

instance, as in the previous similar cases, presented as the first manifestation of metastatic spread. Metastasis from ocular melanoma implies a poor prognosis for survival; Lorigan *et al.*<sup>4</sup> reported that 105 of 110 patients died between 1 and 38 months of the onset of metastatic disease.

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### References

- Font RL, Ferry AP. Carcinoma metastatic to the eye and orbit. III. A clinicopathologic study of 28 cases metastatic to the orbit. *Cancer* 1976;38:1326-35.
- Orcutt JC, Char DH. Melanoma metastatic to the orbit. *Ophthalmology* 1988;95:1033-7.
- Shields JA, Bakewell B, Augsburger JJ, Flanagan JC. Classification and incidence of space-occupying lesions of the orbit: a survey of 645 biopsies. *Arch Ophthalmol* 1984;102:1606-11.
- Lorigan JG, Wallace S, Mavligit GM. The prevalence and location of metastases from ocular melanoma: imaging study in 110 patients. *AJR* 1991;157:1279-81.
- Philps S. Choroidal sarcoma with metastasis in the opposite orbit. *Br J Ophthalmol* 1949;33:732-9.
- Foster J, Henderson W, Cowie JW, Harriman DSF. Choroidal sarcoma with metastasis in the opposite orbit. *Br J Ophthalmol* 1957;41:42-7.
- Shields JA, Shields CL, Shakin EP, Kobetz LE. Metastasis of choroidal melanoma to the contralateral choroid, orbit and eyelid. *Br J Ophthalmol* 1988;72:456-60.
- Paul EV, Parnell BL, Fraker M. Prognosis of malignant melanomas of the choroid and ciliary body. *Int Ophthalmol Clin* 1962;2:387-402.

Sir,

### Choroidal Haemorrhage During Cataract Extraction by Phacoemulsification

A recent letter to the journal by Mr Elliott<sup>1</sup> showed the benefit of phacoemulsification in coping with a potential expulsive haemorrhage. We wish to report a similar case where the haemorrhage occurred earlier in the procedure, requiring further surgical intervention.

### Case Report

A 72-year-old woman was admitted for in-patient cataract surgery. She was hypermetropic and had worn glasses since the age of 16 years. Visual acuity was 6/60 in the right eye and 6/18 in the left due to bilateral cataracts. The anterior chambers were shallow but no other abnormality was seen. She had been treated for hypertension for 14 years, had a history of drop attacks due to atherosclerotic carotid arteries and was a smoker. Local anaesthetic was given using a peribulbar technique. A 5.5 mm scleral tunnel was made and a 3.2 mm keratome was used to enter the eye. Capsulorhexis was uneventful, and phacoemulsification was commenced. The nucleus was cracked and removal of the segments completed. As the instruments

were being changed for irrigation/aspiration the anterior chamber became flat and the eye became hard. It was impossible to re-form the anterior chamber and so the procedure was abandoned. The wound was closed with 10/0 Nylon, and intravenous Diamox 500 mg (Lederle) was given. At that time the blood pressure was 180/115 mmHg.

Examination 3 hours later showed a deep anterior chamber with a tiny piece of nucleus, and plenty of soft lens matter. The intraocular pressure was 45 mmHg and fundal examination showed a choroidal haemorrhage in the superotemporal quadrant.

In the next few days the intraocular pressure was brought under control medically. Six days post-operatively the patient was taken back to theatre, and under a general anaesthetic the wound was reopened, the soft lens matter aspirated and a posterior chamber lens implant inserted in the capsular bag, all without difficulty. The patient was discharged the following day. At her first review 2 weeks later the visual acuity was 6/12 unaided, improving to 6/9 with correction.

### Discussion

In this case a choroidal haemorrhage was proven and, given the high intraocular pressure, would have been very likely to produce an expulsive haemorrhage with standard cataract surgery. This case exemplifies the control over the eye given by the small wound and this allowed the surgeon to return only a few days later to complete the operation, knowing that he still had that control. Expulsive haemorrhage is a rare complication, and has an incidence in one large series of 0.15%, but it is devastating when it does happen.<sup>2</sup> Even without a choroidal haemorrhage, a 'tense' eye with a shallowing anterior chamber is familiar to us all and can make complications such as posterior capsular rupture more likely. With the increasing use of local anaesthetic the problem of a patient coughing during the procedure will become more common. In both these circumstances, phacoemulsification gives much better per-operative control of the anterior chamber throughout the cataract operation, as well as giving the well-recognised benefits of the small wound post-operatively.<sup>3</sup>

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### References

- Elliott AJ. Expulsive haemorrhage during phacoemulsification. *Eye* 1993;7:598-9.
- Speaker MG, Guerriero PN, Met JA, Coad CT, Berger A, Marmor M. A case-control study of risk factors for intra-operative suprachoroidal expulsive haemorrhage. *Ophthalmology* 1991;98:202-9.
- Maloney WF, Grindle L. *Textbook of phacoemulsification*. 1st ed. Fallbrook, California: Lasenda, 1988:125.