ranibizumab in the past 10 months, his vision had reached 20/70, which produced significant difficulties for carrying out his daily activities. Fluorescein angiography was carried out, which revealed a superior extrafoveal leak point temporal to the papilla which caused serous detachment of the entire macula (Fig. 1). After the patient declined the photodynamic therapy option, a single photocoagulation session was performed on the leak point with subthreshold diode laser in a rectangular pattern including 6 treatment points, activating EndPoint Management® (Topcon Medical Laser Systems, Santa Clara, CA, USA) with an intensity of 150 mV and a spot size of 100 μ. Three weeks later, a significant subretinal fluid reduction was observed and patient vision improved to 20/40. Subsequently, after 8 weeks the subretinal fluid had disappeared entirely and vision had improved to 20/25. No anatomic changes were found in the laser treatment area or in infrared reflectance, or autofluorescence or optic coherence tomography.

The option of treating active leak points with subthreshold laser in patients with visual deterioration secondary to CSC could constitute a safe and effective alternative for accelerating visual recovery. Future studies are necessary to verify the excellent results obtained in the case presented herein.

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Use of intracameral triamcinolone in pediatric cataract surgery. Diagnostic and therapeutic usefulness

Uso de triamcinolona intracameral sin conservantes en cirugía de la catarata pediátrica. Utilidad diagnóstica y terapéutica

Dear Sir:

The most frequent complications of pediatric cataract surgery (PC) with or without IOL implants, are early post-surgery inflammation and loss of visual axis transparency. These 2 complications are feared because they hamper visual rehabilitation and give rise to difficult complications like secondary glaucoma. The appearance of these complications diminishes when peripheral iridectomy is not performed and when the surgery begins with the pressurized chamber, which shortens surgery time and enables meticulous aspiration of all cortical residue. In addition, the use of subtenon depot corticoids (Trigon Depot®, Bristol-Myers Squibb SL, Nueva York, NY, USA; Celestone Cronodose®, Schering-Plough, S.A., Madrid, Spain) has demonstrated to be efficient. Subsequently, a presurgery posterior capsulorhexis with anterior vitrectomy has been added as an option for enhancing the prevention of post-surgery inflammation.

Starting in 2009, the use of intra-chamber preservative-free triamcinolone acetate (TA) began to be suggested for application at the end of PC surgery with IOL implant due to its anti-inflammatory effects or as adjuvant for vitrectomy, observing lower incidence of early inflammation and visual axis opacification. Also, the use of enoxaparin (low molecular weight heparin) has been suggested in the infusion liquid (BSS), with results void of significance when compared with the group that does not use this product.

Since 2011 we have included in our clinical practice the use of TA with diagnostic purposes in PC surgery with or without IOL implant—in patients under 6–8 years—for diagnostic purposes for visualizing the vitreous and performing correct vitrectomy, as well as for therapeutic purposes to

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diminish early post-surgery information (Fig. 1). We have not observed in our patients post-surgery endophthalmitis, ocular hypertension or glaucoma with a follow-up exceeding 2 years. At present, we also use TA in the surgeries in which we do not perform vitrectomy. The TA dose is of 0.1–0.2 ml obtained by diluting decanted Trigon depot® (4 mg/0.1 ml) and reconstituted with 1.5 ml 0.9% ClNa 0.9% or BSS, sufficient to impregnate the vitreous and achieve the desired anti-inflammatory effects. TA is liposoluble, which facilitates its addition to the corneal endothelium and iris. However, before introducing TA it is important to previously inject dispersive viscoelastic. A part of TA is extracted by means of the vitrectomy and extraction of viscoelastic while another remains in the vitreous-capsular bag-anterior chamber, and trapped due to its size in the trabecular mesh where it undergoes hydrolysis.

We have recently seen in the market a micronized 4% suspension of triamcinolone without preservatives for intravitreal use (Vitreal® S®, Sooft italia s.p.to., Montegiorgio, Italy), although we have not yet had experience with it.

Accordingly, we consider the use of intrachamber TA useful in PC surgery for diagnostic and therapeutic purposes, due to its significance in the prevention of early post-surgery information and visual axis transparency loss, even though additional research needs to be carried out to assess its potential regarding safety.

Fig. 1 – Patient, age 3.5 years, intervened for cataracts in both eyes as per described protocol, with IOL implant in capsular bag. In the RE (A) triamcinolone was not applied, with post-surgery coursing with severe inflammation leaving iridocapsular synchia as sequel. This result encouraged us to be utilized triamcinolone for the first time in the LE surgery, which involved with very little early post-surgery information, observing one month after surgery a transparent visual axis (B), which persisted after 6 months (C, D).

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