Reminder of important clinical lesson

Missed sclera buckle as a cause of recurrent conjunctivitis

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Summary

A 63-year-old woman was referred to the eye clinic with a 2-year history of unresolving right eye discomfort, irritation and recurrent conjunctivitis, managed by her general practitioner, where frequent use of topical antibiotics and ocular lubricants provided little and transient relief. The right eye was blind following a complicated retinal detachment surgery 30 years ago. Examination revealed an extruding silicone sponge scleral buckle from a previous retinal detachment surgery in the superior conjunctival fornix, under the right upper lid. This was subsequently surgically removed and her symptoms resolved.

BACKGROUND

This case illustrates the importance of thorough history taking and clinical examination when assessing cases of red eyes. The patient made multiple visits to her general practitioner with recurrent symptoms of ocular discomfort and conjunctivitis. However, the association of her presenting symptoms with her ocular history of retinal detachment surgery and the possibility of retained foreign bodies was not considered early on in the presentation, thus delaying the diagnosis and appropriate management.

This case also demonstrates the necessity of eyelid eversion in any case of sore, red eyes, to exclude the possibility of foreign bodies as a cause. It reinforces the value of careful reassessment and consideration of other differential diagnoses when confronted with cases where symptoms are recurrent or non-resolving to seemingly appropriate management.

CASE PRESENTATION

A 63-year-old woman was referred by her general practitioner to the eye clinic with a 2-year history of right eye discomfort. She also complained of recurrent symptoms of intermittent redness, pain and discharge, for which topical antibiotics had been used with transient moderate improvement in symptoms. Topical ocular lubricants have also been used, with limited success. She had been fit and well previously with no medical history of note, and not on regular medications. However, there was an ocular history of a complicated right retinal detachment surgery 30 years ago following a road traffic accident. The right eye was blind as a result, with a visual acuity of no perception of light (NPL).

On examination, unaided visual acuity was NPL right eye, and 6/6 left eye. There was a 1 mm right upper lid ptosis in comparison with the left. The right conjunctiva was injected and hyperaemic with superior chemosis. Superficial punctuate staining on the superior surface of the cornea were present and pointed towards local corneal irritation. On right upper eyelid eversion, a protruding scleral buckle in the superior conjunctival fornix was visible with surrounding purulent discharge (figure 1). Dilated fundus examination revealed right chronic

retinal detachment. Examination of the left eye was unremarkable.

TREATMENT

Scleral buckle was removed under general anaesthetic. As the eye was already blind, there were no concerns about retinal redetachment. In a seeing eye, retinal integrity would need to be assessed before removing the sclera buckle. Nevertheless, the risk of retinal redetachment is low if retinopexy or cryotherapy was performed at the time of retinal detachment surgery.¹

OUTCOME AND FOLLOW-UP

Following the surgical removal of the sclera buckle, the patient's symptoms quickly improved with no recurrence. She continues to use topical lubricating eye drops for occasional discomfort.

DISCUSSION

Conjunctivitis is a common eye condition. The presenting features are hyperaemia, discomfort, pain and watering, with or without accompanying discharge. The most

Figure 1 Protruding silicone sponge scleral buckle visible on lid eversion in the superior fornix with surrounding conjunctival injection.

common causes are infective or allergic, but it can also occur following an ocular chemical injury, as part of a systemic disease such as pemphigoid, or secondary to a retained foreign body.² Symptoms are relatively non-specific in identifying the cause, but good history taking and examination findings can help in identifying the cause.

Chronic and/or recurrent symptoms should prompt reassessment of the diagnosis or search of alternative causes. Conjunctival swabs are useful in identifying chronic infections, such as chlamydia or gonorrhoea. Conjunctival biopsies are done infrequently, but may be of value when granulomatous disease is suspected, or to rule out neoplasia. Her ocular history cannot be underestimated, in particular are previous ocular surgery and contact lens use. A retained foreign body is an infrequent but important cause of chronic conjunctivitis, reinforcing importance of thorough clinical examination and eversion of eyelids.^{3–7}

Scleral buckling has been an effective method for retinal detachment surgery for over half a century. However, with the introduction of vitrectomy and internal tamponade, scleral buckling is performed much less frequently these days. Extrusion of a buckle is a well-known complication, seen in both solid and sponge silicone implants that can erode through conjunctiva.^{8–9} Previous case reports also described transpalpebral scleral buckle extrusion, where the explant eroded through the conjunctiva and the full thickness of the upper eyelid transversing the tarsal plate.^{10–11} Here we have a case where extrusion of silicone sponge occurred almost 30 years after the retinal detachment surgery. Other complications of scleral buckle are intrusion, infection and inflammation.^{8–11}

It is not uncommon for unilateral blind eyes to have recurrent or chronic symptoms of pain, redness and discomfort, which can be attributed to the original blinding disease or injury. The more serious diseases causing significant chronic symptoms in blind eyes include intraocular haemorrhage, glaucoma and uveitis.¹² In many cases, these complications can present 20–30 years after the original problem, where the eye could have been asymptomatic for many years before.¹² Therefore, in our case, an early referral to the local ophthalmologist is warranted, thus emphasising the significance of the ocular history when managing any ophthalmic case.

Learning points

- ▶ Eyelid eversion is paramount when assessing cases of red and/or sore eyes to exclude offending foreign bodies.
- ▶ Re-evaluate the diagnosis and management plan when symptoms are recurrent or non-resolving.
- ▶ The ocular history is of uttermost importance when assessing ocular cases as there can be an association with the presenting complaints.
- ▶ When general practitioners are faced with recurrent, unresolving eye complaints, they should consider seeking second opinion from their local ophthalmologists if appropriate, to minimise the risk of delays in diagnosis and initiating appropriate management plans.

Competing interests None.

Patient consent Obtained.

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