

Figure 1 Total cases of ophthalmia neonatorum in Leeds from 1997 to 2008 by year.

Table 2 Number of positive laboratory samples and cases reported/unreported (2006–2008)

Year	2006	2007	2008
<i>N. gonorrhoeae</i>	0	0	0
<i>C. trachomatis</i>	6	5	3
HPA reports	3	0	0
Cases not reported	3	5	3

Comment

We have shown that there is under notification of ophthalmia neonatorum. It is the responsibility of the referring clinician to report cases of suspected ophthalmia neonatorum, which should be done on clinical grounds, with the laboratory test used as a welcome confirmation of the diagnosis. To improve reporting rates all positive swab reports have had an 'autocomment' added reminding the clinician of their duty to report the case to the HPA. Underreporting of ophthalmia neonatorum has implications for national monitoring and for limiting the morbidity of the condition for patients, mothers, and the community at large. We would welcome similar studies on a national basis to determine how widespread a problem this may be.

References

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- 2 HPA Leeds. Total number of reported cases of ophthalmia neonatorum in Leeds 1997–2008.

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Sir,
Reversed vaulted AcrySof intraocular lens presenting as pupillary block

We report a case of a patient who 4 weeks after uneventful phacoemulsification, underwent a dilated fundal examination, and subsequently developed pupil block. The intraocular lens was noted to be reversed, and thereby vaulted anteriorly. Repositioning of the lens into

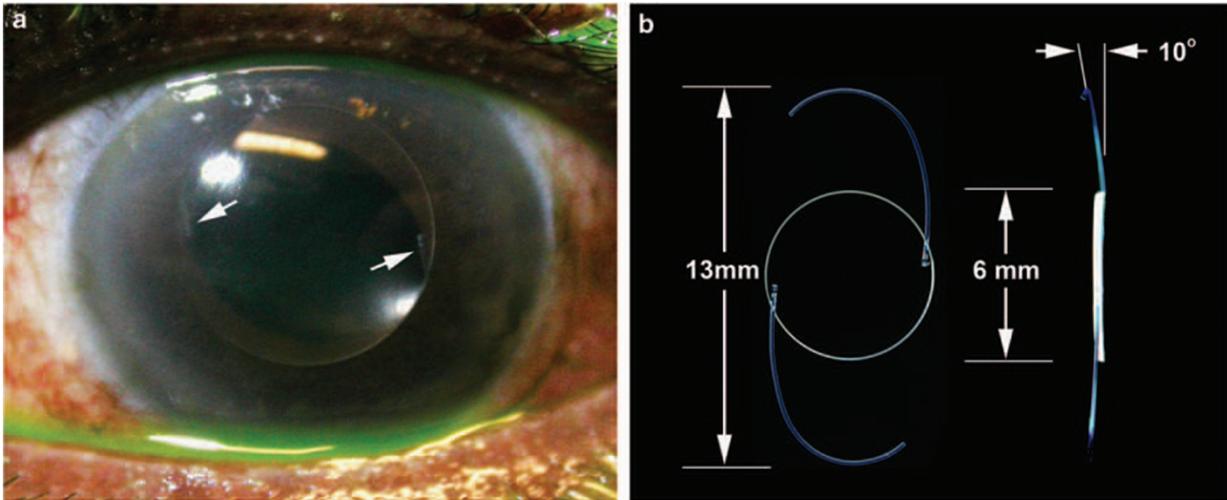


Figure 1 (a) The optic of the intraocular lens (IOL) is anterior to the pupil, with peaking of the pupil at 10 and 4 O'clock where the blue haptics of the lens are visible (arrows). The insertion of the haptics with the lens indicates that the lens is reversed. (b) A photograph of the AcrySof MA60AC IOL showing the correct orientation, lens dimensions, and 10° posterior vaulting.

the bag at the slit lamp lead to resolution of the pupillary block with no further recurrence.

Case report

A 68-year-old man with diabetes and end-stage renal failure underwent routine left phacoemulsification in March 2007 with +22.0 dioptre AcrySof MA60AC lens implantation in the capsular bag (three-piece, 6 mm biconvex optic, 13 mm length, polypropylene haptics posteriorly vaulted 10°). Four weeks postoperatively he could see 6/9 unaided and underwent dilated fundal examination. At 0500 hours the following morning he woke with a severe pain in his left eye but did not present to the eye unit until 2000 hours.

On examination his left visual acuity was hand movements, he had a decompensated cornea, shallow anterior chamber, and an intraocular pressure of 48 mm Hg. The body of his intraocular lens (IOL) was in the anterior chamber (AC) whereas its haptics were in the capsular bag, causing total pupillary capture. It was noted that the haptics were pointing in the opposite direction to normal, indicating that the IOL had been inserted upside down and was thereby vaulting 10° anteriorly rather than posteriorly (see Figure 1).

The patient was managed with oral and topical hypotensive agents, dilated with cyclopentolate and phenylephrine, positioned supine, and underwent ocular massage. This failed to reverse the pupil block, and the cornea was too oedematous for a YAG laser iridotomy. In addition, there was no provision for out of hours operating. The IOL was therefore relocated into the capsular bag at the slit lamp with topical anaesthesia using a nasolacrimal canula, attached to a syringe filled with normal saline, to maintain the anterior chamber. Normal intraocular pressure was restored immediately. Pilocarpine was continued for 1 month, after which the

patient had two trial dilations, the latest 7 months postoperatively, with no recurrence of pupillary capture.

Comment

Pupil capture has been attributed to postoperative shallowing of the AC, anterior displacement of IOLs due to sulcus placement, an oversized capsulorrhexis, or excessive capsular contraction.¹ However, with the advent of small incision phacoemulsification surgery, in-the-bag implantation, and modern IOL designs, partial or complete pupil capture is uncommon and rarely leads to pupil block.²⁻⁵ A pharmacologically dilated pupil and an incorrectly inserted lens causing anterior vaulting were contributory factors in this case. A nasolacrimal canula is curved, facilitating ocular access at the slit lamp, and is blunt, thereby minimising risk to the IOL or ocular structures should there be unexpected movement. An alternative approach could be to use a small gauge needle to reposition the IOL into the bag, or even to flip the IOL in an operating theatre to the correct orientation.

The authors suspect that given time capsular fibrosis prevented further dislocation of the IOL. In the absence of operating facilities repositioning of the IOL at a slit lamp is a feasible alternative, which can be carried out to relieve pseudophakic pupil block.

References

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