Letters to the Editor

Reference


Author reply

Dear Editor:

Dr. Messmer reports her findings of hypopyon after amniotic membrane transplantation (AMT) in two patients. The clinical situation of the described cases is, at least in case 1, different from the situation of our patient. Both patients of Messmer have a significant general medical history with an active atopic dermatitis (case 1) and an acute leukemia treated with full-body irradiation and bone marrow transplantation (case 2) compared with the “burned-out” rheumatoid arthritis in our patient. In case 1, the hypopyon occurred 4 weeks (rather than a few days) after combined superficial keratectomy, limbal allograft, and AMT in the context of limbal graft rejection. The second case with hypopyon formation 2 days after repeated AMT shows some parallels with our patient, although a perforating keratoplasty had been performed between the AMTs. Unfortunately, it is not mentioned whether the amniotic membranes used in case 2 were obtained from the same or from different donor placentas.

Despite the different clinical situations, more evidence emerges from Dr. Messmer’s letter that cryopreserved amniotic tissue may well trigger local immunoreactions under certain circumstances. There is a strong need for more data about complications after AMT in general and for more investigations into the immunologic implications of AMT in particular. It was shown that after cryopreservation in 50% glycerol, the epithelium of the amniotic membrane is structurally preserved, but that there are no longer any viable cells present. However, this does not exclude the possibility of immune reaction to remaining antigenic structures.

We fully agree with Dr. Messmer that particular care has to be taken of the patient in case of repeated or combined use of allogenic tissue that may stimulate/sensitize the ocular immune system. In patients with systemic disorders with immunologic implications (e.g., rheumatoid arthritis, leukemia, immunosuppressed states), this seems to be even more important.

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Reference


Ocular Hypertensive Response to Dexamethasone

Dear Editor:

In reading the paper of Ng et al on the ocular hypertensive effect of dexamethasone, we were reminded of a study we published in 1987. We had abandoned the use of topical steroids after strabismus surgery in favor of nonsteroidal antiinflammatory agents when they became available, without any apparent change in our results. We ceased any routine postoperative preparations after our study convinced us that this traditional practice was not indicated, particularly in our environment, which provides instant access to advice.

Even the imposition of a completely harmless intervention on patients and caregivers raises ethical issues. What is the evidence that the traditional routine use of a topical steroid after strabismus surgery is justified?

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References


Author reply

Dear Editor:

We can easily appreciate the concern of Drs. Dinning and Hagan regarding the use of steroids after routine strabismus surgery. Despite accumulating evidence that nonsteroidal antiinflammatory drugs may be a useful alternative in these eyes, the traditional practice of using topical steroids is still widely prevalent among surgeons. Olitsky, et al.,1 in a recent survey among members of the American Association of Pediatric Ophthalmology and Strabismus, found that more than two thirds (69%) of respondents used topical steroids in the postoperative care of their patients. It therefore seems that topical steroids still remain the “gold standard” treatment in the postoperative management after strabismus surgery. Although we applaud Drs. Dinning and Hagan4 for their pioneering study in trying to establish the safety of day-care surgery for strabismus—a practice widely in use today—we would be more cautious in recommending what they proposed: no postoperative medication after strabismus surgery. There have been rare but documented reports of serious infections after strabismus surgery and, therefore, the use of topical antibiotics seems prudent. The degree of inflammation after surgery can vary in different races, and increased intraocular inflammation has been described after cataract surgery in eyes with brown irides. We are not sure whether the same potential for increased inflammation exists after periorcular surgery as well. Increased inflammation in the postoperative milieu after strabismus surgery may potentiate increased scarring and adhesions that can affect the surgical outcome.

Given the widespread use of steroids in the postoperative period after strabismus surgery, we do not think that there are ethical issues involved in our study. On the contrary, our studies confirm the “exaggerated” ocular-