

system of coding for occurrence of a complication was found to be poor at 50% with 95% confidence interval of 39–62%.

This inaccuracy resulted in gross overestimation of annual complication rates. The annual rate of complication calculation of 4.92% was reduced to 2.51% by this review process. The current system is not robust enough to allow fair comparison between sources. Derivation of cataract surgery complications from such data has resulted in misrepresentation of clinical activity of individual surgeons and surgical units. This may lead to misinformation of patients. Further, preoperative risk stratification<sup>4</sup> was not carried out and visual outcome not considered as the performance outcome.

Several recommendations from this study have been implemented. The current practice has been altered. There is now direct input from the surgeons in the coding process, which results in better understanding of surgical procedures by the coders. An urgent need to update the codes nationally was identified, which has been followed by launch of updated version of OPCS-4.3 in April 2006.

OPCS-4.3 has more appropriate and comprehensive codes in relation to cataract surgery than the older version. However, the new document does not have a complete list of complications and, therefore communication between the coders and the surgical team is still important. Further, uniformity of this system of recording of data is vital for a fair comparison to be made across the UK, NHS hospitals as well as ISTCs.<sup>5</sup> We believe that standardised data sets and a robust coding system, taking into account pre-operative risk stratification, could potentially provide a solution for accurate analysis and fairer comparison in the future.

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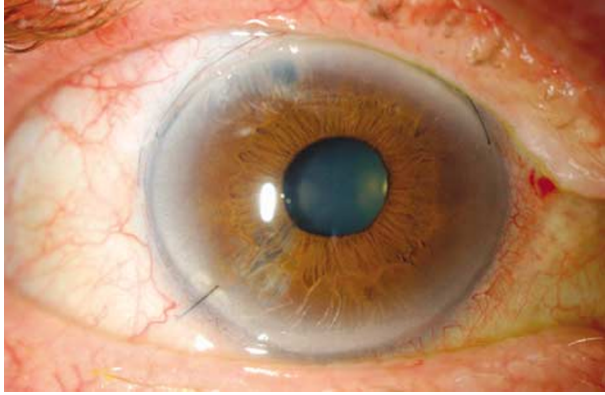
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## Sir, Alpha antagonists and intraoperative floppy iris syndrome (IFIS) during trabeculectomy

The effect of systemic alpha-1 antagonists on cataract surgery has been topical with the recent description of the intraoperative floppy iris syndrome (IFIS).<sup>1–7</sup> This is a triad of billowing of iris stroma with intraocular fluid currents, iris prolapse through corneal wounds, and intraoperative progressive pupil constriction.<sup>1</sup> While tamsulosin (Flomax<sup>TM</sup>) has been associated with the highest rate of IFIS, other alpha-1 antagonists have also been implicated.<sup>1,7,8</sup> We would like to share our experience of a case of IFIS encountered during trabeculectomy in a patient taking doxazosin (Cardura<sup>TM</sup>) for hypertension.

## Case report

A 71-year-old Caucasian male underwent right trabeculectomy for uncontrolled normal tension glaucoma. The operation was performed using the Moorfields Safe Surgery System. A fornix-based conjunctival flap and a 5 × 2 mm<sup>2</sup> rectangular scleral flap was fashioned before inserting an anterior chamber (AC) maintainer via a peripheral corneal tunnel. A 500 μm sclerostomy was made using a Khaw punch. At this point excessive iris prolapse was noted through the sclerostomy. A peripheral iridectomy was performed but there was difficulty repositioning the iris back into the AC. Reducing the flow via the AC maintainer did not help. Switching off the AC maintainer and decompressing the AC allowed reposition of the iris. The scleral flap was secured with releasable sutures before restarting the infusion. At the end of surgery, there was a similar degree of iris prolapse through the AC maintainer wound when this was removed. At this point, IFIS was suspected and a review of the patient's chart found him to be on oral doxazosin for hypertension. Postoperatively,



**Figure 1** Colour photograph showing the slightly central iridectomy and iris trauma near the paracentesis site.

the surgical iridectomy was noted to be less peripheral than desired due to the excessive iris prolapse during surgery. There was also sign of iris trauma near the paracentesis site. Fortunately, there was no obstruction of the ostium by iris and no iris incarceration in the paracentesis wound (Figure 1).

**Comment**

IFIS during cataract surgery has been well described in the recent literature and the increased risks of intraoperative complications discussed.<sup>1-6</sup> This case illustrates that other types of intraocular surgery can be similarly affected. To our knowledge, this is the first report of IFIS encountered during trabeculectomy.

The use of an AC maintainer in trabeculectomy confers a number of significant advantages including the prevention of intraoperative hypotony and collapse of the AC, reducing the risk of suprachoroidal haemorrhage and aqueous misdirection,<sup>9</sup> However with IFIS, the iris stroma becomes flaccid and billows in response to intraocular fluid currents making iris prolapse more likely with the use of an AC maintainer.

There has been recent discussion in the literature regarding the management of IFIS in cataract surgery. In addition to meticulous wound construction, the use of a viscoadaptive agent such as Healon 5™ iris hooks and intracameral phenylephrine have been described.<sup>1,10</sup> These are not applicable in trabeculectomy. Surgeons who routinely use an AC maintainer during trabeculectomy should be aware of this potential complication and screen for the use of alpha-1 antagonists in preoperative assessment. We recommend surgeons to consider lowering the AC maintainer bottle height, reducing the flow or omitting it all together. Preoperative pilocarpine or intraoperative Miochol™ can also be considered.

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Sir,  
**Localised abscess following an injection of subtenon triamcinolone acetonide**

Periocular injections of steroids are commonly used in the treatment of posterior segment intraocular inflammation. We present the case of a localised abscess following subtenon injection of triamcinolone.