

patient's corneal smear indicated a microsporidial infection. There was a rapid and complete response to a short course of topical Fumidil B. Although both Brolene (M&B)<sup>3</sup> and itraconazole<sup>6</sup> have been reported to be effective in treating this disorder, our experience has shown that these agents produce only partial resolution of symptoms.

Fumidil B is an antimicrobial agent commonly used to treat microsporidial infections in honey bees. Following previous reports of successful therapy in humans with chronic use,<sup>5,6</sup> we offered this therapy to our patient. The dosage of 0.11 mg/ml of active fumagillin resulted in improvement of our patient's symptoms and signs after only a 3-day course of therapy without evidence of recurrence of side-effects. This suggests that at this dose, a short course of Fumidil B may be an effective therapy for ocular microsporidiosis. Further investigation is needed to determine the most effective dosing regimen.

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Sir,  
**The Merocel Nasal Tampon: Its Use in Lacrimal and Oculoplastic Surgery**  
Nasal packing for vasoconstriction or tamponade usually

involves using some form of gauze. The gauze, however, is difficult to insert into the nose, too porous, and traumatic to the nasal mucosa when being removed. The following technique involving the use of Merocel nasal tampon is reliable, easy to use and less traumatic.

#### Objective

We set out to investigate the advantages of the Merocel nasal tampon over traditional gauze strips in the management of patients undergoing dacryocystorhinostomy, insertion of nasolacrimal stents and in the harvesting of nasal septal cartilage. We used the nasal tampon in a total of 52 patients undergoing these procedures in our hospital from October 1992 to August 1993.

#### Methods

In dacryocystorhinostomy and for harvesting of nasal septal cartilage the tip of the semi-rigid tampon is smeared with a lubricant ointment and inserted manually into the nasal cavity under direct visualisation using a nasal speculum, with the tip of the tampon being directed towards the medial canthus (Fig. 1). If the procedure is performed under local anaesthesia, the nasal mucosa is first anaesthetised using a local anaesthetic spray. In placement of nasolacrimal intubation stents, the inferior turbinate is first

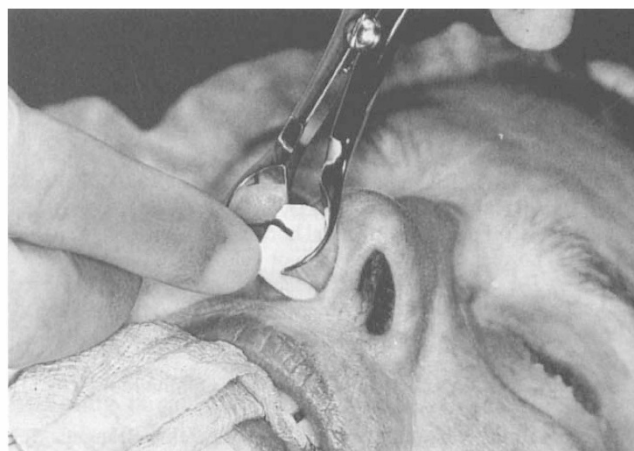


Fig. 1. The Merocel nasal tampon being inserted.



Fig. 2. The injection of cocaine over the tampon.

identified using a headlight and nasal speculum and the tampon, smeared with a lubricant ointment, is directed along the floor of the nasal cavity beneath the inferior turbinate. The tampon can easily be cut and reduced in size for use in infants. We also routinely insert a nasal tampon after harvesting nasal septal cartilage for lid reconstruction.

Once the tampon is in position, a blunt-tipped lacrimal cannula on a 2 ml syringe containing 4% cocaine solution is inserted into the nose along the superior border of the tampon to its tip (Fig. 2). The cocaine solution is then slowly injected as the cannula is gradually withdrawn from the nose. The tampon rapidly softens and expands, filling the nasal cavity. Normal saline is used instead of cocaine following harvesting of septal cartilage. The nasal tampon can easily be removed, after being moistened, by gentle traction on the attached suture.

We leave the tampon (expanded with cocaine) in the nasal cavity for a minimum of 10 minutes before removal for the purpose of dacryocystorhinostomy, insertion of stents or before harvesting nasal cartilage. In the case of a tampon (expanded with normal saline) used for the purpose of controlling epistaxis following harvesting of nasal septal cartilage we leave it in place for 24 hours. If there is significant epistaxis following removal, a fresh tampon can easily be reinserted and left in place for a further 24 hours.

### Results

We have used this technique in a total of 52 patients and have not encountered any difficulties or complications from the use of the device to date. Vasoconstrictors are efficiently delivered to the correct anatomical location resulting in very good decongestion and vasoconstriction pre-operatively, and good control of epistaxis by effective tamponade intra-operatively and post-operatively.

### Discussion

The Merocel nasal tampon is widely used for the management of epistaxis by ENT surgeons. The tampon has been reported to be very useful in pre-operative nasal mucosal decongestion and vasoconstriction and in the control of epistaxis (post-operative or spontaneous). It has been found to fulfil the criteria of ease of insertion and removal, ability to fill the nasal cavity, and production of enough pressure to control and prevent bleeding without macerating the nasal mucosa.<sup>1</sup>

The nasal tampon can also be used in patients developing significant epistaxis following dacryocystorhinostomy, though we have not encountered such a situation.

Our experience with the nasal tampon has been very favourable and we have been very impressed by the ease of insertion and removal. Gauze strips are most readily available and widely used, but they are difficult to insert into the nose, too porous, and traumatic to the nasal mucosa when being removed. For the control of post-operative epistaxis several types of nasal balloons have been described. They are cumbersome and difficult to use.<sup>2</sup>

Toxic shock syndrome, though rare, is a recognised complication of any form of nasal packing. It has been found that the Merocel nasal tampon is the least likely form of nasal packing to produce this complication.<sup>3</sup>

We would advise the use of this form of nasal tamponade, for its significant advantages, in place of the traditional gauze strips.

Merocel is a registered trademark of Merocel Corp., Mystic, CT, USA.

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Sir,

### Vitreous Haemorrhage after Hyperbaric Oxygen Therapy

We report a case of vitreous haemorrhage noticed immediately after treatment with hyperbaric oxygen therapy.

### Case Report

A 37-year-old man with type 1 diabetes mellitus, treated with insulin for 17 years, suffered from diabetic foot ulcers and proliferative retinopathy. At presentation he had a vitreous haemorrhage in the right eye and neovascularisation in the left. He underwent right-sided vitrectomy and extensive panretinal photocoagulation to the left eye. Over the same period he had several exposures to hyperbaric oxygen to assist resolution of his foot ulcers.<sup>1</sup>

Neovascular fronds in the left eye did not resolve completely and further laser treatment was planned when he was readmitted with a breakdown of his foot ulcers. Hyperbaric treatment (one 20 minute and two 15 minute periods of 100% O<sub>2</sub> at 2.4 ATA with 3 minute air breaks) was undertaken in conjunction with surgical treatment of his recurrent foot ulcers. Within a few minutes of completing the eighth treatment in this course the patient noticed clouding of vision in his left eye. Examination showed a fresh vitreous haemorrhage obscuring the visual axis. This vitreous haemorrhage cleared spontaneously and further laser treatment was applied. To date the patient retains a visual acuity of 6/9 in this eye. A follow-up fluorescein angiogram now shows no leak with a few mature loops of neovascularisation.