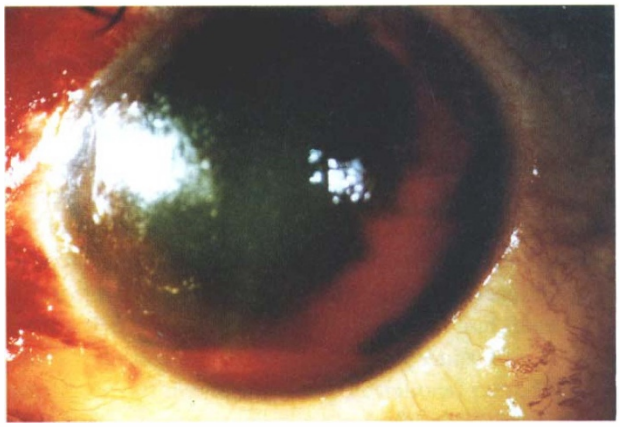

Fig. 1. *The appearance of the eye showing blood in the anterior chamber after removal of the Honan balloon.*

left eye, secondary to the development of posterior subcapsular cataract. A decision for cataract surgery was therefore made.

Immediately pre-operatively she was noted to have old keratic precipitates, a quiet anterior chamber, a well-dilated pupil after pre-operative mydriatics and a normal intraoperative pressure. The drainage angle was also normal. Peribulbar anaesthesia was administered with 2% lignocaine with adrenaline, marcaine 0.5% and hyalase – a volume of approximately 5 ml. Pressure was applied with a Honan balloon for approximately 10 min.

When the patient was brought to the operating table a significant amount of blood was noted in the anterior chamber, distributed mainly around the angle (Fig. 1) and the eye was markedly soft. The procedure was abandoned as an ocular perforation could not be completely excluded. Subsequent slit-lamp examination showed blood and fibrin in the anterior chamber, not appearing to come through the pupil. The intraocular pressure was 4 mmHg. An ultrasound scan showed very little if any blood in the posterior segment. Over subsequent days, as the hyphaema settled, the retina was visualised and a retinal break suggestive of accidental globe puncture during anaesthesia was excluded. Two days later the patient had an acute rise in intraocular pressure to 54 mmHg, which settled slowly on medical treatment. She underwent cataract surgery some weeks later using a retrobulbar anaesthetic, with a good result, without the use of the Honan balloon.

Comment

Fuchs' heterochromic uveitis (FHU) accounts for at least 3.2% of all cases of uveitis.[1] It is usually seen in one eye of young adults, with heterochromia of the iris, and a low-grade uveitis with anterior chamber activity and keratic precipitates but without ciliary injection. Lens opacity is seen frequently and glaucoma slightly less often,[2] and consequently the safety of cataract extraction in FHU has been the subject of many papers. Generally speaking, the surgical outcome is felt to be better in this condition than in eyes with other types of uveitis, but eyes with FHU are prone to specific complications. Problems reported include hyphaema post-operatively and after paracentesis[3] with its associated drop in intraocular pressure, post-operative pressure rises, uveitis and vitreous opacity limiting visual outcome.[4] Although hyphaema has frequently been reported with procedures that open the anterior chamber (paracentesis, cataract surgery), and even with applanation tonometry, mydriasis and gonioscopy,[3] there has been only one previous report of hyphaema after the use of the Honan balloon,[5] and in that case it was possible to proceed with the operation as the hyphaema was small and the eye normotensive. To date there have been no comments in the literature as to whether the route of administration of local anaesthetic (peri- or retrobulbar) has an influence on the incidence of hyphaema.

The cause of the frequent hyphaema is not clear, and although abnormal angle vessels have been described in some cases of FHU there is no link between gonioscopic or histopathological findings and the occurrence of hyphaema.[6] A generalised vascular structural abnormality is assumed in these eyes, causing a usually small haemorrhage from the angle vessels or occasionally from the iris surface secondary to an abrupt change in intraocular pressure. Extensive haemorrhage as in this case is unusual, but reinforces the need for care in these eyes when using any means pre-operatively to reduce the intraocular pressure.

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Tamsin J. Sleep ✉
I.H. Chisholm
Southampton Eye Unit
Southampton General Hospital
Tremona Road
Southampton SO16 6YD, UK

Sir,

Self-induced cicatricial conjunctivitis

Cicatricial conjunctivitis is an uncommon condition characterised by pseudomembrane formation, conjunctival inflammation and scarring. The differential diagnosis includes ocular cicatricial pemphigoid, Stevens Johnson syndrome, chemical burn, bacterial and viral conjunctivitis and drug-induced conjunctivitis.[1] There has been one previous report[2] of severe cicatricial conjunctivitis caused by repeated self-induced trauma, by a patient who readily admitted to an obsessive-compulsive disorder. We report a similar case in a

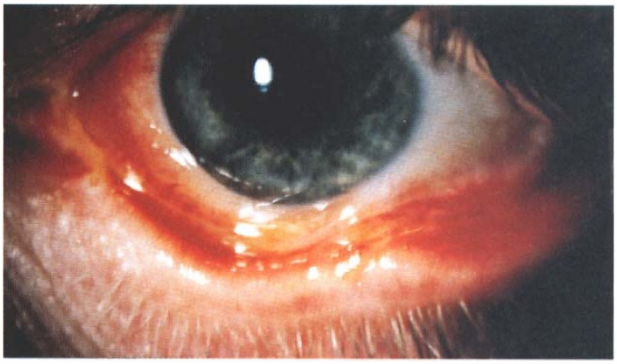

Fig. 1. *Mechanical ectropion of the left lower eyelid.*

patient with a history of mild depression who only admitted to self-harm after considerable investigation and treatment.

