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## Case Report

## An interesting case of implantable contact lens

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## Introduction

Refractive errors are one of the most common ophthalmologic problems. Implantable contact lens (ICL) implantation has received attention for its excellent and rapid visual and refractive results in eyes with high myopia. There are still concerns about complications such as anterior capsule opacity, cataracts,<sup>1,2</sup> pupillary block glaucoma,<sup>3,4</sup> chronic inflammation,<sup>5</sup> pigmentary dispersion syndrome,<sup>6,7</sup> and pigmentary glaucoma.<sup>8</sup> We report an interesting case of a patient who had undergone ICL implantation presenting as a case of pupillary block glaucoma and how the patient was effectively managed.

## Case report

A 23 years old male patient came to the eye opd with a chief complaint of sudden onset Diminution of Vision (DOV) in the left eye since 2 days. The DOV was associated with redness, pain & watering of left eye. Patient gave history of undergoing ICL implantation in both eyes 2 months back. Previous

documents showed that the patient was a high myope and – 17 D STAAR ICL (overall diameter 12.5 mm, optic diameter 4.6–5.5 mm) was implanted in both eyes on the same day 2 months back in a private hospital. The vision recorded post ICL implantation was 6/6 in both eyes. Post operative period was uneventful.

There were no history of flashes, floaters, trauma or similar episodes in the past.

On examination – Distant visual acuity right eye – 6/6 unaided.

Distant visual acuity left eye – 6/36 unaided, no improvement with pinhole.

Right eye – examination of ant segment – lid and adnexa, conjunctiva were within normal limits, cornea-lustrous, anterior chamber – shallow grade II by Van Herrycks, iris showed a LASER peripheral iridotomy at 10 o'clock which was patent, pupil was brisk. ICL in situ, lens was clear, gonioscopy – angle of anterior chamber grade II by Shaffer's grading.

Fundus examination showed presence of myopic changes.

IOP recorded by Goldmanns Applanation Tonometer was 16 mm of Hg.

Left eye-Examination of anterior segment-lid and adnexa were within normal limits, conjunctiva showed circumciliary congestion. Cornea had microcystic edema along with corneal haze. The anterior chamber was shallow grade II (Van Herrycks) cells ++, flare+ [Fig. 1], iris details hazily seen, pupil mid dilated non-reacting to light. Pigment was present on the anterior surface of the ICL [Fig. 2]. Lens appeared clear.

On gonioscopy the details of the angle of anterior chamber of the left eye were not visualized due to the corneal edema.

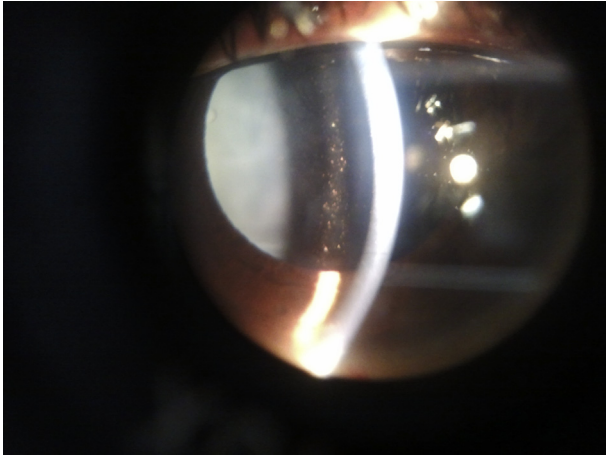
Fundus Examination – Fundus glow was seen, optic disc details not clearly visualized due to media haze.

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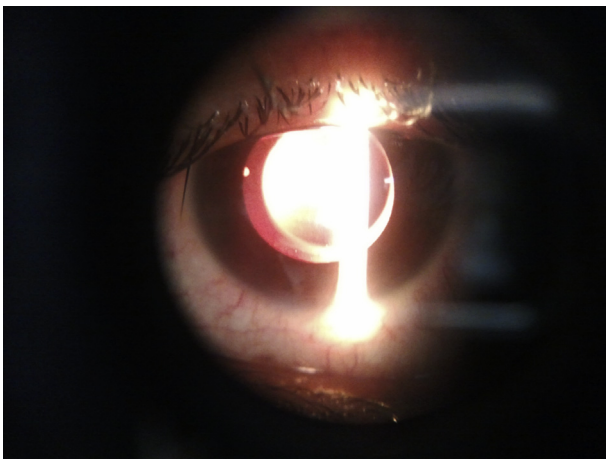
**Fig. 1 – Shallow anterior chamber with cells and flare.**

IOP was 70 mm of Hg by Goldmanns Applanation Tonometer.

