Sir,

Surgeon's experiences of the intraoperative floppy iris syndrome in the United Kingdom

Introduction

Intraoperative floppy iris syndrome (IFIS) in association with tamsulosin occurs during cataract surgery and is associated with an increased complication rate.[1] We conducted a survey of UK consultant ophthalmologists to increase their awareness and gather information on the general epidemiology and current management of IFIS.

Fifty-three per cent of consultants had encountered the syndrome either retrospectively or prospectively in male and female patients on tamsulosin as well as other α-receptor antagonists (Table 1). Although 68% of consultants had patients discontinue tamsulosin preoperatively, they reported no consistent benefit from this step. Sixty-one per cent chose iris hooks, and 72% of that group had found them effective in managing floppy irides intraoperatively. Twenty-seven per cent used Healon 5 (Advanced Medical Optics) and low aspiration settings, and 85% found the technique effective. The use of intracameral phenylephrine has been recently described in the peer-reviewed literature,[2] and only 2% had used this method. Twelve per cent, however, reported that they would consider this measure for future cases of IFIS. Other options for management included bimanual microincisional phacoemulsification, mechanical pupil rings, and the preoperative administration of atropine (Figure 1).

Table 1 IFIS patient drug history

Drug	*Male*	*Female*
Tamsulosin	355	8
Alfuzosin	3	
Doxazosin	5	1
Prazosin	2	
Terazosin	1	
Unknown drug Hx	211	18

Total male 579, female 27.

Comment

Our survey revealed IFIS can occur with all α-$_1$AR antagonists with an isolated case of IFIS in a patient on alfuzosin recently described.[3] The persistence of IFIS, despite discontinuing tamsulosin, suggests that it may occur independent of dosage or duration of treatment; however, it is presently not possible to conclude that discontinuation is of no benefit. The majority of UK consultants now directly ask patients regarding their history of prostate medication, and some eye units have incorporated this question specifically into their preoperative assessment process. As a result, the potential for IFIS may be included as appropriate in the informed consent. These patients are educated about their increased likelihood of a technically difficult operation and possible complications, including prolonged postoperative corneal oedema, uveitis, glare, and dysphotopsia. Posterior capsule rupture occurred in 7% of patients in our survey compared to a previous report of 12.5%.[1]

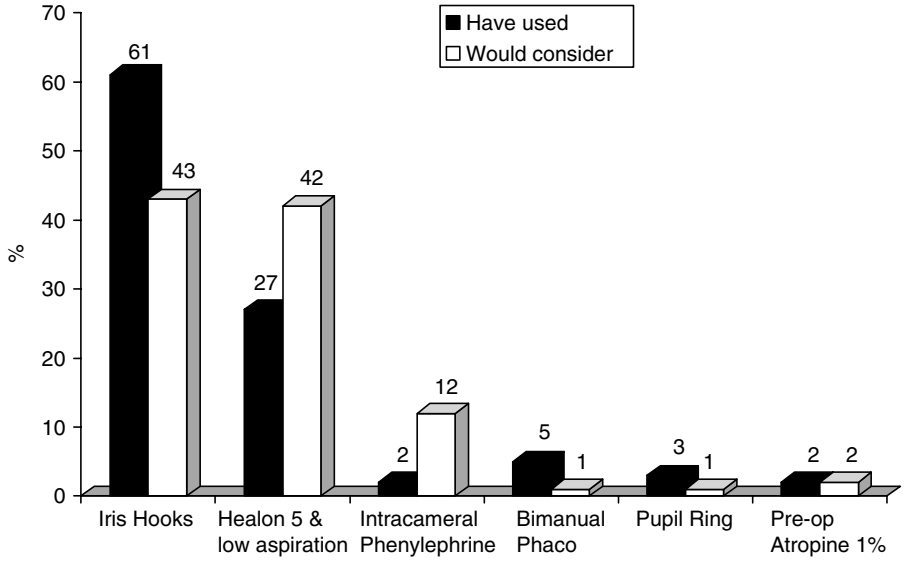

Figure 1 Surgical techniques that surgeons had or indicated that they would use to manage IFIS.

A degree of reporting bias may exist in the sample that responded to our questionnaire and this may have skewed the results. We believe this to be limited as our purpose was to explore individual experiences and determine if there was a general consensus among the array of measures that exists.[2,4–6] Although the prevalence, incidence, and associated risk factors of IFIS are not yet known, it is important for ophthalmologists to anticipate the potential operating difficulties with IFIS and be aware of the wide range of management options available.

Acknowledgements

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Sir,

Ptosis caused by orbicularis myokymia and treated with botulinum toxin: a case report

Myokymia is a manifestation of peripheral nerve disease and classified as excess motor unit activity. Electrophysiologically, it consists of rhythmic or semirhythmic bursts of grouped motor unit potentials occurring at a uniform rate of 2–60 Hz, usually with 2–10 U within a burst.[1,2] We present a 23-year-old lady who presented with left upper eyelid ptosis caused by orbicularis myokymia and treated with botulinum toxin injection.

Case report

A 23-year-old systemically healthy lady presented with complaints of ptosis of the left upper eyelid, present persistently since 3 months.

On examination, the best-corrected visual acuity was 6/6, in both eyes. The left upper eyelid was 1 mm lower in position and the lower eyelid was 1 mm raised, compared to the right eye. There was increased tone noted in the lower eyelid pretarsal orbicularis (Figure 1a). The left upper eyelid showed the presence of constant, rhythmic, fibrillations. The ptosis was constant, on evaluation on three different days, for an hour each. Post-closure, the upper eyelid was also slower to open. The levator action was 15 mm and the lid crease height was 8 mm, in both eyes. Remaining ocular examination was unremarkable.

Magnetic resonance imaging of the central nervous system was unremarkable. Special attention was paid to the VII nerve complex and the cerebropontine angle to rule out a dolichoectatic basilar vessel compression on the VII nerve, as a possible cause. Electro-myography of the left orbicularis muscle was performed and demonstrated over-activity (Figure 1b).

The patient was diagnosed to not only have upper eyelid ptosis, but also reversed ptosis of the lower eyelid; due to increased tone of the orbicularis oculi.

A total of 5 U of botulinum toxin – A injection (Botox, Allergan, Irvine, CA) was given in two locations, intradermally and pretarsally, to the left upper eyelid and to the lower lid, respectively. The orbicularis activity