

Figure 2 FFA of the left eye after CABG showing a significant increase in ischaemia. New vessels are also present at the disc.

followed a similar course irrespective of the cardiac surgery. However, we believe that the decreased tissue perfusion and postoperative anaemia resulting from the CABG accelerated the progression of his retinal vascular disease. Anaemia is a well-known risk factor for progression of diabetic retinopathy² and is likely following aggressive haemodilution for CABG. This case highlights the risk of such a procedure to diabetic retinopathy. Such high-risk eyes should undergo extensive panretinal photocoagulation before any procedure necessitating general anaesthesia or anticoagulation. As with AION,¹ aggressive anaemia therapy may well prove to be beneficial in slowing progression of retinal ischaemia in diabetics undergoing CABG.

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Sir, Eye rubbing causing conjunctival graft dehiscence following pterygium surgery with fibrin glue

The etiopathogenesis and surgical management of pterygium has intrigued surgeons for many years. Although different surgical modalities have been described pterygium excision with conjunctival autograft has been shown to be the most safe and effective method.¹ Fibrin glue is a safe and effective alternative to sutures in attaching the conjunctival autograft.^{2,3} We report the clinical features and management of conjunctival graft dehiscence a previously unreported complication with the use of fibrin glue during pterygium surgery.

Case 1

A 53-year-old male was referred with a growing pterygium in his right eye (OD). He had previously undergone pterygium surgery in the left eye (OS). He had a right nasal pterygium extending 3 mm in to cornea. Following informed consent he underwent right pterygium excision with a free conjunctival limbal autograft (CLAG) harvested from the superotemporal bulbar conjunctival under topical and subconjunctival anaesthesia. The CLAG was secured using a commercially available fibrin sealant (Tisseel Kit VH, 1.0 ml, Baxter, Canada). There were no intraoperative complications. On the first operative visit (postoperative day 3) conjunctival graft dehiscence was noted with all four margins of the graft displaced from the underlying scleral bed (Figure 1, top left). He admitted to premature removal of the eye pad and intense rubbing of the operated eye. Under topical anaesthesia multiple interrupted 10-nylon sutures were used to secure the displaced CLAG. At 8 months follow-up the graft appeared to be well healed with no recurrence of the pterygium (Figure 1, bottom left).

Case 2

A 73-year-old female was referred with a growing pterygium in her OD. Examination revealed bilateral nasal pterygium, with the right pterygium extending 2.75 mm in to the cornea. Following informed consent she underwent pterygium excision with CLAG in the OD. The CLAG was secured in place with fibrin glue. There were no intraoperative complications. On follow-up visit (postoperative day 3) she was noted to have an inflamed, partially dehisced CLAG, with exposure of the underlying scleral bed. (Figure 1, top right). Under topical anaesthesia the graft was refloatated

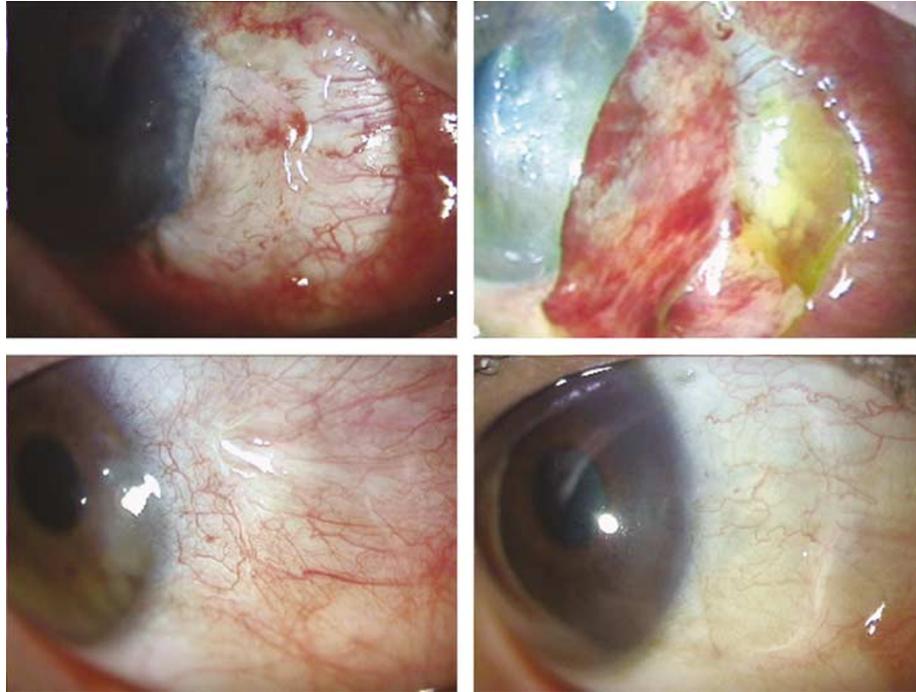


Figure 1 Top left: right eye of case 1 showing total dehiscence of the conjunctival graft with exposure of the underlying scleral bed. Note that all the four quadrants of the autograft are displaced. Bottom left: clinical photograph taken 8 months postoperatively showing a well-healed graft with mild subconjunctival fibrosis. Top right: right eye of case 2 showing subtotal dehiscence of the conjunctival graft. Note that the temporal margins of the graft remain adhered to the limbal margin. Bottom right: clinical photograph at 6 months follow-up shows a well-healed conjunctival autograft.

