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Sir,

Reply to: Intraoperative floppy-iris syndrome associated with chronic use of chlorpromazine

Although intraoperative floppy iris syndrome (IFIS) may even occur without any identifiable causative factor, it was reported to be strongly associated with systemic α -blocker use.¹ As stated in our report² the most probable cause for IFIS in a patient with chronic chlorpromazine use for 29 years should be the α -receptor blocking activity of this drug.

Discontinuation of chlorpromazine before cataract surgery to avoid the possibility of IFIS may merit further discussion. Although chlorpromazine has the advantage of being an inexpensive drug, it is one of the oldest antipsychotics with well-documented adverse effects including orthostatic hypotension, high-resting pulse rates, and impotence. It has antagonistic effects on α -1-adrenergic receptors, serotonin 5-HT₂ receptors, and dopamine D₁ and D₂ receptors.³ Planning of cataract surgery in such a patient may create a chance of trying a new generation antipsychotic drug with less side effects. This should be done with psychiatry consultation. As highlighted in the report, it cannot be guaranteed whether the occurrence of IFIS would be prevented or not if chlorpromazine had been stopped before surgery. Disuse atrophy may have developed in this patient because of long-term use of the drug.

Several other issues raised by the author could not be mentioned in the original report because of limited number of words as per journal policy. Age-related changes in the lens result from multifactorial processes and increasing age is not the only and sole determinant of cataract development in the lens. The patient has a chronic mental illness. For instance, even nutritional factors related with the mental disease may also take place in the early development of cataract. We preferred general anesthesia because of recognition of low cooperation and the poor level of compliance to the instructions in the preoperative evaluation. The patient's history did not reveal any other systemic diseases, eye trauma, or previous ocular surgery.

In conclusion, this report suggests that chlorpromazine may be added to the list of drugs that may cause IFIS because of having α -receptor blocking activities.

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Sir,

Artificial iris rings

Srinivasan *et al*¹ elegantly demonstrated the beneficial effects of the use of artificial iris rings in eyes with iris defect. It was interesting that Morcher type 50C was chosen in case 2, in which the patient developed a permanently dilated 7 mm pupil and cataract after traumatic injury. A pair of type 50C aniridic rings constructs an iris with pupil size of 6 mm, which is only 1 mm smaller than the pupil size of this particular eye, as showed in Figure 3f of the original article. One would presume that the use of the type 50D (4 mm pupil size) or type 50E (3.5 mm pupil size) would provide an even better improvement in the symptoms of glare and photophobia. Type 50D and 50E aniridic rings also appeared to be incorrectly labelled in Figure 1.

While the functional result of these aniridic rings has been well documented, their cosmetic result, which was not addressed in the paper, is often disappointing. Although some of these aniridic rings or implants (intraocular lens implant with a clear central optic and opaque peripheral segment) are available in colour such as blue and yellow, their appearance seems rather unnatural. Therefore, most surgeons will choose the black counterpart even in patients with light-coloured iris.

The same company (Morcher) has recently produced a custom-made iris match implant, which is made of PMMA and composed of a central 4 mm optic and a coloured peripheral segment with matching iris colour pattern to the residual iris of the same eye (type 30B). A colour chart is used by the surgeon to match the iris colour of the patient's eye. Human Optics/Dr Schmidt has produced another version called artificial iris, which is made of foldable, biocompatible silicone. It is custom-made with hand-crafted adjustment of the colour, structure, and diameter of the implant. It is implanted into the ciliary sulcus with or without suture fixation.

However, both of these custom-made iris implants are costly, and their long-term safety profile is not yet known. Nevertheless, these new implants have the potential to provide patients with iris defect both good functional and aesthetically acceptable results.

Acknowledgements

I agree to assign the copyright of the article to the journal as evidence of consent to publication. This article has not been previously published in any other peer-review journal.

Reference

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Sir,

IRIS reconstruction implants

We thank Mr Chung for his interest in our article on iris reconstruction implants.¹ We agree that the types 50 D and 50 E have been incorrectly labelled.

The reason for choosing 50 C implants in case 2 was to provide a 'good' pupil size postoperatively for a detailed retinal examination. In our experience, we have found that patients with ocular trauma not only present with anterior segment injuries but also have traumatic retinal dialysis/detachments, which require adequate pupillary aperture size for the retinal surgeon to work with.

Choosing an implant model in eyes with these kinds of extensive injuries is a trade-off between obtaining a reasonable cosmetic appearance and achieving a pupil size, which does not interfere with performing a detailed retinal exam.

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Sir,

Primum non nocere

We read with interest N Ahmad and J Wests' survey with regard to treatment of asymptomatic retinal detachments.¹ We would like to offer a cautious warning illustrated with sobering case report.

Case report

A 27-year-old woman with a refractive error of -7.00 DS bilaterally presented to the eye casualty with a subconjunctival haemorrhage. She had no previous ocular or medical history; in particular no ocular trauma. Her visual acuity was 6/6 bilaterally. Dilated fundal examination revealed no posterior vitreous detachment and an incidental retinal detachment associated with two round holes inferotemporally on the right eye. A small retinal detachment with no posterior vitreous detachment associated with a round hole was also noted on the temporal retina of the left eye. Faint demarcation lines were noted. Argon laser demarcation was carried out bilaterally. Subsequently, cryotherapy with buckle attachment to the right eye was undertaken. She returned 2 months later with blurring of the vision bilaterally. Her visual acuities were 6/6 and 6/36 on the right and left eye. Examination showed bilateral granulomatous pan uveitis, Dallen Fuchs deposits (Figure 1) with choroidal thickening, confirmed by ultrasonography (Figure 2). Investigations excluding other causes, fundus fluorescein angiography (Figure 3), and indocyanine green angiography suggested the diagnosis of sympathetic ophthalmia. She was started on oral and topical steroids. She developed ocular hypertension, which was managed topically. She improved, and at her last check, 3 months since the onset of the uveitis, her visual acuities were 6/6 bilaterally.

Comment

Although the association between cryotherapy and the development of sympathetic ophthalmia has been reported in the past,^{2–5} all these cases were after cyclodestructive procedures. This is the first such case associated with cryotherapy for retinal holes in the

Figure 1 Left fundus showing Dallen Fuchs deposits.