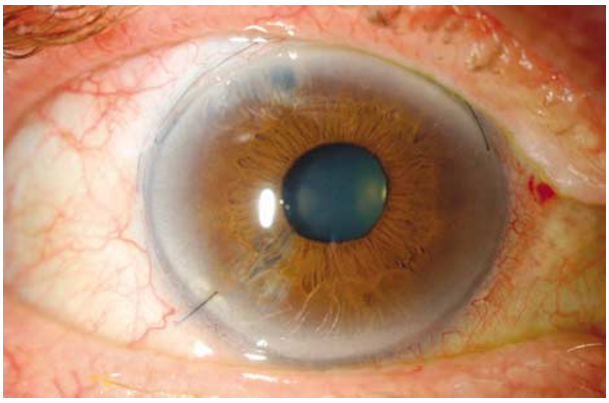

Figure 1 Colour photograph showing the slightly central iridectomy and iris trauma near the paracentesis site.

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 osteum 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.[1–6] 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,[9] 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^{TM} iris hooks and intracameral phenylephrine have been described.[1,10] 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^{TM} can also be considered.

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The authors have no proprietary interest in any material or device described in this paper

Competing interest: none

Eye (2007) **21,** 671–672. doi:10.1038/sj.eye.6702670; published online 9 March 2007

Sir,

Localised abscess following an injection of subtenon triamcinolone acitonide

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.

Case report

A 33-year-old woman presented with a 10-day history of floaters, blurred vision, and a painful red left eye. She was systemically well. Past history included extracapsular cataract extractions and lens implants for secondary cataract (following previous long-term systemic steroid use for mononeuritis multiplex).

Visual acuities (VA) were 6/5 and 6/60 in the right and left eye. There was no relative afferent pupillary defect and a mild anterior uveitis and marked vitritis in the left eye with associated cystoid macular oedema (CMO) was noted. Intraocular pressures were normal. There was no associated retinal vasculitis or optic disc abnormalities. Examination of the right eye was unremarkable. All investigations including inflammatory markers, full blood count, renal function tests, serum-ACE, autoimmune profile, chest X-ray, and previous MRI were normal. A diagnosis of intermediate uveitis was made and she was treated with topical dexamethasone 0.1% followed by a posterior subtenons injection of 40 mg/1 ml of triamcinolone acetonide (Kenalog, Bristol Myers Squibb). Under topical anaesthesia, a short 25G needle was passed through the bulbar conjunctiva as far posterior as directly visible aiming for the subtenon space in the superotemporal fornix with the patient looking inferonasally. The tip was swept from left to right during advancement, and the limbus observed for any movement to ensure that the needle remained superficial to the sclera (technique described by Tanner *et al*[1]). A single drop of chloramphenicol was administered following the injection. The procedure was uneventful, and the vitritis, CMO, and VA improved to 6/12 at 1 week.

She returned 2 weeks after the injection with pain, redness, and yellow discharge in the left eye. There was no evidence of intraocular inflammation and a localised area of hyperaemia and sub-conjunctival infiltrate was noted at the site of the subtenon injection (Figure 1). Culture yielded *Streptococcus pneumonia* and she was started on oral and topical ciprofloxacin (guided by culture sensitivities). Systemic ciprofloxacin was stopped and topical treatment tapered after 10-days following improvement in symptoms and infiltrate. Within 2 days of stopping the oral medication she noticed increased discomfort of the left eye, but there was no visible subconjunctival infiltrate or intraocular inflammation. She was restarted on oral ciprofloxacin and the topical treatment continued. Her symptoms and signs rapidly resolved within 1 week and only a deposit of steroid supernatant remained visible at the injection site (Figure 2).

Three months after initial presentation she was asymptomatic, VA was 6/5 bilaterally and there was no residual signs of infection, intraocular inflammation, or CMO.

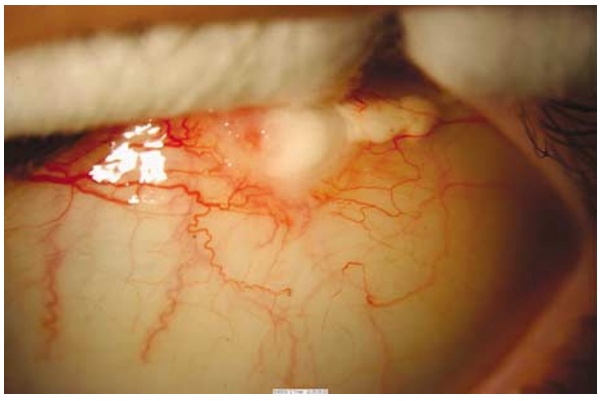

Figure 1 Subconjunctival abscess in the superotemporal area.

Figure 2 Resolution of abscess after 1 week of treatment. Note that the deposit of steroid supernatant is still visible.

Comment

Treatment options for intermediate uveitis include local or systemic immunosuppresion.[2,3] Local injection into the orbital floor or subtenon space has the advantage of facilitating high local concentration of steroid to the posterior segment while minimising unwanted systemic effects, and has been shown to be safe and efficacious in the treatment of posterior uveitis.[1,4]

Reported complications include raised intraocular pressure, inadvertent intravascular injection, globe perforation, cataract, allergy, strabismus, fat atrophy, and conjunctival necrosis.[1,4–7]

Engelman *et al*[8] previously reported an orbital abscess following posterior subtenon injection of triamcinolone. The patient presented 3 weeks after a second injection with an orbital mass, proptosis, and blepharoptosis, which was treated surgically by drainage and with systemic

antibiotics. In our case the small, localised abscess was confined to the site of the subtenon injection, required no drainage, and resolved on oral and topical antibiotics.

The current report while illustrating the efficacy of local steroid in the treatment of intermediate uveitis highlights a further late potential complication of subtenons injection. Further studies comparing the safety and efficacy of different routes of periocular steroid administration and routine use of povidine iodine preoperatively and more prolonged course of topical antibiotics following subtenons injection may be warranted to assess and minimise the risk of this rare complication.

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Eye (2007) **21,** 672–674. doi:10.1038/sj.eye.6702671; published online 15 December 2006

Sir,

Posterior polar cataract: minimizing risk of posterior capsule rupture

I read with interest the recently published article by Siatiri and Moghimi who performed a preferred technique of phacoemulsification in eyes with posterior polar cataract. This is the first study reporting not a single incidence of posterior capsule rupture associated with phacoemulsification of posterior polar cataracts.[1] This is an interesting finding given that has been hypothesized that occasionally the posterior capsule is deficient in the region of the polar opacity.[2–4] This study with 38 cases, however did not find this to be true. The absence of posterior capsule rupture is a remarkable result. I did however feel that some issues that may effect the outcome warrant further discussion.

We are aware that 38 eyes of 23 patients were included in the study. However, information about patient selection, co-existent or previous ocular disease, or surgical intervention, which may influence surgical outcome and an exclusion criteria, would be relevant in interpreting the results. Similarly, no details were provided regarding the possible incidence of other complications excluding posterior capsule rupture following the preferred surgical technique. The range in follow-up period of between 2 and 20 months suggests that further management may have been required for some patients.

Though this technique did prove to be safe, pertaining to the rate of posterior capsule rupture, we are unable to accurately estimate the treatment effect without a comparison to a standard reference by the same surgeon. As we become more aware of the predisposition to posterior capsule rupture with posterior polar cataracts and take the necessary preoperative and intraoperative precautions to minimize the complications, could it be that if the same surgeon had performed careful standard surgery, the incidence of posterior capsule rupture would have been as similarly low.

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