



Abstracts of Poster Presentations

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Poster 1

Orbital metastasis as the presenting feature in the case of non gestational choriocarcinoma

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Purpose

To describe a case of orbital metastasis of non gestational choriocarcinoma, which presented as rapid progressive orbital mass with brain involvement.

Methods

This is a case report of a 7 year old girl who presented with headache and reduce vision of left eyes. Examination of the affected eye found non light perception vision accompanied by a relative afferent pupillary defect. Magnetic resonance imaging result was significant for heterogeneous mass in the left globe, suggestive of metastasis, and inflammatory changes. Additionally, hemorrhagic metastases were also found in the sella and suprasellar region. She underwent left exenteration with left pterional craniotomy and histo-pathological examination of orbit and brain specimen revealed malignant horiocarcinoma with typical admixture of cytotrophoblast and syncytiotrophoblast. Unfortunately, she subsequently died due to metastasis to the brain and lung.

Results

To our knowledge, this is the first case of metastatic non gestational choriocarcinoma to the orbit with brain involvement.

Conclusion

Owing to its rarity and non spesific clinical presentation, the early diagnosis of non gestational choricarcinoma involving the orbit is difficult. The diagnosis of metastatic choriocarcinoma of orbit was only made by histopathology after exenteration, hence the delay for further treatment.

Poster 2

A successful treatment of orbital melioidosis in a child

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Aim

To report a rare case of melioidosis in a healthy child presenting as orbital abscess with cavernous sinus thrombosis, who was successfully treated with high dose of intravenous ceftazidime.

Method

Case Report

Results

An 11-year-old healthy girl presented with history of high grade fever for three days and bilateral eye proptosis for one day. Visual acuity was 6/36 on the right and 6/60 on the left eye. Bilateral eye showed 4mm proptosis. There was presence of positive relative afferent pupillary defect and moderate restrictions of ocular motility in all gazes. Urgent CT Scan of brain and orbit showed bilateral orbital cellulitis with right retroorbital intraconal extension. Her conditions worsen and eye became more proptosed even after starting on intravenous antibiotics. Repeat urgent CT scan brain

and orbit showed features of bilateral orbital abscess, bilateral epidural collection and cavernous sinus thrombosis. She underwent left craniotomy, right craniotomy, evacuation of subdural empyema. Patient was treated with intravenous antibiotics. However, she developed new right eye lower lid and left eye upper lid abscess. She was commenced on intravenous Ceftazidime and incision and drainage was performed. Serology showed presence of immunoglobulin M for Burkholderia pseudomallei. She responded well to high dose of intravenous ceftazidime and vision improved to 6/6 bilaterally.

Conclusion

This case illustrates a rare presentation of orbital abscess due to melioidosis which was complicated with cavernous sinus thrombosis. A prompt diagnosis and accurate management is important to treat this potentially fatal infection.

Poster 3

A bad tooth for a good eye

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Objective

To report odontogenic orbital cellulitis with irreversible visual loss.

Method

Case report

Results

A 37 year old gentleman with no comorbid presented with sudden onset of painful visual loss associated with eye redness, swelling and fever for 3 days duration. He had a right upper molar tooth extraction a week ago followed by right facial pain for 2 days. Ocular examination revealed he has lost of perception to light in the right eye with presence of profound Relative Afferent Pupillary Defect. The right eye was proptosed with swollen, erythematous lids and total ophthalmoplegia. His right conjunctiva was congested with chemosis and the intraocular pressure was 37mmHg. Limited right fundal view due to extensive conjunctival chemosis. Left eye was normal. Systemic antibiotics and IOP lowering agents were initiated immediately. Urgent CT scan revealed pus collection from right upper second molar defect extended to right maxillary sinus and ethmoidal sinus. There were air filled pockets in the extraconal and intraconal regions, but no evidence of cavernous sinus thrombosis.

The patient was immediately referred to ENT team for FESS to decompress the orbit by drainage of the pus. Post operative right eye swelling subsided with improvement in range of extraocular movement, fundus showed right subhyaloid hemorrhage at posterior pole which then subsequently resolved, showing a cherry red spot with a pale retina and pallish disc keeping with right central retinal artery occlusion with optic neuropathy. His right eye vision remained no perception to light.

