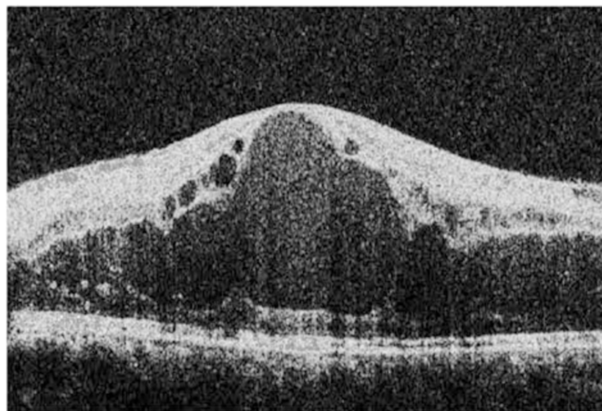

Figure 2 First OCT with macular oedema.

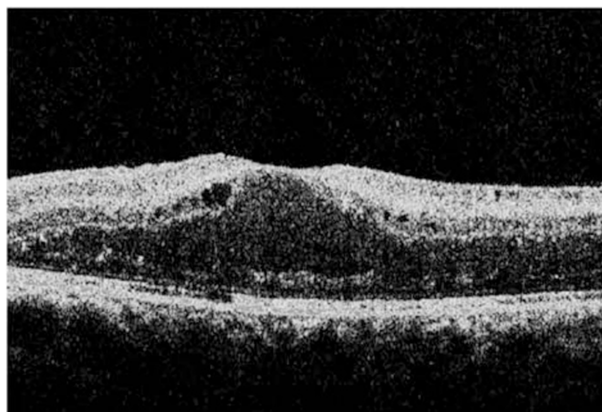

Figure 3 Last OCT, after treatment (peripheral laser and ranibizumab injections).

disease in the literature.[3] FSHD is a muscular dystrophy characterized by weakness of the muscles of the facial and scapulohumeral regions. The age of presentation is in early adulthood. FSHD has an autosomal dominant inheritance and it maps to chromosome 4.[4] Coats' disease, hearing loss, and mental retardation may be extramuscular manifestations of FSHD.[5] Most cases of FSHD are associated with bilateral Coats' disease.[3] There are a few cases of isolated Coats' disease in which other anti-angiogenics were used but, to the best of our knowledge, this is the first case, especially with FSHD, treated with ranibizumab.[2]

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Eyelid necrosis after local anaesthesia for lacrimal sac surgery

A 74-year-old woman (C1) and an 81-year-old woman (C2) with no history of atopy each received a standard injection of 3 ml lidocaine hydrochloride 2% and 1/100 000-epinephrine into the medial canthal region in preparation for dacryocystectomy. For each injection, the contents were obtained from a recently opened sterile bottle and delivered with a single sterile needle. Each woman had received lidocaine local anaesthesia (LLA) in the past, peribulbar administration in the case of C1 and non-ophthalmic administration for the implantation of a pacemaker in C2. During the injection, each of them experienced sudden faintness and local pain, and within a few hours, an extensive periorbital erythema and swelling was observed. Within 8 days, skin necrosis involving the medial canthus occurred and was accompanied by a serous fluid-filled bulla (Figures 1a and 2a). There was no sign of periorbital/orbital involvement on computerised tomography, no abnormal laboratory findings, and microorganisms were absent in direct microscopy and in the culture of bullous fluid. Treatment with intravenous amoxicillin and local and systemic corticosteroids was given. After 15 days, swelling and necrotic skin changes decreased (Figures 1b and 2b), and 6 months later, a retractile pigmented scar with a lower lid cicatricial ectropion (Figures 1c, d and 2c) was noted.

