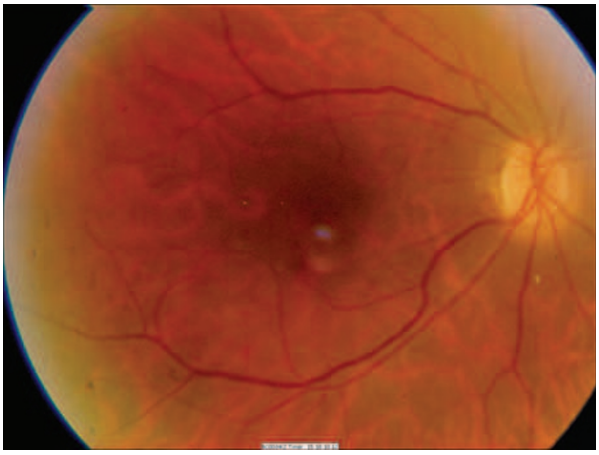

Figure 1 Two fine diamond dust particles at the posterior pole.

diamond-dusted membrane scraper (DDMS™ by Synergetics Inc.) was used to help create an edge to the ILM before peeling. On 2-week postoperative review, the operation was an anatomical and functional success. However, highly refractile deposits of diamond particles were noted on the macula (see Figure 1). Two particles were visible on fundoscopy and optical coherence tomography identified an additional finer particle. The patient was asymptomatic and automated static visual field testing was normal.

It is advised in the literature that particles noted during surgery should be aspirated through the extrusion needle.[3] However, particles may not be appreciated during surgery and small finer particles may not be visible. Our literature search did not reveal any reports of adverse consequences of residual diamond deposits of the size used in VR surgery. The long-term sequelae of residual iatrogenic retinal diamond deposits remain unknown.

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Sir,

Herpes zoster ophthalmicus complicated by incomplete ophthalmoplegia and a neurotrophic ulcer

Cranial nerve involvement in children with herpes zoster ophthalmicus (HZO) is rare.[1–3] A case of incomplete ophthalmoplegia in a child after an episode of HZO is described and a preventable complication is highlighted.

Case report

A 9-year-old girl of Indian origin presented with a vesicular eruption over the left ophthalmic division of the trigeminal nerve with no involvement of the nasal tip (Figure 1). A diagnosis of HZO was made and the patient was initiated on oral acyclovir.

A week later, she developed third (dilated left pupil with partial ptosis), fourth (−2 limitation on dextrodepression), fifth (reduced left corneal sensation), and sixth (−2 limitation on levoversion) nerve palsies. There was no limitation of adduction, elevation, or depression.

Right visual acuity was 6/5 and left visual acuity was corrected to 6/18 with pinhole. Slit lamp examination revealed a left anterior uveitis (+2) with superficial punctate epithelial erosions, which were treated with steroid drops and lubricants, respectively. In addition to acyclovir, intravenous ceftriaxone and flucloxacillin were administered to treat infection of her lesions. Inflammatory markers were raised, but physical, haematological, biochemical, and magnetic resonance imaging assessments were within normal range. Her paediatrician decided not to investigate for immunodeficiency.

She was treated for 6 days and was then continued on oral aciclovir and prednisolone to hasten the resolution of her cranial nerve palsies. She did not attend her follow-up appointment, and her lubricant drops were discontinued by her parents. Eight months after presentation, she returned as an emergency case with a neurotrophic ulcer that resolved following intensive antibiotic treatment.

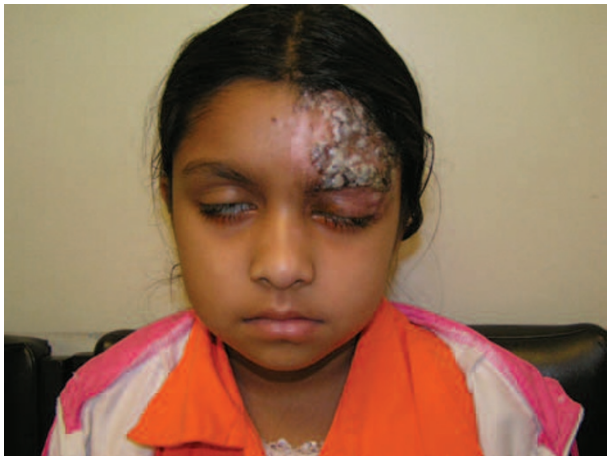

Figure 1 Typical HZO rash.

Eighteen months after her initial attack, her left eye visual acuity was 6/7.5. She still had a dilated left pupil, partial sixth (−0.5) nerve and fourth (−0.5) nerve palsies. There were no stigmata suggestive of an immunodeficiency syndrome.

Comment

Healthy children can develop HZO.[4] This child's unique features of a neurotrophic ulcer in association with ophthalmoplegia have not been reported previously. This case emphasizes the importance of compliance with lubricant drops in a child with an anaesthetic cornea, as neurotrophic ulcers can develop several months after presentation with HZO.

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