the right eye and no light perception in the left eye. Slitlamp examination showed an edematous graft in the right eye and an opacified, vascularized cornea in the left eye. Renewed B-scan ultrasonography in the right eye showed that the patient now had total retinal detachment in a funnel configuration. The left eye showed a tight funnel retina as previously seen. This configuration was considered inoperable, and given the extent of the patient’s anterior segment problems, further surgery was deferred.

Comment. Xerophthalmia (xerosis, dry; ophthalmia, inflamed eye) is a term that includes all ocular manifestations of vitamin A deficiency (night blindness to keratomalacia) and has been categorized by the World Health Organization. The differential diagnosis of keratomalacia includes severe sicca syndrome, exposure keratopathy, or corneal ulcer (infectious, neuropathic, or autoimmune). Xerophthalmic ulceration ranges from small, characteristically sharp-margin ulcers located in the periphery of the cornea, to full-thickness, nearly limbus-to-limbus melting. The mechanism of corneal necrosis remains unclear, but it has been postulated that inflammatory cells releasing proteases such as collagenases may be responsible for the corneal necrosis.

When keratomalacia has progressed to almost total melt involving the entire cornea, vitamin A treatment has virtually no effect. Herein we have described the unexpected tragic evolution of a case of vitamin A deficiency in a boy from a highly educated, affluent family that was diagnosed late and led to blindness despite the best medical effort. This case reminds us once again that social customs, cultural differences, and lifestyle matter in making an accurate and prompt diagnosis.

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**Capsular Bag Hematoma Following Trabeculotomy**

Since its introduction in 1967, trabeculotomy has become the standard surgical treatment modality for most forms of glaucoma. The early postoperative complications reported are hypotony, shallow or flat anterior chamber, hypHEMA, choroidal detachment, uveal effusion, wound leak, malignant glaucoma, suprachoroidal hemorrhage, and endophthalmitis. Describe an interesting case of a capsular bag hematoma following trabeculotomy, a hitherto unreported complication.

**Report of a Case.** A 57-year-old man was initially examined at our tertiary care institute and had a history of total visual loss in his left eye following surgery for glaucoma elsewhere 3 weeks earlier. On examination, his best-corrected visual acuity was 20/30 in the right eye, and hand motions close to his face with accurate projection of rays in the left eye. Intraocular pressure in the right and left eyes was 14 and 12 mm Hg, respectively. The left eye revealed a thin moderate-sized bleb and a quiet anterior chamber with normal depth. Results of a dilated examination revealed a posterior synchiae at the pupil margin at the 1 o’clock position and a peripheral iridectomy in the same meridian. The crystalline lens appeared to have a brownish hue throughout, with a bright red collection in the anterior subcapsular area just behind the area of posterior synchiae (Figure, arrow). There was no view of the posterior segment. Findings from a B-scan ultrasonogram revealed a normal posterior segment in the left eye. The patient was posted for phacoemulsification and aspiration of the blood along with intraocular lens implantation. Capsular staining with trypan blue failed to provide adequate contrast in view of the dark reflex of intralenticular contents. Capsulorhexis was then achieved from the anterior capsule reflex under high magnification. Phacoemulsification power was totally ineffective in removing the blood-impregnated epinucleus shell, and it had to be manually stuffed into the port of the phaco tip with a chopper. A normal red reflex was achieved as soon as this blood clot was removed, and

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Left eye of the patient showing a brownish hue of intralenticular contents. Note the area of bright red anterior subcapsular blood collection (arrow).

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a hydrophilic acrylic intraocular lens was implanted in the capsular bag. The early postoperative period was uneventful, and the patient achieved a best-corrected visual acuity of 20/30. Within the next 2 months, there developed an excessive capsular bag fibrosis with mild upward decentration of the intraocular lens.

Comment. Although hyphema is one of the most common early postoperative complications following trabeculectomy, to our knowledge, intralenticular collection of blood has not been previously reported. Because of the use of an operating microscope and the refinement of surgical techniques, lens injury during trabeculectomy has been infrequently reported. We hypothesized that there had been anterior capsule injury while performing peripheral iridectomy in this case, with seepage of blood into the capsular bag.

The development of a fibrous type of posterior capsule opacification in relation to the presence of blood in the capsular bag, as was evident from the exaggerated postoperative capsular bag fibrosis in this case, has been previously noted. This case highlights the possibility of lens injury during trabeculectomy and provides an insight into the problems encountered while performing phacoemulsification when there is intralenticular blood collection.

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### Episodic Elevations in Intraocular Pressure Associated With Blood in the Schlemm Canal

Elevated intraocular pressure (IOP) associated with blood in the Schlemm canal may be associated with many different conditions. To our knowledge, we describe a previously unreported case of a patient with recurrent, intermittent spikes in IOP associated with episodic and transient blood in the Schlemm canal. Whenever the patient was examined because of elevated IOP in one or both eyes, gonioscopy disclosed the presence of blood in varying quadrants of the Schlemm canal in the affected eye(s). Whenever IOP was normalized, with or without medical therapy, the blood was no longer visualized.

Report of a Case. A 38-year-old woman of Latin American descent sought medical care because of right ocular pain, redness, and decreased visual acuity of approximately 12 hours' duration. The pain was not relieved by ibuprofen. The patient reported a history of similar ocular episodes that had occurred intermittently during the preceding 2 years. Her medical history was significant for systemic hypertension and left elbow surgery; her blood pressure was 160/90 mm Hg at the time of examination. There was no significant ocular, family, or social history.

On initial examination, visual acuities were 20/40 OD and 20/25 OS, with a mid-dilated, minimally reactive pupil in the left eye. We found no proptosis, orbital bruits, or pulsating exophthalmos. The right conjunctival region had a mild red appearance, and mild corneal edema or haze was noted in the right eye. There was no apparent dilation of the episcleral veins. The left anterior segment appeared normal. Goldmann applanation tonometry measurements were 55 mm Hg OD and 17 mm Hg OS. In the right eye, gonioscopy showed open angles with blood in the Schlemm canal inferiorly, temporally, and superiorly (Figure). Gonioscopic findings of the left angle structures were unremarkable. Dilated funduscopic examination of the right eye showed mild vascular tortuosity without leakage on fluorescein angiography. Ophthalmodynamometry measurements were 70 mm Hg OD and 60 mm Hg OS (both within normal limits). The elevated IOP was initially treated with an intensive course of topical medications and oral agents (eg, acetazolamide and glycerin). Once the IOP was normalized, the patient was prescribed an antiglaucoma regimen of timolol maleate, latanoprost, and dorzolamide hydrochloride.

During the next 5 months, the patient experienced recurrent, in-