In ophthalmic surgery, side effects of LLA are uncommon, but they have been reported after subconjunctival injection or retrobulbar anaesthesia.[1–3] Inadvertent intravascular injection, leading to platelet–fibrin emboli or vasoconstriction by epinephrine, resulting in occlusion of the lacrimal artery, is also reported.[3,4] Among the amide anaesthetics, lidocaine shows a higher toxicity to the central nervous and cardiovascular systems; prilocaine produces less vasodilatation and toxicity but causes methaemoglobin formation.[1] In the case of these two women, there was no evidence of peripheral vascular disease or diabetes, but

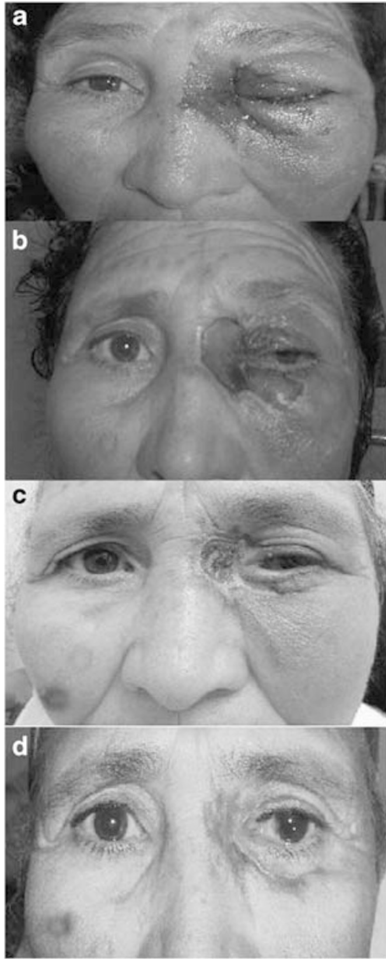

Figure 1 Case 1. (a) One day after injection, the patient presented an eyelid erythematous and swelling with a deep skin necrosis of the medial canthal region in the left eye. (b) 10 days later: the extent and intensity of eyelid ischaemia decreased. (c) 3 weeks later: a peripheral discoloration was observed. (d) 1 year later: a discreet retractile scar of the medial cantus in the left eye.

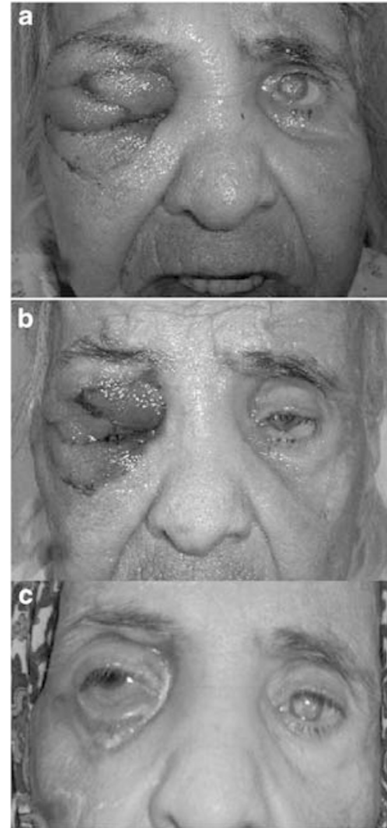

Figure 2 Case 2. (a) One day after injection: eyelids erythematous and swelling, with a deep skin necrosis of the medial canthal region in the right eye. (b) 8 days later: a healing of the necrotic periocular skin. (c) 6 months later: retractile pigmented scar with a total lid cicatricial ectropion.

there had been previous exposure to lidocaine. We hypothesise that an immediate type IV hypersensitivity reaction to lidocaine occurred in these patients.[3,5] It may be impractical to avoid the repeated use of LLA in patients undergoing multiple surgeries, and in any case, a cross reaction between these two main classes of anaesthetic drugs may still occur.[5] What is important is to recognise the possibility of this complication, advise patients accordingly, and have corticosteroids on hand to limit the severity of the inflammatory reaction and ameliorate the progression of necrosis, should it appear.

Conflict of interest

The authors declare no conflict of interest.

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