histology.[1] Steroid-induced myopathy has been documented elsewhere but is typically chronic and degenerative. However, two studies involving intracameral triamcinolone and dexamethasone (Decadron) injection have implicated the vehicle used in steroid preparations in causing mild myopathic ptosis.[2,3] Furthermore, specimens taken of orbital fat, prolapsed after PST triamcinolone injection, have demonstrated histiocytes containing phagocytosed particulate material.[4] We, therefore, hypothesize that in our patient, inadvertent delivery of triamcinolone directly into the levator muscle induced a fibrotic foreign body response, possibly to the vehicle. This is an unusual complication of a common procedure and cautions us regarding the contentious 'off-label' use of triamcinolone acetonide.[5]

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Sir,

**Bevacizumab (Avastin) as a surgical adjunct in diabetic vitrectomy for fibrovascular disease**

Bevacizumab (Avastin) is a recombinant humanised monoclonal IgG1 antibody that inhibits human vascular endothelial growth factor (VEGF). It has been administered intravitreally in VEGF-mediated disease processes such as choroidal neovascularisation,[1] central retinal vein occlusion,[2] proliferative diabetic retinopathy[3] and pseudophakic cystoid macula oedema. We report the use of intravitreal bevacizumab as a preoperative adjunct for severe proliferative diabetic retinopathy and highlight a complication that has not been previously documented in the literature.

### Case

A 36-year-old type I diabetic was referred for deterioration of left visual acuity to 3/36 within 6 months. Examination revealed a dense fibrovascular membrane on the left posterior pole (Figure 1) and comprehensive bilateral panretinal photocoagulation. Optical coherence tomography documented gross cystoid macular oedema. Two weeks following intravitreal bevacizumab (Avastin) 1.25 mg in 0.05 ml there was a marked reduction in the vascularity of the premacular membrane (Figure 2). Pars plana vitrectomy

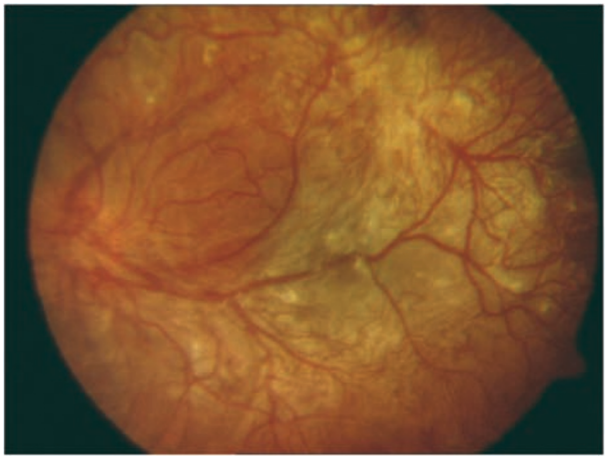

**Figure 1** Fundus photograph at presentation showing a significantly vascularised premacular membrane.

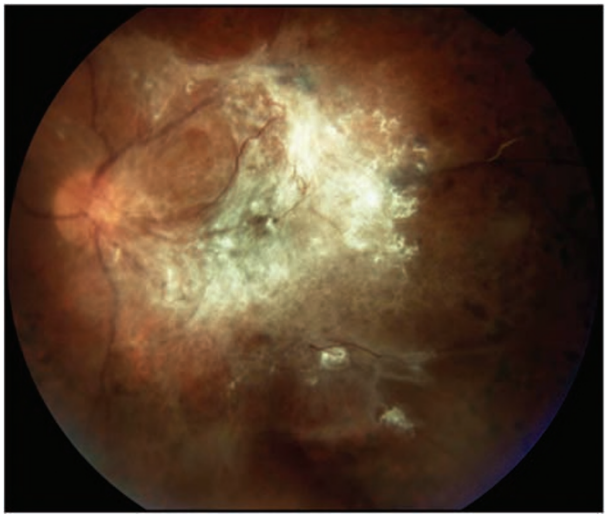

**Figure 2** Fundus photograph at 2 weeks post-injection showing a mainly fibrous premacular membrane.

**Figure 3** Fundus photograph at 3 months post-surgery showing clearance of premacular membrane and a sealed hole.

and membrane peel was performed, revealing a full-thickness macular hole, which was managed conventionally. There was minimal intra-operative bleeding. Three months postoperatively the macula was free of any fibrovascular element (Figure 3) and visual acuity improved to 6/12.

## Discussion

Bevacizumab has proven effective as an adjunctive treatment for reducing the vascularity of membranes before diabetic vitrectomy.[3–5] In our case, the intra-operative finding of a macular hole was unexpected. Contraction of the premacular membrane briskly devascularised by bevacizumab may have resulted in tangential forces on the retina causing macular hole formation.

The marked attenuation of vasculature observed after an intravitreal bevacizumab of 1.25 mg raised concerns of its effects on native retinal vasculature, particularly where there is widespread capillary non-perfusion. In the light of a dose–response relationship reported in proliferative diabetic retinopathy[3] and the likely causation of macular hole in our patient, a smaller dose of bevacizumab would have been preferable. Intravitreal bevacizumab is a powerful pre-operative adjunct for extensive diabetic fibrovascular disease but caution should be exercised in titrating the dosage to minimise complications associated with rapid devascularisation.

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Sir,

## Floppy Iris Syndrome Hull Hooks (FISH Hooks): a new technique for managing IFIS in trabeculectomy surgery

Further to the paper entitled 'Alpha antagonists and intraoperative floppy iris syndrome (IFIS) during Trabeculectomy' by Au *et al*[1] in May 2007 (the only reported case in the literature), we report two further cases—one anticipated, the other not.

### *Case 1: 'the problem'*

A 73-year-old Caucasian male with primary open angle glaucoma underwent augmented trabeculectomy surgery. Pilocarpine 4% was administered preoperatively. During the sclerostomy using a Khaw punch, the iris was noted to be atonic and immediately prolapsed through the ostium (see Figure 1). This was not anticipated.

With direct questioning on the operating table, the patient explained that he had been taking the α-1 antagonist, Tamsulosin®, but this had been stopped 3 months before. The diagnosis of IFIS was made. Several different methods failed to reposit the iris including: cutting a large peripheral iridectomy; stroking the cornea; sweeping the iris with a Rycroft cannula through the paracentesis; and using any intracameral injection (BSS, Miochol, or viscoelastic) exacerbated the prolapse. Ultimately, the scleral flap was sutured with one fixed 10/0 nylon suture and a second corneal paracentesis was made to sweep the iris back into the anterior chamber with the bimanual irrigation/aspiration probes. The remainder of the procedure was uncomplicated and the patient made excellent postoperative progress.