discharged home on pilocarpine 2%, betnesol, and chloramphenicol drops, all 4 times a day. Two weeks later, her best-corrected visual acuity was 6/6 N5 OD.

Only a few cases of pupil block glaucoma have been described after phacoemulsification with posterior chamber IOL.[1–4] Causative factors reported were wound leak, choroidal detachment,[1] capsulorhexis size larger than IOL optics,[3] or fibrinous reaction with posterior synechiae.[2,4] In our case, the IOL was inadvertently placed back to front with the haptics in the S shaped configuration instead of the reversed S configuration (Fig. 2). The Sensar IOL has haptics angulated at 5°. It seems that the IOL was vaulted sufficiently forwards to allow pupil capture as the iris returned to normal size after dilatation. At her last follow-up, the patient's eyes were dilated, and there was no capture of the IOL optic, presumably because of fibrosis of the capsular bag.

Lindstrom and Herman[5] reported a lower incidence of pupil capture with angulated haptic IOLs compared with uniplanar IOLs (1% vs 3%). An angulated IOL implanted back to front would therefore be expected to increase the risk of pupil capture, as in our case. To our knowledge this is the first case report of pupil block glaucoma secondary to pupil capture of a posterior chamber IOL inadvertently placed back to front.

References

1. Marcus M, Azar D, Boerner C, Hunter DG. Pupillary capture of a flexible silicone posterior chamber intraocular lens. *Arch Ophthalmol* 1992;110:609.
2. Nagamoto S, Kohzuka T, Nagamoto T. Pupillary block after pupillary capture of an AcrySof intraocular lens. *J Cataract Refract Surg* 1998;24:1271–4.
3. Khokhar S, Sethi HS, Sony P, Sudan R, Soni A. Pseudophakic pupillary block caused by pupillary capture after phacoemulsification and in-the-bag AcrySof lens implantation. *J Cataract Refract Surg* 2002;28:1291–2.
4. Gaton DD, Mimouni K, Lusky M, Ehrlich R, Weinberger D. Pupillary block following posterior chamber intraocular lens implantation in adults. *Br J Ophthalmol* 2003;87:1109–11.
5. Lindstrom RL, Herman WK. Pupil capture: prevention and management. *Am Intra-Ocular Implant Soc J* 1983;9:201–4.

James F. Li Yim, Jonathan Z. Ross, Jeffrey L. Jay
Tennent Institute of Ophthalmology, Gartnavel General Hospital, Glasgow, Scotland

Correspondence to James Li Yim, MRCOphth: jamesly@doctors.org.uk

Can J Ophthalmol 2010;45:293–4
doi:10.3129/i10-064

"Large" Descemet membrane detachment successfully repaired with intracameral air injection

A 75-year-old female was referred to our centre after 2 failed intracameral injections of perfluoropropane gas 14% for Descemet membrane (DM) detachment in her OD secondary to phacoemulsification, which was noted intraoperatively 3 months prior to presentation. On presentation to us, her best-corrected visual acuity was counting fingers OD and 20/60 OS. The intraocular pressure was normal in both eyes. Slit-lamp examination revealed mild hyperemia, diffuse corneal edema (Fig. 1A), increased corneal thickness, and central DM detachment OD (Fig. 1B). The OS was unremarkable except for mild cataract formation. Anterior segment optical coherence tomography (OCT) showed a "large" ellipse-shaped DM detachment, with diameters varying from 5.36 mm vertically to 7.23 mm horizontally (Fig. 1C). Anterior chamber tamponade with air injection was done to reposition the DM detachment. However, the DM detachment did not resolve. The procedure was repeated 2 days later, during which the liquid between the DM and corneal stroma was drained with a 27-gauge needle through the corneal incision. DM detachment resolved the next day, and the hazy cornea became clear. Her visual acuity OD increased to 20/200 and 20/100 with a pinhole. At the ninth day of follow-up, anterior segment OCT showed that the DM had repositioned completely and the corneal thickness had returned to normal (Fig. 1D). Her best-corrected visual acuity OD had increased to 20/20 at follow-up 24 months later. Confocal microscopy showed that endothelial cell density was 1062 cells/mm^2 OD and 2099 cells/mm^2 OS.

DM detachment is a not uncommon complication of intraocular surgery, most often cataract extraction. Small and localized DM detachments are rarely problematic and may resolve spontaneously. However, large and persistent DM detachments may require surgical intervention for restoration of vision.[1,2] Anterior chamber tamponade with air or inert gas, mostly sulfur hexafluoride (SF_6) 20% or perfluoropropane (C_3F_8) 14%, has been demonstrated to be effective in reattaching DM. Generally, air is preferred in small DM detachments and inert gas in relatively tough cases, especially "large" and (or) long-existing DM detachments.[3–5] However, the paradigm is variable among different practitioners. The successful repair in our case demonstrated that anterior chamber tamponade with air may also be effective in "large" DM detachments, even those that failed to apposition after inert gas–fluid exchange.

