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 refloated 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

and cyclopentolate 1%. On review 3 days later the keratitis had resolved but the IOL had migrated into the anterior chamber (AC) (Figure 2a). With spectacle correction VA was 6/18. The patient was delighted to be able to wear spectacles again and declined surgical intervention. Pilocarpine 1% tds was prescribed in order to reduce the chances of the IOL migrating back into the vitreous.

One year later he presented with severe left eye pain and decreased vision. On examination the left VA was perception of light and pupil block glaucoma secondary to the IOL was evident. There was iris bombe, IOL-cornea touch, generalised corneal oedema, and an intraocular pressure of 56 mmHg. Following laser peripheral iridotomy the pressure normalised and the bombe and IOL-cornea touch resolved (Figure 2b). Despite surgical removal of the IOL the corneal oedema persisted and the VA remained counting fingers. He is currently being considered for penetrating keratoplasty and secondary IOL.

Comment

The high incidence of PCO following cataract surgery in RP is well described.[1,2] In addition there appears to be a higher rate of lens tilt and dislocation following laser capsulotomy.[2,3] This is thought to be one to a combination of severe anterior capsule fibrosis, zonular

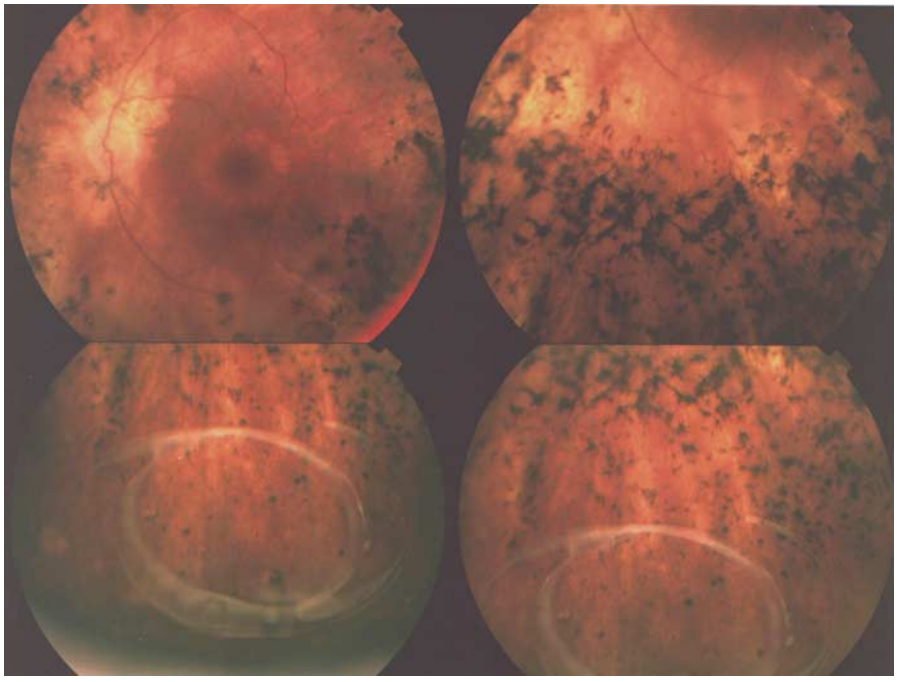

Figure 1 'Bone spicule-like' retinal pigmentation typical of RP with the dislocated IOL visible in the inferior vitreous cavity.