Conclusion

Odontogenic orbital cellulitis has poor visual outcome and is life threatening if diagnosed late. Hence, prompt diagnosis and good multidisciplinary collaborative management is mandatory to prevent complications.

Poster 4

A rare case of Rhabdomyosarcoma in an infant

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Objective

To report a rare case of Rhabdomyosarcoma in a 10months old infant

Method

Case report

Results

10 month old Somalian baby girl presented with progressive left eye proptosis in 1 month. Since born, the mother noticed that the left eye is slightly protruded compared to the right eye. There was no history of trauma prior to it. The left eye was blind and severely proptosed. She developed cornea ulcer secondary to exposure keratopathy which later perforated. The lesion was extensive which involving the craniofacial structure and intracranial extension. Incisional biopsy was done and the histopathology result reported as embryonal rhabdomyosarcoma.

Conclusion

Rhabdomyosarcoma is a rare tumour among infant population. Histopathology diagnosis is crucial to determine the management and prognosis.

Poster 5

Idiopathic orbital inflammatory disease (OID) in a child: A case report

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Purpose

To report a case of OID in children.

Method

Case report

Results

An 11-year-old healthy Indian boy presented with insidious onset of left eye swelling and redness over one month duration. Bilateral vision was 6/9. There was mild left proptosis with ophthalmoplegia in all directions. Lid was normal and conjunctiva was moderately congested. Optic disc was swollen with macular striation. Left B-scan showed thickened sclera with positive T-sign. Fellow eye examination was normal. Systemic examination and blood investigations were unremarkable, and were not suggestive of infective process, thyroid dysfunction, connective tissue disease or masquerade syndrome. CT revealed diffuse inflammatory process of left orbit, with uveoscleral, extraocular muscle, tendon and optic nerve thickening. A diagnosis of OID was made. He was started on corticosteroid and responded well, with complete resolution of symptoms. However, over the period of four months, he has had two recurrences while tapering the steroid. His condition was also unfortunately complicated by steroid induced diabetes. He was co-managed by medical retinal and paediatrics team and was started on immunosuppressive agent (mycophenolate mofetil). He has been doing well so far.

Conclusion

IOID is a diagnosis of exclusion. Due to its rarity in children, it is a challenge to diagnose as well as to manage as paediatric patients are more susceptible to the side effects of treatment.

Poster 6

Devastating effect of orbital abscess

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Objective

To describe a case of orbital abscess which results in devastating visual compromise

Method

Case report

Results

A 52 year old Chinese lady with undiagnosed Diabetes Mellitus presented with left painful red eye with blurring of vision for 1 week. She denied any history of fever, upper respiratory tract symptoms or ocular trauma. Her vision was perception to light OS and 6/9 OD. Relative afferent pupillary defect was negative. Examination revealed copious pus discharge from a sinus opening (suspicious of chalazion) at medial palpebral surface of left upper lid. Her left eye was proptosed with corneal epithelial defect inferiorly. Extraocular movements were all restricted. CT orbit showed an ill-defined soft tissue density mass in intraconal fat pad with streakiness in the intraorbital tissues without evidence of intraorbital abscess. She was treated as orbital cellulitis secondary to chalazion. Intravenous Rocephine and Flagyl was started, however patient did not respond to treatment. Her left eye proptosis progressed and patient developed infective keratitis secondary to purulent discharge which subsequently ended up with perforated cornea within 2 days. A repeated CT orbit showed a huge intraconal orbital abscess indenting onto left globe with displacement of optic nerve. Surgical drainage of abscess was carried out and a connection was noted between intraconal abscess with a sinus opening at the left upper lid. Patient's left eye was eviscerated in view of unsalvageable cornea perforation.

Conclusion

Orbital cellulitis usually presented with subperiosteal abscess which cause compressive optic neuropathy. In rare instances, it may present with intraconal orbital abscess with sinus opening at upper lid. Purulent content from the sinus caused secondary infective keratitis with corneal perforation.

Poster 7

A 7-year review of culture-positive endophthalmitis in Hospital Universiti Sains Malaysia

Objective

To analyze the clinical presentation of culture-positive endophthalmitis and risk factors seen in Hospital Universiti Sains Malaysia (HUSM) from January 2007 until December 2013.