To the best of our knowledge, this is the first report on "large" DM detachment with anterior segment OCT accurately mapping the area of the detached DM. Our case may serve as a reference for any future "large" DM detachments, for which the ophthalmologist may consider anterior chamber tamponade with air. The other point

we would like to highlight is that draining the fluid between the DM and the corneal stroma may have been critical to the success of the reattachment. In our first attempt to reposition the DM with air tamponade, which failed, we did not drain the entrapped fluid between the DM and the corneal stroma. During the second procedure, we facilitated the escape of the entrapped fluid with a 27-gauge needle through a corneal incision, and succeeded to reattach the DM.

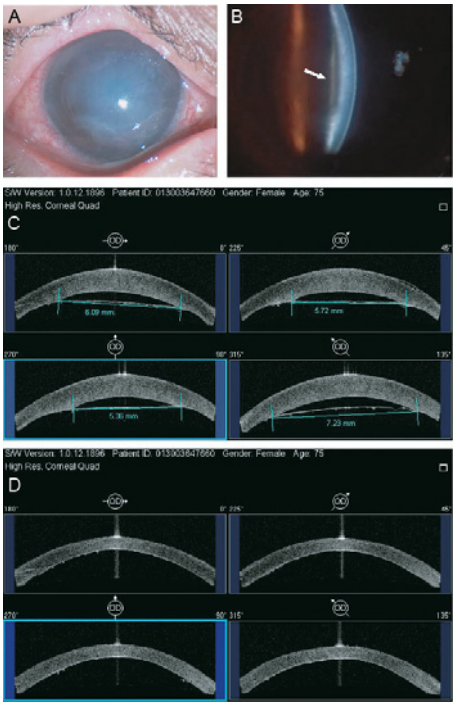

Fig. 1—(A) Slit-lamp examination showing diffuse corneal edema and mild conjunctival hyperemia. (B) Detachment of the Descemet membrane (white arrow) and increased central corneal thickness. (C) Anterior segment optical coherence tomography (OCT) images before surgical repair. (D) Anterior segment OCT images at the ninth postoperative day.

References

1. Ball JL, Stewart O, Taylor R. Spontaneous reattachment of extensive Descemet's membrane detachment following uneventful phacoemulsification surgery. *Eye* 2004;18:962.
2. Potter J, Zalatimo N. Descemet's membrane detachment after cataract extraction. *Optometry* 2005;76:720–4.
3. Lucena Ada R, Lucena Dda R, Macedo EL, Ferreira Jde L, de Lucena AR. C_3F_8 use in Descemet detachment after cataract surgery [in Portuguese]. *Arq Bras Oftalmol* 2006; 69:339–43.
4. Mannan R, Jhanji V, Sharma N, Titiyal JS, Vajpayee RB. Intracameral C_3F_8 injection for descemet membrane detachment after phacoemulsification in deep anterior lamellar keratoplasty. *Cornea* 2007;26:636–8.
5. Wylegala E, Nowińska A, Dobrowolski D, Wróblewska-Czajka E. Management in Descemet's membrane detachment after cataract surgery—case report [in Polish]. *Klin Oczna* 2008;110:67–70.

Guoping Qing, Jing Fu, Ningli Wang
Beijing Tongren Eye Center, Beijing Tongren Hospital, Capital Medical University, and Beijing Ophthalmology and Visual Sciences Key Lab, Beijing, China

Correspondence to Guoping Qing, MD: gptsing@126.com

Can J Ophthalmol 2010;45:294–5
doi:10.3129/i09-242

Oblitération de la veine centrale de la rétine et anticorps anti-phosphatidyléthanolamine isolés : à propos d'un cas

Nous décrivons le cas d'une jeune fille âgée de 17 ans consultant en urgence pour gêne visuelle gauche rapidement progressive sur 3 semaines. À l'entrée, l'acuité visuelle est de 25/20 P1.5 pour l'œil droit et 20/25 P2f pour l'œil gauche. L'examen du fond d'œil (Fig. 1) ainsi que l'angiofluorographie (Fig. 2) concluent à une occlusion de la veine centrale de la rétine (OVCR) œdémateuse de l'œil gauche. Un traitement comportant un veinotonique (Troxérutine) et une héparine de bas poids moléculaire à dose isocoagulante a été débuté.

Parallèlement, le bilan étiologique biologique (hémogramme, bilan de coagulation, bilan inflammatoire et infectieux) et d'imagerie standard (angiofluorographie) s'est révélé être négatif. Néanmoins le bilan immunologique approfondi a permis l'avancé diagnostique en révélant la présence d'une cryoglobulinémie mixte de type III polyclonale à un faible taux, et surtout la présence isolée d'un anticorps anti-phosphatidyléthanolamine (anti-PE) de type IgM à un taux significatif (86 recontrôlé 6 mois après à 68 unité

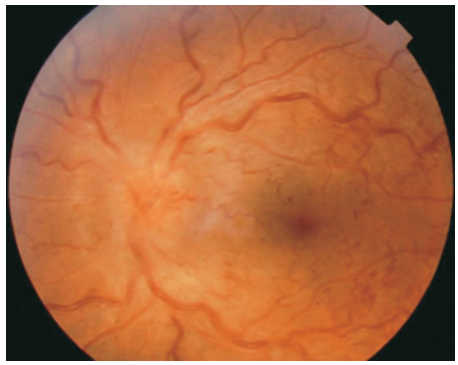

Fig. 1—Rétino-photo de l'oeil gauche.