

Complication of cataract surgery that leads to evisceration

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ABSTRACT

Objective: To present an unusual case of corneal decompensation and secondary glaucoma after secondary iris-claw Intraocular Lens (IOL) implantation that leads to evisceration. **Method:** A case report of a 68-year-old woman who came with a worsening vision of the left eye after cataract surgery. The patient underwent small incision cataract surgery 2 months prior without IOL implantation. Initial ophthalmological examination showed visual acuity of 1/60. The iris was irregular with pupil diameter more than 4 mm, and the superior part of the iris is pushed by the vitreous. There was slight opacity in the cornea. Correction of sphere +10.00 was given and the visual acuity improved to 6/40. The patient underwent anterior vitrectomy and secondary iris-claw IOL implantation. **Results:** Three days after the implantation, visual acuity improved to 5/60. The patient came back again after one year with a loss of vision and severe pain of the left eye. Ophthalmological examination showed no light perception, corneal opacity and increased intraocular pressure. Diagnosis of corneal decompensation and secondary glaucoma were made. Conservative management was given but there was no improvement. Therefore evisceration was done. **Conclusion:** Corneal decompensation and secondary glaucoma may still develop after iris-claw IOL implantation despite its good safety profile. Moreover, scleral-fixated posterior chamber IOL can be considered to be a more safer technique for a patient with iris atrophy. If the complication of cataract surgery were found in the early stage, it can be treated with a good visual outcome. Therefore, follow up is important and education to improve patient compliance must be given.

KEY WORDS:

Cataract, corneal opacity, orbital evisceration, secondary glaucoma

Dematiaceous fungal keratitis - A treatment conundrum

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ABSTRACT

Objective: To discuss the difficulty in treating a rare fungal keratitis. **Method:** a Case report. **Results:** A 53-years-old Malay gentleman underwent an uncomplicated left eye cataract surgery with the best corrected visual acuity of 6/12. Three months later noted the presence of stromal infiltration and branching white lesion overlying endothelium at the main incision site. He was covered with intensive topical fortum and vancomycin. Subsequently, guttae dexamethasone started as the anterior chamber (AC) tap yield no organism. The lesion worsened and shows clinical signs of fungal keratitis, prompting initiation of oral fluconazole and topical amphotericin. Later, topical fluconazole and voriconazole added with cessation of dexamethasone. The condition deteriorates with the formation of fibrin, hypopyon and small whitish mass in AC resembling a fungal ball. He was referred to Cornea consultant who stopped topical and oral fluconazole and added oral itraconazole, clarithromycin and topical amikacin. Unfortunately, the cornea becomes thinner at the lesion site and it perforated while doing AC washout. The perforation was glued temporarily, and amphotericin switched to guttae natamycin. A week later, he underwent corneal biopsy and therapeutic penetrating keratoplasty. Corneal histopathology showed findings consistent with fungal infection. Despite all the antifungal, the infection spread to become endophthalmitis. Multiple intravitreal antifungal injections were given. Eventually, non-sporing dematiaceous fungi were isolated. The eye improved with topical voriconazole and natamycin with hand movement vision. **Conclusion:** This case highlights that clinicians should have a high suspicion of fungal infection based on clinical signs although the culture inconclusive. It is necessary to cover with antifungal before commencing steroid as it might flare up the infection.

KEY WORDS:

Dematiaceous Fungi, Keratitis