

Rycroft cannula 6 days previous, was noted; this was repaired with vitrectomy cryotherapy and gas tamponade. At the most recent follow-up (1 month following the original injury), visual acuity was 6/60 and the retina remains flat with some thin subretinal haemorrhage.

Comment

It is the responsibility of the surgeon to check that cannulae/needles are appropriate for the task in hand and well secured before use. It is expected that the scrub nurse also follows the above procedure. Despite adherence to these recommendations, an accident occurred. While not belittling the importance of the above, we believe that safety in the operating theatre could be improved if only syringes with a luer lock are used while performing intraocular surgery. We recognise that if not appropriately fitted, cannulae can still detach from the luer lock system.

This case has been reported to the Medical Devices Agency.

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Sir,

Spontaneous suprachoroidal haemorrhage following a valsalva manoeuvre

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Suprachoroidal haemorrhage is the accumulation of blood within the suprachoroidal space, which is a potential space situated between the choroid and the sclera.¹ It has been reported to occur in all types of intraocular procedures.² Sudden hypotony is thought to be responsible for the haemorrhage.²

We describe a patient who developed a small SCH apparently induced by a valsalva manoeuvre.

Case report

A 65-year-old gentleman presented to the eye casualty, after straining severely during a bowel movement. He felt a sudden 'popping' in his right eye followed by pain and reduced vision in the right eye.

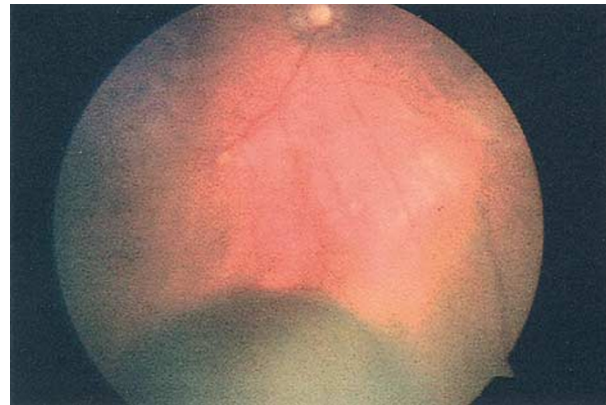


Figure 1

There was no past or family history of eye disorders. He was known to be asthmatic and had recently developed a well-differentiated prostatic cancer that was being treated with Indoramin (a selective alpha-blocker). There was no history of bleeding disorder; routine coagulation screening test results were normal.

On examination, the best corrected visual acuity was 6/24 in his right eye and 6/5 in his left eye. Intraocular pressures were 38 mmHg on the right and 12 mmHg on the left. There was epithelial oedema affecting the lower half of the right cornea. The anterior chambers were deep and clear and both angles were open. Fundus examination of the left eye revealed an elevated, dark-brown choroidal mass, approximately five disc diameters in size, located in the inferior half of the fundus (Figure 1). A contact ultrasonographic examination of the right eye confirmed the presence of a choroidal lesion 4 mm in thickness (Figure 2).

An intravenous acetazolamide 500 mg stat dose was given and the right intraocular pressure came down to 16 mmHg.

One week later his right cornea cleared and the right visual acuity had improved to 6/5. The swelling had reduced considerably and it had disappeared by the end of the second week. Ultrasound revealed total resolution of the choroidal haemorrhage. We suggest that he suffered small choroidal haemorrhage caused by valsalva manoeuvre, and this resulted in a sudden increase in intraocular pressure and subsequent corneal oedema.

Comment

A valsalva manoeuvre results in a rapid rise in intrathoracic or intra-abdominal pressure against closed glottis. As a result of the absence of valves in the venous system, this pressure is transmitted to the eye causing

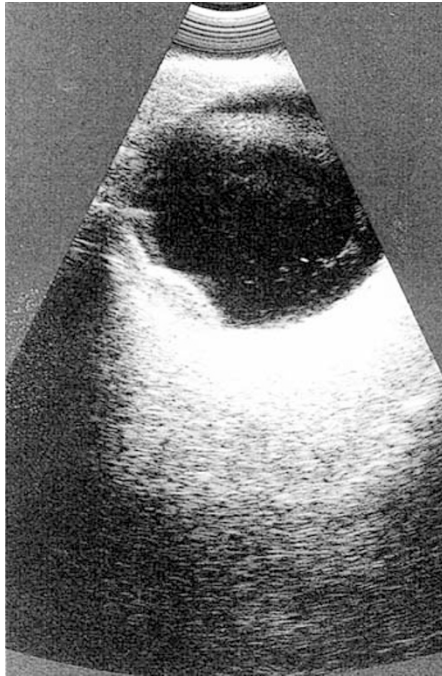


Figure 2

vessel wall rupture by an apparently excessive pressure gradient across the vessel wall.³

A spontaneous suprachoroidal haemorrhage can result in angle closure glaucoma and corneal oedema secondary to forward displacement of the iris-lens diaphragm.⁵ In our case the angle was open at the time of examination.

Typically, patients experience a sudden onset of severe ocular pain with a subsequent loss of vision. Headache, nausea and vomiting may also accompany the ocular pain.¹

Suprachoroidal haemorrhage after valsalva manoeuvre has been reported in patients either on systemic anti-coagulants, treated with streptokinase or in eyes with previous ocular surgery (scleral buckle).²⁻⁵

To our knowledge, this is the first reported case of spontaneous choroidal haemorrhage in an individual who is not on any anticoagulants or has had no past history of ocular surgery.

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Sir,

Complete spontaneous regression of a basal cell carcinoma

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A case of spontaneous regression of a basal cell carcinoma is presented.

Case report

A 76-year-old man under review for glaucoma in the right eye presented to the eye clinic with a large lesion on the medial aspect of the right lower lid in January 1997. The lesion had a maximum horizontal diameter of 11 mm and a vertical diameter of 12 mm. It had a central ulcerated crater with a raised pearly rolled edge (Figure 1a). Based on the location and clinical appearance of the lesion, a provisional diagnosis of basal cell carcinoma (nodular) was made and an incisional biopsy was performed. Histology was consistent with an adenoid basal cell carcinoma. The patient was put on the waiting list for excision of the basal cell carcinoma with a skin graft in February 1997. When reviewed in March 1997 the lesion had become smaller in size, so surgery was postponed. On subsequent follow-up in June 1997, it had disappeared completely (Figure 1b). The patient has been under follow-up for 4 years with no evidence of recurrence of the basal cell carcinoma.