Abstract 130

BUCKLE INDUCED PANOPHTHALMITIS, SCLERAL ABSCESS AND ENDOPHTHALMITIS- A CASE REPORT

Ganesh M.*, Chawla R., Aggarwal V.

Dr Rajendra Prasad Eye Centre for Ophthalmic Sciences, All India Institute of Medical Sciences ~ New Delhi ~ India

A 19 year old male patient presented with post traumatic total retinal detachment in the left eye, for which he underwent scleral buckling procedure. His vision was 6/12 in the left eye and IOP was 12mmHg post buckling on day one postop.

Presentation 1- One week postop he presented with a vision of 3/60 and IOP of 15mmHg in the left eye associated with ocular pain, upper eye lid edema with peri-orbital discharge, conjunctival chemosis and with mild limitation of extraocular movements. Left eye retina was attached.
Management 1- He was started on intravenous ceftriaxone 1gm BD and intravenous vancomycin 1gm BD and underwent left eye buckle explant, the 5-0 ethibond suture-infiltrates were sent for culture sensitivity. The cultures came out to be positive for methicillin resistant staphylococcus aureus which was sensitive to gentamycin, tobramycin, amikacin, tetracycline, chloramphenicol and vancomycin. Post buckle explant, his lid edema and conjunctival chemosis reduced drastically. Vision was 6/24 improving to 6/12 with pinhole, IOP was 13mmHg and retina was attached in the left eye. Intravenous antibiotics were continued for one week. After one week, the patient was started on oral tablet doxycycline 100mg BD and eye drop tobramycin concentrated 1.3% TDS in the left eye. Oral tablet doxycycline and eye drop tobramycin in the left eye were stopped two weeks post buckle explant. Panophthalmitis had resolved completely and retina was attached post buckle explant.
Presentation 2- Two weeks and six days post buckle explant, patient present with a temporal scleral abscess, an attached retina with a supero-temporal focus of whitish exudate corresponding to the scleral abscess seen through indirect ophthalmoscopy. There was no vitritis. His vision was 6/12 and IOP was 12mmHg in the left eye.
Management 2- The patient was given three subconjunctival gentamycin 0.3% (1.5mg in 0.5ml) injections on three consecutive days around the scleral abscess. Oral tablet doxycycline 100mg BD was restarted. Oral tablet vancomycin 250mg QID was started. Eyedrop tobramycin concentrated 1.3% was restarted two hourly and eyedrop chloramphenicol 0.5% TDS was added in the left eye.
Presentation 3- There was no improvement in the scleral abscess post the subconjunctival injections in the left eye. Left eye retina was attached, the supero-temporal focus of whitish exudate was increasing in size seen through indirect ophthalmoscopy. The patient developed grade one vitritis in the left eye. His vision in left eye was 6/24, not improving with pinhole and IOP was 16mmHg.
Management 3- The patient was given intravitreal injection vancomycin 1mg in 0.5ml, intravitreal injection amikacin 0.4mg in 0.5ml and intravitreal injection tobramycin 200ug in 0.5ml in the left eye. Oral tablet doxycycline 100mg BD and oral tablet vancomycin 250mg QID were continued. Eyedrop tobramycin concentrated 1.3% two hourly and eyedrop chloramphenicol 0.5% TDS were continued in the left eye.

One week post intravitreal injections, left eye vitritis had resolved, retina was attached and the supero-temporal focus of whitish exudate had resolved completely as seen on indirect ophthalmoscopy. The temporal scleral abscess was healing. Patient's vision in left eye was 6/24 improving to 6/12 with pinhole and IOP was 14mmHg. Oral antibiotics were continued for two months post intravitreal

antibiotics, keeping his kidney function in check every two weeks. Topical eyedrops were continued for three months post intravitreal antibiotics, tapering eyedrop tobramycin concentrated 1.3% from two hourly to TDS after one month. Three months post intravitreal antibiotics, patient's vision in left eye was 6/9 with an IOP of 15mmHg. Temporal scleral abscess in the left eye had completely healed. Retina was attached.

We report a case of a young healthy patient who developed panophthalmitis, scleral abscess and endophthalmitis after scleral buckling procedure. Once scleral implant infection occurs, panophthalmitis results requiring removal of the implant with resolution.