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Sir,
Day care vs inpatient cataract surgery: factors governing choices of patients and surgeons in the developing world

Day care surgery has been proven to be economical and a more patient friendly option in the developed world.¹ Even with its benefits, many patients do not opt for day care services. Using the cataract surgery register of our hospital, we identified those patients who were treated as in-patients and analysed the reasons for not treating them on day care basis. The reasons for not performing day care cataract surgery in these patients were analysed. A total of 1160 patients were posted for cataract surgery between January and June 2006, of which 260 patients (22.4%) were operated as in-patients. Many poor patients refused day care ($n = 133$; 51.1%) and opted for inpatient surgery citing economic reasons, as existing government policy provided free surgery only on in-patient admission. Eighteen (6.9%) refused day care because their medical insurance benefit required inpatient hospital stay. Seven (2.6%) had the other eye operated after admission few years back and were more comfortable with the inpatient care. Twelve (4.6%) wanted admission because they were outstation patients.

Inpatient admission and cataract surgery was advised by the operating surgeon in cases with systemic illness ($n = 41$; 15.7%) and complicated cataract ($n = 49$; 18.8%). Of the cases which were diagnosed to have complicated cataract, 16 had post-uveitic cataract, 13 had corneal opacity due to healed keratitis, eight had subluxated cataractous lens (Figure 1).

Comment

Cataract accounts for about 40% of the cases of treatable blindness all over the world. Day care cataract surgery is a relatively newer strategy for government hospitals in developing countries where resources of inpatient care are limited.^{2,3} In settings offering in-patient and day care services, the impetus should be towards channelisation of more patients towards day care. This should include government and infrastructure support for day care surgery of routine cataracts. Utmost care should be taken

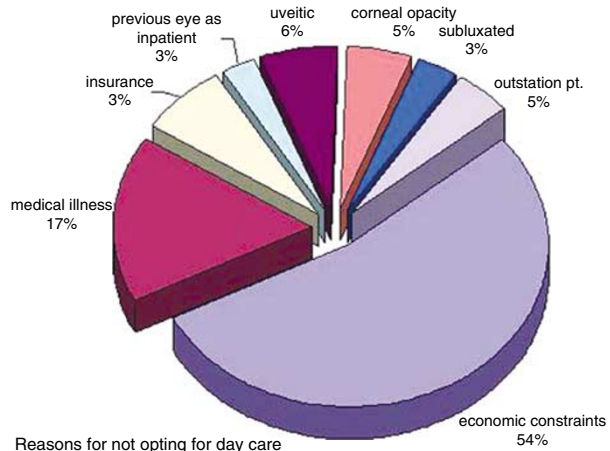


Figure 1 Pie chart showing the distribution of various factors for rejection of patients in day care cataract surgery service.

in the preoperative assessment done at out patient basis. However, as noted in our study, many patients will require inpatient care and thus both systems should coexist synergistically. The reasons for rejection of a patient in day care cataract services therefore require proper validation.

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Sir,
Orbital cellulitis following intralesional corticosteroid injection for periocular capillary haemangioma
Intralesional corticosteroid injection is a treatment for capillary haemangioma of the orbit and eyelid which rarely gives rise to serious complications.¹ We report a

case of orbital cellulitis following treatment for periocular capillary haemangioma.

Case report

A 2-month-old infant presented with a left lower lid swelling and non-axial proptosis. Magnetic resonance imaging (MRI) revealed a haemodynamically high-flow lesion suggestive of a capillary haemangioma (Figure 1) in her inferior orbit. Oral prednisolone (15 mg twice daily) was initiated with no response after 6 weeks. A preseptal injection of triamcinolone 40 mg/ml and betamethasone 4 mg/ml was then given under aseptic conditions. A post-septal injection under ultrasound guidance was performed 6 months later.

Four weeks after the second injection, there was a sudden increase in size of the lesion. MRI revealed an increase in soft tissue density with loculated areas of contrast enhancement (Figure 2), suggestive of an abscess in the inferior orbit. She was afebrile and blood cultures were negative. Intravenous amoxicillin, clavulanic acid, and gentamicin were

started and she underwent drainage of the abscess. Laboratory studies confirmed a capillary haemangioma and the presence of *Staphylococcus aureus*, *Streptococcus viridans*, and *Acinetobacter*. She presented again with a recurrence of infection 3 weeks later, which required another surgical drainage and a further 2 weeks of antibiotics. She has remained well at her last follow-up aged 2 years.

