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Lawrence Gnanaraj Veena J. Rao Department of Ophthalmology Royal Victoria Infirmary Newcastle upon Tyne, UK

Dr L. Gnanaraj, FRCS, DO, DNB Department of Ophthalmology Royal Victoria Infirmary Newcastle upon Tyne NE1 4LP, UK

Tel: +44 (0)191 282 4002 Fax: +44 (0)191 227 5246

Sir

Chronic conjunctivitis due to lacrimal system blockage relieved by dacryocystorhinostomy

Chronic conjunctivitis has many aetiologies and is often misdiagnosed for long periods. This can result in multiple therapy complicating the clinical picture and obscuring the original diagnosis. We present two similar cases where the patient received prolonged topical medication for chronic conjunctivitis before the correct diagnosis of lacrimal system blockage with recurrent infection was made. Both patients responded well to dacryocystorhinostomy (DCR) operations.

Case reports

Case 1. A 91-year-old woman with primary open angle glaucoma treated with timolol 0.5% had bilateral papillary conjunctivitis, which had been treated with courses of g. chloramphenicol and g. fucithalmic. Conjunctival swabs had grown *Staphylococcus aureus* sensitive to both antibiotics on two occasions. She had a sac washout in casualty, which had demonstrated a partial blockage on both sides.

At her next appointment she had a diffuse bilateral papillary conjunctivitis associated with a mucopurulent discharge. The possibility of cicatricial conjunctivitis was considered and so the patient was referred to the External Eye Disease clinic.

At this time she was noted to have bilateral lower lid ectropion, mucopurulent discharge and papillary conjunctivitis (Fig. 1). Syringing of both sides revealed a hard stop with no passage of fluid into the nasopharynx but reflux of copious amounts of mucopurulent material.



Fig. 1. Case 1. On referral the patient had lower lid ectopica, mucopurulent discharge and papillary conjunctivitis.

This fluid grew *Staphylococcus aureus* but treatment with topical and systemic antibiotics was unsuccessful. She was referred to the Orbital team and underwent bilateral DCRs after which she is asymptomatic.

Case 2. An 80-year-old woman was referred to the External Eye Disease clinic with a possible diagnosis of ocular cicatricial pemphigoid. She had a 4 month history of a sore and red eye which had initially been treated by her general practitioner with topical antibiotics with no improvement. She was subsequently seen in another ophthalmic clinic and found to have a copious green discharge associated with marked papillary conjunctivitis and diffuse punctate erosions.

At the first consultation she had papillary conjunctivitis with a thick mucopurulent discharge. She also had a significant number of punctate epithelial erosions that had diminished the vision. A conjunctival swab grew *Staphylococcus aureus* sensitive to flucloxacillin and chloramphenicol. She was commenced on g. chloramphenicol and g. predsol 0.5%. Four weeks later her condition was unchanged and syringing of her nasolacrimal system demonstrated a complete blockage of the nasolacrimal duct. She was commenced on oral antibiotic with no benefit. She underwent a DCR with silicone tubes that were removed 3 months postoperatively. She has been asymptomatic since then.

Comment

We present two similar cases where elderly women were treated for chronic conjunctivitis for long periods (1 year and 4 months, respectively) before a definitive diagnosis was made.

Chronic conjunctivitis is a well-recognised consequence of delayed tear clearance due to punctal obstruction,¹ chronic canaliculitis due to *Actinomyces israeli*² or nasolacrimal duct obstruction³ that is often misdiagnosed. Although prolonged use of topical medication is usually associated with upper lacrimal system problems they can also cause nasolacrimal duct blockage.³

Both our patients had been seen by both junior and senior grade ophthalmologists in the Casualty department. Nasolacrimal duct obstruction with secondary bacterial infection should be considered in any patient with chronic or recurrent conjunctivitis.

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S. Banerjee P.J. McDonnell Birmingham and Midland Eye Center Birmingham, UK

S. Banerjee 💌 Birmingham and Midland Eye Centre City Hospital NHS Trust Dudley Road Birmingham B18 7QH, UK Tel: +44 (0)121 554 3801 Fax: +44 (0)121 507 6853 e-mail: pinkubanerjee@hotmail.com

Sir

Recurrent lens epithelial cell proliferation with an AcrySof lens implant

Since their introduction, AcrySof intraocular lenses (IOLs) have been shown to perform favourably compared with PMMA and silicone IOLs in terms of biocompatibility and posterior capsule opacification rates.^{1,2} As far as the authors are aware, this case highlights a previously undescribed post-operative complication associated with an AcrySof IOL.

Case report

A 68-year-old man underwent uneventful phacoemulsification of right cataract and insertion of an MA60BM AcrySof foldable posterior chamber implant under local anaesthetic. A small adherent plaque of soft lens matter remained on the posterior capsule. First day post-operative visual acuity was 6/12 unaided and no abnormalities were noted. One month following surgery the patient was reviewed and had an unaided visual acuity of 6/6-1 and the eye was uninflamed. His standard post-operative medication was discontinued and he was discharged to his optometrist for new spectacles.

The patient was re-referred 13 months later by his optometrist with reduced best spectacle corrected visual acuity (BSV) of 6/18 and symptoms of glare from the right eye. Slit-lamp examination showed significant posterior capsule opacification for which Nd-YAG laser posterior capsulotomy was performed. One month after



Fig. 1. Upper: Recurrent retrolenticular opacification 6 months after Nd-YAG posterior capsulotomy. Lower: Retroillumination view, 1 month after Nd-YAG 'membranotomy'.

capsulotomy his BSV was 6/7.5 and he was asymptomatic with an ample capsulotomy. He was discharged from further follow-up.

Five months later the patient was again referred with recurrence of glare and reduced visual acuity. He was found to have BSV of 6/15+1 in the right eye and slitlamp examination appeared to show a diaphanous membrane adherent to the posterior surface of the IOL in the region of the capsulotomy site (Fig. 1, upper). The anterior vitreous was visible as separate and discrete from this membrane. Nd-YAG laser resulted in quick disruption of the membrane with no damage to the IOL (Fig. 1, lower). Following this the patient's BSV returned to 6/7.5.

One year following the 'membranotomy' the BSV is 6/9+1 and the patient remains asymptomatic. Interestingly, on slit-lamp examination there appears to be evidence of further lens epithelial cell (LEC) proliferation on the posterior surface of the IOL at the periphery of the capsulotomy (Fig. 2). The patient now has significant cataract in the left eye and has been listed for cataract extraction.

Comment

Posterior capsule opacification is the most common postoperative complication of cataract surgery and much research has been directed at finding ways of reducing this cause of poor visual result in an otherwise successful operation.^{3,4}