LETTERS TO THE EDITOR

Malignant glaucoma after laser iridectomy

SIR,—With reference to the article by Brooks, Harper, and Gillies,[1] we feel that the title 'Occurrence of malignant glaucoma after laser iridotomy' may be misleading. There are two reasons for the occurrence of malignant glaucoma in this case: the use of pilocarpine 4%, and the central retinal vein thrombosis. As the authors correctly pointed out in the discussion, pilocarpine and central retinal vein thrombosis are both recognised causes of malignant glaucoma. We therefore think that in this case malignant glaucoma was unrelated to the laser iridotomy.

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1 Brooks AMV, Harper CA, Gillies WE. Occurrence of malignant melanoma after laser iridotomy. *Br J Ophthalmol* 1989; **73**: 617–20.

SIR,—We agree with Drs Geyer, Rothkoff, and Lazar that both the use of pilocarpine and the presence of central retinal vein thrombosis may be factors in the production of malignant glaucoma. However, in the patient we described the central retinal vein occlusion was noted on his presentation with typical acute angle closure glaucoma with a shallow but not flat anterior chamber, of the same measured depth as that of the fellow eye. The malignant glaucoma in this patient followed directly after the exhibition of pilocarpine 4% in the presence of a patent laser iridotomy and was accompanied by documented abrupt shallowing of the anterior chamber. This malignant glaucoma was relieved by mydriatic, particularly phenylephrine 10%. Even though some degree of angle closure recurred after discharge from hospital with the use of atropine but no phenylephrine the anterior chamber did not shallow, and the angle reopened when atropine was stopped, emphasising the instability of the lens-iris diaphragm in this patient.

Therefore, though in this patient malignant glaucoma followed immediately on the use of pilocarpine 4%, and the pre-existing central retinal vein occlusion may have been a contributory factor, it was not the precipitating factor. What appeared particularly important to us was that the presence of a patent iridotomy, performed by the non-invasive method of laser iridotomy, did not have a protective effect against the occurrence of malignant glaucoma. To our knowledge this has not previously been reported.

Since publishing our paper reports of two possible cases of malignant glaucoma following laser iridotomy have been drawn to our attention.[1,2] In one of these[1] it was concluded that the malignant glaucoma already existed prior to the laser. In the other[2] there was extensive laser iridoplasty as well as peripheral iridotomy, and a marked inflammatory element resulted. Neither of these cases clearly documents a case of malignant glaucoma following a simple patent laser iridotomy.

The title of our paper emphasises the important clinical finding that malignant glaucoma can be precipitated even in the presence of a patent laser iridotomy and we believe this title should stand.

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1 Takeuchi H, Okubo K. A case of malignant glaucoma occurring without past invasive surgery. *Jpn J Clin Ophthalmol* 1986; **40**: 399–402.
2 Levene R. Malignant glaucoma: proposed definition and classification. In: Shields MB, Pollack IP, Kolker AE, eds. Perspectives in glaucoma. *Transactions of first scientific meeting of the American Glaucoma Society.* New Jersey: Slack, 1988: 243–50.

NOTE

Ophthalmic echography

A course on standardised echography in ophthalmology will be held at the University Eye Hospital, Munich, West Germany, on 8–13 October, 1990. The English and German languages will be used in separate sessions. Further information from Professor Dr G Hassenfratz, Augenklinik der Universität München, Mathildenstrasse 8, D-8000 München 2, West Germany.

FIFTY YEARS AGO

Ophthalmic eye lithotrite for removal of non-magnetic intra-ocular foreign bodies

DEAR SIRS,—Can any one tell me where I can obtain such an instrument?

Amongst my father's instruments, this is the one I valued most, and I found it invaluable for removing glass or other non-magnetic foreign bodies from the eye.

I understand it was made specially for him.

Owing to being called up at short notice my own is in such a safe place I cannot find it. It consists of an ivory handle about three inches long containing a delicate spring controlled by a button lever, and the forceps portion extends to about one inch. The teeth open about an eighth of an inch when the spring is released. To insert the forceps, which are very fine and delicate as no crushing is required, the teeth are closed by pressing the lever with the forefinger, then they are opened by releasing the lever and closed firmly on the foreign body to hold it and withdraw it.

In view of the large numbers of intra-ocular foreign bodies in wartime, and my colleague Mr. L. H. Savin tells me many are a compound of magnesium and aluminium, I thought this instrument would be of interest to your readers—also I want to replace my own.

Yours faithfully,
J. MYLES BICKERTON,
Wing-Comdr.

Br J Ophthalmol 1940; **24**: 414-5.