Sir,

Response to 'The use of Medpor-coated tear drainage tube in conjunctivodacryocystorhinostomy'

Thank you for your kind letter. I am willing to talk about our experience about the exuberant conjunctival overgrowth because of the tube implantation.

First, I would like to thank Dr R Redmond[1] for his dissective study. According to our experience, conjunctival overgrowth was in faith the most common complication in the use of the Medpor-coated tear drainage tube and would cause tube obstruction. In our paper, we had discussed the problem. The reason for the exuberant conjunctival overgrowth is not very clear, and may be related to the porous polyethylene coat of the tube.

About the conjunctival overgrowth, for one thing, to reduce the granulation tissue overgrowth, we should tell the patients in detail how to care for the tube after operation. For another, the hypertrophic tissues can be excised and the stump cauterized to prevent the tissue regrowth. Then it is necessary to suture the conjunctiva around the tube.

If the recurrent conjunctival overgrowth actually happened time after time, removing the tube is the last choice. According to our experience, it is easy to remove the borosilicate glass tube. We first slit the Medpor sheath with a blade or scissors, then removed the glass tube with forceps. During the surgery it is necessary to avoid spalling the glass tube and to completely remove the Medpor sheath.

Reference

1 Redmond R. Correspondence to X Fan *et al* – the use of Medpor coated tear drainage tube in conjunctivodacryocystorhinostomy. *Eye* 2010; **24**: 196.

X Fan, X Bi, Y Fu and H Zhou

Department of Ophthalmology, Shanghai Ninth People's Hospital, Shanghai Jiao Tong University, Shanghai, PR China
E-mail: fanxq@sh163.net

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Sir,

Cytomegalovirus endotheliitis following fluocinolone acetonide (Retisert) implant

We report a case of cytomegalovirus (CMV) corneal endotheliitis following fluocinolone implant for uveitis.

Case report

A 21-year-old HIV-negative Chinese woman presented to Singapore National Eye Centre with panuveitis and Snellen acuity 6/45 bilaterally. Behcet's disease was diagnosed and systemic immunosuppression commenced. Vision improved to 6/7.5 bilaterally, with relapsing inflammation. Her left eye became quiescent after insertion of fluocinolone acetonide 0.59 mg implant. The non-implanted eye required continued systemic therapy for control. Left phacoemulsification was required 4 months postimplant.

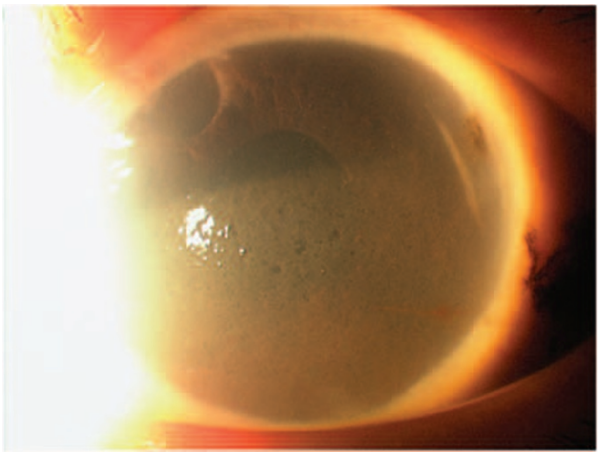

Figure 1 Inferior corneal oedema and keratic precipitates consistent with endotheliitis.

After 14 months, pigmented keratic precipitates and corneal oedema developed inferiorly. Trabeculectomy was performed for elevated intraocular pressure. Corneal oedema increased over the next 9 months (Figure 1). There was no evidence of retinitis (although fundoscopy was impossible once diffused corneal swelling occurred). At 2-year postimplantation, aqueous humour was positive for CMV DNA (3.6×10^4 copies viral DNA per ml) and mRNA by polymerase chain reaction. CMV endotheliitis was diagnosed. Serology for CMV IgG was positive, but negative for IgM and CMV antigen.

Fluocinolone was explanted to reverse local immunosuppression, and systemic valganciclovir commenced. Vitreous was positive for CMV DNA and mRNA. Eight months later, she remained CMV mRNA positive. Corneal oedema persisted despite subsequent insertion of a ganciclovir implant. This eye has only light perception vision.

Comment

Cytomegalovirus has been identified as a cause for anterior uveitis and endotheliitis in immunocompetent patients.[1,2] CMV retinitis can complicate intravitreal triamcinolone administration, and one case of post fluocinolone implant has been reported.[3]

Our patient had CMV endotheliitis, and this is the first report of this complication following fluocinolone implantation. We cannot explain why the cornea was the predominant site of infection in our patient, considering vitreous was positive for CMV. However, histopathological studies of CMV-infected eyes in immunodeficiency showed the presence of virus in iris, ciliary body, and cornea.[4] We suspect that CMV remains latent in the anterior segment in some eyes and reactivates if local immunity is altered. This is supported by the patient's serological findings.

Anterior segment CMV infection can develop in immunocompromised eyes, and clinicians should be