Table 1 Preoperative and postoperative examinations

	Right eye	*Left eye*
Intraocular pressure (mmHg)		
Preoperative	16	12
Postoperative: 8 weeks	15	22
6 months	20	28[a]
7 months	17[a]	16[b]
10 months	15	22[a]
16 months	12	18[a]
3 years	14	11
Axial length (mm)		
Preoperative	17.68	17.69
Postoperative: 6 months	21.48	22.75
16 months	22.63	23.99
Central corneal thickness (μm)		
Preoperative	681 ± 4.7	665 ± 3.5
Postoperative: 6 months	745 ± 7.6	779 ± 7.2
16 months	66 ± 3.0	667 ± 2.7
Refraction (diopters)		
Postoperative: 6 months	−4.50+1.50 × 85	−13.00+4.00 × 75
3 years	−8.25+1.25 at 102	−6.25+1.00 at 83[c]

[a]Timolol.
[b]Timolol and phospholine iodine.
[c]After IOL exchange.

routinely use intracameral triamcinolone when a child is left aphakic because the triamcinolone immediately mixes with the formed vitreous of the child and may be retained for many months. In this case, the IOL was placed in the ciliary sulcus of both eyes instead of in the capsular bag. It was felt that the family would not likely comply with the wearing of glasses, and the sulcus placement was chosen to make the lens easier to exchange later. It is likely that this ciliary sulcus placement allowed the triamcinolone to more easily migrate into the vitreous space. This happened in one eye and not in the other. A portion of it lodged in a location that escaped detection at EUA and at glaucoma surgery. Glaucoma has been reported to occur in children who have intravitreal injection of triamcinolone,[2] but this complication is thought to be very rare when intracameral placement is used.[3–6] This single-case report cannot establish a cause and effect relationship, meaning it is difficult to say if retained-triamcinolone led to glaucoma. However, it is important to note that in the case described herein, other risk factors for glaucoma (eg, age at surgery) were identical in both eyes, and glaucoma developed in the eye with retained-triamcinolone, but not in the eye without it. We now place triamcinolone intracamerally only when an IOL has been placed into the capsular bag. We have not, to date, had another incident of long-term retained-intravitreal triamcinolone following pediatric cataract surgery.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Surgical management of anterior capsular plaque associated with persistent pupillary membranes

Case report

A 3-week-old female infant presented with an absent red reflex in the left eye. Her past medical and ocular histories were unremarkable.

Examination revealed a persistent pupillary membrane (PPM) and what appeared to be an anterior polar cataract in the left eye (Figure 1). Dilated fundus examination and B-scan ultrasonography were unremarkable. Examination of the right eye was within normal limits.

The patient was scheduled for a left lensectomy and membranectomy. Two stab, clear corneal incisions were fashioned, and cohesive viscoelastic material was used to fill the anterior chamber. A Sinskey hook was used to lyse the PPM 360º. There was no evidence of an anterior polar cataract, and thus lensectomy was not performed. A whitish-grey plaque adherent to the external surface of the anterior capsule was noted. This was peeled off using

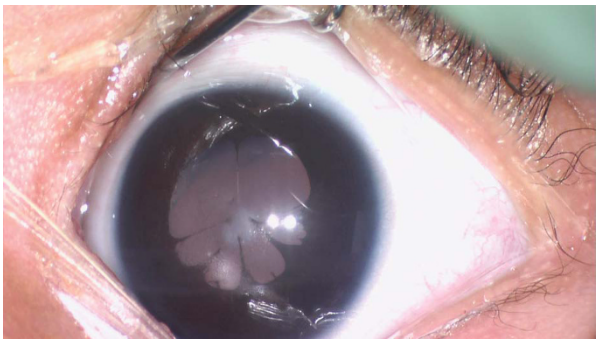

Figure 1 Intraoperative view of an opaque plaque on the external surface of the anterior capsule associated with PPM.

a 25G cystotome, and Utrata forceps were then used to excise the remnant plaque (Supplementary Media). The anterior capsule was not violated and there were no intraoperative or postoperative complications. At 6 months of age, the patient had equal vision in both eyes as determined by Teller acuity cards in the right and left eyes, respectively, with part-time occlusion.

Comment

Most PPMs are fine strands that regress within the first weeks of life.[1] Some may be amblyogenic;[2] the decision to excise them depends on an assessment of their likely effect on visual development. They can be associated with cataracts and other ocular pathologies.[3] Although anterior capsular plaques have been previously studied in the paediatric population, they are commonly on the internal aspect of the anterior capsule. They are thought to occur secondary to the differentiation of epithelial mesenchymal cells into myofibroblasts that secrete extracellular matrix.[4] The plaque seen here was supracapsular, adherent to its external surface. Although careful removal of the plaque avoids unnecessary lensectomy, an iatrogenic secondary cataract may occur. Similar opacities have been anecdotally observed in other eyes with PPM. The mechanisms of anterior capsular synthesis and development are unclear.[5]

We illustrate a case of firmly adherent plaque on the external surface of the anterior capsule in a young patient with PPM. These can often be confused with anterior polar cataracts pre-operatively. Intraoperative differentiation of the two is critical to avoid unnecessary cataract extraction. We highlight a safe and simple technique using a cystotome and Utrata forceps to remove external capsular plaques while leaving the capsule intact.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
TORCH testing in non-familial paediatric cataract

As TOxoplasmosis, Rubella, Cytomegalovirus and Herpes Simplex Virus are recognised as potential causative pathogens, it has become common practice to include TORCH serology in the investigation of non-familial paediatric cataracts. The paediatric subsection of the 2010 Royal College of Ophthalmology Cataract Surgery Guidelines endorses this practice.[1] These guidelines reference a 2004 paper by Raghu *et al*,[2] which reported four cases of Herpes Simplex Virus (HSV) 1-associated congenital cataract; however, none of the four patients required treatment for HSV. The guidelines do not provide further evidence to support routine TORCH testing.

Following institutional board approval from the Standards, Quality and Audit Department of the Belfast Health and Social Care Trust (BHSCT), the clinical and laboratory findings for paediatric patients (≤16 years old) who underwent cataract surgery between January 2006 and December 2013 were retrospectively analysed using the Northern Ireland Electronic Health Care Record system. Patients with a family history of paediatric cataracts or traumatic cataracts were excluded. TORCH titres had been performed on all 30 patients identified with non-familial paediatric cataract in this study. Five children had abnormal results; of these, one was an insufficient sample, one was a raised CMV on PCR and three further 'positive' results were considered insignificant on discussion with virology colleagues (Table 1). The characteristics of these 5 patients are given in Table 2. None of the five patients with abnormal results