Comment

Brachytherapy is the most common method for treating uveal melanoma. However, complications that include inter alia, radiation retinopathy and radiation optic neuropathy have been described.^{1,2} Such complications have been treated by various methods, including laser photocoagulation, systemic corticosteroids and recently, intravitreal injections of triamcinolone acetonide.³

HBOT has been suggested in the treatment of various retinal pathological conditions,⁴ and optic neuropathies, including radiation-induced optic neuropathy.⁵ In our present case, we report the response of irradiation retinopathy and optic neuropathy to HBOT with marked improvement in the clinical appearance of the fundus and the visual field.

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Sir,
Microbial contamination of ophthalmic operating microscopes

Endophthalmitis is an uncommon but devastating complication of any intraocular procedure. It has been

shown that microbial contamination of the operative eye increases the risk of endophthalmitis.¹ Several studies have isolated bacteria inside the operating room on everything from the ventilation systems to surgical drapes, most commonly isolating coagulase-negative *Staphylococcus*.^{2–5}

Case report

In order to investigate the potential of ophthalmic operating microscopes to contaminate the surgical field, we cultured four ophthalmic operating microscopes, two at a university hospital and two at a Veteran's Administration hospital. All four operating rooms were frequently used by multiple resident and faculty physicians for ophthalmic surgery. Microscope ages ranged from 5 to 22 years.

On each microscope, the objective lens cover and the vertical and horizontal moving plates were cultured with a sterile cotton applicator moistened with thioglycolate broth and applied over a blood, chocolate, and Sabouraud culture plate (Figure 1). Cultures were taken at 0600 h and repeated at 1700 h. No growth was detected in any culture after 6 weeks of incubation.

Both OR staffs reported occasional light dusting of the microscope on an as-needed basis without any recent dusting before the cultures. During surgeries, sterile knob covers were routinely placed on all microscope knobs at both facilities. None of the microscopes had ever been cleaned by any aseptic means. The baseline swabs in our cultures revealed various amounts of grime, confirming the OR staff's reports.

Comment

We were surprised to learn that no bacteria or fungi could be isolated from frequently used, teaching hospital microscopes that had never been cleaned with any antiseptic chemical. Although more elaborate methods of culturing could have been considered, most contaminants with a significant chance of seeding the operative field should have been isolated with standard swabbing techniques.

Figure 1 The culture sites. Site one was the objective lens cover. Site two was the vertical adjustment plate. Site three was the horizontal adjustment plate.

Some ophthalmology practices continue to spend the time and cost necessary to fully drape the operative microscope despite the lack of studies in the literature to support this action. Our findings are the first to suggest that ophthalmic operating microscopes do not pose a significant risk for bacterial or fungal contamination of the surgical field and hence routine microscope draping may not be necessary.

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Sir, Transmuscular migration of solid silicone band

The article 'Transmuscular migration of 240 silicone encircling band' by Kreis *et al*¹ has prompted us to share our experience with a similar case.

We recently reviewed a 71-year-old man who presented with an 8-week history of horizontal binocular diplopia after bumping his head against a lamppost. Past ocular history included left retinal detachment surgery in 1999 with MIRA 276 and 240 silicone bands without post-operative diplopia at discharge. Visual acuities were 6/6 OD, 6/36 OS. There was limitation of abduction in the left eye and a left esotropia worse for distance than for near, mimicking sixth nerve palsy. Slit lamp examination revealed several eyelashes embedded beneath the conjunctiva, drawing attention to an area of conjunctival erosion superotemporally (Figure 1), where the silicone band and anchoring suture were found to be exposed (Figure 2). During surgery for removal of the silicone band, the lateral rectus was not recognized at its

Figure 1 Several eyelashes embedded in the conjunctiva drawing attention to area of erosion superotemporally.

Figure 2 Exposed buckle and anchoring suture. (Reproduced from Eye News 2007, in press. Courtesy of Pinpoint Scotland Ltd.).

insertion. Although repositioning of the muscle was not attempted, his diplopia improved postoperatively and was successfully treated with prisms.

This suggested a possible element of mechanical restriction contributing to the diplopia, as a bulky explant beneath the tendon of the medial rectus can effectively shorten the muscle, limiting its ability to stretch.²

Diplopia with ocular motility disturbances as a result of migrating buckling elements through the recti muscles has been well documented,^{3–5} including those requiring surgical repositioning of the transected tendon.³ Ocular motility disturbances did not occur as one might expect in several cases^{4–5} that were thought to be unique, in that reattachment of the muscle fibres or sheath relatively closely behind the migrating element possibly allowed preservation of recti function.⁴ Lanigan,⁵ in a series of five patients, reported two with ocular motility disturbances