DOI: 10.5958/2319-5886.2015.00076.4

International Journal of Medical Research & Health Sciences

www.ijmrhs.com Volume 4 Issue 2 Coden: IJMRHS Copyright @2015 ISSN: 2319-5886

Received: 25th Feb 2015 Revised: 7th Mar 2015 Accepted: 17th Mar 2015

Letter to editor

RETAINED STONE PIECE IN ANTERIOR CHAMBER

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Dear Editor,

We read with interest the article by Surekha et al. regarding the retained stone piece in anterior chamber.[1]Similar to the results of previous studies, the authors found that delayed intraocular foreign body (IOFB) management can result in good visual outcome without an apparent increased risk of endophthalmitis or other deleterious side effects.[2]

However, the authors failed to explain the exact reason for the diminution of vision in patients left eye. It is unclear what the uncorrected visual acuity was and what kind of correction was used, more precisely type and amount of cylinder, given the presence of the corneal opacity. Since the size of the IOFB is approximately 4x4x1mm, significant irido-corneal angle changes resulting in intraocular pressure raise and optic nerve head damage can be expected. Traumatic glaucoma following open globe injury can occur in 2.7 to 19% of cases, with several risk factors associated with glaucoma development (advanced age, poor visual acuity at presentation,perforating rather than penetrating ocular injury,lens injury, presence of vitreous hemorrhage and presence of an IOFB).[3] Earlier reportsof latetraumaticoptic neuropathy onset, even after several years, indicate that this possibility cannot be completely ruled out too.[4] Therefore, repeated intraocular pressure measurements, gonioscopy, pupillary reaction assessment, together with through posterior segment examination including visual field and optical coherence tomography examinations can be useful in determining the possible optic nerve damage as one of the possible reasons for visual acuity reduction.

The authors did not suggest any operative treatment at this time. However, it should bear in mind that the inert anterior chamber IOFB could be a risk factor for non-infectious endophthalmitis development even after many years.[5]Also, long term retained anterior chamber foreign body leads to permanent endothelial cell loss and can even result in a corneal ulcer formation.[6] On the other side, it is not clear what was the grade and morphology of the lens opacity, especially if it is known that visual acuity in right – healthy eye is 6/12 with presence of immature senile cataract. Retained IOFB is a risk factor for prolonged postoperative inflammation and endophthalmitis after cataract surgery.[7,8] Therefore, surgical intervention including cataract extraction, foreign body removal with possible toric intraocular lens implantation could be therapy of choice for this patient.

For these reasons, we would kindly ask the authors to present the data regarding the uncorrected visual acuity, required spherical and cylindrical correction, keratometry and refractometry readings, intraocular pressure values, grade and morphology of the lens opacification, state of the iridocorneal angle, possible changes in the vitreous, retina and optic nerve head. Without this information's it would be difficult to hypothesize that the IOFB in the anterior chamber was completely inactive forthe past twenty years and it did not produce any adverse effect in patient's eye. These findings will significantly contribute to the papers scientific value and contribution.

Overall we agree with Surekha et al. that IOFBs can be variable in presentation and outcome. There is still significant controversy in the management of IOFBs, particularly the timing and method of surgery.[9]

Conflict of interest: Nil

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