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Sir,

## Unusual corneal foreign body

Many types of foreign bodies can enter the cornea.[1] We report an unusual case of a corneal foreign body that migrated through the corneal epithelium and stroma. The foreign body was a fragment of the patient's own hair that had migrated from the limbus to the paracentral cornea 6 weeks after a haircut.

### *Case report*

A 27-year-old female patient was referred by her optician to the casualty department of Moorfields Eye Hospital for corneal opacity in her right eye. It had never been noticed before and there was no history of trauma to the eye.

Her best-corrected visual acuity was 6/5 in both eyes. Slit-lamp examination revealed a foreign body embedded in the stroma of the right cornea, surrounded by a very thin stromal reaction and an intact overlying epithelium. A stromal track of the moving foreign body was also noticed (Figure 1). The foreign body looked like a fragment of hair. Direct questioning revealed a haircut a few weeks before visiting her optician.

The foreign body was removed under topical anaesthesia and was recognised as the patient's own hair. At follow-up the cornea was clear with no signs of stromal scarring.

### Comment

Hair usually penetrates deeply into the cornea and anterior segment, and once embedded can migrate or advance deeper into the cornea.[1] Although various theories have been proposed, the exact mechanism by which hair migrates or advances into the deeper layers of the cornea is not known.[2] The mechanism may vary depending upon the nature of the hair and the individual's immune response.[2] In principle, it is necessary to remove the foreign body adequately and identify it.[3]

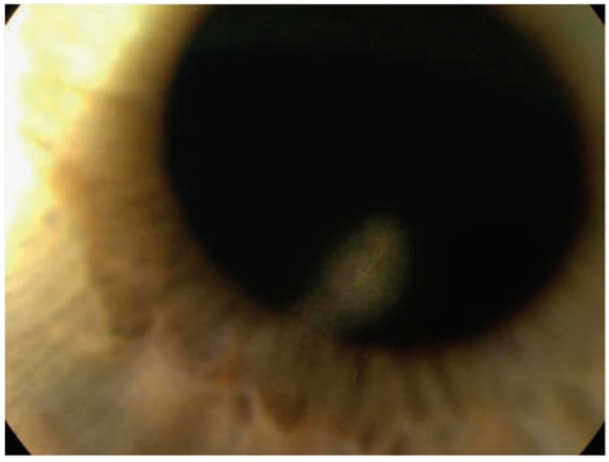

**Figure 1** Astromal track of the moving foreign body.

We highlight this case because the corneal foreign body caused no symptom to the patient but caused corneal scarring. It entered the eye at the limbus and migrated in a centripetal fashion to the paracentral cornea. It would eventually have compromised the vision if the foreign body had migrated further into the central visual axis.

We are unaware of any similar report where a patient's own hair has been embedded in the cornea.

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Sir,

## Premacular subhyaloid haemorrhage in Eales' disease managed with Nd:YAG laser

Eales' disease is an idiopathic inflammatory obliterative vasculopathy.[1] We describe a case of premacular subhyaloid haemorrhage in Eales' disease managed with Nd:YAG laser posterior hyaloidotomy. We are unaware of such finding in world literature.

*Case report*

An 18-year-old male patient presented with sudden loss of vision in his left eye. The best corrected visual acuity (BCVA) was 20 of 20 OD and 20 of 800 OS. Slit lamp biomicroscopy revealed normal anterior segment examination bilaterally. The intraocular pressure was 12 mm Hg bilaterally. Fundus examination of the left eye showed premacular subhyaloid haemorrhage, with associated vascular sheathing and superficial haemorrhages along the superotemporal arcade. Fluorescein angiography demonstrated leakage of dye along the areas of vascular sheathing. The right eye fundus was normal with no evidence of leakage of dye or peripheral nonperfusion. Systemic examination was normal.

Laboratory investigations showed haemoglobin of 12 g/100 ml, leukocyte count of 4600/mm$^3$, platelet counts of 230 000/mm$^3$, and ESR of 8 mm. VDRL for syphilis and ELISA for HIV were negative. Chest X-ray was normal.

