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Sir,

Staining of filtering bleb with trypan blue during phacoemulsification

We describe the inadvertent staining of the filtering bleb caused by the use of trypan blue during phacoemulsification in an eye that had previously undergone a trabeculectomy.

Case report

A 28-year-old man with juvenile open-angle glaucoma had undergone trabeculectomy with mitomycin C. The patient presented to us after 6 months with poor vision in his right eye. The patient had a best-corrected visual acuity of 20/200 OD and 20/40 OS. The intraocular pressure (IOP) was 14 mmHg OD and 16 mmHg OS. He had an anterior subcapsular cataract in the right eye (records indicated a shallow anterior chamber in the initial postoperative period), while the left eye lens was clear. Diffuse, elevated, avascular microcystic blebs were noted in both the eyes. The vertical cup-disc diameter ratio was 0.8 : 1 OD and 0.7 : 1 OS.

During cataract surgery, anterior capsular staining was carried out with 0.1 ml of 0.06% trypan blue to enhance the capsule visibility during the capsulorhexis. Staining of the filtering bleb with passage of dye into the bleb was noted. The patient underwent uncomplicated phacoemulsification, followed by implantation of an Acrysof® single piece intraocular lens.

On the first postoperative day, the best-corrected visual acuity was 20/30 OD with an IOP of 14 mmHg. Diffuse staining of the filtering bleb was noted (Figure 1). The staining faded away and was barely visible at 2 weeks follow-up. There was no change in the bleb characteristics as compared to the preoperative status.

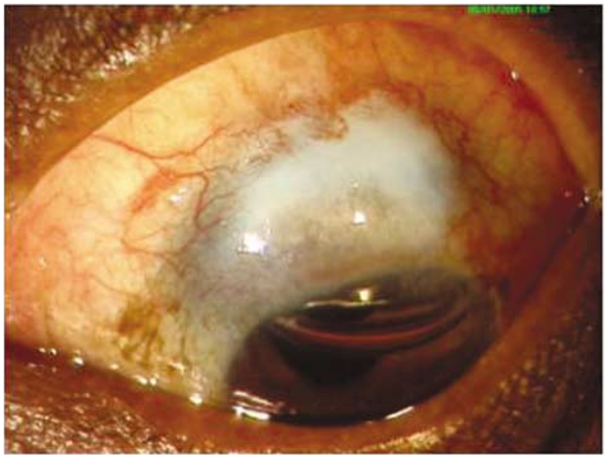

Figure 1 Trypan blue-stained filtering bleb on the first postoperative day after phacoemulsification.

Comments

The present report highlights a benign complication of capsular staining, which is routinely used to aid in the visualization of the anterior capsule during phacoemulsification.[1,2] The surgeon needs to inform the patient preoperatively about the use of the dye and the possibility of transient bleb staining in the postoperative period.

Bleb function may be assessed by slit-lamp examination, by ultrasound biomicroscopy, or indirectly by the control of IOP.[3,4] The inadvertent staining of the bleb as seen in the present case may provide a clue to the adequacy of aqueous drainage through the filter and further studies should be conducted to test this hypothesis.

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Sir,

Medically unexplained visual loss

We commend the authors[1] for a summary of the clinical characteristics of patients with 'medically unexplained visual loss (MUVL)'. We are pleased to note that all their patients had neuroimaging given the resource constraints. Our experience of over two and half years in managing patients with MUVL is similar except for a much lower rate of neuroimaging due to resource constraints—a common problem in hospitals up and down the country. We find the following 'checklist'

Patient sticker + Date

PLACE THIS CHART IN THE NOTES

PATIENT CLAIMING NPL / LP / HM:

☐ RAPD not present.
☐ OKN induced: **Drum (VA >3/60) or Mirror twisted infront of face (VA >LP)**
☐ Good forced choice preferential looking.
☐ Diplopia induced: **By 8prism base down over blind eye.**
☐ Fusion observed with base out prism.
☐ Stereoacuity present.
☐ Can't touch tips of fingers together with both / blind eye open: **This is a test of proprioception and not vision.**
☐ Bizarre writing**..**
☐ Deliberately avoids or crashes into objects.
☐ Visual recovery after a few days in hospital.
☐ Normal ERG / VEP: **remember abnormal VEP may be due to patient defocus. Focal defects can be missed. Dilated with refractive correction for test distance may help.**
☐ Dislikes strong light in the 'blind' eye.
☐ Fast visual location to an object dropped on the ground: **Make sure sound not a factor in ocular movement.**
☐ Inconsistencies with Worth lights and Bagolini glasses. **Describe ……**

PATIENT CLAIMING 6/9 – HM:

☐ Near vision @ 15' does not equal distance vision @ 6m. **6/60=N24 or J17 6/24=N10 or J9-11 6/12=N6 or J4-5.**
☐ Marked visual improvement with plano refraction: **+4 /-4 lens or rotating 2-6D +/- cylinders to cancel.**
☐ Suddenly stopping at a line on the Snellen chart: **most patients can usually see a few letters on the line below.**
☐ Can now read better with 'affected' eye with +4 fogging infront of the good eye.
☐ Same Snellen line read at 3m as at 6m.
☐ Improved acuity with +4 gradual reducing fogging down to their prescription.
☐ No RAPD: **this may be a small macular lesion.**
☐ Normal ERG / VEP: **remember abnormal VEP may be due to patient defocus. Focal defects can be missed. Dilated with refractive correction for test distance may help.**
☐ Ishihara inconsistencies: **Make sure patient not colour blind. Healthy eye behind a green lens will only see test plates #1 and #36. If any others seen VA > 3/60 in the 'affected' eye.**
☐ Inconsistencies with Worth lights and Bagolini glasses. **Describe ……**

PATIENT CLAIMING VISUAL FIELD DEFECT: **(any field may be artifact)**

☐ Visual fields not consistent between static / confrontation / kinetic. **(automated may look reliable)**
☐ Goldman spiral / star (**Most common) or** crossing / reversal of isoptres.
☐ Humphrey '4 leaf clover' field.
☐ Refixation with prism displacing the image into the blind field: **Eg if field < 20 degrees a 20 dioptre prism will displace the image into the blind field. Refixation should not occur if the field is truly blind.**
☐ Field loss vanishes with the knowledge of loosing driving license legality.
☐ 1m and 4m field of vision equal: **Field with 5mm pin @ 1m should be X4 the size with a hand @ 4m. Note that this only tests the central 15 degrees of vision.**
☐ Saccade outside 'seeing' field: **ask the patient first if they have any eye pain with eye movements, tell them you are checking their eye muscles (not vision). Use if they claim not to see in the periphery. Look directly at the object**

ADDITIONAL TESTS:

☐ Walking with arms stretched out: **Blind people do not do this.**
☐ "Look at your hand" – but patient looks elsewhere.

OTHER COMMENTS: …… ***NAME / SIGNATURE***

Figure 1 Checklist.