

artery, and other end arteries.¹ The raised troponin on admission suggests secondary myocardial damage,³ again owing to a low perfusion pressure. His secondary LE vitreous haemorrhage is likely to be owing to a combination of warfarin anticoagulation in the presence of abnormal choroids.^{4,5}

Complications of acute massive PE are rare in those who survive the initial insult. Small bowel hypoperfusion (presenting as fluid-filled dilated bowel loops—'shock bowel')⁶ and cerebral hypoperfusion (presenting as fits) are reported owing to the systemic hypotension of acute PE.⁷ This is, to our knowledge, the first report of bilateral choroidal detachments in association with PE. We could not find any specific reason why this patient should suffer from this complication. Practitioners should be alert to signs of end organ damage following PE, and investigate promptly visual disturbance following a thromboembolic event.

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A Gurbaxani¹, GV Robinson², L Crawley¹, A Desai¹, J Wiggins² and J McAllister¹

¹Prince Charles Eye Clinic, King Edward VII Hospital, Windsor, UK

²Department of General Medicine, Wexham Park Hospital, Slough, UK

Correspondence: A Gurbaxani,
King Edward VII Hospital, St Leonard Road,
Windsor, Berks SL4 3DP, UK

Tel: +44 079 7729 6469;
Fax: +44 017 5368 0441.
E-mail: avigurbaxani@yahoo.co.in

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Sir,
Intraoperative floppy iris syndrome in a patient taking alfuzosin for benign prostatic hypertrophy

Intraoperative floppy iris syndrome (IFIS) is a recently described phenomenon affecting cataract surgery. It consists of poor preoperative pupil dilation together with progressive intraoperative pupil constriction, billowing of a flaccid iris stroma, and iris prolapse to the surgical incisions. IFIS has, to date, only been reported in patients symptomatic for benign prostatic hypertrophy (BPH) treated with tamsulosin, a subtype α 1A-selective adrenergic receptor blocker.¹ We present a case of typical IFIS occurring in a patient taking alfuzosin, a nonsubtype-selective α 1-adrenergic receptor blocker.

Case report

An 85-year-old man presented with age-related cataract. He had no other ocular findings of significance. He had been treated for 3 years with alfuzosin for symptoms of BPH. He had never received any other α 1-adrenergic receptor blockers. Small-incision phacoemulsification cataract surgery was planned. He was not asked to discontinue the alfuzosin before admission.

Preoperative pupil dilation was poor despite several instillations of cyclopentolate 1% and phenylephrine 2.5%. Lidocaine 2% (2 ml) was injected into the sub-Tenon's space inferonasally. A tunnelled temporal clear corneal incision was made. Iris behaviour typical of IFIS became apparent at hydrodissection. Disposable flexible translimbal iris retractors (Synergetics – Cat. No. Ref: 40.02) were therefore inserted in a diamond configuration similar to that described by Chang *et al.*¹ Surgery was completed without further complications, with in-the-bag implantation of a flexible hydrophilic acrylic implant.

Comment

It has been postulated that α 1A-subtype-selective adrenergic receptor antagonists cause IFIS by blocking

the $\alpha 1A$ -adrenergic receptors on the iris dilator muscle, resulting in disuse atrophy of the muscle; this in turn affects iris rigidity.¹ Controversy exists over the receptor subtypes present in the prostate and the precise mechanism of action of this type of agents.²⁻⁴ Recent experience in our unit is in accord with Chang's report;¹ the majority of patients treated with tamsulosin undergoing cataract surgery seem to display the features of IFIS. We have noted no benefit from the temporary cessation of treatment preoperatively.

The case we present here was, we believe, typical of IFIS. We are not aware of any previous reports of IFIS in patients treated with $\alpha 1$ -adrenergic receptor blockers other than tamsulosin. It has been suggested that the $\alpha 1A$ -subtype selectivity of tamsulosin might be accountable for the clinical manifestation of IFIS.¹ Alfuzosin, although not $\alpha 1A$ -subtype-selective *in vitro*,^{2,3,5-9} displays uroselective properties *in vivo*.⁵⁻⁷ We postulate that the overall *in vivo* affinity of the $\alpha 1$ -adrenergic receptor blockers towards $\alpha 1A$ -subtype receptors might be responsible for IFIS rather than the *in vitro* $\alpha 1A$ -selectivity *per se*.^{2,7}

We agree with previous authors that preoperative recognition of patients at risk of IFIS allows for appropriate surgical planning in anticipation of IFIS, with the intention of reducing the risk of preoperative complications.¹ It is our practice to insert, at commencement of surgery, disposable flexible translimbal iris retractors in a diamond configuration, as described by Oetting and Omphroy.¹⁰ This seems to allow the operation to be completed safely and with little added difficulty.

We believe that surgeons should anticipate IFIS in patients taking alfuzosin, in addition to those taking tamsulosin, and quite possibly in patients taking any of the uroselective $\alpha 1$ -adrenergic receptor blockers. We are not aware of any reports of the nonuroselective $\alpha 1$ -adrenergic receptor blockers causing IFIS.

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G Settas and AW Fitt

Department of Ophthalmology, Peterborough District Hospital, Peterborough, Cambridgeshire, UK

Correspondence: G Settas, Department of Ophthalmology, Peterborough District Hospital, Thorpe Road, Peterborough, Cambridgeshire PE3 6DA, UK
Tel: +44 01733 874344;
Fax: +44 01733 875281.
E-mail: settasg@doctors.net.uk

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Sir, **Ocular trauma caused by a loose slip-lock cannula during corneal hydration**

It is easy to become complacent when using such widely used medical instruments as needle and syringes. Needle and syringe systems have many uses in modern day ophthalmic surgical practice. There are two main types of system commonly used: push-fitting 'slip-lock' systems, where the needle hub is pushed