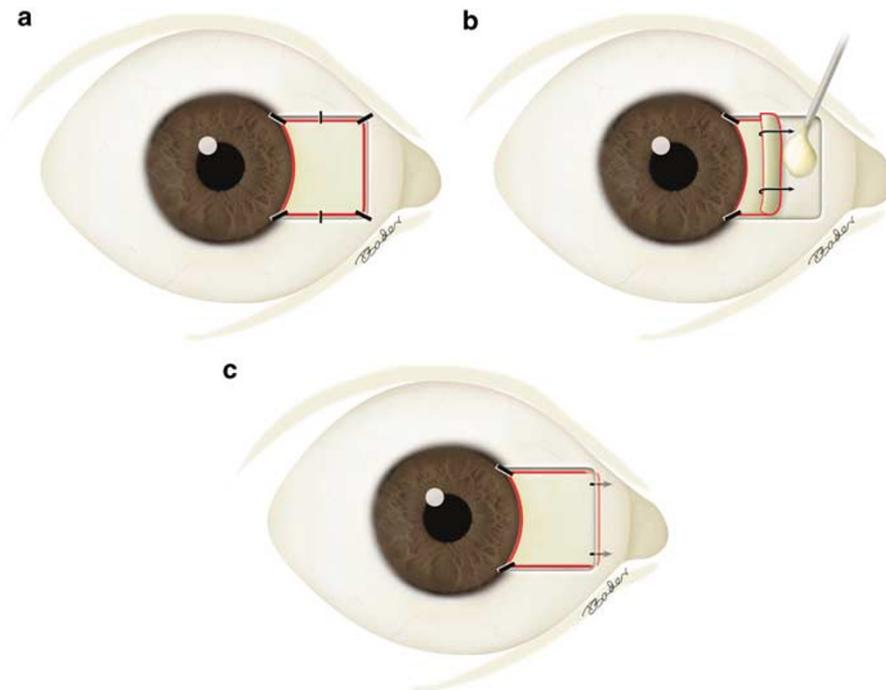


Figure 2 (a) Schematic diagram showing multiple interrupted sutures used to secure the graft in case 1. (b) Diagram showing the application of fibrin glue to the nasal margin of the displaced autograft in case 2. The temporal margins of the graft have been secured with two interrupted nylon sutures. The arrows indicate the direction in which the graft was repositioned and the red line denotes the margin of the conjunctival autograft. (c) The graft being repositioned following the application of fibrin glue. Note that the nasal margin of the graft is tucked underneath the cut edge of the conjunctiva for better closure.

with fibrin glue and two anchoring 10-0 nylon sutures were applied to the superior and inferior edges of the graft close to the limbus. Postoperative period was uneventful and at 6 months follow-up showed a well-healed graft with no recurrence (Figure 1, bottom right).

Comment

Both these patients with graft dehiscence were among a continuous cohort of 62 patients who underwent pterygium surgery with fibrin glue at our centre. The details of surgical technique and follow-up of our cohort has been described previously. (Srinivasan S, Dollin M, Rootman DS, Slomovic AR. Application of fibrin glue to conjunctival autograft during primary pterygium surgery. Annual meeting of the American Society of Cataract and Refractive Surgery, March 2006, San Francisco.) In short, following pterygium excision the fibrin glue containing both the sealant protein and sealant setting solution loaded on separate syringes was injected simultaneously on to the scleral bed using a Duploject injector. The CLAG was placed over the glue-coated scleral bed and secured in place by tucking the edges of the graft underneath the free edge of the cut conjunctiva. Postoperatively all were treated with a topical antibiotic and steroid combination (Tobradex, Alcon, Canada), which was tapered over a period of 2 months. All patients in our cohort were instructed not to remove the patch for 24 h and not to rub the eye for the first 2 days. Both these patients admitted to premature pad removal and intense rubbing of the operated eye from postoperative day 1. No other eyes in our cohort developed this complication. In case 1, as the graft was completely displaced multiple interrupted 10-0 nylon sutures to secure the graft. In case 2, owing to partial dehiscence, the graft was refloatated with fibrin glue. Although the nasal margins were tucked underneath the cut edges, the temporal edge of the graft was secured with two interrupted anchoring 10-0 nylon sutures (Figure 2a–c).

Although fibrin glue is safe and effective alternative to sutures, intense eye rubbing in the early postoperative period can lead to graft dehiscence. If noted early, these grafts can be rescued by re-glueing with anchoring sutures.

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Sir, Intraocular lens migration following posterior capsulotomy in retinitis pigmentosa

Retinitis pigmentosa (RP), in addition to its retinal manifestations, results in abnormalities of the vitreous and crystalline lens. Cataracts are common and following surgery there is a high risk of posterior capsular opacification (PCO). In addition problems with intraocular lens (IOL) tilt and dislocation have been reported following laser capsulotomy. This unusual case serves to highlight the problems that can arise owing to the lens and vitreous abnormalities which occur in RP.

Case report

A 67-year-old farmer with a history of autosomal-dominant RP presented with left visual loss. Twelve months before presentation he had undergone bilateral YAG laser capsulotomies following uncomplicated extracapsular cataract extraction and insertion of one-piece polymethyl methacrylate IOLs 12 years previously. On examination the left visual acuity (VA) was reduced to hand movements and the IOL had dislocated into the inferior vitreous cavity (Figure 1). With contact lens correction the left VA was 6/12 and the patient declined surgical intervention.

Two years later during an episode of left contact lens-related keratitis he was treated with topical antibiotics