Method

A retrospective review of medical records of patients diagnosed with endophthalmitis between January 2007 until December 2013 in Hospital Universiti Sains Malaysia (HUSM).

Results

Seventeen patients were admitted with a diagnosis of endophthalmitis within this 7 years of review. The majority were Malay (87.5%) and predominantly males were (68.7%). The age range was from 6 years old to 89 years old, with a mean of 47.9 ± 25.9 . Microbiological culture-proven endophthalmitis was seen in only 6 cases; 4 cases were cultured from eye specimens and another 2 cases from blood specimens. Bacterial culture revealed *Pseudomonas aeruginosa* in two cases, while in the remaining two, one culture was positive for Methilin-resistant *Staphylococcus aureus* and *Aspergillus flavus* while the other grew *Enterococcus faecium*. The remaining two cases were *Fusarium species* and *Candida Parapsilosis*. The risk factors were ocular trauma, corneal keratitis, chemical injury, severe urinary tract infection and cancer. 50% of cases could be salvaged. Three cases required surgical intervention in which two cases underwent evisceration while one underwent enucleation. All these three cases were culture-positive endophthalmitis which grew *Fusarium spp*, *Pseudomonas aeruginosa* and Methilin-resistant *Staphylococcus aureus* and *Aspergillus flavus* respectively.

Conclusion

The visual outcome of positive-culture endophthalmitis was poor prognosis. Both bacterial and fungal were found to be responsible in our culture positive endophthalmitis.

Poster 8

Management of Marcus Gunn jaw winking synkinesis

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Background

To report our experience in managing Marcus Gunn jaw winking with synkinesis.

Methods

The records of 4 patients (3 female, 1 male) presenting to tertiary referral centre with Marcus Gunn Jaw Winking synkinesis between 2012 to 2013 were retrospectively analyzed. Preoperative measurement of ptosis and levator function by Berke's method, and marginal distance were all evaluated. Moreover the amount of winking found in the upper eyelid on primary gaze was graded on a scale from 1 to 111. Generally, patient mild wink and ptosis underwent unilateral upper eyelid retractor surgery. Patients with moderate or marked wink and ptosis underwent bilateral levator weakening procedures and brow suspension.

Results

1 patient had moderate ptosis with mild jaw wink where he underwent unilateral levator resection and the other 3 patients underwent unilateral levator excision with frontalis suspension with fascia lata. 3 patients achieved good or fair final result and one patient in whom had worsening of ptosis even after reoperation. Some degree of lagophthalmos was observed in all patients in the early postoperative period. However the lagophthalmos improved in all patients without any cornea problem.

Conclusion

The management of patients with Marcus Gunn Jaw Winking syndrome is a challenging endeavor. Surgical approach will differ, depending on whether the synkinesis, ptosis or both are the main concern. Satisfactory results with a low complication rate can be achieved.

Poster 9

Herpes Zoster Ophthalmicus complicated with keratouveitis and acute third nerve palsy with pupil involvement

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Objective

To report a rare manifestation of acute third nerve palsy with pupil involvement in a case of herpes zoster ophthalmicus (HZO) in a healthy 10-year-old child.

Method

Case report

Results

A 10-year-old girl presented with painful progressive blurring of vision, diplopia and drooping of eyelids in the right eye following the onset of HZO. On examination the visual acuity was counting fingers in the right eye and 6/7.5 in the left eye. She had severe ptosis obscuring her visual axis, mid dilated pupil and superior rectus palsy of the right eye. She also developed herpetic ulcerative keratouveitis in the right eye. The cornea of the right eye had a large epithelial defect with central corneal edema at the pupillary axis. She had typical vesicular eruptions over the trigeminal dermatome of the right side of her face with positive Hutchinson's sign.

Conclusion

HZO may present with acute third nerve palsy with pupil involvement in young children.

Poster 10

Management of extensive facial capillary haemangioma with oral propranolol in a case of PHACES Association

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Aim

To report a case with PHACES Association with extensive facial capillary haemangioma which was managed with oral propranolol.

Method

Case report

Results

A 3 month old Chinese girl who was diagnosed with PHACES association was referred for massive segmental haemangioma of the face. Intralesional and oral steroids with oral steroids were initially administered with only slight improvement noted. The child was then treated with a course of oral propranolol in tapering doses for 1 year and significant improvement in the capillary haemangioma occurred.

