**Sir,
Blebitis with scleral abscess in a case of operated
trabeculectomy with mitomycin C and a
subconjunctival ologen implant**

We report a case of juvenile open-angle glaucoma who underwent mitomycin-augmented trabeculectomy with subconjunctival ologen implantation, and subsequently developed scleral abscess and endophthalmitis.

Case report

A 19-year-old male presented with BCVA of 6/24 OD and 6/6 OS. His intraocular pressure was 20 mm Hg OD and 18 mm Hg OS on maximal medical therapy with a vertical cup:disc ratio of 0.9:1 OU. Gonioscopy showed open angles with prominent iris processes with severely depressed visual fields.

Superior fornix-based trabeculectomy with adjuvant 0.01% mitomycin C (1 min) along with subconjunctival ologen implantation was done OU. Conjunctiva was secured using 7-0 Vicryl. He was prescribed topical moxifloxacin 0.5%, prednisolone 1%, and tropicamide 1% drops at discharge on day 2; following which he was lost to follow-up. Two months postoperatively, the patient presented with sudden painful visual loss in his right eye. On examination, his BCVA was perception of light only with inaccurate ray projection; he had diffuse circumcorneal congestion and fibrinous exudates in anterior chamber, an exposed ologen implant, a necrotic bleb, and a scleral abscess (Figure 1). Ultrasonography of posterior segment showed endophthalmitis along with suprachoroidal exudates. Culture of bleb exudates revealed *Staphylococcal* species. He was treated with intravenous ceftriaxone and vancomycin, fortified antibiotics, and cycloplegic drops along with intracameral 5% vancomycin. Because of partial reabsorption, a well defined ologen could not be appreciated to allow explantation. In consultation with a retinal specialist, intravitreal antibiotic instillation or pars plana vitrectomy was not considered in view of suprachoroidal infiltrates. Despite best efforts, patient lost light perception in that eye.

Comment

Trabeculectomy with combined use of low-dose mitomycin C and subconjunctival ologen implant has been found to be effective in controlling IOP.¹ No difference has been found in relative incidence of BRI when trabeculectomy is performed with adjuvant mitomycin or ologen implant.² Although bleb leaks and shallow chambers have been reported with ologen use,³ exposure of the implant is a rare occurrence,⁴ and its association with endophthalmitis has not been previously reported. Bleb related infections (BRI), though infrequent, are potentially vision threatening; usually present with the most likely causative organisms being *Streptococcus*, *Staphylococcus*, and *H. influenzae*.⁵ Meticulous conjunctival closure should be done during trabeculectomy to prevent ologen exposure as it can act as a nidus of infection. Primary care eye physicians should explant ologen without delay if any exposure is

Figure 1 Clinical photograph of the affected eye showing an exposed ologen and an inflamed and red conjunctiva over the area of bleb which has partially receded back. Mucopurulent exudates can also be seen through the receded conjunctiva indicating an underlying scleral necrosis.

seen associated with signs of blebitis. It is important to counsel patient that if they develop symptoms of BRI (diminution of vision, redness, pain, and photophobia) at any time after surgery, immediate check-up at the nearest eye care facility is mandatory.

Conflict of interest

The authors declare no conflict of interest.

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