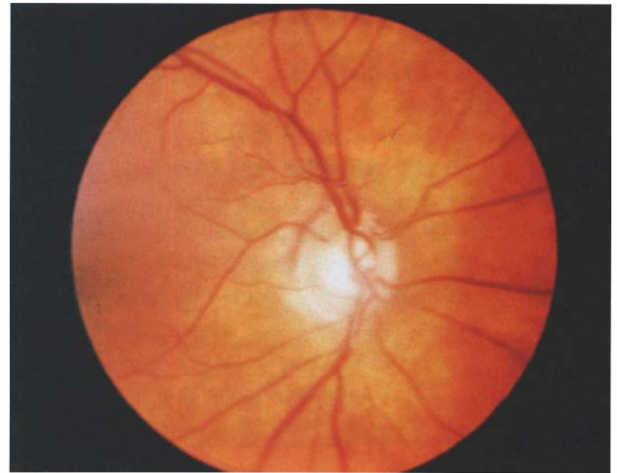


(a)



(b)

Fig. 2. Fundal view of the right eye after cataract surgery: (a) at 2 days showing a normal disc and (b) at 3 months demonstrating pallor of the inferior half of the disc.

the needle, or the optic nerve may have been damaged by adrenaline-induced vasospasm. Local anaesthetic agents have also been implicated in a myotoxic effect,³ causing a spectrum of manifestations ranging from paresis to contracture of the antagonist or the affected muscle. The ptosis and left hypertropia are explained by paresis of the levator and superior rectus muscles followed by secondary contracture of the antagonist inferior rectus.^{1,4} The other sequelae described by Capo and Guyton⁵ are transient paresis of the affected muscle followed by its overaction caused by segmental contracture acting as surgical resection. In our case this may explain the initial esotropia subsequently developing into exotropia due to lateral rectus involvement.

In summary, a complex clinical picture may rarely complicate retrobulbar anaesthesia. Topical, subconjunctival or sub-Tenon's anaesthesia would obviate these complications.

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Jyoti Raina
 Gregory S. Kosmorsky
 Kenneth W. Wright
 Department of Ophthalmology, A-31
 Cleveland Clinic Foundation
 9500 Euclid Avenue
 Cleveland
 Ohio, USA

Jyoti Raina, FRCS, FRCOphth ✉
 1, The Asters
 Goffs Oak
 Waltham Cross
 Herts EN7 6SD, UK

Sir,

An unusual cause of an acute red eye

Numerous reports exist of lost hard contact lenses presenting as lumps in the upper lid and fornix. Recently a report of a soft contact lens presenting as an intraocular foreign body, following a perforating eye injury, was documented.¹ To our knowledge there are no previous reports of lost soft contact lenses presenting as an acute red eye many years after discontinuation of wear.

Case report

A 43-year-old woman presented to the eye casualty with a 2-day history of discomfort in the left eye. On the third day she awoke with pain, redness and epiphora. Past ophthalmic enquiry elicited that she had worn soft contact lenses. Lens wear was discontinued 6 years previously because a tremor associated with multiple sclerosis caused difficulty handling the lenses.

Slit-lamp examination revealed a soft contact lens positioned over the temporal bulbar conjunctiva (Fig. 1). There was marked circumlimbal injection and a large corneal erosion. The anterior chamber was quiet and there was no corneal stromal infiltration. Corneal hypoaesthesia was not demonstrated on clinical testing.

Bacteriological investigations of the soft contact lens and conjunctival swab, including *Acanthamoeba* culture, were negative. Histopathological examination showed eosinophilic acellular material surrounding the lens (Fig. 2).



Fig. 1. Anterior segment photograph after fluorescein instillation.

Comment

Contact lenses have a wide range of effects on the eye including decreased corneal epithelial metabolic rate, epithelial microcysts and reduced adhesion and hypoaesthesia.²⁻⁴ All these changes are reversible soon after discontinuing wear. Conjunctival hypoaesthesia has been documented with hard corneal contact lenses within a crescent area below the cornea corresponding to the low riding of the lens.

The contact lens surface rapidly becomes coated with material from the tear film including bacteria, cell debris, mucus and proteins. The acquisition of this coating can result in an allergic response clinically evident as papillary conjunctivitis. Low-grade inflammation has been detected in asymptomatic lens wearers.⁵ Examples of this subclinical immune response include increased vascular permeability of the conjunctiva and elevated levels of neutrophil chemotactic factor.

It is of interest that this soft contact lens remained as a comfortable foreign body for a protracted length of time. Several mechanisms may be involved. Conjunctival hypoaesthesia related to the lens itself, or as a consequence of multiple sclerosis, are possible explanations. The acellular material coating the contact lens may present a subthreshold immunological stimulus. An understanding of the immunobiology of asymptomatic contact lens wear would assist in the understanding of the pathophysiology of lens intolerance.

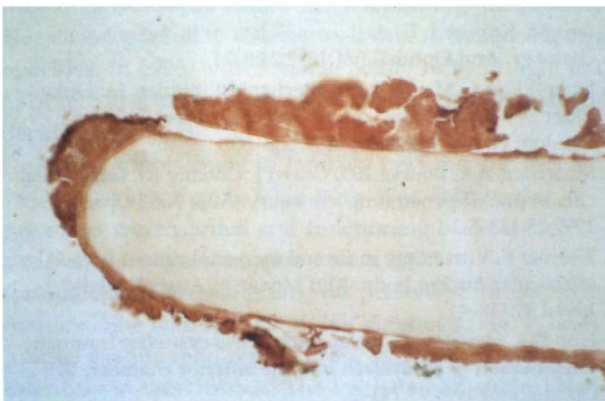


Fig. 2. Contact lens with surrounding material stained with H&E.

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S.O. Brannan
D.K. Chitkara
Department of Ophthalmology
Walton Hospital
Liverpool, UK

Ms S.O. Brannan ✉
Department of Ophthalmology
Walton Hospital
Rice Lane
Liverpool L9 1AE, UK
Tel: +44 (0)151 525 3611
Fax: +44 (0)151 529 4283

Sir,

Retained eyelashes in the anterior chamber following corneal perforation

Retained intracameral foreign bodies following corneal perforating injuries are rare. Several cases of retained cilia were reported following perforating injury.¹⁻⁴ These lashes may cause variable responses in the eye, ranging from no response, to severe uveitis or endophthalmitis. We report a case of retained eyelashes in the anterior chamber that were found on a routine examination 2 months following suturing of a corneal perforation.

Case report

A 49-year-old man was referred to the Department of Ophthalmology because of penetrating corneal trauma caused by a knife. On admission, a stab wound was found including the left side of his nose and the lower and upper lids. Visual acuity was 20/20 in the right eye and 20/200 in his left eye. A linear cut was observed in the left cornea, beginning in the sclera, 1 mm from the limbus at 7 clock-hours, and extending superotemporally for 7 mm. There was no iris prolapse, and the anterior chamber was shallow with a mild cellular reaction. Under general anaesthesia the anterior chamber was thoroughly washed out with balanced salt solution, and the corneal wound was sutured. At the end of surgery the anterior chamber was deep and no foreign bodies were observed. Subconjunctival gentamicin and cephalosporin were injected. Topical 5% cephalosporin, 1.4% gentamicin and 0.1% dexamethasone were applied six times daily for 1 week.

Two months following surgery, a solitary eyelash was found in the anterior chamber (Fig. 1). The tip of the lash was embedded within the superior iris stroma, while its root was floating in the aqueous humour. A mild cellular