Conclusion

Initial mainstay of treatment of extensive capillary haemangioma is with oral and intralesional corticosteroids. Beta-blocker treatment using propranolol is a revolutionising new therapy, producing impressive response as illustrated in this case report. Use of propranolol in PHACES association may prove to be superior to corticosteroids.

Poster 11

Lower lid mass in infants

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Purpose

To report a rare case of a lower lid mass in infancy

Method

Case report

Results

An Indian child presented at day 5 of life with right lower lid swelling. The swelling was persistent and started to progressively become prominent when she was at 1 year old. She was treated with systemic propranolol following standard regime for capillary hemangioma. Despite 8 months of medical treatment, the mass does not regress. The child started to have blurring of vision in the right eye with astigmatism up to -4.0DC due to compression effect from the mass. Revision of diagnosis was made. Patient was then planned for Right sclerotherapy. Regression noted as early as 1 month prior to the procedure and subsequently the mass disappeared. A diagnosis of cavernous hemangioma was made.

Conclusion

Lid mass in infancy can be difficult to diagnosed of the proper diagnosis and origin. First line of treatment is by observation and medical treatment. However, once failed, revision of other possible differential diagnosis should be made.

Poster 12

Congenital cryptophthalmos: A continuous challenge in management

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Introduction

Congenital cryptophthalmos is a very rare condition, characterized by failure of the development of eyelid folds. In most instances, the visual potential is very poor and the maldevelopment carries a significant social impact to the patient and family. The aims of the management are to preserve vision and to attain a cosmetically acceptable outcome.

Purpose

To describe 2 cases of congenital cryptophthalmos, stages of surgical procedures and outcome of surgical intervention.

Methods

Two patients were encountered in Serdang Hospital within year 2012-2013. Consents were obtained from parents for serial photographs pre and post operatively. The goal and stages of surgical procedures was informed to patients and parents.

Results

Two patients were studied. Both patients had unilateral cryptophthalmos and classified under symblepharon variant. There was no visual potential of the cryptophthalmic eye demonstrated at the first presentation. Both patients underwent 3 or more stages of surgery with a final goal for a cosmetically acceptable and well fitted ocular prostheses.

Conclusions

Management of congenital cryptophthalmos is a great challenge. The main aim is to preserve vision if there is any and subsequently to get a cosmetically acceptable surgical outcome to reduce social impact to the patient and family. Detailed discussions regarding each procedure stage must be performed to address patient & family's anxiety and expectations prior to surgery.

Poster 13

Tumour secondaries to lacrimal gland

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Purpose

To describe a case of metastasis to the lacrimal gland from breast carcinoma.

Method

Case report

Results

A 31-year-old woman presented with a solitary, painless superotemporal mass of the right eyelid for 2 months duration. Ocular examination revealed indistinct superior border mass not tethering to the skin. The mass was firm to hard in consistency and immobile. There was no dilated vessels overlying the skin. Her extraocular movements were intact and no cranial nerve deficits were present. The patient also has a past history of estrogen receptor positive breast carcinoma 6 years ago and completed chemotherapy and radiotherapy. Orbital computed tomography revealed right lacrimal gland mass. She underwent excision biopsy of the right lacrimal gland. Histopathological examination revealed involvement of the lacrimal gland with mucinous carcinoma with infiltration of neoplastic cell clusters forming papillae floating in a pool of mucin. The cells exhibit pleomorphic hyperchromatic nucleus with abundant cytoplasm. Aggregates of lacrimal gland and ducts are also included. The cells are immunoreactive to estrogen receptor and progesterone receptors. Latest CT scan revealed multiple secondaries to the lungs and also the bones.

Conclusion

Lacrimal gland metastasis may prove to be a diagnostic challenge in view of the analogous clinical presentation of other upper lid swellings. This condition may afflict both young adults and elderly. This case highlights a rare cause of a lacrimal gland mass. It can be a differential for lacrimal gland mass.

