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; opthalmia, 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). Xerophthallic ulceration ranges from small, characteristically sharp-margined 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.

Margarita I. Rodrigues, MD
Claes H. Dohlman, MD, PhD

The authors have no relevant financial interest in this article.

Correspondence: Dr Dohlman, Department of Ophthalmology, Massachusetts Eye and Ear Infirmary, 243 Charles St, Boston, MA 02114 (claes_dohlman@meei.harvard.edu).


Capsular Bag Hematoma Following Trabeculectomy

Since its introduction in 1967, trabeculectomy 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, endophthalmitis. We describe an interesting case of a capsular bag hematoma following trabeculectomy, 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 pupillary 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

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

G. S. Brar, MS 
Jagat Ram, MS 
Jaspreet Singh, MS 
Ravinder Kaur, MS 
Amod Gupta, MS 

The authors have no relevant financial interest in this article.

Correspondence: Dr Brar, Department of Ophthalmology, Postgraduate Institute of Medical Education and Research, Chandigarh 160012, India (eyepgi@satyam.net.in).