syndrome at the initial presentation.[4] Computed tomography has a high sensitivity (91–98%) for the detection of subarachnoid haemorrhage, although it cannot unequivocally exclude subarachnoid haemorrhage.[5]

In summary, while we agree that it is possible for vitreous haemorrhage to occur in DHF, we wish to highlight that Terson's syndrome could be a plausible explanation for the occurrence of vitreous haemorrhage in DHF and this life-threatening condition should not be overlooked.

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Sir,

Late traumatic scleral flap dehiscence following trabeculectomy

We report the case of a patient who suffered a blunt ocular injury 13 years after a trabeculectomy with postoperative 5-fluorouracil (5-FU) injections, which resulted in dehiscence of the scleral flap causing acute hypotony and choroidal detachment. To our knowledge, this consequence of ocular trauma has not been described previously.

Case report

A 62-year-old female patient was seen in the Eye Emergency Department following a fall, in which she struck her right eye on the side of a car door. She was myopic and had undergone radial keratotomy (RK) in 1990. In 1992, she developed a right rhegmatogenous retinal detachment, which was repaired with cryotherapy and a scleral buckle. A diagnosis of chronic glaucoma was made in 1987, and in 1993, she underwent a right trabeculectomy followed by four 5 mg 5-FU subconjunctival injections to suppress the fibrovascular healing response. She developed a diffuse microcystic bleb, with an intraocular pressure (IOP) of 15 mmHg. In 1997, she underwent extracapsular cataract extraction with implantation of a posterior chamber intraocular lens.

The retina in the right eye redetached in 2001 and she underwent a posterior vitrectomy and replacement of the posterior chamber implant with an Artisan iris fixation intraocular lens. Her vision stabilised at 6/12 OD, with an IOP of 16 mmHg in the presence of a diffuse filtration bleb.

On presentation following the injury, the visual acuity was 'counting fingers' OD and 6/9 OS. A right relative afferent pupillary defect was present. The cornea was clear, with evidence of previous surgery (RK). She had a large diffuse bleb extending 6 o'clock hours (Figure 1). The anterior chamber was deep with a microhyphaema and a stable intraocular lens. The IOP was measured at 0 mmHg and dilated examination of the fundus showed retinal folds and choroidal detachment

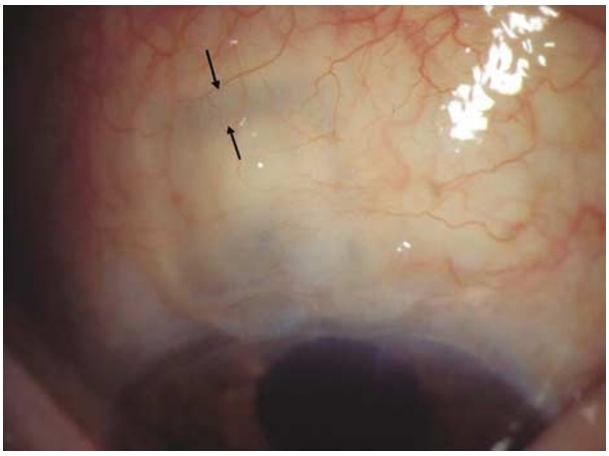

Figure 1 Photograph of a large diffuse bleb extending posteriorly and nasally. Black arrows show the area of scleral flap dehiscence.

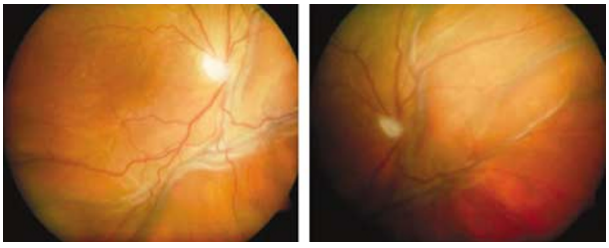

Figure 2 Fundus photographs showing choroidal folds and choroidal detachment.

(Figure 2). A diagnosis of scleral flap dehiscence with acute overdrainage through the trabeculectomy site was made. Because the inner eye structures could be clearly visualised and surgery to the scleral flap might cause bleb failure, a conservative approach was taken. The patient was started on topical steroids, cycloplegics, and oral acetazolamide, and reviewed on a daily basis. After 1 week, her vision had improved to 6/24 OD, topical steroids were stopped, and the acetazolamide continued. Two weeks after the injury, her vision had returned to her pretrauma level of 6/12, the IOP was 10 mmHg, and the bleb had reduced in size. All treatment was stopped.

Comment

Wound dehiscence following blunt trauma to an eye that has undergone previous surgery has been well documented.[1–4] It has been described following cataract surgery, penetrating keratoplasty, and refractive surgery (RK), and can occur at any time in the postoperative period.[1–4] To our knowledge, there is only one study of wound dehiscence after glaucoma filtration surgery.[4] Three of these cases followed combined cataract extraction, intraocular lens implantation, and trabeculectomy, and the fourth occurred in a patient who had undergone a previous trabeculectomy alone. In this patient, a flat bleb was found, but a 2 mm scleral laceration was present extending posteriorly below the scleral flap. This differs from our case where there was no scleral wall rupture present, but rather scleral flap dehiscence causing a large bleb.

Wound dehiscence occurs because of two factors: firstly, the original surgical wound does not regain the tensile strength of the normal intact tissue, and secondly, the prolonged use of topical steroids postoperatively can delay healing and may further contribute to surgical wound weakness.[2,4,5] In this case, the use of 5-FU postoperatively may also have played a role. In a patient who had undergone multiple eye operations, one would have expected the dehiscence to occur in the old cataract wound or the radial keratotomy incisions, rather than the scleral flap. Remarkably, there was no prolapse of intraocular contents, the implant remained stable, and the problem settled completely over a short period without surgical intervention.

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