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D Mitry, C Schmoll, V Hegde, S Borooah, J Singh and H Bennett

Princess Alexandra Eye Pavilion, Edinburgh, UK
E-mail: mitryd@gmail.com

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Sir,

Ketamine sedation during treatment of retinopathy of prematurity: more data required

I thank the authors for their interesting case series describing the use of ketamine sedation for the treatment of retinopathy of prematurity.[1] I agree that no ideal agent exists but have reservations about the use of ketamine in this age group, which merits discussion.

There still remain questions over the potential neurotoxic effects of some anaesthetic agents in this age group, and ketamine has been the most strongly implicated in the debate.[2] Volatile agents, midazolam, and ketamine can cause neuroapoptosis (programmed neuronal cell death) in the neonatal rat model, evidence which has concerned the Food and Drug Administration in the United States to instigate trials in a primate model.[2] Exposure may result in adverse cognitive sequelae, but at present, the risk is difficult to quantify.[2]

Remifentanil has been shown to have predictable pharmacokinetics and pharmacodynamics in neonates, importantly an offset time similar to that of older children and adults.[3] This allows early extubation, and can be used on a neonatal unit, negating the need for transfer to theatre.[4–5]

Remifentanil is a unique opioid in neonatal practice and may be an ideal agent either alone or as a sedative in combination with Sub-Tenons block. As described, ketamine has significant potential disadvantages. I would suggest that more data are needed as well as careful consideration before recommending its widespread use in management of retinopathy of prematurity.

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DF Marsh

Department of Anaesthesia, Portsmouth Hospitals NHS Trust, Portsmouth, Hants, UK
E-mail: debbie.marsh@porthosp.nhs.uk

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Sir,

Ocular Behçet's disease presenting with retinal tear and panuveitis

Behçet's disease (BD) is a chronic disorder characterized by relapsing uveoretinitis, oral and genital ulceration, and skin lesions. Long-term complications of ocular BD include vitreous hemorrhage, vitreous opacification, retinal pigmentary epithelium atrophy, cystoid macular edema, macular hole, optic disc neovascularization, and optic nerve atrophy.[1,2] Retinal tear is a rare consequence of ocular BD.[3] Here, we report a case of BD presenting with retinal tear and panuveitis.

A 31–year-old male admitted for an acute visual loss accompanying photopsias. He had a history of oral and genital ulcers, arthralgia, and erythema nodosum. Snellen visual acuity was 0.3 (OD) and hand motions (OS). Refractive error was low myopic astigmatism. Ophthalmic examination of both eyes revealed keratic precipitates, 2+ cells in the anterior chamber and vitreous. Fundus examination showed retinal vasculitis and a fresh horseshoe retinal tear at the 10 o'clock position in the right eye (Figure 1a). A small amount of subretinal fluid was observed around the tear. No vitreous traction was detected at the edges of the tear. Detailed fundus examination revealed no retinal degenerations. Topical and oral steroids with oral cyclosporine were started. Prophylactic laser treatment was applied around the tear (Figure 1b). On the follow-up, no additional tear formation was detected.

The characteristic posterior segment lesion of BD is retinal vasculitis, which may involve both veins and arteries. Occasionally, secondary neovascularization and rhegmatogenous/traction breaks and/or exudative and rhegmatogenous/traction retinal detachment may develop. Retinal breaks associated with uveitis have been shown in a few cases, including BD besides toxoplasmic chorioretinitis, and familial Mediterranean fever.[3–5] As