shown to be a relatively safe and successful method of lowering IOP.<sup>1-3</sup>

Development of ciliochoroidal effusion after needling has been reported previously in the literature.<sup>1,4,5</sup> Generally effusions settle with conservative management. Serious complications of needling have been reported including suprachoroidal haemorrhage.<sup>6</sup>

The initial management of ciliochoroidal effusion is conservative as once the hypotony is reversed the detachments normally resolve. Surgical management of chronic ciliochoroidal effusions includes reformation of the anterior chamber with viscoelastic or, if this fails, surgical drainage.

During ciliochoroidal drainage, it is important to minimise anterior chamber collapse to prevent the risk of suprachoroidal haemorrhage and further extension of the ciliochoroidal effusions in a hypotonus eye. Anterior chamber maintainers or higher density viscoelastic agents may be utilised to this effect.

It may be argued that removing the cataract alone may have resulted in resolution of the ciliochoroidal effusions, thereby avoiding the additional risks of choroidal drainage. The authors feel, however, that this would have led to a significant delay in visual rehabilitation in view of the absence of useful vision in the fellow eye.

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### References

- 1 Allen LE, Manuchehri K, Corridan PG. The treatment of encapsulated blebs in an out-patient setting using a needling

- technique and subconjunctival 5-fluorouracil injection. *Eye* 1998; **12**: 119–123.
- 2 Shin DH, Juzych MS, Khatana AK, Swendris RP, Parrow KA. Needling revision of failed filtering blebs with adjunctive 5-fluorouracil. *Ophthalmic Surg* 1993; **24**: 242–248.
  - 3 Chen PP, Palmberg PF. Needling revision of glaucoma drainage device filtering blebs. *Ophthalmology* 1997; **104**: 1004–1010.
  - 4 Mardelli PG, Lederer Jr CM, Murray PL, Pastor SA, Hassanein KM. Slit-lamp needle revision of failed filtering blebs using mitomycin-C. *Ophthalmology* 1996; **103**: 1946–1955.
  - 5 Potash SD, Ritch R, Liebmann J. Ocular hypotony and choroidal effusion following bleb needling. *Ophthalmic Surg* 1993; **24**: 279–280.
  - 6 Howe LJ, Bloom P. Delayed suprachoroidal haemorrhage following trabeculectomy bleb needling. *Br J Ophthalmol* 1999; **83**: 757.

A Alwitry, AJ King and SA Vernon

Eye, Ear, Nose and Throat Centre  
Queens Medical Centre, Nottingham NG7 2UH, UK

Correspondence: AJ King  
Tel: +44 115 9249924 x 44247  
Fax: +44 115 9709963  
E-mail: Anthony.King@nottingham.ac.uk

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Sir,  
**Phacoemulsification and intraocular lens implantation following pars plana vitrectomy: a prospective study**

I congratulate Ahfat *et al*<sup>1</sup> for quantifying the well-recognized complications of phacoemulsification cataract surgery following vitrectomy. Cataract will eventually develop in almost all patients after vitrectomy. The obvious solution to preventing such difficult surgery is to combine lens removal with vitrectomy at the time of the original operation even if no lens opacity is present. This has been my practice for the past 3 years in presbyopic patients. The lens having lost its ability to accommodate can be replaced by an intraocular lens with no detriment to the patient. Combined surgery has many other advantages for the surgeon including excellent visibility during vitrectomy (especially when using wide-angle viewing systems), the ability to perform a more extensive vitrectomy and creating space for larger gas or oil fills.<sup>2</sup> ‘Core vitrectomy’ can be avoided as it carries the risk of incomplete vitreous separation at the time of surgery

with continued separation in the postoperative period with possible retinal tear formation.<sup>3</sup> The advantage to the patient is not having to return for further surgery.

Most vitreoretinal surgeons in the UK have extensive cataract experience, and combining the surgery does not significantly prolong the procedure. It is important, however, to keep a stable anterior chamber during vitrectomy, and subsequent intraocular lens insertion to keep anterior chamber inflammation to the postoperative period to a minimum. I would not routinely advocate combined surgery in diabetics who are at risk of increased intraocular inflammation and rubeosis following lens removal or in patients with active uveitis unless significant cataract was present.

**References**

- 1 Ahfat FG, Yuen CHW, Groenewald CP. Phacoemulsification and intraocular lens implantation following pars plana vitrectomy: a prospective study. *Eye* 2003; **17**: 16–20.
- 2 Simcock PR, Scalia S. Phacovitrectomy without prone posture for full thickness macular holes. *Br J Ophthalmol* 2001; **85**(11): 1316–1319.
- 3 McLeod D. Giant retinal tears after central vitrectomy. *Br J Ophthalmol* 1985; **69**: 96–98.

PR Simcock

West of England Eye Unit,  
Royal Devon and Exeter Hospital,  
Barrack Road, Exeter EX2 5DW, UK

Correspondence: PR Simcock,  
Tel: +44 1392 406007;  
Fax: +44 1392 406022.  
E-mail: psimcock@hotmail.com

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Sir,  
**Zonular disinsertion five years after implantation of a plate haptic silicone intraocular lens**

We report a case in which progressive anterior capsular fibrosis associated with a plate haptic silicone intraocular lens led to zonular disinsertion and dislocation of the capsular bag and implant 5 years after uncomplicated surgery. It is proposed that the same mechanism that leads to capsular phimosis may go on to cause late zonular disinsertion even up to 5 years after intraocular lens implantation.