Figure 3 (a) Photomicrograph showing tumour consisting of pigment-containing polygonal cells arranged in tubule like groups with vascularised connective tissue septae, and prominent basement membrane (Hematoxylin and Eosin, original magnification $\times 6.6$). (b) At 4 weeks following phacoemulsification cataract surgery with capsular bag placement of iris prosthesis to mask the surgical coloboma.

prosthesis (Ophtec Inc., Boca Raton, USA) was placed in the capsular bag to mask the surgical coloboma. At 4 weeks postoperatively, the uncorrected visual acuity was 20/25 and patient had no visual complaints (Figure 3b).

Adenoma of the iris pigment epithelium is a rare benign tumour which usually appears as a solid dark coloured mass arising from the posterior aspect of the iris with sparing of the iris stroma.^{1,2} Iris pigment epithelial adenoma should be differentiated from iris melanoma.^{3,4} In symptomatic cases, adenoma can be excised. Surgical coloboma can be corrected by iridoplasty, painted contact lens, or by capsular bag placement of iris prosthesis at the time of cataract surgery.⁵

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Sir, Dye-assisted small incision cataract surgery in eyes with cataract and coexisting corneal opacity

Visual rehabilitation in eyes with cataract and coexisting corneal opacity can be best performed by a corneal triple procedure (combined penetrating keratoplasty with cataract surgery). However, factors like graft rejection and infection may jeopardize the outcome of penetrating

keratoplasty. This may be of special relevance in developing countries like India, where there is a long waiting period for keratoplasty because of paucity of good-quality donor material. Moreover, the consequences of graft failure can be grave in one-eyed individuals who have lost vision in the other eye due to an irreversible ocular pathology. In these patients, particularly if the corneal opacity is vascularized, cataract extraction with intraocular lens implantation may provide a suboptimal but long-term vision. However, cataract extraction is difficult in these eyes because of poor visibility through the corneal opacity.

We used trypan blue dye to stain the anterior capsule to enhance visualization during surgery. Trypan blue is commonly used to stain the anterior capsule in order to enhance visualization for capsulorhexis in white cataracts.^{1,2} This dye has been considered safe for intraoperative use as it has been used clinically to examine endothelial cell damage after cataract extraction³ and is also used to examine endothelium of donor corneoscleral button before corneal transplantation.⁴ In eyes with cataract and coexisting corneal opacities, trypan blue has been used successfully to enhance visualization to perform phacoemulsification.⁵

We performed manual non-phaco small incision cataract surgery (SICS) in 12 eyes of 12 patients with cataract and coexisting corneal opacity using 0.1% trypan blue dye and evaluated the outcome. All these patients were one eyed and had corneal opacity with deep stromal vascularization, thereby having a high risk of graft rejection and failure. The aim of performing this procedure was to provide ambulatory vision to these patients and to defer corneal triple procedure as long as possible.

In all, 12 eyes of 12 patients with significant cataract and corneal opacity, which was only partly covering the visual axis, were selected. Surgery was performed under peribulbar anesthesia. A small peritomy was performed superiorly and a 6 mm frown-shaped scleral groove was made, which was then tunnelled by crescent knife and the anterior chamber was entered by a 3.2 mm angled keratome. Trypan blue 0.1% (Vision Blue, Dorc International, The Netherlands) was injected under air bubble over the anterior capsule and then washed with balanced salt solution after 15 s and viscoelastic was injected. A large continuous curvilinear capsulorhexis of approximately 6.0 mm was made and hydrodissection and hydrodelineation were performed. Nucleus was prolapsed and delivered by irrigating vectis and cortical matter aspirated by simcoe cannula. A single piece intraocular lens (IOL) of polymethylmethacrylate of 6.5 mm optic size was implanted into the capsular bag.

The anterior chamber was reformed from the side port with balanced salt solution. No suture was placed for wound closure.

Postoperatively, patients were prescribed topical betamethasone sodium phosphate 0.1% and ciprofloxacin 0.3% q.i.d. each for 4 weeks and tropicamide 1% t.i.d. for 1 week. Patients were followed up on day 1, 1 week, and 6 weeks. On the postoperative day 1, there was no residual staining of the anterior capsule and all eyes showed a quiet anterior chamber with normal intraocular pressure.