Case report

In January 1997, a 28-year-old man was referred to the external eye disease clinic with bilateral blepharitis, conjunctival scarring and symblephara. He gave a 2.5-year history of swollen eyelids with discharge, and the right lower eyelid had twice shown an excoriated pustule, which had improved after treatment for blepharitis. He had no complaint of reduction in vision.

On review of systems he was well, apart from mild reactive depression monitored by his general practitioner for 2 years. He had not complied with antidepressant medication. He had no history of rashes or skin reactions, previous chemical burn, asthma, stomatitis or balanitis. He had no known allergies. He had worn gas-permeable contact lenses intermittently until 8 months previously. The patient was taking oral tetracycline and using oc. chloramphenicol for meibomian gland disease.

On examination, best corrected visual acuity was 6/6 in the right eye and 6/9 in the left. There were signs of bilateral meibomian gland dysfunction and extensive conjunctival scarring bilaterally with symblepharon, actively inflamed on the left. The inferior fornices were shortened by approximately 50% and there was

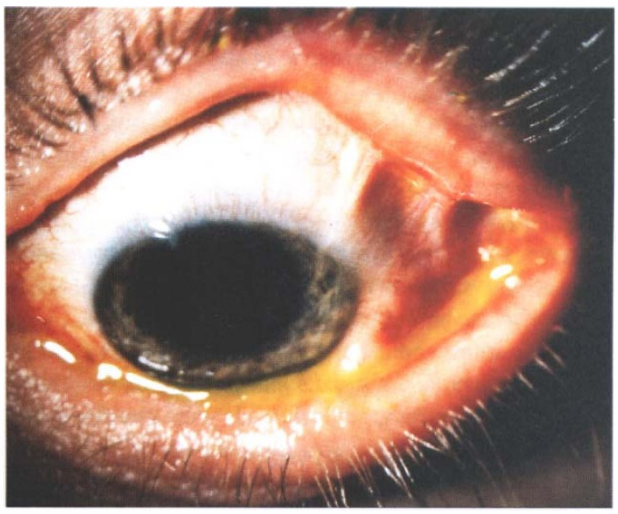

Fig. 2. *Symblepharon of the superior conjunctiva, left eye.*

mechanical ectropion of the lateral third of the left lower eyelid, caused by bulky subtarsal tissue (Fig. 1). Otherwise ocular examination was normal, with healthy tear film and corneae.

Investigations showed normal C reactive protein and immunoglobulins. Autoantibodies were negative. Conjunctival biopsy taken from the left eye showed chronic inflammation and no antibody deposition to suggest cicatricial pemphigoid. The patient refused oral mucosa biopsy.

There was no improvement on preservative-free topical chloramphenicol, prednisolone and hypromellose. During 3 months' observation, the patient developed recurrent epithelial defects and inflammation of the inferior tarsal surface of the left eye. A trial of oral steroid failed to produce significant improvement. On the next visit the eyelids were bruised and the inferior conjunctiva inflamed and bleeding from multiple lacerations. He then admitted to cutting the inner surface of his eyelids with sharp instruments (nail clippers, scissors and paper clips), often daily, for many months, in the belief that he was 'letting out infection from around his eyes'. He refused psychiatric assessment and general supportive measures. Despite agreeing to discontinue this interference, his left eye continued to be inflamed. One month later, when healed, the inferior fornix of the left eye was completely obliterated. He had developed diplopia on dextroversion due to limitation of movement and buckling of the lower lid on laevoversion. There was
S-shaped ptosis of the left upper lid with lacrimal ductules identified adjacent to the symblepharon (Fig. 2) and lid margin.

In order to improve cosmesis and relieve the discomfort and diplopia, the patient underwent buccal mucous membrane grafting to the inferior fornix of the left eye. This has healed well over a follow-up time of 12 months and he has improved motility, so that diplopia is only present on extremes of movement.

Comment

Management of this case was complicated by the delayed admission of self-harm by the patient. In the one other report[2] of self-induced cicatricial conjunctivitis, the patient readily admitted an obsessive-compulsive disorder which caused him to damage his eyes. The present case highlights self-harm as a cause of cicatricial conjunctivitis and that it should be considered in the differential diagnosis, even if not readily admitted by the patient, particularly where the course is atypical.