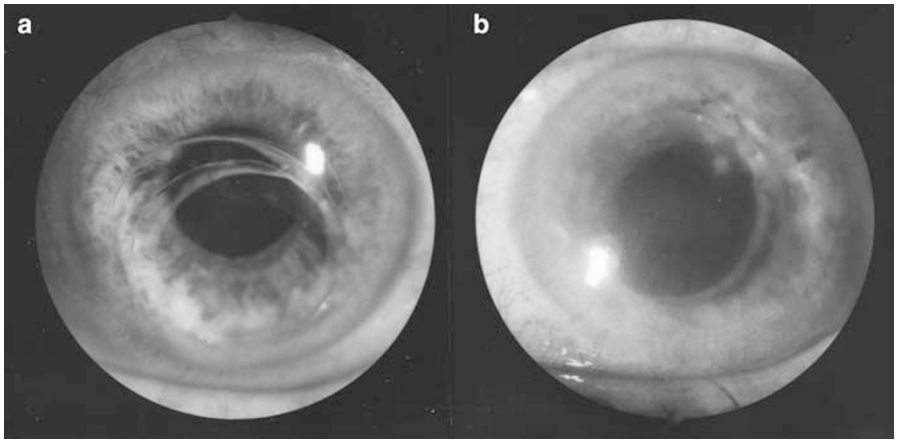

Figure 2 (a, left) The IOL has migrated into the AC. (b, right) Following laser iridotomy the pupil block glaucoma has resolved but the cornea remains hazy.

weakness, and extensive vitreous degeneration, all of which are associated with RP.[3,4] In this case, vitreous degeneration is also likely to have facilitated migration of the IOL from the vitreous cavity to the AC following pharmacological mydriasis. Following 1 year of conservative management he presented with pupil block glaucoma. Although this resolving following laser iridotomy a combination of the acute attack and IOL-cornea touch has resulted in corneal decompensation.

This case serves to highlight the problems that can arise owing to the lens and vitreous abnormalities which occur in RP. Although similar cases are likely to be rare we would recommend prophylactic laser iridotomy in any case where the IOL has migrated into the AC.

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Sir,

Corneal striae in thyroid eye disease

We report a patient with thyroid eye disease (TED) in whom corneal striae were a sign of increased orbital pressure.

Case report

A 48-year-old Oriental lady with TED was referred urgently to the orbital clinic. She had had previous radioactive iodine treatment and was euthyroid. She was a smoker.

Although her best-corrected visual acuities were 6/12 bilaterally, examination of the anterior segments revealed bilateral corneal stromal vertical striae (Figure 1a and b) and shallow anterior chambers. Hertel exophthalmometry was 21 mm bilaterally. Ishihara colour vision and visual fields to confrontation were normal.

Gonioscopy confirmed the angle grade as 0-I in all quadrants using Schaffer's method. Her intraocular pressures (IOPs) in primary position were right 22 mm Hg and left 25 mmHg with further increase in upgaze (right 28, left 31 mmHg). She was started on topical latanoprost to both eyes.

A few months before her referral she had undergone bilateral 11/2 wall endoscopic orbital decompression for bilateral optic nerve compression. The corneal striae had also been noted at that point.

Orbital computed topography was performed revealing adequate bony decompression but increased rectus muscle bulk on both sides. In view of increased muscle bulk and risk of further compressive optic neuropathy from increased orbital pressure (as evidenced by anterior segment findings), she underwent a three-wall external orbital decompression followed by orbital radiotherapy (20 G in 12 fractions).

After her surgery, visual acuities were 6/9 (pinhole 6/6) bilaterally and anterior segment examination revealed minimal corneal punctate epitheliopathy with reversal of all corneal striae. The anterior chamber also deepened (grade II–III in all quadrants). The IOPs were controlled on topical latanoprost (right 18, left 18) and dilated fundoscopy confirmed normal discs and retina. There was no change in her refraction at any point.

Comment

Corneal disease in TED has been described in the context of tear film instability, lagophthalmos, exposure keratitis, and corneal astigmatism. [1]

The Oriental upper eyelid has subcutaneous, suborbicularis, and pretarsal fat components. The orbital septum is tighter compared to the Caucasian orbits with the orbital septum fusing with the levator aponeurosis below the superior tarsal border.[2]

Our patient had enlarged extraocular muscles, mild proptosis, a tight orbital septum and we feel that the