Poster 14

A vision threatening chalazion

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Objective

To report a case of chronic and recurrent styelid in a child

Method

Case report

Results

A 9 year old Chinese girl presented with history of intermittent eye redness for the past 2 years. Associated symptoms include eye itchiness, discomfort and blurring of vision. There was also history of recurrent styelid for the past 1 year. She had been seen by various ophthalmologist but her symptoms did not improve much. Examination revealed blepharitis on both eyes with a partially treated external hordeolum on the left. Right vision with glasses was 6/12 and left vision was 6/18. The eyes were mildly injected with paracentral stromal thinning. Peripheral corneal vascularization was present almost 360 degrees. Otherwise anterior chambers were deep and quiet with intraocular pressure of 10mmHg. Posterior segment examination was unremarkable. She was treated as poorly controlled blepharokeratoconjunctivitis (BKC). Warm compression with lid hygiene was advised and her topical ketotifen and artificial tears continued. Subsequently, she developed another styelid and early signs of infective keratitis on both eyes. She was then started on topical moxifloxacin, fucithalamic ointment and oral erythromycin. Her symptoms improved after 1 week with bilateral best corrected vision of 6/9.

Conclusion

BKC in children are often under-treated. In view of the disease chronicity, compliance issues have to be emphasized especially in this age group.

Poster 15

The itchy eye

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Objective

To describe and graphically illustrate a case of ocular infestation by crab louse which can easily be misdiagnosed by naked eye

Method

Case report

Results

A 60 year old Indian gentleman presented with severe itching, irritation and gritty sensation of both eyes for one month. He visited several primary health care centers and was treated as dry eye and allergic contact dermatitis. However, his eye itchiness never resolved. Further history revealed that he had associated body itchiness especially at groin area after visited India. Ophthalmologic evaluation revealed best corrected visual acuity of 6/9 in both eyes. Slit lamp examination showed extensive nits and pin point blood tinged debris along the eyelid margin of both eyes. Adult lice were

also visualized embedded into the lid margin. The cornea and conjunctiva were unremarkable in both eyes as was the remainder of the eye examination. Crab louse were mechanically removed and he was treated with Vaseline jelly. He was co-managed with Dermatology team for systemic treatment and contact tracing.

Conclusion

Phthiriasis palpebrarum could easily be misdiagnosed as other non-infestation condition. It is important to get proper history and detect early to prevent further spread of Phthiriasis.

Poster 16

A case series of neurofibromatosis with ocular involvement in children

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Purpose

To report 3 cases of Plexiform Neurofibromatosis in children presented to Ophthalmology Department Hospital Kuala Lumpur

Method

Case report

Results

First case- A five year old boy with neurofibromatosis presented to us with buphthalmos and secondary glaucoma in the left eye. In addition he had plexiform neurofibromatosis of the left upper lid. The glaucoma was absolute. As the left eye and the eyelids appeared unsightly a decision was made to reconstruct the left upper lid, debulking of the tumour and evisceration of the left eye with glass ball implantation. Surgery was performed successfully and in one month patient showed significant cosmetic improvement.

Second case- A seven year old boy with left plexiform neurofibromatosis with left mechanical ptosis obstructing the pupil was seen in our clinic. Excision of left upper eyelid neurofibroma was done. Three years later eyelid growth had increased covering the eye. Left excision of plexiform neurofibroma, lateral canthal reformation and reconstruction of the upper lid was done. Subsequent follow up in the clinic patients is plan for excision and tumour debulking of the left lower lids.

Third case- A three month old baby girl presented with right eye buphthalmos and secondary glaucoma with neurofibromatosis. Following an examination under anaesthesia, trabeculectomy with MMC 0.5% was performed to the eye. Subsequent examination showed good intraocular pressure control.

These three cases illustrated the rare presentation of plexiform neurofibromatosis in children and the challenges managing them.

Poster 17

Oculomotor ophthalmoplegia and distal myopathy in neurofibromatosis type 2 – A case report

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Objective

To report a case of oculomotor ophthalmoplegia and distal myopathy in a patient with neurofibromatosis type 2.