Investigations in this case had not shown any other underlying cause, with no evidence of infection, previous chemical injury or atopy. Immunological tests were non-specific and conjunctival biopsy was negative for pemphigoid. Our case fulfils criteria for Munchausen's syndrome,[3] when the patient knowingly deceives the doctor but appears unable to control his actions.

Most reports of self-inflicted eye injury record attempted self-enucleation,[4] which is commonly associated with schizophrenia but also with drug use,[5] obsessive-compulsive neuroses and organic states such as epilepsy and encephalitis. Other forms of ocular self-mutilation are described such as eye-banging,[6] alkali burns[3,7,8] and cellulitis due to self-injection.[3] This case emphasises the addition of cicatricial conjunctivitis to this list even in cases with no apparently significant psychiatric history.

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Fiona M. Chapman ✉
Sunderland Eye Infirmary
Queen Alexandra Road
Sunderland SR2 9HP, UK

A. Jane Dickinson
Francisco C. Figueiredo
Royal Victoria Infirmary
Newcastle upon Tyne NE1 4LP, UK

Sir,

Periorbital necrotising fasciitis in a child

Necrotising fasciitis (NF) is a soft tissue infection caused by toxin-producing virulent bacteria. NF of the face is extremely rare in children; only 3 cases have been described in the literature. We describe a case of periorbital NF in a child.

Case report

A 5 years and 6 months old boy presented to the eye casualty with swelling of the right uppr and lower lids 12 h after being kicked in the right eye. He had a temperature of 39.1°C, pulse was 110/min, he vomited once and on central nervous system examination he was fully conscious and orientated but lethargic. He had marked periorbital redness and swelling making it difficult to assess his vision, but he could see 6/5 with his left eye. A plain radiograph of the orbits did not reveal any fracture.

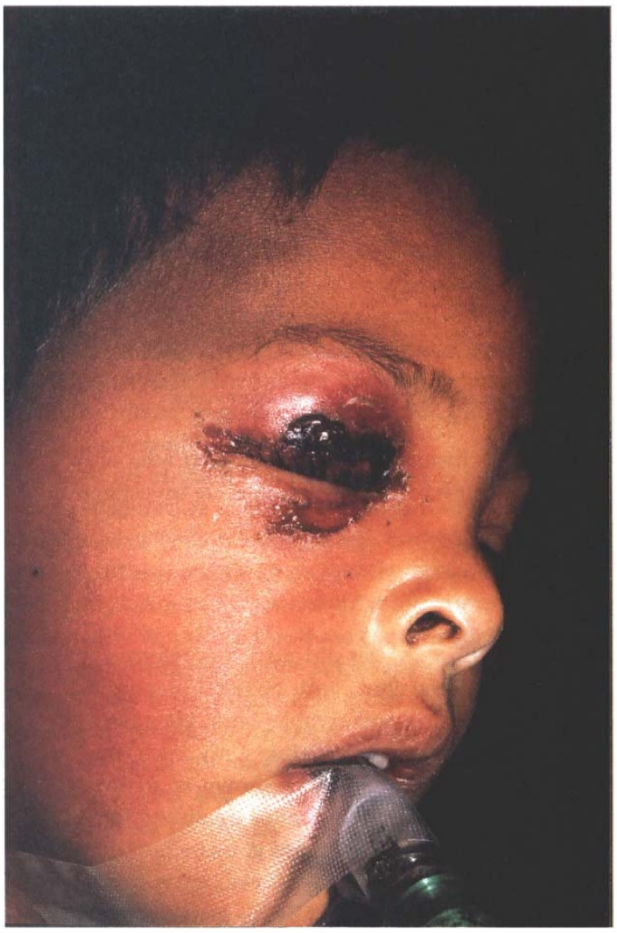

Fig. 1. *Oedema and necrosis involving the whole upper lid.*

A working diagnosis of orbital cellulitis was made and the child was admitted under the paediatricians. FBC, CRP, U+Es were all normal (WCC 15.7); also an eye swab and blood culture were taken. The child was then started on intravenous flucloxacillin (100 mg/kg per day), cefotaxime (200 mg/kg per day) and metronidazole (22.5 mg/kg per day).

On the second day a CT scan showed evidence of large soft tissue mass in the front of the right orbit extending medially to the right side of the nose and laterally to the lateral orbital margins without involvement of the optic nerve or the extraocular muscles. There was no evidence of gas collecting within orbital tissues.

On the third day the child was apyrexial but with increased pain, tenderness and erythema of the right cheek. There was no obvious proptosis and ocular movements were normal.

An eye swab grew group A *Streptococcus pyogenes* and *Staphylococcus aureus*, while blood culture grew *Streptococcus pyogenes* (group A). Antibiotics were changed to intravenous benzyl penicillin (1 g) and chloramphenicol (500 mg q.d.s.), according to sensitivity results. Blood chloramphenicol levels were checked daily.

On the fourth day black necrotic spots started to develop on the skin of the upper lid and the suspicion of necrotising fasciitis was raised.