

Letter to editor

Temporal sutureless vitrectomy in infectious scleritis with retinal detachment

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Dear Editor

We shall like to share a novel effort, in which 23-gauge sutureless vitrectomy was done using a modified approach as an eye saving procedure. A 63-year-old male was referred after a buckling surgery done 5 days back OD. The patient had a total retinal detachment along with sloughing of the sclera in the superonasal quadrant. Microbial analysis of the slough confirmed the presence *Staphylococcus epidermidus*. The left eye was phthisical. In view of a “single eyed” status early intervention was planned for management of retinal detachment. Due to the location of scleritis, the pars plana port placements were refashioned temporally. The infusion cannula was inserted along the horizontal meridian and surgical ports inserted superotemporally and inferotemporally. Vitrectomy was completed with vitreous base shaving. 23 gauge ports allowed us to leave the incisions sutureless and maintain a smooth ocular surface without incising the conjunctiva. The scleritis responded to intensive topical antibiotic therapy and the patient recovered a BCVA of Snellen 4/60 at 3 months.

Pars plana vitrectomy is conventionally done with the help of three ports constructed at 3-4 mm from the limbus with the surgeon sitting at the head end of the patient. The infusion cannula is placed at the lower border of lateral rectus. The second scleral incision, usually for the endo-illuminator, is made superonasally. It is best made near along an imaginary line extending from the lowest part of the bridge of the nose through the center of the pupil. The third scleral incision is primarily for the vitreous cutter is placed along an imaginary line extending from the lowest part of the bridge of the lateral aspect of the supraorbital rim through the center of the pupil (Charles et al, 2007).

In our case we deviated from the conventional approach by placing all the ports temporally to avoid manipulating the infected tissue. Shroff et al (2010: 86) in an isolated case used this maneuver to do a more complete vitrectomy around breaks located in the temporal quadrant without having to cross the clear crystalline lens and hence avoiding the chances of a lens touch. Posterior segment access from the temporal position helped us avoid the infected sclera and 23 gauge instrumentation helped us avoiding conjunctiva disturbance and maintain a smooth ocular surface thus salvaging the eye.

References

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