

Sir,

### Purulent orbital cellulitis

Regarding the case report by Redmill, Sandy and Rose,<sup>1</sup> it should not be intuitively surprising that purulent orbital cellulitis resulted from a sub-Tenon's local anaesthetic given in the presence of active corneal ulceration. The authors do not state whether corneal scrapings were taken nor what the culture results of the scrapings were. The fact that they administered topical ofloxacin however suggests at least a clinical suspicion of active infection.

My personal experience suggests that sub-Tenon's or other invasive local anaesthetic are not necessary for the procedure of corneal gluing. This can be accomplished quite satisfactorily using topical anaesthesia in every case that I have dealt with. (A highly uncooperative patient would generally be unsuitable for gluing since they also presumably would be uncooperative following the procedure with a risk of eye rubbing.)

Perhaps therefore the main lessons to be drawn from this case report are firstly, that if invasive local anaesthesia is not necessary, it should not be used, and secondly, that it should be used with extreme caution in the presence of suspected or proven active infection of the external eye.

### References

- 1 Redmill B, Sandy C, Rose GE. Orbital cellulitis following corneal gluing under sub-Tenon's local anaesthesia. *Eye* 2001; 15: 554–556.

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Sir,

### Reply

We are grateful for the comments in this letter. Our patient presented with a full-thickness corneal melt associated with rheumatoid arthritis with no evidence of infection; therefore corneal scrapings were not taken. Topical ofloxacin was administered as a prophylactic measure in view of the use of a soft contact lens in the presence of an aqueous leak. We agree that topical anaesthesia is the most suitable technique for corneal gluing. Our report is of a previously unrecorded, but clinically significant complication of sub-Tenon's anaesthesia. This remains an invasive technique, which is not risk-free and should only be used if necessary.

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Sir,

### 'Lost' metallic vitrectomy port scleral plugs and MRI scanning

In pars plana vitrectomy the two active ports are sealed with either gold or silver plated scleral plugs (Figure 1) when performing steps such as scleral

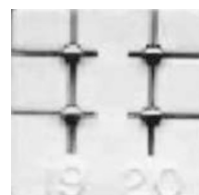
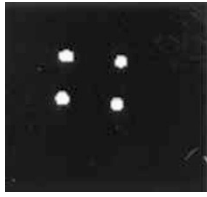


Figure 1 Gold and silver plated vitrectomy port plugs.



**Figure 2** X-ray appearance of the plugs.

depression. Occasionally these plugs cannot be located at the completion of surgery, and are either on the drape, in the suction bottle, on the operating theatre floor or located sub-conjunctively. When vitrectomy is combined with scleral buckling the sub-conjunctival space is opened extensively and plugs can slip posterior to the equator and prove difficult to locate.

In conjunction with our Department of Medical Physics and Bioengineering we investigated the magnetic compatibility of these plugs: both gold and silver plated plugs were found to be radio-opaque, and further analysis in a magnetic field revealed that they exhibit considerable ferromagnetism (Figure 2).

Consequently their presence in the orbit is an absolute contra-indication to performing MRI scanning in a patient. We therefore recommend that all patients with suspected per-operative loss of scleral plugs be x-rayed postoperatively and if plugs are present, they should be advised against having an MRI scan at a future date.

An alternative is to use non-metallic or MRI compatible scleral plugs.

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