Cavernous sinus thrombophlebitis can progress very rapidly—often in a matter of hours—and even with appropriate surgical and antibiotic treatment, it can be fatal or result in serious complications. Escardo et al reported a case of orbital cellulitis caused by F. necrophorum that required 3 urgent surgical interventions and 30 days of intravenous antibiotic treatment. Despite this intensive treatment, the patient’s vision did not fully recover. Early examination of the patient with only a 1-day history of proptosis may have allowed early diagnosis and treatment and possibly helped to preserve sight.

This case also illustrates the prolonged period that may be required to isolate Fusobacterium organisms. It is therefore imperative that cultures be allowed a protracted incubation period so that important pathogens are not missed following isolation of rapidly growing pathogens, resulting in inappropriate antimicrobial therapy.

Although rare, F. nucleatum can be a cause of severe septic thrombophlebitis of the orbit and cavernous sinus, which, despite intensive treatment, may result in severe morbidity.

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Orbital Abscess Following Subtenon Triamcinolone Injection

Orbital infections are often associated with pain, erythema, swelling, and warmth of the periorbital tissue and may affect pupillary responses, ocular motility, and visual acuity. The most common cause is sinusitis; however, inoculation as a result of trauma or bacteremia or as an extension from adjacent infected teeth, lacrimal sac, or eyelids has also been described. Abscess formation is a potential complication that often requires surgical drainage in addition to systemic antibiotic therapy. In this report, we describe an orbital abscess that developed following a subtenon injection of triamcinolone acetonide without associated signs or symptoms of inflammation.

Report of a Case. We evaluated a 90-year-old woman for a progressively enlarging orbital mass. She had macular edema secondary to a branch retinal vein occlusion in the left eye that was unresponsive to treatment with laser photocoagulation. She subsequently had 2 subtenon triamcinolone injections performed 1 month apart in a standard manner by passing a 25-gauge needle through the superotemporal conjunctival fornix. Three weeks after the second injection, the patient noted a left orbital mass that became progressively larger without any associated pain, discharge, diplopia, or change in visual acuity.

Visual acuity was 20/100 OS. There was a soft, well-demarcated, 2-3 cm mass located in the superotemporal left orbit with blepharo-phtosis but no erythema, warmth, or tenderness (Figure 1). Exophthalmometry measurements were 21 mm OD and 23 mm OS. The pupil reactions were normal without an afferent defect, and motility was full in all directions of gaze. Funduscopy revealed a laser grid pattern along the superotemporal arcade and macular edema but no optic nerve swelling.

A computed tomographic scan with contrast was obtained and revealed a low-density mass with an enhancing rim just above the lacrimal gland but with no intracanal extension, bone erosion, or paranasal sinus disease (Figure 2). Seven milliliters of green, purulent fluid was removed by fine-needle aspiration. A stab incision was made into the mass, and loculations were disrupted by curettage. A drain was inserted, and the patient was given an oral course of clindamycin hydrochloride because of a previous peni-
Comment. Subtenon corticosteroid injections are commonly used in the treatment of macular edema or posterior segment intraocular inflammation. Complications include inadvertent intravascular injection, globe perforation, cataract formation, ocular hypertension, blepharoptosis, orbital fat atrophy, strabismus, or allergic reactions. To our knowledge, this is the first report of an abscess resulting from such an injection. The lack of inflammation was atypical for an infection and was likely related to the local immunosuppressive effects of triamcinolone.

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Acute Angle-Closure Glaucoma Associated With Intranasal Phenylephrine to Treat Epistaxis

Phenylephrine hydrochloride is a direct-acting α1-adrenergic agonist used for its mydriatic and vasoconstrictive properties. In addition to its ophthalmic uses, phenylephrine is used in the management of epistaxis for which it is instilled intranasally to induce vasoconstriction prior to cautery or packing. We describe a patient who developed sequential ipsilateral acute angle-closure attacks after intranasal phenylephrine use.

Report of a Case. At initial examination, a 67-year-old woman had right eye pain, redness, blurry vision, and nausea. Prior to the onset of symptoms, the patient had experienced right-sided epistaxis that was treated in an emergency department with intranasal 0.25% phenylephrine hydrochloride, topical tetracaine, silver nitrate cautery, and nasal packing.

Visual acuity was 20/200 OD and 20/40 OS. The patient’s refractive error was +1.75 diopters (D) OD and +2.00 D OS. The right pupil measured 7 mm and was nonreactive. The left pupil measured 4 mm and constricted to direct and consensual stimulation. Intraocular pressure was 62 mm Hg OD and 18 mm Hg OS. The right eye had conjunctival hyperemia, corneal edema, a quiet anterior chamber, and iris bombe. The lens had moderate nuclear sclerosis. Findings from the left eye were unremarkable, except for similar lens changes. There was a hazy view of the right fundus. The left fundus was normal, with a cup-disc ratio of 0.2.

The patient was treated with 1 drop of 0.5% timolol maleate and 2% dorzolamide hydrochloride to the right eye followed by 100 mL of oral glycerin. This was repeated 15 minutes later. An attempt to create a Nd:YAG laser peripheral iridotomy was unsuccessful. The patient had multiple episodes of emesis during treatment, and she was transferred to the emergency department, where she received 12.5 g of intravenous mannitol and 1 drop of 4% pilocarpine hydrochloride. Intraocular pressure improved to 30 mm Hg. The patient was given 12.5 mg of promethazine hydrochloride for emesis and subsequently developed mental status changes, and she was admitted for observation.

The evening prior to hospital discharge, the patient had an episode of left-sided epistaxis and was emergently treated, without ophthalmic consultation, with intranasal 0.25% phenylephrine hydrochloride and nasal packing by the hospital staff (not affiliated with the hospital of initial examination) who were unaware of the inciting event of her