Method

Case report

Results

A 23-year-old Malay female presented with a history of drooping of the left upper lid and limitation of upward movement in the left eye since 8 years prior to presentation. For the past 2 years, she also had right-sided body weakness, change in voice and hearing disturbance in the right ear. Examination revealed mild ptosis and limitation of elevation of the left eye. She also had posterior subcapsular cataract in both eyes. Fundoscopy showed bilateral generalised optic disc swelling. Neurological examination revealed involvement of the 3rd, 8th and 10th cranial nerves. There was wasting of the distal muscles of her right hand, with decreased muscle power. Pedunculated cutaneous lesions were seen over her body and scalp. MRI revealed bilateral acoustic and trigeminal schwannomas with multiple extra-axial lesions and intradural extramedullary nodules.

Conclusion

Neurofibromatosis type 2 may present with eye symptoms initially rather than auditory symptoms, which are seen in 90% of patients. The patient's failure to seek timely intervention allowed us to observe the atypical progression of this disease, which has never been documented previously.

Poster 18

Harada-Ito procedure in superior oblique palsy

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Objective

To report 2 cases of treatment of superior oblique palsy using Harada-Ito procedure

Method

Case report

Results

Case 1

A 33 year old male following a motor vehicle accident presented with constant diplopia in all gazes. His visual acuity was 6/6 both eyes. There was presence of alternating exotropia but no ptosis. Extraocular muscle movement showed an increase of elevation in adduction. Marshall Parks 3-step test was positive. Orthoptic assessment showed left alternating exotropia at 35-45 prism dioptre at 1/3m and 25 prism dioptre at 6m. Double maddox rod showed 10 degrees of left excyclotorsion in primary position and downgaze. He underwent right eye modified Harada-Ito with bilateral lateral

rectus recession. Intraoperatively, noted atrophic superior oblique. Post operatively, he was orthophoric and had no diplopia

Case 2

A 26 year old male who was involved in a motor vehicle accident presented with torsional diplopia with a visual acuity of 6/9 both eyes. There was presence of left eye hypertropia. Extraocular muscle movement showed increased elevation in adduction. Orthoptic assessment showed left alternating exotropia 1-2 prism dioptre at 6m and extorsion of 20 degrees excyclotorsion on double maddox rod. He underwent bilateral Harada-Ito procedure. Postoperatively, he was orthophoric at 6m

Conclusion

Harada-Ito is a procedure typically performed in cases with significant torsion and minimal vertical deviation with successful outcomes especially with patients with <10degrees of preoperative torsion.

Poster 19

Correction of Duane syndrome with Y splitting technique

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Aim

To present the result of recession of the lateral rectus muscle with Y-splitting in the treatment of Duane syndrome

Method

Case report

Results

A 9-year-old female had Left Duane's Syndrome Type III with exotropia. Her best-corrected visual acuity was found to be 6/6 for the right eye and 6/7.5 for the left eye. She manifested abnormal head positioning in the primary position, with the face turned to right side. She shown upshoot and downshoots of the left eye on adduction, retraction of the globe and also fissure-narrowing on adduction of the left eye. Orthoptic assessment shows presence of left eye 20 prism diopters exotropia for distance and 14 prism diopter exotropia for near. She had some binocular single vision with loose stereoacuity.

She underwent 5.0-mm recession of the left lateral rectus with Y-splitting. Left lateral rectus muscle was isolated, and the muscle was split into two halves as far back as 14mm from the insertion. The split muscle then was disinserted and 5.0mm recession done. 7-0 Vicryl sutures were used to suture both ends of each half of the muscle at its new insertion site. As early as 2 weeks postoperative, the leash phenomenon with left eye upshoot and downshoot was eliminated, and there is marked decrease in globe retraction and head turn. It appears cosmetically acceptable.

Conclusion

Recession of lateral rectus muscle with Y-splitting is an extremely effective procedure in the treatment of significant upshoot and downshoot associated with globe retraction in Duane syndrome.

Poster 20

EDTA chelation therapy for vernal shield ulcer: A case report

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Purpose

To report a case of 10 years old boy with unilateral vernal shield ulcer that did not respond to medical therapy but healed rapidly after EDTA chelating procedure.

Method

Plaque of the corneal shield ulcer was easily removed with EDTA chelating procedure.

Results

Complete re-epithelization of cornea shield ulcer was observed within 7 to 14 days post chelating therapy. Visual outcome was excellent (6/9-6/6). However the presence of thin corneal opacity at the anterior stromal layer was unavoidable.

