Correspondence

Anterior chamber angle in the exfoliation syndrome

SIR, Wishart, Spaeth, and Bryzees[1] report an incidence of 14% of angle closure glaucoma among 76 patients with the exfoliation syndrome. They believe that earlier reports indicating no association between a narrow anterior chamber and the exfoliation syndrome represent incomplete observation.

I reported an association between angle closure and exfoliation syndrome in 1979.[2] In 1981[3] I gave a full description of 13 patients with angle-closure glaucoma out of a total of 107 with glaucoma and exfoliation syndrome, 12%, a percentage similar to that of Wishart *et al.* I suggested a mechanism of 'iridocapsular' block and presented three patients cured by peripheral iridectomy, first described by Herbst,[4] and one by mydriasis. I concluded that such cases would be discovered by better observation and therefore correct management would follow.

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References

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3 Bartholomew RS. Pseudoexfoliation and angle closure glaucoma. *Glaucoma* 1981; 213–6.
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SIR, We thank Dr Bartholomew for his interest in our article[1] and for drawing our attention to two of his earlier publications.[2 3]

In the first of these two papers Dr Bartholomew reports an average fall in intraocular pressure following cataract extraction in seven patients with exfoliation syndrome and glaucoma. He suggests relief of iridocapsular block as a possible mechanism responsible for this fall in pressure. However, as no record of gonioscopic findings appears, this suggested mechanism remains conjecture and we fail to see the relevance of this to our results.

In the other paper to which he refers Dr Bartholomew describes 16 cases of acute glaucoma, 13 of which were ascribed to acute angle closure. The lack of details of material and method, the absence of information about the angle appearance in all patients included in this study, and the lack of explanation as to why peripheral iridectomy was such a rarely used treatment for acute angle closure all make it difficult for the reader to draw any conclusions from this study about the anterior chamber angle in the exfoliation syndrome.

Dr Bartholomew's two papers are in support of the theory of iridocapsular block as a mechanism of glaucoma in the exfoliation syndrome. Our study was of the gonioscopic findings in patients with exfoliation syndrome and does not speculate on the possible dynamics involved in the production of angle-closure glaucoma.

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References

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Angle closure following neodymium—YAG (Nd-YAG) laser capsulotomy in the aphakic eye

SIR, The Nd-YAG laser has gained popularity as a 'non-invasive' means of dividing intraocular membranes. Initial reports suggested that complications were rare.[1] Recently intraocular lens damage,[2 3] rupture of the anterior hyaloid face,[2] corneal endothelial damage,[5] and significant pressure rise[2 4 6] have all been reported to follow Nd-YAG posterior capsulotomy in the aphakic eye. We wish to report a case in which Nd-YAG capsulotomy was followed by acute angle-closure glaucoma.

Case report

A 49-year-old woman underwent a planned, uncomplicated, left extracapsular cataract extraction for a unilateral lens opacity. A peripheral iridectomy was not performed. Postoperatively she received topical atropine and steroids for four weeks. She initially achieved a visual acuity of 6/9 with a contact lens, but one year later her corrected visual acuity fell to 6/60 owing to thickening of the posterior capsule. She declined further surgery. Three years after her operation she elected to have a Nd-YAG capsulotomy. No preoperative medication was administered. A Q-switched Nd-YAG laser (Cooper Vision) was employed in its burst mode, and a successful capsulotomy achieved with three bursts of four shots with a total energy delivery of 36 mJ. One drop of atropine 1% was instilled and she was allowed home.

Forty-eight hours later the patient presented with a 24-hour history of left painful red eye. Corneal oedema was present with an intraocular pressure (IOP) of 50 mmHg and minimal activity in the anterior chamber. The pupil was dilated, the anterior chamber was deep centrally but shallow peripherally, and the angle closed all round.