

## LETTERS TO THE EDITOR

### Withdrawal of 0.6% Glauine (metipranolol)

SIR,—Following reports of a number of cases of anterior uveitis associated with the 0.6% strength of our ophthalmic  $\beta$  blocker, Glauine, we are now withdrawing this strength from the market. The 0.1% and 0.3% concentrations remain available for prescription as usual.

Our advice to ophthalmologists and general practitioners is that all patients managed with 0.6% Glauine should have their medication reviewed as soon as possible and changed to the 0.3% strength or to an alternative ocular hypotensive. If a patient presents a prescription for Glauine 0.6% following this notification, pharmacists are asked to contact the prescriber to confirm that it should be dispensed.

As we appreciate the difficulty in seeing all patients to make this change immediately, we will continue to make Glauine 0.6% available until 1 October 1990 to ensure that their prescriptions can be met in the interim. We will be recalling unused stock at a later stage.

We have written individually to ophthalmologists, general practitioners, and pharmacists concerning the withdrawal and would be grateful if you could include reference to it in your publication.

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### Anaphylactic reaction following application of chloramphenicol eye ointment

SIR,—Ophthalmic preparations of chloramphenicol are favoured by ophthalmologists because of their broad spectrum of antibacterial activity, low corneal toxicity, the availability of preservative free solutions, and their ability to provide therapeutic levels in aqueous humour after topical application.<sup>1</sup> Chloramphenicol eye ointment is therefore commonly used in external eye infections. To the best of our knowledge this is the first report of an anaphylactic reaction following administration of chloramphenicol eye ointment.

A 30-year-old healthy man with no history of allergy underwent in 1987 excision of a chalazion cyst in his right lower lid under local anaesthesia with lignocaine 1%. The excision was uneventful, and the eye was patched with chloramphenicol eye ointment 5%. Three hours after the procedure, angioedema and urticaria developed. The patient was referred to the nearest emergency room and was admitted to hospital because of severe angioedema, urticaria, and bronchospasm, which necessitated treatment with adrenaline and intravenous corticosteroids for two days. As the only medications used were the local anaesthetic

and the ointment, it was presumed that the reaction was to the local anaesthetic. In 1989, however, the patient experienced the same episode again, this time after applying topical chloramphenicol on a finger wound of his daughter's. Once again his condition necessitated admission to hospital and vigorous treatment with adrenaline and corticosteroids. The diagnosis of allergy to chloramphenicol was made, and the patient was cautioned accordingly.

Systemic effects of eye ointments result from absorption through conjunctival membranes, or from drainage down the lacrimal duct and absorption through nasopharyngeal mucosal membranes. The allergic reaction is caused by systemic circulation of the antigen. The occurrence of an anaphylactic reaction following systemic administration of chloramphenicol is rare.<sup>2</sup> Six reports involving 10 patients with presumptive anaphylaxis due to chloramphenicol were reviewed by Palchick *et al.*<sup>3</sup> The occurrence of anaphylactic reaction after administration of topical chloramphenicol to the skin has been reported in two patients.<sup>4</sup> The only systemic side effect after application of chloramphenicol to the eye is aplastic anaemia, which has been reported in five cases as reviewed by Brodsky *et al.*<sup>5</sup> We did not find any description of anaphylactic reaction following administration of chloramphenicol eye ointment.

It appears to be justifiable in our patient to attribute the two allergic reactions to chloramphenicol eye ointment. It seems to us, that though anaphylaxis is surely rare following the use of chloramphenicol eye ointment, physicians should be aware of this complication to aid early detection and treatment.

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- 1 Beasley H, Boltralik JJ, Baldwin HA. Chloramphenicol in aqueous humor after topical application. *Arch Ophthalmol* 1975; 93: 184.
- 2 Reynolds JEF, ed. *Martindale: The Extrapharmacopoeia*. London: Pharmaceutical Press, 1989: 106, 186, 192.
- 3 Palchick BA, Funk EA, McEntire JE, Hamory BH. Anaphylaxis due to chloramphenicol. *Am J Med Sci* 1984; 288: 43-5.
- 4 Schewach-Millet M, Shpiro D. Urticaria and angioedema due to topically applied chloramphenicol ointment. *Arch Dermatol* 1985; 121: 587.
- 5 Brodsky E, Zeidan Z, Biger Y, Schneider M. Topical application of chloramphenicol eye ointment followed by fatal bone marrow aplasia. *Isr J Med Sci* 1989; 25: 54.

### Eye surgery in Eritrea

SIR,—We have just finished a ward round of 27 patients: 24 extracapsular cataract extractions with posterior chamber intraocular lenses, one anterior chamber intraocular lens, and two trabeculectomies. All the eyes look good; corneae were clear and only the anterior chamber lens a little hot.

All were done by an Eritrean in the air

conditioned theatre of this rocket blasted hospital. We brought the equipment and lenses from Australia, and instructed and supervised. They did them.

This eye surgery is the first to be done here since the Eritreans recaptured Massawa Port some five months ago. It is certainly the first series of modern cataract operations to be done in this part of the world.

Many of the patients come from Danakel, said to be the hottest place on earth. One such man, an Afar of no more than 40 years, had the whitest of white cataracts. Like most of the others he was blind. But not now. In this place, 'somewhere east of Suez, where... a man can raise a thirst,' it is hard not to see a link between light, heat, and cataract. After all, Dahlak blindness (Labrador keratopathy, climatic droplet keratopathy) is common here, as are corneae burgeoning with clusters of spheroidal droplets.

We came via Sudan and the arid hills of Northern Eritrea. There, in a base hospital camouflaged and half underground, we did or instructed Eritreans (all but one not 'medically qualified'), while they did another 25 or so cataracts with intraocular lenses. Locally produced Ringer's lactate was used, with all corneae lustrous.

Travelling is tough by any standard—done at night in four-wheel drive vehicles over river beds. The equipment, previously tested in rural Nepal and outback Australia, is well packed and so travels without damage.

Africa, with about 500 million people, needs at least 3½ million eye operations each year just to keep up with cataract, glaucoma, and trachoma blindness. However, it has only about as many eye surgeons as Australia with its population of 17 million. The Eritrean medical assistants have good hands and need only microscope training and surgical tuition to become modern eye surgeons. As surgeons emerged from barbers, so must medical assistants in Africa become the ones to shoulder the enormous eye surgery load of this continent.

Eritrea's battle to regain its identity has lasted almost 30 years. We have seen some of that conflict's casualties. In a single camp 150 young people are blind from multiple perforating injuries and intraocular foreign bodies. Most of the injuries would defy the skills of even the best vitrectomist, corneal grafter, and anterior segment reconstructor combined. We have also seen many cases of blinding sympathetic ophthalmitis. Perhaps earlier and more skilful microscopic trauma repair would prevent some of this.

The Eritreans, friendly, considerate, and hardworking, are well organised and keen to play a part in leading Africa into better times. This makes helping them an easy task. For good eye surgeons who can handle some 'hard going', we recommend an approach to the Eritrean Relief Association, 96 White Lion Road, London, N1 9PF, UK. Volunteers should expect to instruct rather than do, and bring and leave microscopes and other items as we have done.

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## Eye surgery in Eritrea

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