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Case Report

Traumatic pseudophacocele: A case report with review of literature

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ABSTRACT

A elderly male presented with painful loss of vision in the left eye for 20 days with expulsion of intra-ocular content following a blunt trauma. The best corrected visual acuity was counting fingers close to face (CF-CF). Slit lamp examination revealed ciliary tissue prolapse with gaping of incision scar along with a posterior synechia, iris pigments, vitreous in Anterior chamber, cells and flare. Patients presented aphakic and had the extruded rigid PMMA IOL with a broken haptic with him. Fundoscopic examination and B scan imaging were suggestive of vitreous haemorrhage. Pseudophacocele happens following blunt trauma leading to dehiscence of the corneo-scleral wound scar. Subconjunctival dislocation is the most common type, however sub-choroidal dislocation has also been seen. Our case is an extreme one where the IOL is completely extruded from the eye.

An early diagnosis can help prevent serious infective complications and have good visual outcomes.

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1. Introduction

Sub-conjunctival dislocation of intra-ocular lens implant is termed as pseudophacocele.¹ It is a rare complication that occurs due to blunt trauma in eyes having cataract surgery. Unlike traumatic phacocele, which is the dislocation of the crystalline lens, the occurrence of pseudophacocele is much rarer. Such injury often reported after blunt trauma caused by animal horn injury.² We present a case of traumatic pseudophacocele with complete expulsion of the intra-ocular lens

2. Case Report

A 69-year-old male, had under gone an uneventful small incision cataract surgery with implantation of a posterior

chamber intraocular lens in the left eye 5 years back. He recently presented with painful loss of visual acuity in the left eyes of 20 days duration with expulsion of the intraocular lens. No systemic disorder or medication history was found.

On examination His best corrected visual acuity was 6/9p in the right eye and counting fingers close to face (CF-CF) in the left eye. Slit lamp examination revealed an evident ciliary tissue prolapse with gaping of the incisional scar. Hypotony was also noted; however anterior chamber was well formed with a variable depth (Figure 1 a & b). Further examination revealed a posterior synechia with iris pigments and vitreous in anterior chamber. Patient also had an active anterior chamber with 3+ cells and flare of 2+. Patients were aphakic at presentation and had the expelled IOL with him. IOL was a rigid PMMA of which one haptic was broken. (Figure 2)

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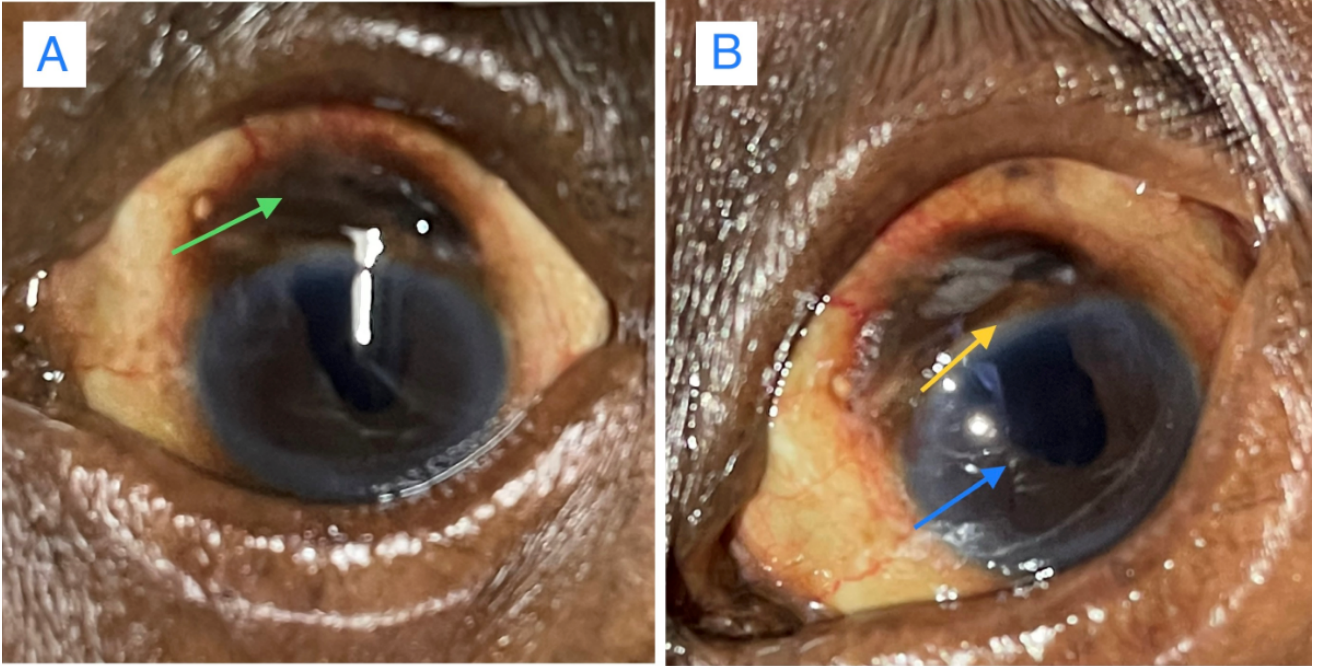


