dispersion, and tumour-related symptoms gave rise to the possibility of an iris melanoma. Our patient demonstrated that iris naevus can present with recurrent spontaneous hyphema.

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Sir,

Pars plana vitrectomy and lensectomy for a nanophthalmic cataract

Cataract extraction in the nanophthalmic eye offer challenges in management because of potential difficulties encountered during the operation and the risk of postoperative complications. Various surgical methods have been described including extracapsular cataract extractions with/without sclerostomies and phacoemulsification. We present a case of cataract extraction in a nanophthalmic eye with par plana vitrectomy, lensectomy, and C_3 F_8 tamponade.

Case report

A 41-year-old Asian female patient with nanophthalmos, chronic narrow-angle glaucoma, microcornea, high hypermetropia ($+17.00$ DS OD, $+16.00$ DS OS), congenital nystagmus, and crowded optic discs presented with poorly controlled glaucoma despite having peripheral iridotomies and iridoplasty. Despite maximum medical treatment in the right eye, she underwent trabeculectomy with mitomycin C and inferior sclerostomies. Four months post-trabeculectomy, she developed a very shallow anterior chamber with iridocorneal touch paracentrally (Figure 1), 360 degrees posterior synechiae, and dense white cataract with visual acuity of perception to light. She was referred to the vitreoretinal service for the management of her cataract and she underwent a right pars plana vitrectomy, lensectomy through pars plana approach, posterior capsulectomy and anterior capsulotomy, and cryotherapy and tamponade with 12% C_3 F_8. Cryotherapy and gas tamponade were performed for entry site breaks. We used long-acting gas tamponade, as the patient was 6 weeks postpartum and positioning would have been difficult. Even after a generous anterior capsulotomy, she developed dense anterior capsular phimosis, which precluded the view of the retina, and subsequently she underwent a capsulectomy through the pars plana approach. At her last follow-up, 2 months after cataract extraction, her vision was counting fingers without aphakic correction. She had stable intraocular pressure and her retina was attached without choroidal effusion.

Comment

Nanophthalmos is a rare condition characterised by thickened sclera, small corneal diameter, crowding of the anterior chamber, and high hypermetropia causing patients to be at risk of angle-closure glaucoma.[1,2] These eyes have axial lengths that measure 20 mm or less, usually two standard deviations below the mean.[3]

Cataract surgery in nanophthalmos eyes can be a definitive treatment for angle-closure glaucoma. Pentacam and ultrasound biomicroscopy images, as analysed by Sharan *et al*,[4] showed an increase in anterior chamber volume, depth, and opening of the angles after extraction of cataracts from nanophthalmic patients.

Sclerostomies were made 3 mm from the limbus, which required treatment for entry site breaks. The use of gas tamponade may have been advantageous in this case in preventing uveal effusion. Superior bulbar conjunctiva was preserved as there was a functioning bleb.

Other approaches, such as extracapsular cataract extraction, carry the risk of uveal effusion postoperatively, even with prophylactic sclerostomies. Prophylactic measures to reduce risk of uveal effusion include oral steroids, intravenous acetazolamide, and mannitol preoperatively and operative sclerotomies to release suprachoroidal fluid.[5,6]

The management of cataract extraction through pars plana vitrectomy with gas exchange can be successful in selected cases, without complications such as uveal effusion that are seen with extracapsular cataract extraction method.

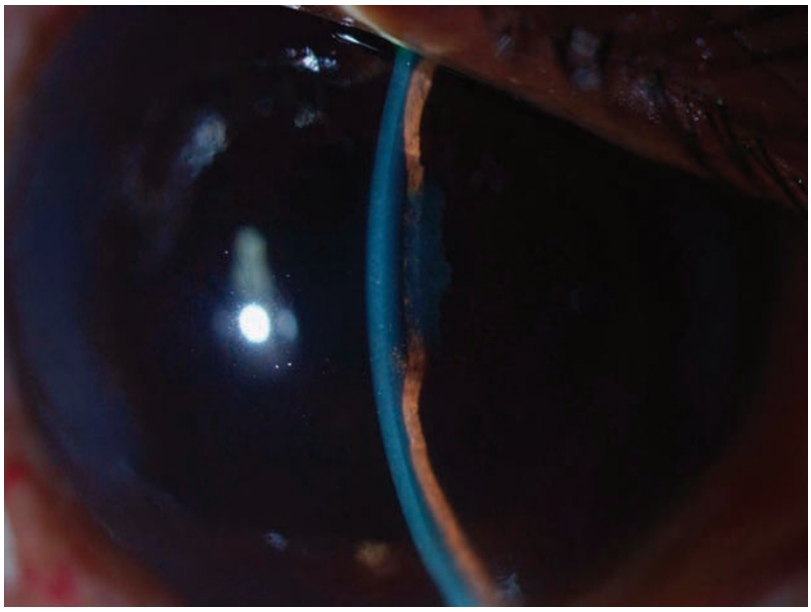

Figure 1 This slit-lamp photograph demonstrates very shallow anterior chamber, small pupil, and seclusio pupillae encountered before vitrectomy.

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Sir,

Large-angle congenital exotropia due to 'absent' medial recti: a case of congenital cranial dysinnervation disorder

Congenital cranial dysinnervation disorders (CCDD) are a heterogeneous group of disorders affecting the development and function of the extraocular muscles due to failure of normal innervation of the target muscle. The surgical management of these disorders can be complex requiring combinations of supramaximal recessions, muscle transpositions, and botulinum toxin (BT). We report an unusual case of large-angle exotropia due to absent medial recti, the subsequent surgical management, and outcome.

Case report

A 3-month-old Caucasian girl of non-consanguineous parents presented with a congenital alternating exotropia measuring 70 prism dioptres (PD) (Figure 1a). Neither eye adducted beyond the midline; other ductions were full. No ptosis, fissure changes, or synergistic divergence were observed. Apart from talipes equinovarus, there were no medical or developmental problems. A magnetic resonance imaging (MRI) scan (Figure 1c) appeared normal apart from somewhat thin medial rectus muscles. Bilateral lateral rectus BT injections reduced the exotropia to 50 PD. Adduction improved in the left eye only. At a planned bilateral maximal recession/resection procedure, only connective tissue was identified medially after recession of the left lateral rectus (Figure 1b). This eye was then fixated by traction sutures. A similar situation was encountered in the right eye; here a full tendon vertical recti transposition was combined with a BT injection to the lateral rectus. After 3 years (and two repeat BT injections), there is an alternating exotropia of 10 PD for near and 14 PD for distance. Adduction limitation is −3 in the right and −1.5 in the left eye.

Comment

Agenesis or hypoplasia of individual or combinations of extraocular muscles has been reported since the eighteenth century.[1] The extraocular muscles derive from superior and three inferior complexes of orbital