SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 58 To 59

Fatema Jawad (7/6, Rimpa Plaza, M. A. Jinnah Road, Karachi.)

TREATMENT OF DRY EYE WITH VITAMIN A. Khan, A.J. Pak. Ophthahnol., 1987; 3:134-138.

19 cases of dry eye treated with vitamin A ointment are presented. 3 cases resulted due to Stevens-Johnson syndrome, 5 cases were of Kerato conjunctivitis sicca, 6 had chronic conjunctivitis and 3 were cases of filamentary keratitis. All these conditions create squamous metaplasia in the conjunctiva characterised by loss of goblet cells, keratinization, vacuolation with enlargement and degeneration of the epithelial cells. All the 19 cases of dry eye had been treated previously by various combinations of eye drops and ointments including antibiotics, steroids, gels and artificial tears. A conjunctival biopsy was taken from the lower fornix from each patient. Vitamin A ointment was prescribed four times a day to all cases. A biopsy was repeated after one week, one month and two months. In cases of Stevens-Johnson syndrome and pemphighoid, steroid drops were also used. After one month of treatment with vitamin A ointment, keratinization completely disappeared, except in pemphigus cases. In all the cases there was a 75 percent revival of goblet cells. Xerophthalmia has been treated with oral or parenteral vitamin A. Local application of vitamin A ointment in dry eyes has also been reported. This presented study, though limited in the number of patients and the duration, gives promising results. It can be recommended to use vitamin A as an ointment locally and trials conducted as chronic eye disease is very commonly encountered in our country.

CHOROJDAL HAEMORRHAGE MISTAKEN FOR MALIGNANT MELANOMA. Khan, AJ. Pak Ophthalmol., 1987; 3:139-143.

A 56 year old known hypertensive female underwent an intra-capsular lens extraction for hard brown cataract in the right eye. The pupil-lazy reaction was good with an accurate PL, PR and coloured light perception. The pre-operative IOP was 18 mmHg which was reduced to 10 mm Hg by the Honan's balloon. After closure of the corneoscleral wound a dark brownish black reflex was noted through the microscope in the fundus. There was no bleeding in the anterior chamber. A detailed examination on the next day revealed a dark brown mass arising from the temporal side, lying behind the iris. There was no pain and the PL and PR were satisfactory. Ultrasonography with A and B Scans was carried out. The A Scan suggested a malignant melanoma where as the B Scan showed a cystic choroidal mass. A second operation was undertaken under local anaesthesia. A sclerectomy was performed 7 mm from the limbus when a blood clot started protruding through the wound. This was expelled out after applying gentle pressure on the eye ball. BSS solution was injected in the vitreous cavity to prevent hypotony and to expel the suprachoroidal blood clots. At IOP of 2OmmHg no more blood clots appeared and the sclecal wound was closed. On the third postoperative day the patient had a vision of finger counting at 3 feet. It is known that cataract surgery can be complicated by supra-choroidal haemorrhage which can be expulsive choroidal haemorrhage, limited choroidal haemorrhage or delayed nonexpulsive choroidal haemorrhage. In the present case, a known hypertensive, it was a limited non-expulsive suprachoroidal haemorrhage. The quick lens removal and wound closure averted the catastrophy of expulsive haemorrhage. Ultrasonographic and CT Scan studies help in arriving at an early diagnosis. Effective treatment is by drainage through scierectomy with maintenance of lOP by BSS or air.

TREATMENT OF ADVANCED 'UNCONTROLLED GLAUCOMA BY SIUCONE TUBE 1W PLANT IN THE ANTERIOR CHAMBER. Khan, A. J. Pak.Ophthalmol., 1988;4: 11-16.

Silicone tube implants were used in glaucoma surgery on 13 eyes between 1986 and 1988. Of the 13 patients included in the study, 11 were male and 2 female. The ages ranged between 18 and 55 years. 3

patients had neovascular glaucoma following CRVO, 2 had neovascular glaucoma following branch retinal vein occlusion, 5 had neo-vascular glaucoma due to diabetes mellitus, 2 had total PAS due to aphakia and 1 developed glaucoma after congenital cataract operation. All the cases had a previous trabeculectomy done. Preparation for surgery was made with Tab. Dichlorphenamide 50 mg twice daily along with topical timolol maleate, one week earlier. Two hours prior to surgery 500 cc of 20% Man. nitol was infused intravenously to reduce the IOP. A mixture of 20% xylocaine and 0.5% Bupivacaine in equal volumes was used as local anaesthesia. After this Akhtar's modified pressure reducer balloon was applied to the eye for 20 minutes. A conjunctival flap was made followed by a Scleral tunnel. The silastic tube with a 0.5 mm inside diameter, was introduced in the anterior chamber and secured. The scleral and conjunctival flaps were reposited and sutured. In all the cases the eyes became comfortable. The pain and lacrimation stopped and visual acuity improved. In one case with diabetes mellitus the his neovascularization disappeared. No anti-glaucoma medication was required in the post-operative follow up, which lasted for one year. In the immediate postoperative period the drug regime used was topical dexamethasone and gentamycin and systemic piroxicam 20 mg at bed time. The presented experience is short but encouraging and long term follow up will evaluate the use of the artificial filtering device.

MELKERSSON - ROSENTHAL SYNDROME. Yondemli, F., Yondemli, H. Pak. J. Otolaryng., 1988;4: 71-73.

A 52 year old Turkish male presented with oedema of the right eye, proptosis, weakness, fissured tongue and reduced taste. Proptosis was present since birth and other symptoms for the last 30 years. Laboratory tests were all within normal limits. A diagnosis of Melkersson-Rosenthal Syndrome was made and treatment started with Transcutaneous Electrical Nerve Stimulation 30 minutes daily for ten days. Electric current was applied at 50Hz between 10 and 20 mA. The therapy decreased the facial oedema and improved the paralysis. The taste recovered partially. Facial paralysis and oedema were linked together by Melkersson in 1928. Rosenthal supplemented the information on lingira plicata. The symptom complex was named as MellcerssonRosenthal Syndrome in 1949. It is usually encountered in the second decade of life and in both sexes. The etiology is obscure but allergy, infections, heredity and sarcoidosis can be the exciting factors. TENS has been used as the treatment for the syndrome. The frequency and velocity of the Electrical Stimulation varies with every patient. The average amplitude used is 25-65 mA for 50-100 microsecond and a frequency of 50Hz. Melkersson-Rosenthal Syndrome is now accepted as an indication for TENS.