Fig. 1:



Fig. 2:

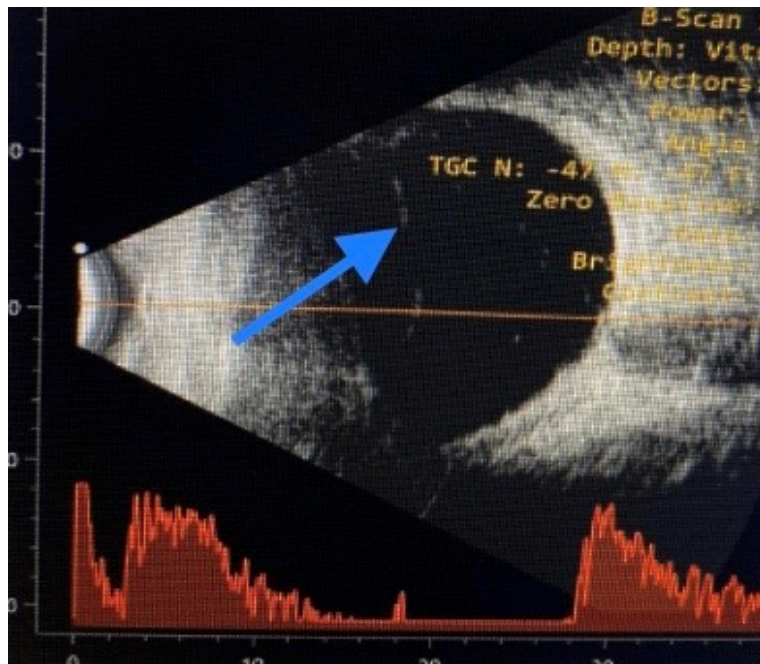


Fig. 3:

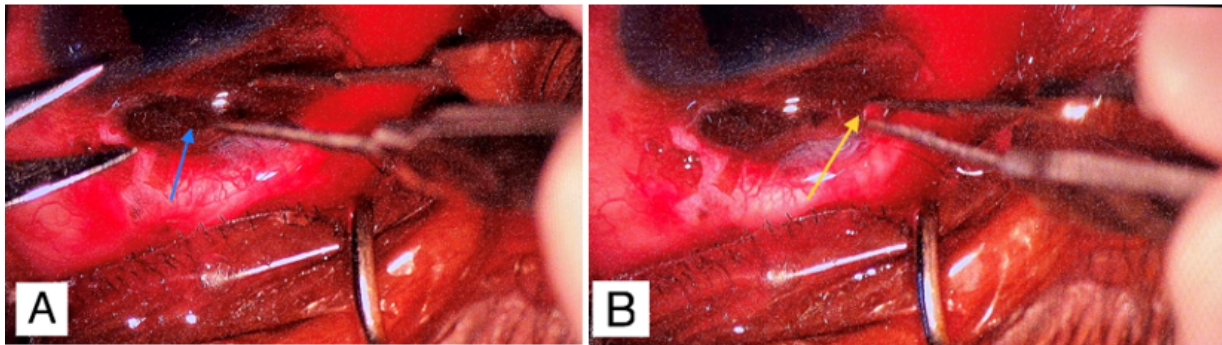


Fig. 4:

