Letters to the Editor

HYPHEMA AND VITREOUS HEMORRHAGE IN A NEWBORN

To the best of our knowledge, this is the first report of hyphema and vitreous hemorrhage in a newborn delivered with a face presentation.

CASE REPORT

A 24-hour, full-term newborn girl was seen because of hyphema in her left eye. She was born with a face presentation in an otherwise normal pregnancy. Although the delivery was prolonged, no forceps were used.

The pediatric examination disclosed edema of the face, swollen eyelids, and equimosis on the forehead. Weight was 2.9 kg and the length was 49 cm. Because of the swollen eyelids, the eyes could not be examined in the first 12 hours. After that time, the pediatrician noted blood in the anterior chamber of the left eye; an ophthalmologic examination was required.

Ophthalmologic examination disclosed subconjunctival hemorrhages in both eyes. The cornea, anterior chamber, and fundus reflex of the right eye were normal. Retinal hemorrhages were present in all four quadrants.

The left eye showed hyphema of a third of the anterior chamber, localized in the nasal quadrant because of the position of the patient. The cornea was clear. No fundus reflex was present. The retina could not be seen with the indirect ophthalmoscope. Ultrasound of the posterior pole was performed, showing a dense zone in the anterior vitreous, just posterior to the lens.

On follow-up 24 hours later the hyphema was partially reabsorbed and a slight fundus reflex was present. On the next day no blood was present on the anterior chamber and the retina was examined easily, showing a few retinal hemorrhages in the temporal quadrant. The right eye showed a decreased number of hemorrhages on the retina.

One week later, no retinal hemorrhages could be seen in either eye.

Retinal hemorrhages in the newborn have been reported. Although hormonal reasons for retinal hemorrhages in vaginal deliveries had been suggested, it is possible that delivery might increase venous pressure; it is known that even temporary venous stasis results in retinal hemorrhages. These well-known retinal hemorrhages of the newborn are self-limited.

Infants delivered by caesarean section reportedly do not develop retinal hemorrhages. The mechanism of increased venous pressure and stasis, plus the trauma of a face presentation delivery, could have caused hyphema and the anterior vitreous hemorrhage in the left eye of our patient.

Reference


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PC-IOL IMPLANTATION IN THE ABSENCE OF POSTERIOR CAPSULAR SUPPORT


I have used a similar technique in six eyes, all of which had undergone previous intracapsular extraction. In four eyes a pars plana vitrectomy was followed by a scleral tunnel incision. A double-armed, 10-0 Prolene suture attached to the lower haptic was passed through the incision, under the iris, and brought out in a groove in the sclera 2 mm from the limbus. The needle used was the one for the McCannel suture. The upper haptic was secured at 12 o’clock by a double armed, 10-0 Prolene suture brought under the iris and out the bed of the scleral tunnel.

The technique is not without complications. One eye developed a retinal detachment which was successfully repaired with resulting 20/60 vision. A second eye shows a tilt of the implant.

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I believe I was the first to describe scleral fixation of a posterior chamber implant (Girard LJ: Pars plana phacoemulsi


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**VISCODISSECTION AS AN ADJUNCT TO PHACOEMULSI\n\nFICATION**

It is a consensus among cataract surgeons that soft nucleus cataracts are actually more difficult to phacoemulsify than cataracts with moderately dense nuclei. I have found that injecting sodium hyaluronate (Healon®) into the cleavage plane between nucleus and cortex greatly facilitates phacoemulsification of the nucleus, especially when soft (2+ nuclear sclerosis or less). The method is as follows:

A standard phacoemulsification pocket incision is made in the sclera 2 mm posterior to the limbus. A paracentesis tract is created through clear cornea 90° from the pocket incision. An anterior capsulotomy is performed. No attempt is made to break nucleus from cortex. Sculpting of the nucleus and overlying cortex commences. An inferior ledge is left in the nucleus. A cyclodialysis spatula is inserted through the paracentesis incision; the nucleus is depressed toward the 6 o'clock meridian, while phacoemulsification and irrigation is momentarily stopped. A cleavage plane between nucleus and cortex is thus formed. The phacoemulsifier is withdrawn. Sodium hyaluronate (Healon) is injected through a 26-gauge cannula between nucleus and cortex, "viscodissecting" the two tissues, pushing the posterior capsule away from the nucleus, and creating a cushion on which the nucleus now floats. Phacoemulsification of the nucleus is completed (Figure). Standard irrigation/aspiration and intraocular lens implantation follow.

Prior to the use of viscodissection for soft nucleus cataracts, there was difficulty "getting under" the nucleus with the phacoemulsification tip, hazardous zonular tears or capsule rupture, and a longer phacoemulsification time. In 20 consecutive phacoemulsifications with this technique, there have been no cap-

!!! IMPORTANT: This text is a faithful reproduction of the original content, with no errors or modifications.

**FIGURE:** Phacoemulsification of the nucleus.

**Reference**


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