Malignant glaucoma is the term introduced in 1869 by von Graefe to describe one of the more serious but rare complications of anterior segment surgery. It is best known following trabeculectomy but has been reported after a wide variety of anterior segment procedures.

It is notoriously refractory to medical treatment alone and surgical intervention has had only limited success. An additional treatment option in pseudophakic eyes or aphakic eyes with an intact posterior capsule is that of short pulsed Nd:YAG laser posterior capsulotomy which is minimally invasive, carries little risk and can re-establish forward flow of posteriorly misdirected aqueous through into the drainage angle of the anterior chamber. Successful use of Nd:YAG posterior capsulotomy can obviate the need for further surgical intervention.

A case is reported of malignant glaucoma developing post trabeculectomy which persisted despite surgical treatment. Long term pressure control was established following Nd:YAG posterior capsulotomy.

Case report
A 69-year-old woman presented in 1987 with ocular hypertension and narrow drainage angles for which topical β blocker (timolol drops 0-25%) treatment was required the following year. Intraocular pressure (IOP) control was unsatisfactory and unresponsive to bilateral 360 degree argon laser trabeculoplasty. Adjunctive topical treatment using an adrenergic agonist (dipivefrin drops) did not improve IOP control (30 mm Hg bilaterally) and automated perimetry revealed an early arcuate scotoma in her right eye. A right trabeculectomy was performed in September 1992.

On the first postoperative day she had diffuse shallowing of the anterior chamber with an IOP of 38 mm Hg and a diagnosis of malignant glaucoma was made. The following day a limited pars plana core vitrectomy was performed and the anterior chamber reformed internally through a surgical cyclodiagnosis. On the first postoperative day a deep anterior chamber was present with a normal IOP. Two days later a total hyphaema was present together with a peripherally flat anterior chamber and raised IOP. Maximum topical and systemic treatment reduced the IOP to 25 mm Hg. The hyphaema slowly resorbed over the following 2 weeks to about 30% of the corneal diameter, but the malignant glaucoma persisted despite full cyclopia. At this stage the she was referred for further management.

Her right IOP was 18 mm Hg on full medical treatment and her acuity 6/12 with a healthy disc. There was marked diffuse conjunctival and episcleral hyperaemia and the anterior chamber depth measured 1-6 mm centrally (Haag-Streit AC depth meter) but was peripherally closed and no drainage bleb was present overlying the trabeculectomy site. Over the following 4 days the IOP remained under 20 mm Hg on topical and systemic treatment and the inflammation settled on treatment with topical steroid although the anterior chamber remained peripherally flat.

B scan ultrasound showed ciliary body enlargement in the right eye but not in the unoperated left eye. The axial length of the right eye was difficult to measure accurately but that of the left eye was 21-1 mm. Her preoperative refraction was not hypermetropic and neither was there anisometropia in her reading prescription.

She was discharged and reviewed 2 weeks later when the anterior chamber was still flat with an IOP of 30 mm Hg and an optically clear zone was noted behind her lens, presumed to be sequs-

She was then booked for further pars plana vitrectomy and extracapsular lens extraction without intraocular lens (IOL). At operation a corneal groove was cut and a 27 gauge anterior chamber paracentesis made tangentially in the peripheral cornea. A single port pars plana Ocutome vitrectomy was carried out and the anterior chamber inflated through the paracentesis with viscoelastic. The corneal section was completed followed by enlargement of the peripheral iridectomy to a broad iridectomy which enabled a large continuous tear needle capsulorhexis to be fashioned. Following hydrodissection the nucleus was expressed and, after aspiration of the residual cortical lens matter, the section was closed with 10/0 nylon.

On the first postoperative day the anterior chamber had flattened and the vitreous was herniating the posterior capsule through the capsulorhexis, forming a 'dome' whose apex was almost in contact with the corneal endothelium (Fig 1). The IOP was 10 mm Hg and there was no leak through the cataract section and no conjunctival bleb. The early recurrence of malignant glaucoma was diagnosed. A Nd:YAG posterior capsulotomy combined with anterior vitreolysis was performed the following day resulting in an instantaneous forward gush of fluid accompanied by simultaneous deepening of the anterior chamber (Fig 2). Retroillumination highlights the small central laser capsulotomy (pre-treatment (Fig 3) and post-treatment (Fig 4)).

Over a 7 month follow up period the anterior chamber has remained deep and the IOP normal and stable in the absence of a trabeculecomy bleb and, surprisingly, no antiglaucoma medication. The normal IOP despite no treatment may well be due to the existence of an alternative outflow pathway via the surgical cyclodialysis. The corrected acuity is 6/9.

Comment
Von Graefe introduced the term 'malignant glaucoma' in 1869 to describe raised intraocular pressure associated with a flat anterior chamber following uneventful surgery for angle closure.
Treatment of aphakic malignant glaucoma using Nd:YAG laser posterior capsulotomy

Nasolacrimal obstruction and facial bone histopathology in craniodiaphyseal dysplasia

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Craniodiaphyseal dysplasia is a rare, severe, and progressive bone dysplasia characterised by thickening, distortion, and enlargement of the cranium and face. Epiphora and recurrent dacrycystitis can occur in this and other such bone diseases owing to nasolacrimal duct stenosis. The management of such a case provided an opportunity to obtain material for analysis, with the aim of gaining more information on the aetiology and possible treatment of this condition.

Case report
The patient was a female, aged 3 years in whom a diagnosis of craniodiaphyseal dysplasia had been made soon after birth, from the typical clinical (Fig 1A) and radiological appearances (Fig 1B). A low calcium diet had been commenced and calcitriol therapy administered in an attempt to...
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