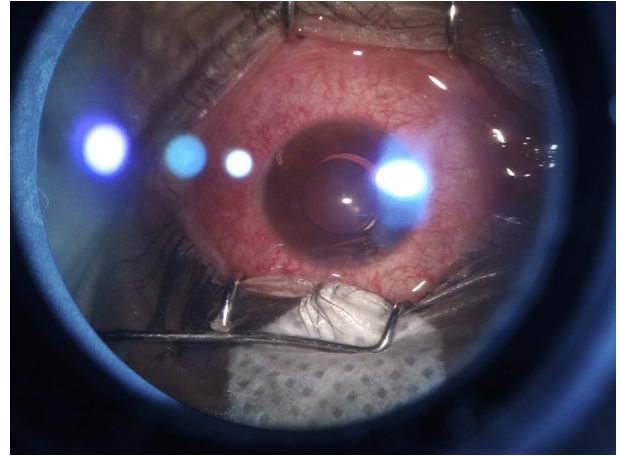
### Treatment

Patient was diagnosed as case of pupillary block glaucoma secondary to ICL implantation. The patient was admitted and started on intravenous mannitol 300 ml, oral acetazolamide 250 mg QID along with topical anti glaucoma medication (timolol 0.5%, brimonidine 0.2%, dorzolamide 2% and pilocarpine 4%).

After 48 h, in spite of these medications the IOP in the LE was 52 mm of Hg and the pupil was mid dilated, not reacting to light. Patient was planned explantation of the ICL on the second day after effective IOP control was not achieved. Pre operatively mannitol 300 ml was given, and it was decided on the operation table to go in for a surgical peripheral iridectomy under topical anesthesia and monitor the IOP. Peripheral surgical iridectomy at 11 o'clock was performed by entering into the same site of the main port incision which was used to implant the ICL (Fig. 3).



**Fig. 2 – ICL seen on retroillumination, also note the mid dilated pupil not reacting to light.**



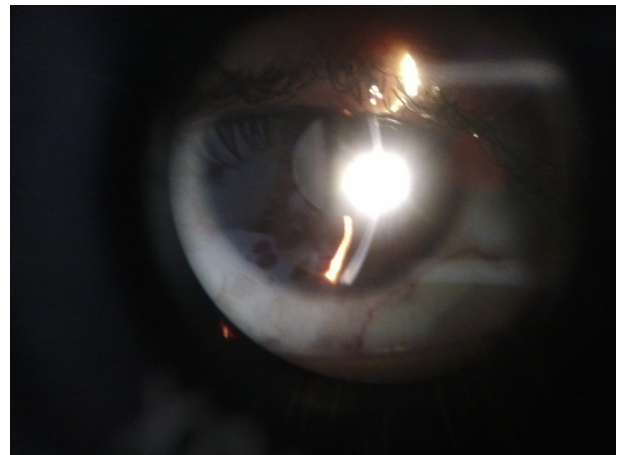
**Fig. 3 – Intraoperative picture showing the conjunctival and circumciliary congestion.**

First post operative day the IOP dropped to 21 mm of Hg. Patient was then taken off the parenteral and oral anti glaucoma medications but no rise in IOP was recorded. All the topical anti glaucoma medications were stopped from the 4th post operative day, patients IOP was 16 mm of Hg. Patient was discharged after 1 week with vision of 6/6 and an IOP of 14 mm of Hg in the left eye. Patient was called for weekly follow up for the next 2 months and IOP was closely monitored during this period. There was no record of raised IOP during the patients follow up (Fig. 4).

During the follow up period slit lamp biomicroscopy of left eye showed the absence of krukenberg spindle or iris transillumination defects. Gonioscopy revealed grade II angles by Shaffer's grading and absence of heavily pigmented trabecular meshwork. Fundus examination showed an optic disc which was normal with a healthy neuroretinal rim, CDR 0.4 and myopic changes similar to the right eye.

### Discussion

Phakic Intraocular Lens (PIOL) for the correction of high myopia, and also for high hyperopia, have several potential



**Fig. 4 – Patient on discharge from hospital the eye is quiet.**

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