Sir,

A lash foreign body complicating subtenon's anaesthesia

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A 65-year-old lady underwent routine left phacoemulsification and intraocular lens implantation with subtenon's local anaesthesia, comprising 3 ml of 2% lignocaine administered inferonasally using a blunt subtenon's cannula.

She had no relevant past ocular history. Her medical history included hypertension, for which she was on treatment, and transient ischaemic attacks, for which she was under investigation.

The patient attended her postoperative review 3 weeks later. Visual acuity was 6/24, 6/18 and she was complaining of a sore, red left eye. Examination revealed the inferior conjunctiva to be injected and there was a conjunctival epithelial defect at 8 o'clock in the region of the previous subtenon's incision, just posterior to the limbus. An eyelash was visible in the subtenon's space associated with some small white infiltrates (Figure 1).

The patient underwent removal of the eyelash under topical anaesthesia the next day. The edges of the tenon's and conjunctival defect were scraped with a surgical blade and the wound was opened slightly to facilitate removal of the lash. After lash removal, the conjunctiva was closed with 3 × 8.0 vicryl sutures. She was given subconjunctival betnesol and continued on g. betnesol N qid, with chloramphenicol ointment at night.

On review 1 week later, the eye was much more comfortable and the steroid drops were tapered. After 1 month, the eye was quiet and the conjunctiva had completely healed (Figure 2).

Figure 1 Injected eye with conjunctival epithelial defect (black arrow). Note lash in subtenon's space with surrounding infiltrate (white arrow).

Comment

Injection of local anaesthetic into the subtenon's space has become a popular method of local anaesthesia in cataract surgery. The conjunctiva and tenon's capsule are opened and the anaesthetic is introduced via a blunt cannula, thus avoiding the potential complications of peribulbar and retrobulbar anaesthesia with a sharp needle near the globe. Increasingly, cataract surgery is being undertaken using topical anaesthesia only, but where additional analgesia or akinesia are required pre- or peroperatively, anaesthetic solution can easily be administered via the subtenon's route. Furthermore, subtenon's anaesthesia can be a useful preoperative adjunct to retrobulbar anaesthesia in vitreoretinal surgery and glaucoma surgery.^{1,2} Subtenon's anaesthesia may be more effective at inducing akinesia than single injection peribulbar anaesthesia.³

There are relatively few reports of complications associated with subtenon's anaesthesia. Reports of significant complications with this technique include globe rupture after previous posterior segment surgery⁴ and rectus muscle trauma.⁵

We present the case of a patient who underwent uncomplicated phacoemulsification using subtenon's anaesthesia. She presented 3 weeks after surgery with a nonhealing conjunctival and tenon's defect associated with an embedded eyelash. It seems probable that the lash had become embedded at the time of initial subtenon's injection. Removal of the lash and closure of the wound allowed healing of the defect to take place.

As far as we are aware, this is the first report of such a complication associated with a lash 'foreign body'. This case emphasises the need to ensure that lashes are kept away from the surgical field.

Figure 2 1 month following removal of the lash and closure of the conjunctiva, the eye is quiet and the epithelial defect has healed (arrow).

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Sir,

YAG laser capsulotomy, an unusual complication
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Posterior capsule opacification (PCO) is the commonest cause of diminished visual acuity following cataract extraction. Visually significant PCO may occur in up to 25% of patients over a 5-year period.¹

PCO is readily treated by the use of the neodymium yttrium aluminium garnet (NdYAG) laser to cause photodisruption of the thickened posterior capsule, and thereby clear the visual axis.

We report a patient with an uncommon complication following uneventful NdYAG capsulotomy and describe a potential treatment.

Case report

A 71-year-old Caucasian lady presented 12 months after uncomplicated right cataract surgery with a gradual

reduction in vision of the operated eye. On examination, her best-corrected visual acuity was noted to be 6/18 in the right eye, and slit-lamp biomicroscopy revealed PCO. NdYAG laser capsulotomy was performed using a circular pattern of laser treatment. Following treatment, an optically clear visual axis was seen and the patient was commenced on G dexamethosone drops four times a day.

The patient returned to the eye clinic 1 week later complaining of a persistent, large 'floater' in the right eye, which was distressing her. This 'floater' became apparent on moving her eyes in any direction and slowly disappeared on keeping her eyes still. Her best-corrected visual acuity had improved to 6/6, but slit-lamp examination revealed a large freely mobile remnant of her posterior capsule floating within the retrolental space, Figure 1. An attempt to directly disrupt the remnant was made with further NdYAG laser treatment, with the patient moving her eyes until the fragment crossed the visual axis and laser being applied as it did so.

Despite limited success in obliterating the offending fragment, the patient's symptoms completely subsided the following day.

Slit-lamp examination 6 weeks later revealed no evidence of the posterior capsular remnant.

Comment

NdYAG capsulotomy is generally a safe and successful method in relieving the symptoms of posterior capsular opacification. Documented complications include, transient rise in intraocular pressure,² retinal detachment,³ lens subluxation or dislocation,⁴ lens pitting,⁵ and exacerbation of local endophthalmitis.⁶

Figure 1 Posterior capsule remnant floating in retrolental space.