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Eye (2006) **20**, 955–957. doi:10.1038/sj.eye.6702065;
published online 5 August 2005

Sir,
**Loose cilium in meibomian gland: mimicking early
postoperative endophthalmitis**

Eyelashes (cilia) are normally arranged in two to three rows on the upper and lower lid, being more numerous and longer in the upper lid. On an average there are 150 lashes on the upper lid and around 75 in the lower lid.¹ Occasionally lashes may be found in aberrant locations appearing to grow from these unusual locations. The clinical significance of such an occurrence lies in a possible diagnostic difficulty. Some surgeons prefer to have cilia trimmed preoperatively. This may cause loose cilia to get lodged in the eye or adnexa.

We present a case of single cilia lodged in the orifice of meibomian gland, which simulated the symptoms of endophthalmitis after uneventful phacoemulsification.

Case report

A 53-year-old male underwent uneventful phacoemulsification and foldable posterior chamber intraocular lens implantation in the right eye. On the day preceding surgery, eyelid cilia were trimmed using a pair of scissors and the area was cleaned with antibiotic ointment applied on a sterile cotton-tipped applicator. The patient was advised to wash his face and scalp on the morning of surgery.

At 20 min before surgery the lid margins were cleaned with the cotton-tipped applicator soaked in betadine (5% w/v) solution. Under aseptic precautions the right eye was cleaned and draped. Sterile disposable eye drape was used, which was in turned towards fornices with the help of a wire speculum, covering the lid margins and the trimmed cilia. Uneventful phacoemulsification was

completed using a scleral tunnel incision. No sutures were applied. Antibiotic ointment was applied on the lid margins and the eye patched. The postoperative follow-up on day one was unremarkable. Acuity of vision was 6/9 compared to preoperative visual acuity of 6/36. On the third postop day the patient complained of redness, pain, watering, and foreign body sensation. Visual acuity had dropped to 6/12. Severity of symptoms raised the suspicion of early postoperative endophthalmitis. On slit-lamp examination the cornea was clear except for a few fluorescein positive superficial punctuate erosions. The anterior chamber was quiet and the intraocular lens was well placed. Fundus examination revealed a media clarity of grade one. On careful examination a cilium was found protruding out of one of the upper meibomian gland orifice (Figure 1a). The tapered end of the hair shaft was hidden within the gland and the trimmed end seemed to rub against the cornea causing the corneal lesions.

The cilium was removed with epilation forceps very smoothly without the need to pluck it out (Figure 1b). No change in the postoperative regimen of topical drops was

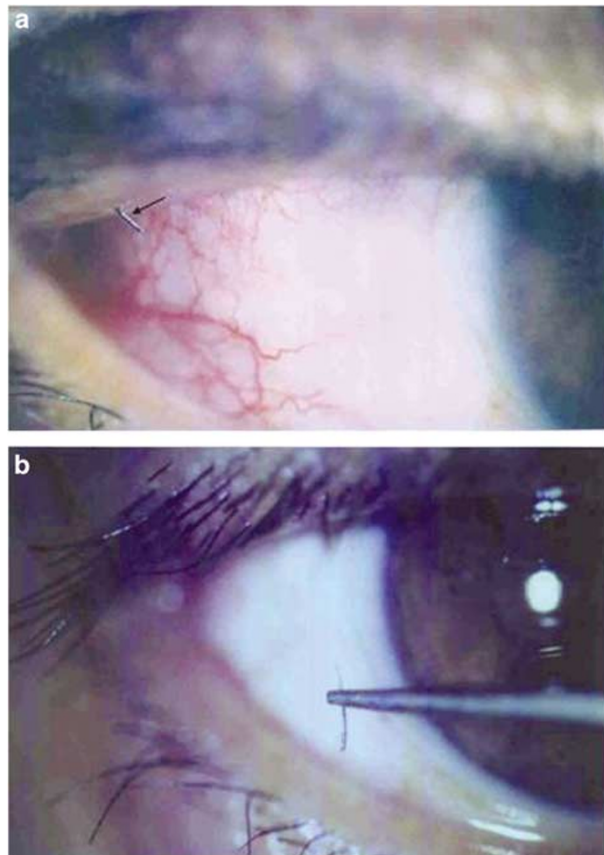


Figure 1 (a) Slit-lamp photo of the right eye showing cilium protruding through the orifice of meibomian gland (arrow). Associated conjunctival congestion is also seen. (b) Eyelash removed with forceps. Note the tapered and the trimmed end of the cilium.

made. The signs and symptoms resolved within the next two days. No evidence of trichiasis or distichiasis was observed in either eye.

Comment

Unusual location of cilia, which have settled after falling out of their follicles or have misdirected during their growth, may cause diagnostic difficulty unless carefully looked for. The likely mechanism relates to mechanical factors like rubbing or negative pressure produced by blinking. The latter has been suggested to explain the strange occurrence of cilia in the lacrimal puncta.² Gutteridge *et al*³ in their series of four patients reported one case of lash in the meibomian gland orifice. Agarwal *et al*⁴ observed two symptomatic cases with cilia embedded in the meibomian gland orifice. In the present case preoperative trimming of cilia along with the mechanical action of cleaning the lid margin may have resulted in the cilia firmly embedding in the gland orifice.

The normal lash must be differentiated from distichiasis where the lashes are shorter, thinner, and less pigmented.³ Our patient had a single lash which resembled normal cilia. But here the tip of the cilium was inside the meibomian gland tract and the trimmed end was projecting out. Careful slit-lamp examination to rule out any lid margin abnormality should be a part of the preoperative examination.

Although such cases have been reported in the literature before, we would like to highlight the fact that a cilium lodged in the meibomian gland can mimic the symptoms of endophthalmitis and should carefully be looked for in postoperative cases of phacoemulsification which present with unusual symptoms of pain and foreign body sensation where intraocular examination is normal. Trimming of eyelid cilia should preferably be avoided preoperatively.

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Eye (2006) **20**, 957–958. doi:10.1038/sj.eye.6702066;
published online 27 January 2006

Sir, A case of bilateral Adie's pupil following acute pancreatitis

We report a case of bilateral Adie's pupil with bilateral facial nerve palsy, following acute pancreatitis, which has not been previously reported.

Case report

A 41-year-old in-patient with gallstone pancreatitis was referred to ophthalmology with blurred vision and red eyes. On examination he had bilateral acute anterior uveitis. He was started on G.dexamethasone 0.1% and G.cyclopentolate 1% for both eyes. Overnight he developed bilateral facial nerve palsies, and was further investigated for sarcoid by MRI, lumbar puncture, CXR and CT thorax, and serum/CSF ACE. These results were negative, as were investigations for Lyme disease and syphilis. The patient was later discharged, but was readmitted with a recurrence of pancreatitis. On review his facial nerve palsies had improved. VA was 6/5 bilaterally; pupils were dilated with no reaction to light but a slow accommodation response. After 4 weeks, the patient's facial nerve palsies had completely resolved. VA was 6/6 bilaterally, his right pupil was 6.5 mm and unresponsive to light. His left pupil was 6.2 mm with a sluggish light response and segmental vermiform iris movement. Pilocarpine 0.125% was instilled into both eyes and the pupils rechecked after 25 min. Both pupils had constricted significantly, and the patient reported an improvement in near vision. In the absence of other pathology, a diagnosis of bilateral Adie's pupil was made.

Comment

Reported causes of Adie's pupil include infection,¹ inflammation,² ischaemia, anaesthesia, toxicity,