The patient was started on oral prednisolone 1 mg/kg. Subsequently, Nd:YAG laser posterior hyaloidotomy was also performed far from the fovea, enabling diffusion of the premacular haemorrhage into vitreous cavity. The laser power required was 2 mJ and single bursts were emitted. Fundus showed clearing of premacular haemorrhage and evidence of resolving vasculitis in the left eye after 2 weeks (Figure 1). The BCVA improved to 20 of 32 OS.

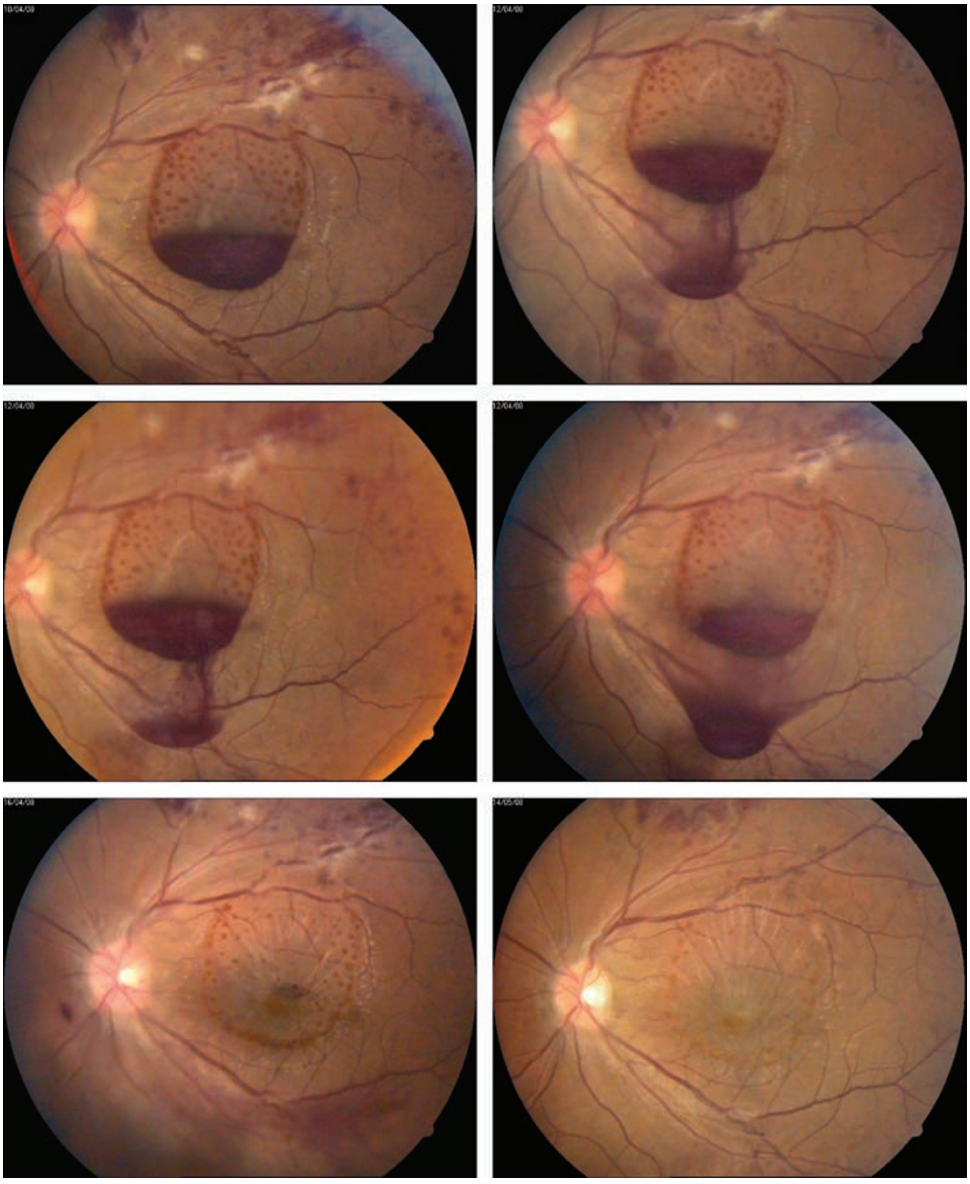

**Figure 1** Fundus photographs showing drainage of premacular subhyaloid haemorrhage into vitreous gel following Nd:YAG laser posterior hyaloidotomy. Active vasculitis can be seen along the superotemporal arcade (top left photograph). Post-treatment fundus photograph (bottom right) showing complete resolution of premacular haemorrhage and resolving vasculitis.

