Spontaneous posterior dislocation of IOL is uncommon. It has been reported in ocular trauma, surgical complications compromising the posterior capsule or weak zonules, and capsular contraction syndrome. Brilakis has reported a case of posterior dislocation of IOL in a patient with intermediate uveitis who had undergone pars plana vitrectomy and phacoemulsification. The IOLs dislocated in both eyes 24 and 41 months postoperatively. Pathogenesis was weak zonules. In intermediate uveitis, diffuse phlebitis causes breakdown of the blood–aqueous barrier and release of inflammatory mediators that settle in the inferior fundus due to gravity, damaging zonules. Ciliary body inflammation also destabilizes zonules at their insertion.

In our case, the repeated episodes of inflammation and pars plana vitrectomy probably lead to zonular weakness causing dislocation 26 months after vitrectomy. The exact mechanism of dislocation needs further elucidation.

A case report by Yasuda et al. showed dislocation of IOL 23 months after vitrectomy and phacoemulsification for diabetic vitreous haemorrhage. No surgery was planned in our case as the patient had poor vision in that eye, and the lens was not mobile.

We recognize that this complication can occur postoperatively in uveitic and vitrectomized eyes and warrants a meticulous dilated fundus evaluation at regular intervals.

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Recurrent Candida albicans endophthalmitis in an immunocompromised host

Candida species are an uncommon but potentially devastating cause of chronic exogenous postoperative endophthalmitis. We present a rare case of postoperative Candida endophthalmitis recurring after a course of chemotherapy.

A 74-year-old man developed mild anterior uveitis 3 weeks after uneventful left eye cataract surgery. Despite topical treatment with antibiotics, steroids, and cycloplegia, a 1 mm hypopyon and a mild vitreal reaction appeared together with decreased visual acuity to 20/80. The patient underwent vitreous tap and irrigation of the capsular bag with vancomycin in conjuction with topical and systemic treatment with vancomycin and ceftazidime. Sabouraud’s dextrose agar from the anterior chamber grew Candida albicans, and topical hourly amphotericin B was initiated, with a good response. During hospitalization, non–small-cell lung adenocarcinoma was diagnosed and chemotherapy was started.

Four months after the primary surgery, his visual acuity dropped to hand motion, accompanied by a 3 mm hypopyon and white reflex in the vitreous. A white blood cell count showed leucopenia of 4870 cells/mL (70.1% neutrophils, 12.5% lymphocytes). Sabouraud’s dextrose agar culture from the anterior chamber grew Candida albicans again. Intravenous amphotericin B, followed by oral fluconazole treatment, was initiated, with significant improvement in visual acuity and
inflammation. The patient continued the chemotherapy with no further signs of recurrence.

Exogenous *Candida* endophthalmitis is a rare entity presenting usually several weeks after surgery in an indolent fashion, with minimal pain, relatively good vision, progressive iridocyclitis, and mild vitritis.1–3 Its treatment consists of pars plana vitrectomy, intravitreal amphotericin B and systemic antifungal preparations, and amphotericin B or fluconazole (in cases of yeast endophthalmitis).4

Two factors may have contributed to the recurrence of this patient’s infection: lack of intravitreal and systemic antifungal treatment, and the patient’s immunocompromised status.

Invasive fungal infections pose a major threat to patients with impaired immune defences.5 A nidus of the infective organism may have been left in the eye after the first episode of endophthalmitis, becoming active subsequent to leucopenia and causing the recurrence of the endophthalmitis.

Clinicians should be aware of the possibility of recurrent fungal endophthalmitis in immunosuppressed patients and treat them accordingly.

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**Transverse chop: new or old phaco technique**

The chopping techniques have been progressively displacing the previous techniques of central bowling or cracking because they have been shown to require less ultrasound energy, intraocular manipulation, and operating time.1–5 The preferred technique (54%) is still the divide and conquer nucleofractis, however.5

In our experience, the so-called transverse chop has been applied on white cataracts, particularly those with moderately hard nuclei, making the manoeuvres in the transverse plane smoother and easier in comparison with vertical and horizontal chop techniques. The transverse technique was applied in our practice only as a minor supplement to other techniques during phaco surgery.

We have applied the transverse technique in about 200 cases and obtained very good results during the past 3 years. All steps are the same as in the standard coaxial phaco, up to the cracking of the nucleus core into 2 halves with the phaco spatula and phaco tip.

For standard coaxial phaco, a 1.0 mm side-port incision is made approximately 70°–80° to the left of the main incision. In my group, the Millennium phaco unit is used (Bausch & Lomb). The main biplanar incision for coaxial phaco is 2.8–3.0 mm wide and 1.5 mm long, with a superior approach and mostly through clear cornea. In white and brunescent cataracts, we use an anterior capsular staining method with 0.05% trypan blue. Air, continuous curvilinear capsulorhexis, hydrodissection, and hydrodelineation are performed in the usual manner.

The transverse chop technique is simple. A groove is made, followed by cracking of the nucleus core into 2 halves with the phaco spatula and phaco tip. Thereafter, the phaco tip is used for grasping the fragment of nucleus with the tip bevelled from 0° to 30°, lifting the nuclear fragment a little more above the capsulorhexis.