The best corrected visual acuity (BCVA) was $\leq 3/60$ preoperatively in all the eyes and at 6 weeks postoperatively, this improved to $\geq 6/36$ in all the eyes of which four eyes had BCVA of $\geq 6/18$.

In the present study, we observed that the dye improved visualization of the anterior capsule and a complete capsulorhexis could be performed successfully in all the eyes. The anterior capsule could be seen throughout the surgical procedure. In all the eyes, the procedure could be performed successfully and without any complication.

Patients with nebulomacular corneal opacities and a visually debilitating cataract may become ambulatory with cataract surgery alone. To bring about a faster visual rehabilitation, cataract extraction is performed these days through a small incision and is preferred over the conventional extracapsular extraction. Among the small incision surgeries, the choice can be between phacoemulsification and manual nonphaco small incision cataract surgery. In a similar study, phacoemulsification has been performed in such eyes using trypan blue dye.⁵ However, we felt that the risk of complications is higher in phaco than in nonphaco small incision surgery. This is especially relevant in these eyes as it is difficult to manage complications like posterior capsular tear and nucleus/IOL drop in eyes with corneal opacity.

Although the visual outcome in these cases was less than optimal, all patients had enough vision to enable them to carry out their daily activities. Trypan blue-assisted SICS in cases of corneal opacities with cataract is safe and feasible, both in terms of faster visual rehabilitation and minimal risk of complications.

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Sir,

Conjunctival ischaemia subsequent to posterior subtenon's triamcinolone acetonide injection

Triamcinolone acetonide is a potent corticosteroid frequently used for the treatment of a variety of ocular inflammatory conditions. Numerous complications have been reported. We report a case of conjunctival ischaemia following posterior subtenon's triamcinolone acetonide for diabetic macular oedema. To the best of our knowledge this has not been previously reported.

Case report

A 58-year-old male patient was seen in the retinal clinic. He was diagnosed with diabetes 16 years ago and was subsequently diagnosed hypertensive. He had bilateral cataract extractions with lens implants in the early 1990s and his best-corrected visual acuities were 6/4 OD and 6/6 OS. His medication included insulin, ACE inhibitors, and aspirin. There was no history of allergic reactions. He had focal argon laser treatment for clinically significant macular oedema (CSMO)—once to the right and three times to the left eye over a period of 30 months. His vision deteriorated to 6/18 OS and the macular oedema persisted despite laser treatment. Fluorescein angiography revealed florid macular oedema with no

Figure 1 Subconjunctival deposit of triamcinolone superotemporally. Early reperfusion of conjunctival vessels 3 months postinjection (black arrows).

evidence of capillary nonperfusion. In all, 40 mg of triamcinolone acetonide was injected into the posterior subtenon's space superotemporally. At 2 weeks after the injection, a deposit of triamcinolone located anteriorly under the conjunctiva was evident (Figure 1). The overlying conjunctival vessels were obliterated, and showed no sign of perfusion until 3 months after the injection, when larger vessels were noted to appear superiorly (Figure 1). His vision has remained stable at 6/18 OS, with nonresolution of the macular oedema.

Comment

High-dose periocular corticosteroid injections are routinely used for the treatment of numerous inflammatory eye conditions.^{1–4} They are commonly used in the management of intermediate or posterior uveitis and cystoid macular oedema. Different modes of administration of the injection have been described—orbital floor,⁴ posterior subtenon's and trans-tenon's retrobulbar infusions.³ The aim of these periocular injections is to deliver high doses of the drug locally, while reducing to a minimum unwanted systemic side effects. However, local complications do occur and many have been described—including: raised intraocular pressure, cataract progression, ptosis, retrobulbar haemorrhage, subconjunctival haemorrhage, globe perforation, retinal and choroidal vascular occlusions, and conjunctival ulceration.^{1–4}

The patient we describe had a localized collection of subconjunctival triamcinolone, associated with conjunctival vasculature nonperfusion. Glucocorticoids have been well documented to potentiate the vasoconstrictive effects of circulating catecholamines,⁵ which may be responsible for this area of focal