

lesions. Ophthalmologists should be aware of the devastating damage due to this ascarid.

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Cataract After Minor Trauma in a Young Patient With an Iris-fixated Intraocular Lens for High Myopia

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PURPOSE: To report a case of traumatic cataract in a young patient with an iris-fixated phakic intraocular lens (PIOL).

DESIGN: Interventional case report.

METHODS: A 32-year-old woman with bilateral iris-fixated PIOLs for high myopia presented with a cortical cataract 2 weeks after minor ocular trauma. Ultrasound biomicroscopy and endothelial cell count were performed before and after cataract surgery.

RESULTS: The distance between the PIOL and the crystalline lens was 0.82 mm; the distance between the PIOL and the corneal endothelium was 2.30 mm. Endothelial cell count was 2,500 cells/mm² before surgery and 2,476 cells/mm² at 1 year follow-up.

CONCLUSIONS: Patients with iris-fixated PIOLs are at risk of rapid cataract progression after minor ocular trauma. (*Am J Ophthalmol* 2003;135:890–891. © 2003 by Elsevier Inc. All rights reserved.)

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IRIS-FIXATED PHAKIC INTRAOCULAR LENSES (PIOLS) CURRENTLY are used for the correction of high myopia.^{1–3} The main problems posed by the iris-claw PIOLs include the possibility of endophthalmitis, corneal endothelial damage, retinal detachment, instability of the lens fixation, and the development of glaucoma, uveitis, or cataract.

A 32-year-old white woman complained of pain in her right eye 24 hours after minor ocular trauma from her 2-year-old daughter's finger. Two years earlier, the patient had undergone surgery for high myopia at another center, and iris-fixated PIOLs (Artisan, Ophtec, Groningen, The Netherlands) had been implanted in both eyes. Best-corrected visual acuity was 20/25 in her right eye. Slit-lamp examination disclosed a small paracentral corneal epithelial defect, an iris-fixated PIOL 1.5 mm decentered inferiorly, a clear crystalline lens, and no signs of intraocular inflammation. Topical tobramycin ointment was applied, and the eye was occluded for 24 hours. Two weeks after initial examination, the patient complained of progressive loss of vision in her right eye to 20/200. Slit-lamp examination revealed an anterior cortical cataract affecting the visual axis with no signs of intraocular inflammation (Figure 1, top and bottom). Intraocular pressure was

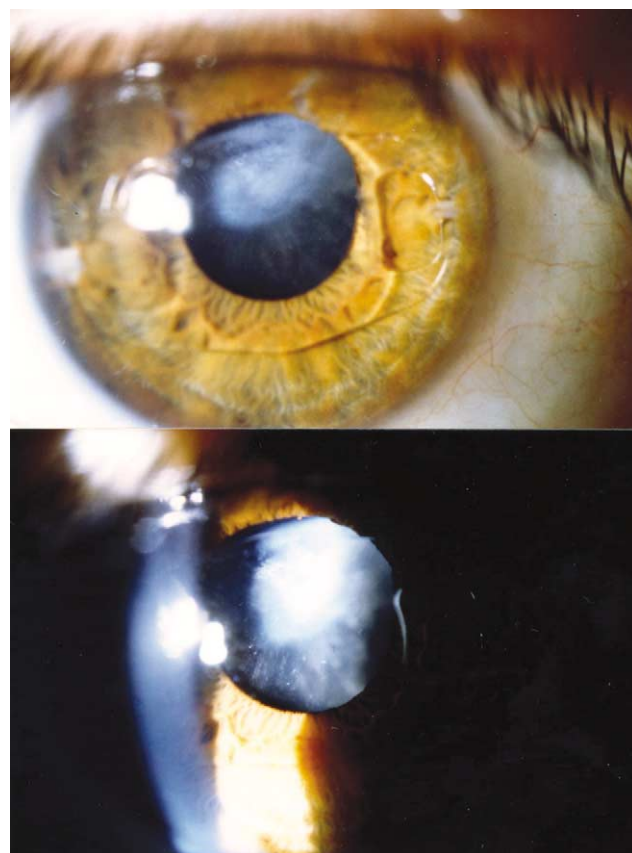


FIGURE 1. (Top and Bottom) Anterior cortical cataract affecting the visual axis 2 weeks following minor ocular trauma in a patient with an iris-fixated phakic intraocular lens for high myopia.



FIGURE 2. The same eye after phakic intraocular lens explantation, phacoemulsification of the cataract and intraocular lens implantation.

14 mm Hg, and posterior segment examination was unremarkable.

Using ultrasound biomicroscopy, echograms were taken in the anterior chamber to measure the distance between the posterior surface of the PIOL and the crystalline lens (0.82 mm), the distance between the PIOL and the corneal endothelium (2.30 mm), and the anterior chamber depth (3.12 mm). This procedure revealed a lens thickness of 3.57 mm and total axial length of 31.9 mm. Endothelial cell count was 2,500 cells/mm². Explantation of the PIOL and phacoemulsification of the cataract was performed under topical anesthesia, and a 7-mm optic polymethylmethacrylate intraocular lens of -1 diopter (AL3, Chiron Vision, Domilens, Paris, France) was implanted within the capsule (Figure 2). No anterior capsular breach was detected during surgery. One year after PIOL explantation and cataract surgery, best-corrected visual acuity was 20/25 + 1, -0.75 × 105 degrees. Corneal endothelial cell count was nearly unchanged, with a density of 2,476 cells/mm².

Cataract progression in eyes with iris-fixated PIOLs has been reported previously in relation to premature aging of the crystalline lens in eyes with high myopia.⁴ To the best of our knowledge, no case of traumatic cataract developing in a young patient with an iris-claw PIOL has been reported. Anterior chamber depth of 3 mm is normally accepted as the lower limit for safe implantation of an anterior chamber PIOL because this depth allows sufficient distance from the corneal endothelium. Pop and coworkers,⁵ however, demonstrated that the anterior chamber depth is reduced by 28% to 34% after implantation of an iris-claw PIOL. It is remarkable that the anterior chamber depth of 3.12 mm in the eye presented here was within acceptable limits and that the anterior capsule was shown to be intact. Hence, we propose that during the trauma, the PIOL optic could have been pushed against the crystalline lens, precipitating the changes that ultimately lead to cataract development. In conclusion, patients with iris-fixated PIOLs should be counseled to avoid even minor

ocular trauma because of the possibility of rapid cataract progression.

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Corticosteroid-induced Modulation of Acute Syphilitic Posterior Placoid Chorioretinitis

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PURPOSE: To report a case of corticosteroid-induced modulation of acute syphilitic posterior placoid chorioretinitis.

DESIGN: Interventional case report.

METHODS: A 38-year-old homosexual male who presented with a unilateral uveitis secondary to syphilis developed large placoid macular lesions after treatment with oral prednisone that resolved when the corticosteroids were discontinued.

RESULTS: A cause-and-effect relationship was demonstrated between oral prednisone and the appearance of acute syphilitic posterior placoid chorioretinitis.

CONCLUSION: The clinical appearance of posterior placoid chorioretinitis in syphilis may be modulated by the immune status of the patient. (*Am J Ophthalmol* 2003;135:891-894. © 2003 by Elsevier Inc. All rights reserved.)

OCULAR MANIFESTATIONS OF ACQUIRED SYPHILIS include an acute iritis, posterior uveitis, panuveitis, diffuse chorioretinitis, neuroretinitis, and periphlebitis. Other manifestations can include central vein occlusion,

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