pseudophakia are accompanied by clear, clinical descriptions of an immobile iris that is tethered to the anterior capsule where the rhexis edge lies, typically in the mid periphery.[3–5] In the largest case series, Gaton *et al* describe 'iris bombé and a shallow anterior chamber with a fixed, non-reacting pupil and increased IOP (40 and 60 mm Hg)'. In our case, the pupil was mobile, and ~2–3 mm smaller than the adequately sized anterior rhexis. The iris did not have the typical bombé appearance and pupil dilated uniformly without any signs of pigmentation on the anterior capsule suggestive of prior iridocapsular adhesion.

Choroidal effusions are increasingly being implicated in primary angle closure. It remains unclear if they are a causative factor or consequence. We could find no reports where choroidal effusions were seen in the context of seclusio pupillae, and the findings in phakic primary angle closure may not be directly transferrable to our case. In the paper by Sakai *et al*,[6] inclusion into the acute primary angle closure (APAC) group required bilateral narrow angles, IOP >40 mm Hg, nausea/vomiting, and corneal oedema in phakic patients. This is quite different from the case we present. Of their APAC patients, only 2 of 70 had grade 3 effusions and they make no mention of these extending beyond the equator. Our patient had large choroidal detachments, with folds visible at the posterior pole through an undilated pupil.

Utilizing the facilities available to us, we performed dynamic ultrasonography and were happy that the iris was fully mobile. High-resolution ultrasound biomicroscopy would have been helpful in confirming the pathology, however, this modality was unavailable at our institution.

Peripheral iridotomy is not without risk. It is only of value in cases of pupil block and as such would be ineffective in this case.

We were fortunate enough to be able to document what we recognized as an unusual case and have included a video highlighting some of the salient features that we believe support our interpretation (Supplementary Video).

Conflict of interest
The authors declare no conflict of interest.

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Sir,

Spontaneous resolution of early postoperative intraocular lens opacification in a patient with uveitis

Opacification of intraocular lenses (IOLs) is a complication of cataract surgery that may result in IOL explantation.[1,2] We describe a patient with uveitis who developed early postoperative IOL opacification, which subsequently resolved spontaneously.

Case Report

A 50-year-old Chinese female with quiescent idiopathic intermediate uveitis underwent left uneventful 1. 8 mm clear cornea phacoemulsification with in-the-bag implantation of a hydrophilic acrylic IOL (Akreos MI60, Bausch and Lomb, Rochester, NY, USA) in 2007. Posterior synechiae and pupillary membrane were absent. She received prophylactic intracameral dexamethasone 0.4 mg/0.1 ml at the end of surgery.

During postsurgery visits at 1 day and 1 week, there was 1+ anterior chamber (AC) cells, no flare, and the IOL was clear. Her unaided visual acuity (UAVA) was 6/9.

A haze was seen on the anterior surface of the IOL, within the capsulorhexis opening but distinct from the plane of the anterior capsule margin, at 1 month postsurgery (Figures 1a and b). There was 1+ AC and anterior vitreous cells. She was asymptomatic with 6/9 UAVA.

The central optic haze cleared by 2 months (Figure 1c). At six months, the IOL had completely cleared (Figure 1d) and has since remained clear despite further uveitis recurrences, resulting in 6/7.5 UAVA.

Comment

The IOL opacification seen in our patient differs in its appearance and clinical course from other causes including calcification,[2] whitening, glistening,[3] and lens epithelial cell (LEC) outgrowth.[4]

Calcium phosphates deposits, described in older hydrophilic IOLs, usually appear more than 1 year postoperatively.[2] LEC outgrowth onto the anterior IOL surface starts early postoperatively.[4] It is thought that hydrophilic IOLs with higher water content may promote LEC migration.[5] Calcifications

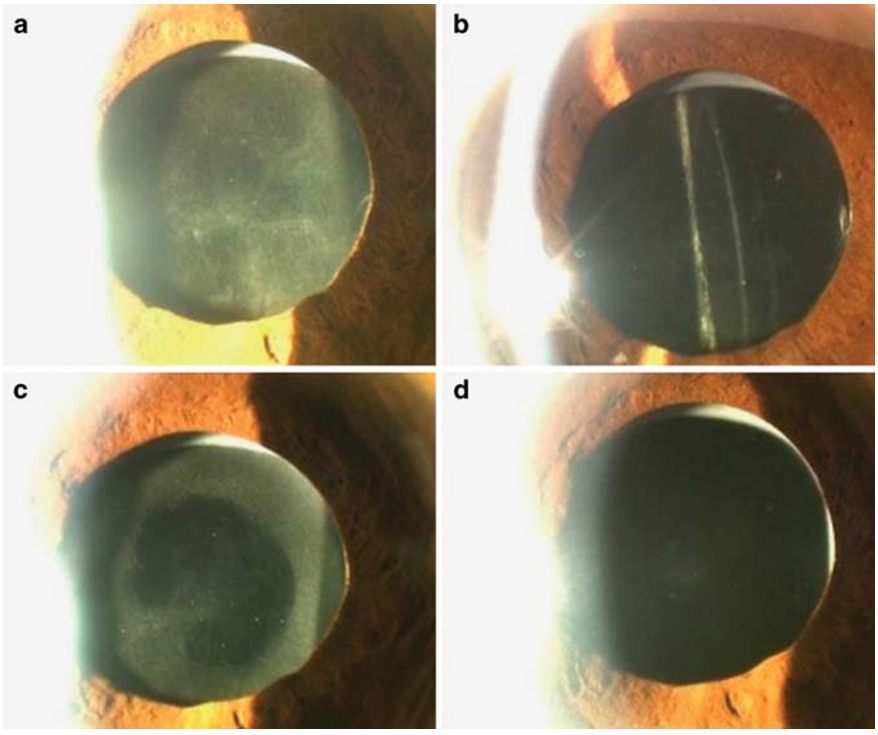

Figure 1 Slit lamp photograph of the left eye (a) showing a haze on the surface of the hydrophilic acrylic intraocular lens at 1 month postsurgery; (b) The rest of the intraocular lens and the posterior capsule are clear; (c) at 2 months postsurgery, showing partial resolution of the deposit; (d) The deposit had cleared entirely by 6 months and the intraocular lens remained clear at 3 years after surgery.

and LEC outgrowth are persistent and frequently impact vision significantly. In our patient, the opacification minimally affected her vision and cleared spontaneously.

Inflammatory deposition from blood-aqueous barrier disruption[6] is another possible explanation for the haze, especially in a uveitic eye.

Although the cause of IOL haze in our patient remains uncertain, this case suggests that cataract surgeons may consider conservative management in patients with uveitis implanted with hydrophilic IOLs who develop an early haze that minimally affects vision as it may clear spontaneously.

Conflict of interest

The authors declare no conflict of interest.

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