Comment

Intralesional corticosteroid injection is the most common treatment for capillary haemangiomas and 76% of clinicians use a combination of triamcinolone and betamethasone.^{1,2} Various local (eg, skin, fat atrophy, and necrosis³) and systemic (eg, Cushingoid features, growth retardation⁴) complications have been described but orbital cellulitis had only been previously reported in low-flow vascular malformations.⁵

In our patient, we postulate that the needle tract created during the injection could have served as

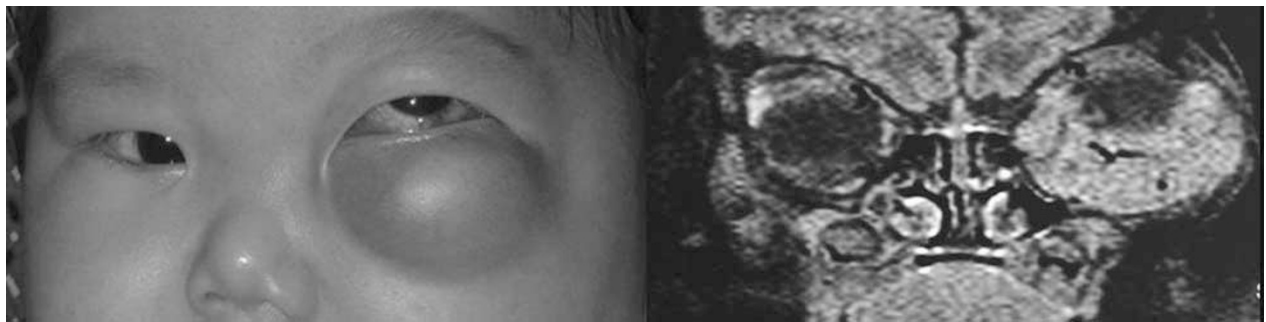


Figure 1 Photo on the left showing a large lower lid swelling causing non-axial proptosis and a coronal MRI scan on the right showing flow voids in the left orbit suggestive of a capillary haemangioma.



Figure 2 Sagittal and coronal MRI showing an inferior fluid collection in the left orbit suggestive of an abscess.

a site for entry of pathogens. The concurrent use of systemic prednisolone may have induced an immunocompromised state, increased her susceptibility to infection, and caused delayed wound healing leading to the late onset of infection.

Although intralesional corticosteroid remains the treatment of choice and is generally safe, clinicians should still be wary of the potential morbidity associated with this procedure.

Acknowledgements

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Sir,
Peripheral ulcerative keratitis in pityriasis rubra pilaris
Pityriasis rubra pilaris (PRP) is an idiopathic, inflammatory, papulosquamous disease characterised by keratotic follicular papules, reddish-orange scaly erythroderma, and palmoplantar keratoderma. The skin, nails, mucous membranes, and eyes can be affected.¹ Histopathology shows follicular plugging, acanthosis, hyperkeratosis, and a lymphohistiocytic

dermal infiltrate.² Treatment includes emollients, systemic steroids, retinoids, and immunosuppressants.³

Among the documented ocular signs and symptoms are ectropion and dry eyes (Figure 1). Duke-Elder⁴ described changes including connective tissue invasion of Bowman's zone, linear streaks on the cornea, interstitial keratitis, epithelial erosions, and conjunctival keratinisation in PRP. To our knowledge, peripheral ulcerative keratitis (PUK) has not been reported in association with PRP. This report describes a patient with PRP who presented with a possible PUK complicated with a perforation, requiring tectonic penetrating keratoplasty.

Case report

A 69-year-old female patient presented with a 3-day history of a 'foreign body' sensation in the left eye. This was noticed following minor trauma, when she had hit her left eye with the leg of her spectacles.

On examination, she had bilateral ectropion. Her visual acuities were 4/9 OD and 4/60 OS. In the left eye, there was a corneal perforation measuring 2 × 1 mm at the inferior mid-periphery plugged by iris tissue. There was no epithelial defect or apparent infiltration beyond the margin of the perforation. Siedel test was negative with a quiet, formed anterior chamber and intraocular pressure of 11 mm Hg. This patient was diagnosed with PRP in 2002 and had been on systemic steroids and acitretin for 3 years. She previously had a right tarsorrhaphy and was on regular ocular lubricants.

An urgent tectonic penetrating keratoplasty and lateral tarsorrhaphy were performed. Corneal histopathology including HSV-1 immunocytochemistry revealed no evidence of an infectious aetiology. A remarkable feature was the absence of Bowman's membrane between the site of perforation and the inferior margin of the cornea (Figure 2). There was associated epithelial thickening and basement membrane irregularity. Inflammatory cells were seen scattered in the vicinity of the perforation and elsewhere in the epithelium. These changes appeared to be a pre-existing abnormality, which may have predisposed to corneal perforation following the trivial injury.

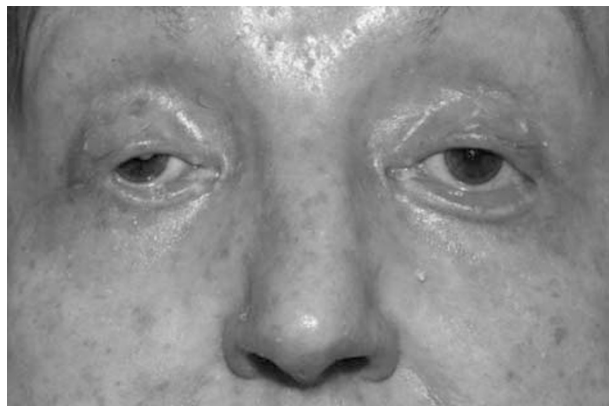


Figure 1 External picture of patient with PRP, with facial erythroderma and ectropion.