

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

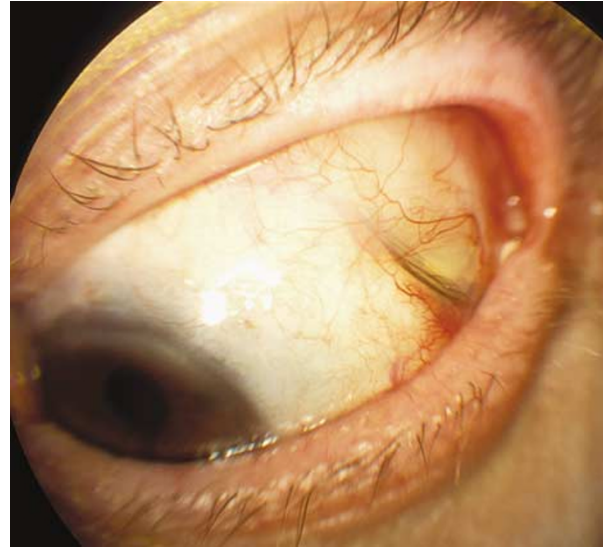


Figure 1 Several eyelashes embedded in the conjunctiva drawing attention to area of erosion superotemporally.



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

and cautioned that a larger series is needed before one can comment on the true incidence of ocular motility dysfunction following this complication. Therefore, it may be misleading to conclude that 'the migrating encircling band is not usually linked to ocular motility disturbance'. We suggest that it is important to consider migration of encircling elements in the differential diagnosis of diplopia in patients with previous scleral buckling procedures to ensure that important clinical signs are not overlooked in examination.

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Sir,
Eccentric macular hole formation associated with macular hole surgery

We read with interest the article by Polkinghorne and Roufail¹ on eccentric macular hole formation associated with macular hole surgery. From their series of four eyes, they described that the 'risk appears higher in eyes operated on by vitreoretinal fellows' and christened it the 'fellow eye syndrome,' which is a clever wordplay that hopefully is not derogatory or uncharitable. However, Rubinstein *et al*² in their seminal report of four patients stated that 'one experienced vitreoretinal surgeon performed all the operations (RB)'. Likewise in our experience with two patients, the development of eccentric macular hole did not occur in the hands of fellows, but in the hands of a more experienced vitreoretina fellowship-trained surgeon (KGAE). Incidentally, one of our two patients was also a myope with associated myopic chorioretinal degeneration who developed multiple eccentric macular holes after undergoing standard pars plana vitrectomy and internal limiting membrane peeling for macular hole.

Although we agree with the authors' suggestion that the eccentric macular hole probably results 'from excessive manipulation,' we believe that the culprit is not necessarily the direct iatrogenic insult alone. We concur with their opinion that 'outer retinal degenerative changes may increase the risk of eccentric macular hole formation.'¹ Concomitant predisposing degenerative weaknesses as in the presence of 'extensive drusen'¹ or myopic chorioretinal degeneration (as in our case) as well as weakening of the glial structure of the retina caused by decapitation of the Muller cells³ may also play a role in the development of eccentric macular hole.

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Sir,
Reply to Sangtam *et al*

We thank Sangtam *et al* for their useful comments on our observations regarding eccentric macular holes as a complication of macular surgery. In our letter, we described this phenomenon occurring subsequent to surgery for epiretinal membrane formation.¹

Rubinstein *et al*² first reported this complication in a series of patients who had undergone macular hole surgery. Our report suggested that other surgeries might also precipitate this outcome and identified three possible contributing factors, namely, excessive manipulation, outer retinal degenerative changes and experience of the surgeon.