

## Surgery on the Eye with Uveitis

### Uveit Olan Gözün Cerrahisi

Jagdeep Singh Gandhi



Dear Editor,

I absorbed with interest the paper by Keles and colleagues on cataract surgery in Fuchs' uveitis [1]. They highlighted that in these eyes there can be marked and prolonged inflammation after the operation. As appendix to their comments, it can be said that combining the cataract removal with intravitreal steroid leads to a fine control of inflammation in the wake of surgery.

In the past, a surgeon working on the Fuchs' eye would use intensive topical steroid for the postoperative weeks. However, in the last decade a shift to the fore of intraocular drugs has made these agents a valuable adjunct to cataract surgery. When removing cataract from eyes with noninfectious uveitis I routinely employ a dose of intravitreal steroid. This approach results in a settled course in the days and weeks following operation. It is helpful where fierce uveitis is guaranteed since the surgery has entailed the peeling of a fibrotic membrane from the pupil, the retraction of the iris, and the deployment of much ultrasound to fragment the lens. Intraoperative steroid as a strategy has been so effective that I have not needed a heavy course of anti-uveitis drugs in the preamble to surgery.

The cellular reaction that occurs in the vitreous of the Fuchs' eye – to which Keles and colleagues refer – can thus be avoided by injecting intravitreal steroid at the time of phacoemulsification. Macular oedema is a related concern in the person with ocular inflammatory disease. In such a patient the step of intraocular steroid at cataract extraction curbs any tendency towards postoperative macular oedema.

A few formulations of glucocorticoid are being used around the world for vitreal injection and from among these a suspension of preservative-free Triamcinolone Acetonide will prove economical for many healthcare settings. The steroidal side-effect to be considered is that of ocular hypertension. However, cataract excision itself lowers ocular tension and - should problematic pressure arise - I have usually found topical antipressure therapy to be adequate. The effect of steroid suspension in the vitreous lingers for some 3 to 4 months and carries the eye sedately through the post-surgical window. If the anti-uveitic effect is to be sustained into later postoperative months the intravitreal steroid is easily repeated.

It is lastly worth noting, as a general point, that if a patient cannot instil steroid eyedrops for many weeks after cataract surgery an intravitreal bolus of steroid given at operation is an alternative. In my experience, this option has been a saviour in cases of mental



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impairment, cases of poor compliance with medication, or where a recipient of eyecare has been very elderly and living with little social support.

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## References

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