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Sir,
**Treatment of a vasoproliferative tumour with
intravitreal bevacizumab (Avastin)**

Vasoproliferative retinal tumours (VPRT) may cause retinal exudates, haemorrhages or detachment, macular oedema and epiretinal membranes.^{1,2} Treatment modalities include perforating diathermy, photocoagulation, cryotherapy, brachytherapy,¹ photodynamic therapy,² and vitrectomy for tractional detachment or macular pucker.¹

Since Bevacizumab (Avastin) was approved by the American Food and Drug Administration (FDA) in February 2004 for treatment of metastatic colorectal cancer,³ it has been used to treat various neovascular ocular pathologies, macular oedema, and bleb needling following trabeculectomy.

We report a patient with VPRT, who showed visual and clinical improvement after intravitreal Avastin.

Case report

A 59-year-old lady was referred in April 2006 with a right VPRT. She had been treated elsewhere with laser photocoagulation. Her general health was good apart from systemic hypertension. Examination showed right visual acuity of 6/6–1, and infero-temporal, pre-equatorial VPRT surrounded by hard exudates and old vitreous haemorrhage inferiorly (Figure 1). On ultrasonography, this tumour measured 5.0 mm in diameter and 1.7-mm thick (Figure 2). The patient was

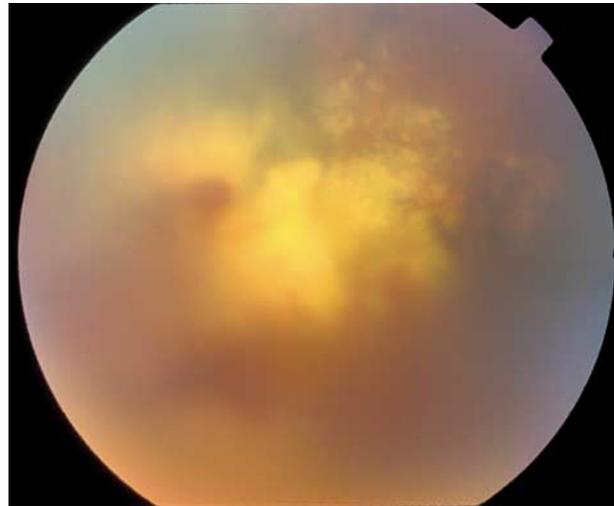


Figure 1 Colour fundus photograph of right inferotemporal region showing vasoproliferative retinal tumor with hard exudates and vitreous haemorrhage.

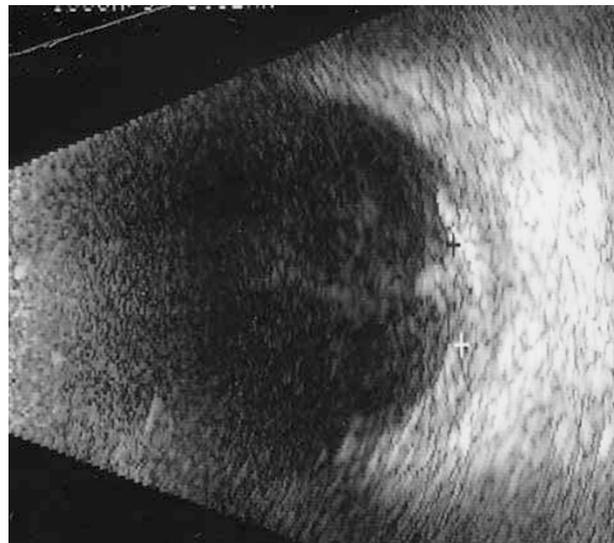


Figure 2 RE VPRT on B scan ultrasonography showing tumour diameter of 5.0 and 1.7 mm thickness.

treated with triple freeze-thaw cryotherapy. In June 2006, the visual acuity worsened to 6/19 due to cystoid macular oedema (Figure 3a), and the tumour thickness increased to 2.6 mm. A decision was made to treat the patient with intraocular Avastin, 2.5 mg in 0.1 ml was administered in September 2006. Immediately after, the patient reported loss of sensation and weakness of her left arm and leg and was investigated for cerebrovascular accident, which was excluded. Five days later, the vision in the right eye had improved to 6/9 + 3 and the macular oedema was no longer visible. Twenty-four days after treatment, the visual acuity was 6/6–1, tumour thickness

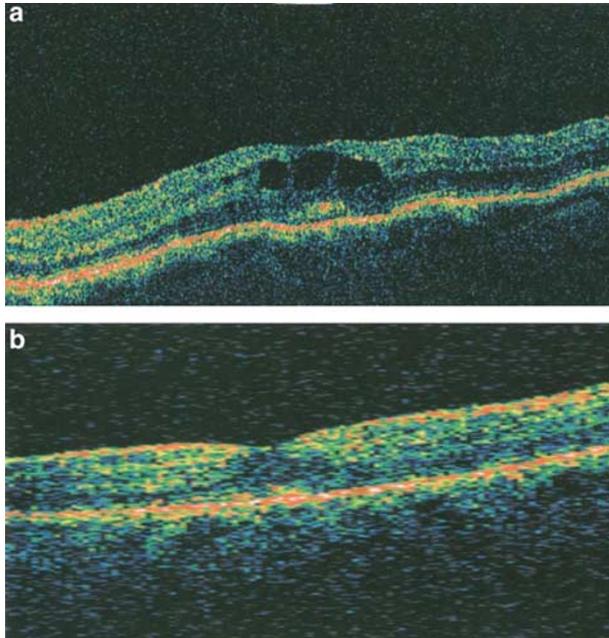


Figure 3 OCT of the right macula (a) before Avastin treatment, showing cystoid oedema, and (b) 3 weeks afterwards, when the oedema had resolved.

was 1.0 mm and the macular oedema was no longer demonstrable on OCT (Figure 3b).

Comment

To our knowledge, this is the first report of intravitreal Avastin treatment for VPRT. The injection was followed by a dramatic improvement within 3 weeks. Although the patient experienced sensory and motor weakness, no physical abnormality was detected.

This promising result warrants further studies to assess the efficacy of Avastin in the treatment of VPRT, and to determine whether repeated injections are required.

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Sir,
A novel manoeuvre using a Kelly punch in the management of severe capsule contraction syndrome

Capsule contraction syndrome is an exaggerated fibrotic response reducing the size of the anterior capsule opening after continuous curvilinear capsulorhexis. The condition complicates uneventful phacoemulsification cataract extraction but can be associated with certain pre-existing co-pathologies, certain intraocular lenses, and surgical technique. We report a case of severe, recurrent anterior capsule contraction which was eventually successfully treated using a Kelly Descemet’s membrane punch.

Case report

A 77-year-old black African gentleman with past ocular history of open-angle glaucoma was admitted for daycase cataract surgery. In December 2002 he underwent right phacoemulsification with implantation of a 21.0 dioptre three-piece loop haptic silicone posterior chamber intraocular lens (IOL) (Allergan S140NB). His surgery was uneventful and 1 week postsurgery he achieved an unaided visual acuity of 6/9. Eight months later, he presented with reduction in vision and on examination he was found to have a fibrosed and contracted anterior capsule. He underwent radial YAG laser relaxing capsulotomies using 25 laser shots at an energy of 3.0 mJ. Initially, the patient was able to see 6/9 unaided, but within 2 months further growth of his anterior capsule had occurred with a resulting drop in visual acuity down to 6/60. Subsequently, the patient underwent surgical anterior capsulotomy using microscissors, again restoring his vision to a level of 6/9.