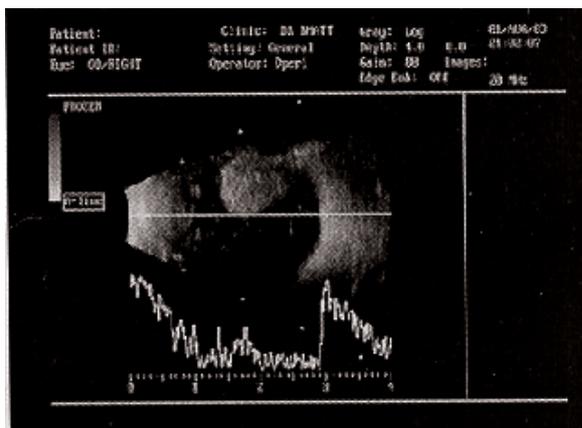


consultation section

An Interesting Case Presentation of
Complications of Retina Detachment Surgery

Dr. Vatsal Parikh

Mr. X 44 year old male, high myope was one eyed and had sudden loss of vision for 2 days. He had nasal retinal detachment with 6/18 and macula on, large posteriorly placed horse shoe tear. Patient had undergone Phako with IOL 2 years back and had laser to lattice degeneration prior to cataract. The horseshoe tear was at posterior edge of the treated lattice. Patient underwent vitrectomy. During surgery posterior hyaloid was attached to the horseshoe tear. Posterior hyaloid was stripped and good base excision was done, retina was settled with fluid gas exchange. Endolaser was done. It was decided to buckle the break. 280 buckle was put over the break. The posterior edge was just covered; anterior edge was well covered by the buckle. Again on examination of the retina, fluid was seen at posterior pole. So fluid gas exchange was done. This time temporally choroidal haemorrhage was seen. The eye was closed and 1 cc C3F8 was injected. Patient was given prone position. On day 1 postoperative, Patient had hyphaema and no fundal glow. On day 3 condition was same. B scan Ultrasonography showed bullous nasal choroidal and shallow temporal choroidal detachment with suprachoroidal haemorrhage which was in solid state. He was put on oral prednisolone 30 mg/dai with 3 acetazolamide tablets a day in addition to other postoperative treatment.



USG showing solid choroidal detachment

Opinion was taken of Dr. Tarun Sharma, Sankara Nethralaya and Dr. Manish Nagpal from Ahmedabad as to what they would do.

Dr. Tarun Sharma:- He would monitor Intraocular pressure, repeat B scan ultrasonography and wait for 2 weeks to allow blood to liquefy in suprachoroidal space. If the pressure is not under control or media are not clearing, or patient develops retinal detachment on sonography, he would then intervene and do surgery again and use silicone oil to tamponade the retina. He mentioned (when asked how he would have prevented such an occurrence) that he would not have used such a large buckle in highly myopic eye in one-eyed patient. Instead he would have used silicone oil as tamponade and a belt buckle with primary vitrectomy.

Dr. Manish Nagpal:- In addition he would use periocular or systemic steroids and intervene early as patient is one-eyed.

The patient was monitored by repeated ultrasonography every week. IOP was controlled by repeated paracentesis along with maximal medical therapy including acetazolamide 3 tablets a day and oral steroids. Patient had hyphaema and vitreous haemorrhage for 6 weeks with blood staining of the cornea though IOP was always kept under control. After 6 weeks the hyphaema and vitreous haemorrhage cleared allowing view of the retina. After 9 weeks choroidal detachment settled well and after three and half months, patient has recovered 6/18, N6 vision, preoperative vision and blood staining of cornea is clearing.

To summarise, a highly myopic eye developed choroidal haemorrhage due to fragile choroidal vessels and IOP fluctuation at the end of vitrectomy, which was conserved and cleared and patient recovered good vision. To prevent such an episode, it is better not to put high buckles, not to have too much fluctuation of IOP during surgery, not to use Cryo in myopic eyes.

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