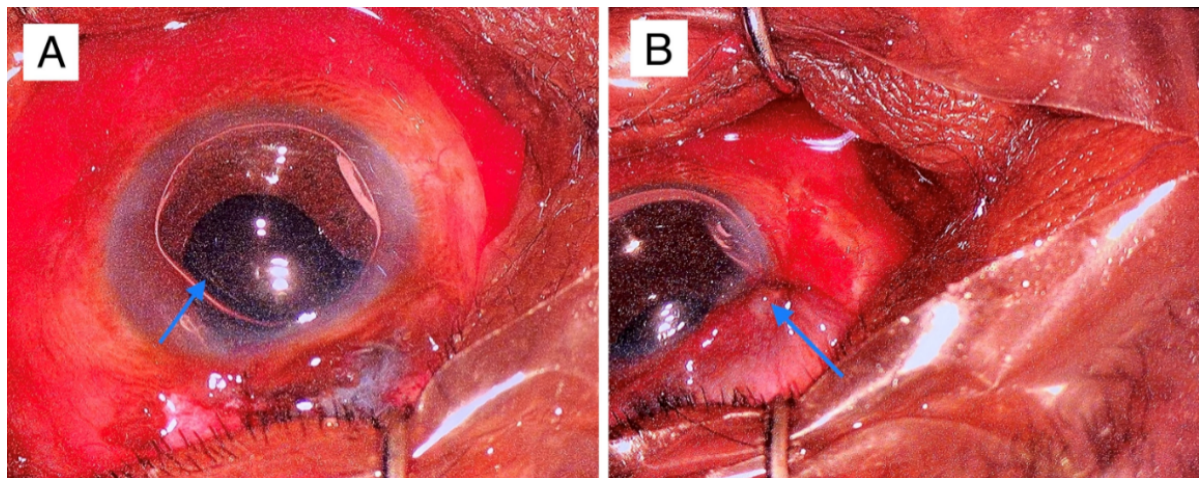


Fig. 5:

On fundus examination a mild vitreous haemorrhage in the background of the affected eye was noted, with a normal disc and the retina ON. B-scan imaging showed dot like echo's suggestive of posterior vitreous detachment or vitreous haemorrhage (Figure 3). After a complete evaluation, the patient was operated the next day during which An Iris abscission was performed with suturing of the incision scare gaping wound. (Figure 4 a & b). An anterior vitrectomy was also performed after intra-cameral injection of KENACORT to clear the anterior chamber of the vitreous strands; this was followed by an anterior chamber reconstruction and wash. 0.01ml Intra-cameral moxifloxacin 0.5 percent was also given. An air bubble was injected in the anterior chamber and sutures closed. (Figure 5 a & b). Patient is planned for a secondary scleral fixated intra-ocular lens (SFIOL) implantation on a later date.

3. Discussion

Although a rare phenomenon, sub-conjunctival dislocation of the intra ocular lens have been reported previously in a few cases, however an expulsion of the dislocated lens is almost unheard of. Biedner et al, first reported a case of subconjunctival dislocation of an IOL implant in 1977 and termed it pseudophacocele.³ Bene and Kranias⁴ and Sandramouli et al⁵ reported dislocation of posterior chamber IOL into the subconjunctival space following blunt trauma.

Sub conjunctival dislocation of the IOL happens following a blunt trauma due to dehiscence of the corneal-scleral wound scar. Conjunctival disruption was not noted at the limbus, which can be due to the higher elasticity of the conjunctiva. Sub-conjunctival dislocation is the most common type, however sub-choroidal and supra-choroidal dislocation have also been seen as reported by Foster et al⁶ in which they described a PC IOL that had dislocated into the suprachoroidal space. In extreme cases, the PC IOL may be completely extruded from the eye. In our case, blunt trauma had caused subconjunctival extrusion of the PC IOL producing pseudophacocele with dehiscence of the corneal-scleral wound and hypotony without any disruption of the limbal conjunctival attachment. This could be explained by the higher conjunctival elasticity compared to the sutured corneal-scleral wound. Our case is an extreme one where the IOL is completely extruded from the eye.

4. Conclusion

An early presentation and diagnosis help prevent the more serious complications such as endophthalmitis and

panophthalmitis. In our case the prolapsed ciliary tissue and vitreous might have helped in preventing infection by plugging the wound. Early intervention paves the way for a better surgical outcome and eventually a more promising visual outcome

5. Conflict of Interest

None.


6. Source of Funding

None.


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