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Sir,

Simple method to reduce iatrogenic retinal trauma during vitreous surgery

Posterior iatrogenic retinal trauma is a known complication of vitreous surgery.[1] We have had two cases where the endoillumination pipe has caused direct retinal trauma during epiretinal or internal-limiting membrane peel. This is a delicate procedure that demands intense concentration, often using a viewing lens that greatly restricts the visible field.

To reduce the likelihood of trauma during this stage of the procedure, we employed the simple use of a length of butterfly tubing (Figures 1 and 2) threaded along the illumination pipe to limit the depth to which the illumination instrument can be inserted into the eye. This butterfly tubing can be adjusted in length as required. This has also been employed during a complex four-port diabetic delamination surgery, where an assistant holds the light pipe. The technique should be particularly useful for trainee retinal surgeons.

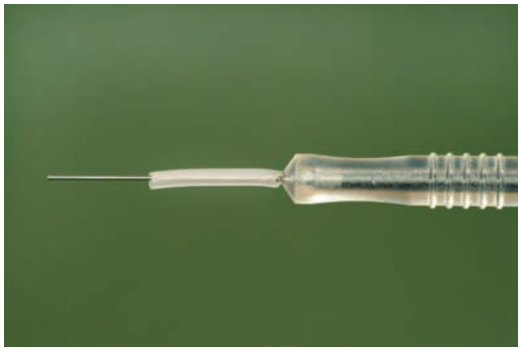

Figure 1 Butterfly tubing cut to desired length and threaded along endoillumination pipe.

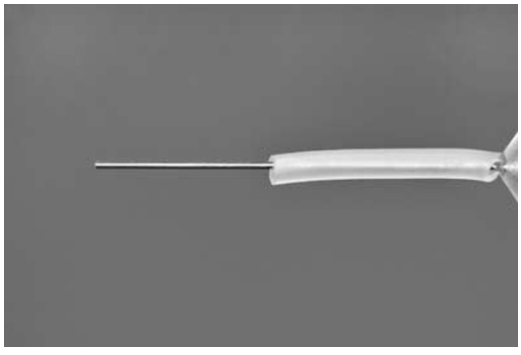

Figure 2 Butterfly tubing cut to desired length and threaded along endoillumination pipe.

Thankfully, we have not had any similar iatrogenic breaks after employing this device.

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Reference

1 Michels RG, Wilkinson CP, Rice TA. *Retinal Detachment*. C V Mosby: St Louis, 1990, p869.

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Sir,

Intravitreal triamcinolone acetonide as an adjunct in the treatment of severe ocular toxoplasmosis

Treatment of ocular toxoplasmosis is highly controversial. Results of such treatment depend on host factors, such as age and immune status, as well as on parasite factors.[1] The use of corticosteroids is even more debatable. Although most uveitis specialists agree that corticosteroid therapy without the concurrent use of antimicrobial agents can lead to severe ocular tissue destruction, patients who did well treated with corticosteroids alone have been seen.[1]

Aggressive cases, such as the one reported by Backhouse *et al*, have also been reported. It is important to note, however, that clinical deterioration did not occur immediately after the introduction of oral or intravitreal corticosteroids. On the contrary, in these two circumstances it appears that some improvement was initially observed. Of note, the antimicrobial agent was introduced 1 month following intravitreal triamcinolone acetonide. Taking into account that clinical picture worsening occurred only 2 weeks thereafter (6 weeks following intraocular injection), the temporal relationship strongly suggests that the intravitreal triamcinolone acetonide injection was not directly related to the outcome.

In our opinion, intravitreal corticosteroids should be used with caution in active ocular toxoplasmosis. Clinicians should avoid their use on recalcitrant, rapid worsening cases or those with questionable diagnosis. Intravitreal steroids without appropriate antimicrobial drugs should also be discouraged. On the other hand, there may be a role for them in patients with relatively controlled infection, as those we reported previously on this journal.[2]

References

1 Holland GN LX Edward Jackson Lecture Ocular toxoplasmosis: a global reassessment Part II: disease