## Comment

Eales' disease characterized by perivascular sheathing, peripheral retinal nonperfusion, and neovascularization, predominantly affects young males.[1,2] Bilateral involvement is present in 80–90% of patients.[1] In this case, other conditions such as sarcoidosis, tuberculosis, syphilis, systemic lupus erythematosus, and primary HIV infection, which could be associated with a similar clinical picture were ruled out.

Macular involvement in the form of cystoids macular oedema and macular pucker has been reported in Eales' disease;[3] however, premacular subhyaloid haemorrhage was present in this patient during the active inflammatory stage. Premacular haemorrhage produces profound visual loss, which may be prolonged and cause permanent macular changes. Nd:YAG laser hyaloidotomy has been described as an effective procedure for management of premacular haemorrhages.[4,5] The present case also had immediate clearing of the premacular haemorrhage and early recovery of vision after Nd:YAG laser hyaloidotomy (Figure 1). No retinal or choroidal damage was observed.

To conclude, premacular subhyaloid haemorrhage can be present in Eales' disease, which can be managed effectively with Nd:YAG laser posterior hyaloidotomy.

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Sir,

## Two non-infectious forms of endophthalmitis after intravitreal triamcinolone and cataract extraction

Intravitreal triamcinolone acetonide (IVTA) has been used to treat resistant macular oedema associated with diabetes, vascular occlusion, and uveitis.[1] Three forms of endophthalmitis have been described with IVTA use: infectious, sterile, and pseudoendophthalmitis. We report the occurrence of sterile endophthalmitis and pseudoendophthalmitis in the same eye after IVTA.

### *Case report*

A 62-year-old male non-diabetic patient with a 10-year history of idiopathic anterior uveitis OU developed cystoid macular oedema (CME). He required topical steroids and four subtenon's triamcinolone injections OU. In October 2006, the patient received the first IVTA (4 mg) for recalcitrant CME OD. The CME cleared but his vision remained 20/100 because of the posterior subcapsular cataract. Focal zonular weakness was noted during the cataract surgery. A capsular tension ring and an acrylic intraocular lens were placed in the bag. The case concluded with an IVTA (4 mg).

Six hours after surgery, a 0.5-mm hypopyon was noted with a mixture of fibrin and cells (Figure 1). Visual acuity was *hand movement* and intraocular pressure (IOP) of 52 mmHg. Initial treatment included topical gatifloxacin, timolol/dorzolamide, and brimonidine. On postoperative day 2, aspirates from the anterior chamber and vitreous cavity were sent for culture; intravitreal vancomycin, and ceftazidime were given at the same time. The culture remained negative. On postoperative day 6, a bright white crystallin material was found above the original cream coloured hypopyon (Figure 2). Over the next week, the layered hypopyon cleared (Figure 3). The macula did not develop oedema, and visual acuity was 20/20 at 10 months after surgery.

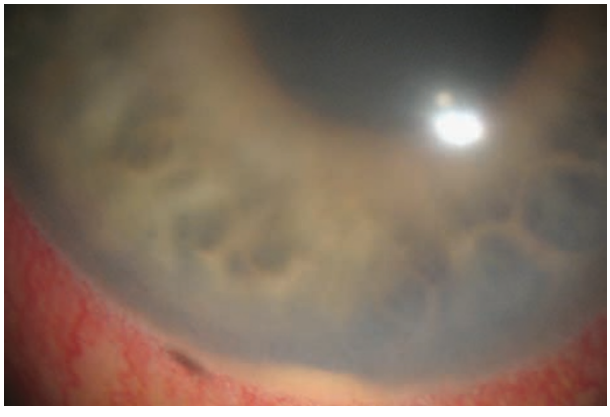

**Figure 1** Sterile endophthalmitis. A 0.5-mm hypopyon was noted 6 h after surgery. Visual acuity was hand motions and the intraocular pressure was 52 mmHg.