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"RETINAL DETACHMENT ASSOCIATED WITH MORNING GLORY ANOMALY: DECISION MAKING"

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I present the case of a 16-year-old male, who came to the first consultation accompanied by his mother and reported that he had had a white spot in his left eye for 2 years. He reported that he had always had poor vision in that eye. On ophthalmologic examination he presented a white cataract and a visual acuity of light perception.
In order to rule out infectious etiologies, several tests were requested but were negative. In addition, an ocular ultrasound was performed which revealed the presence of a retinal detachment.
He was scheduled for phacoemulsification + vitrectomy surgery of the left eye under general anesthesia.

Vitrectomy via pars plana was performed in combination with external drainage. The surgery was performed with a conservative approach to avoid further damage.

Description of the surgical procedure:
The patient had a white cataract with anterior fibrosis and marked zonulodialysis. Phacoemulsification was performed, maintaining an integral posterior capsule, with persistent fibrosis at the periphery of the anterior capsule.
A retinal detachment associated with Morning Glory anomaly was evidenced, which was of inferior predominance, with subretinal bands and glial tissue over the optic disc, forming central radial retinal folds, in addition to a traction fold towards the inferior nasal periphery.
By aspirating and cutting more vitreous, the retina became more mobile and bullous, which increased the risk of an iatrogenic rupture, however, liquid perfluorocarbon was not placed due to the risk of migration. I aspirated near the excavation, hoping to drain subretinal fluid, since it has been reported that there may be retinal holes at that level, but no subretinal fluid was obtained.
With the aid of micropincers, the glial tissue located within the optic disc excavation was removed. Triamcinolone was used to facilitate removal of the hyaloid. As the surgery progressed, no retinal breakpoint was identified, so it was felt that the glial tissue over the optic disc was likely responsible for the traction and retinal detachment. At that point, the retina was even more baggy and mobile, with inferior nasal radial traction that was less than at baseline. Drainage retinotomy versus external drainage was considered, and the latter was finally chosen. An inferior temporal peritomy, a small sclerotomy and puncture with a 22G needle were performed to achieve this.
On re-entering the vitreous cavity, a much more applied retina was observed, although some inferior nasal traction persisted. The conjunctiva was sutured with 7-0 vicryl. Liquid-air exchange was performed, at the end of which small collections of subretinal fluid were still visualized, which were left, hoping that, in the absence of retinal holes, the RPE would be in charge of reabsorbing it. The trocars were removed and C3F8 gas was placed.

- The retina was successfully applied, with only mild inferior nasal traction persisting.
- Better ocular cosmesis was achieved for this adolescent patient.
- Visual acuity changed from light perception to hand movement. The patient's visual potential was

evaluated with lens testing, however, it did not improve further due to amblyopia in that eye, so it was decided not to perform a second surgery for intraocular lens implantation.

Highlighting the individualized approach, the decisions made comply with the principles of retinal detachment management, however, given the rare nature of this pathology, these approaches could be subject to discussion and revision, which opens the door to an enriching debate on best practices in these complex cases.