

Comment

Recently, anti-VEGF therapies, using bevacizumab or ranibizumab, show favourable results in CNV to various underlying diseases.^{2–5} However, there has been no report treated with ranibizumab in angioid streaks. In our case, though the left eye treated with PDT showed disappointing results, the VA of the right eye treated with ranibizumab has been stable for 1 year after treatments. We think that the treatment of CNV in angioid streaks with ranibizumab is also promising and encouraging therapy, which merits further investigations.

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Sir,
A novel use of intravitreal injection callipers

Intravitreal injection is an increasingly employed option in the management of posterior segment disease. Approval of anti-VEGF agents for the treatment of exudative age-related macular degeneration has led to preprepared and single-use surgical packs being provided by the manufacturers. A 3.5-mm/4-mm caliper, facilitating the needle introduction through the pars plana in pseudophakic and phakic patients respectively, is also included (Figure 1). Excision of non-melanoma skin cancers with 4-mm margins has been well described with favourable results.¹ We have chosen to use the 4-mm end of the calliper to mark the margins for excision of BCC and

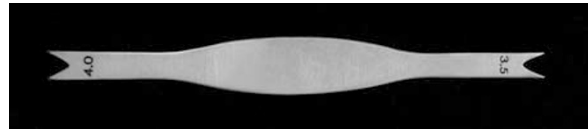


Figure 1 4 mm/3.5 mm calliper supplied with intravitreal injection pack.

low-risk SCC, as we normally would do with a standard adjustable caliper, thus saving a new instrument from being opened, putting through sterilisation procedures and the cost.

Cleaning of non-surgical instruments using a 70% isopropyl alcohol swab has previously been shown to be sufficient to prevent the spread of iatrogenic infectious disease, and this technique has made the calliper reusable.²

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Sir,
Iatrogenic retinal diamond deposits: an unusual complication of using the diamond-dusted membrane scraper

Internal limiting membrane peeling (ILM) is recognised as an integral step in the success of macular hole (MH) repair.¹ Needles and picks are effective in raising a membrane edge, but their sharp points can perforate the retina.² Diamond-coated instruments (30 µm diamond particles fixed with non-toxic silicone adhesive) have been developed to facilitate cortical vitreous and ILM separation from the retina.^{2,3} The diamond surface provides an abrasive edge that rubs against the retinal surface and can be effective in creating a membrane-edge that can be grasped with fine forceps. During the use of diamond-coated instruments for vitreoretinal (VR) procedures, diamond particles can be shed and deposited on the retinal surface, especially when the instruments are introduced through the sclerostomy or applied to retinal surface.

We recently performed 23-gauge pars plana vitrectomy with ILM peel for a stage III MH. A Tano

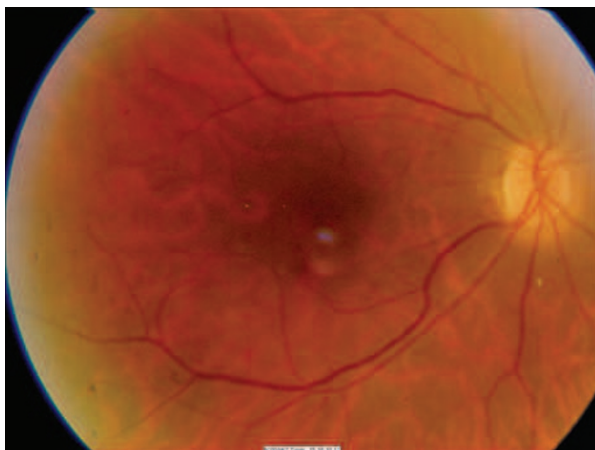


Figure 1 Two fine diamond dust particles at the posterior pole.

diamond-dusted membrane scraper (DDMS™ by Synergetics Inc.) was used to help create an edge to the ILM before peeling. On 2-week postoperative review, the operation was an anatomical and functional success. However, highly refractile deposits of diamond particles were noted on the macula (see Figure 1). Two particles were visible on fundoscopy and optical coherence tomography identified an additional finer particle. The patient was asymptomatic and automated static visual field testing was normal.

It is advised in the literature that particles noted during surgery should be aspirated through the extrusion needle.³ However, particles may not be appreciated during surgery and small finer particles may not be visible. Our literature search did not reveal any reports of adverse consequences of residual diamond deposits of the size used in VR surgery. The long-term sequelae of residual iatrogenic retinal diamond deposits remain unknown.

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Sir,
Herpes zoster ophthalmicus complicated by incomplete ophthalmoplegia and a neurotrophic ulcer

Cranial nerve involvement in children with herpes zoster ophthalmicus (HZO) is rare.^{1–3} A case of incomplete ophthalmoplegia in a child after an episode of HZO is described and a preventable complication is highlighted.

Case report

A 9-year-old girl of Indian origin presented with a vesicular eruption over the left ophthalmic division of the trigeminal nerve with no involvement of the nasal tip (Figure 1). A diagnosis of HZO was made and the patient was initiated on oral acyclovir.

A week later, she developed third (dilated left pupil with partial ptosis), fourth (–2 limitation on dextrodepression), fifth (reduced left corneal sensation), and sixth (–2 limitation on levoversion) nerve palsies. There was no limitation of adduction, elevation, or depression.

Right visual acuity was 6/5 and left visual acuity was corrected to 6/18 with pinhole. Slit lamp examination revealed a left anterior uveitis (+2) with superficial punctate epithelial erosions, which were treated with steroid drops and lubricants, respectively. In addition to acyclovir, intravenous ceftriaxone and flucloxacillin were administered to treat infection of her lesions. Inflammatory markers were raised, but physical, haematological, biochemical, and magnetic resonance imaging assessments were within normal range. Her paediatrician decided not to investigate for immunodeficiency.

She was treated for 6 days and was then continued on oral aciclovir and prednisolone to hasten the resolution of her cranial nerve palsies. She did not attend her follow-up appointment, and her lubricant drops were discontinued by her parents. Eight months after presentation, she returned as an emergency case with a neurotrophic ulcer that resolved following intensive antibiotic treatment.



Figure 1 Typical HZO rash.