Conclusion

Cornea shield ulcer and plaques are serious complications of vernal keratoconjunctivitis, which recalcitrant to medical therapy. Chelation is a fast and effective procedure to improve healing of shield ulcer. It offer a non invasive technique compare to surgical procedure.

Poster 21

Bilateral corneal perforation in young girl

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Objective

We report a patient with bilateral corneal perforation.

Method

Case report

Results

A 7 year old Malay Girl, with underlying allergic conjunctivitis since age of 4, presented with 5 days history of blurring of vision associated with red eye. She was not on regular follow up since age of 4. Her visual acuities at presentation were 6/24 on right eye and 6/60 on left eye. There was no relative afferent pupillary defect. Both lids had severe meibomianitis, no papillae, conjunctiva mildly congested. Examination under anaesthesia was done. Right eye showed paracentral corneal perforation measuring 1mm x 1mm with surrounding corneal scar and iris plugging. Left eye showed central corneal perforation measuring 1mm x 1mm with scarring edges and iris plugging. Fundus examination showed normal fundus. Bilateral corneal gluing was performed. However noted on day 1 post operatively, bilateral corneal glue had dislodged. Anterior chamber was flat bilaterally. She then underwent bilateral lamellar keratoplasty. Post operatively, vision was stable bilaterally.

Conclusion

Ocular surface disease in young should not be neglected. Early and prompt treatment can restore patient's vision to normal.

Poster 22

Unexpected high myopia after penetrating keratoplasty

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Background

High myopia is a rare complication following penetrating keratoplasty(PK). High degree of myopia can produce anisometropia and limit visual rehabilitation by conventional methods in eyes with clear corneal grafts. This is also often coupled with large degree of astigmatism. However, there are methods in correcting this defect and optimising visual outcome.

Objective

To report a case of unexpected high myopia post penetrating keratoplasty and modalities of visual rehabilitation.

Method

Case report

Results

A 50 year old female was diagnosed with bilateral corneal lattice dystrophy. Preoperatively, patient had visual acuity of 6/60 in right eye and 6/9 in left eye with myopia of -3.5 D and astigmatism of -1.50x140 bilaterally. She underwent uncomplicated right PK 7 years after presentation due to progression of the disease and poor visual acuity. Post operatively the patient developed slowly progressive axial myopia due to possibility of topographical changes in the corneal graft until 5 years after the PK, the myopia in the right eye was -9.00D with astigmatism of -1.25x20. The left eye vision and refraction was stable. Patient underwent right clear lens phacoemulsification due to anisometropia and post operatively the right visual acuity was 6/9.

Conclusion

Anisometropia resulting from unilateral high myopia is often distressing for patients and can be addressed with spectacles or contact lens. For those who are unable to tolerate these, photorefractive keratectomy(PRK), laser in situ keratomileusis (LASIK), and four incisional radial keratotomy are other modalities to correct myopia. However, they have limited value in post PK patients. As seen in this case, clear lens extraction is an effective treatment modality to overcome anisometropia.

Poster 23

Simple limbal epithelial transplantation (SLET) with symblepharon release for extensive pterygium

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Aim

To report a case of SLET combined with amniotic membrane transplant (AMT) with symblepharon release for extensive pterygium

Method

Case report

Results

This is to report a case of a 43 year old gentleman, who worked as a beach boy for 17 years and at a chemical factory prior to that. He developed both eye extensive pterygium obscuring the visual axis with symblepharon extending from the inferior palpebral conjunctiva to central cornea. There was no view of fundus. Subsequently he underwent right eye Pterygium excision with symblepharon release, fornix deepening with silicone band and SLET combined with AMT. A 2x2mm strip of donor limbal tissue was obtained from the superior limbus of the same eye and divided into 3 pieces. After surgical preparation of the recipient ocular surface, these tiny limbal transplants were distributed evenly over an amniotic membrane placed on the cornea and a BCL was applied.

After surgery, a completely epithelialised, avascular and stable corneal surface was seen by 8 weeks. Visual acuity improved from hand movement before surgery to 6/60 postoperatively. At present, the fornices were deep without recurrence of symblepharon. Histopathology of contact lens showed presence of non keratinized stratified squamous epithelium of cornea.

Conclusion

Combined transplantation of autologous limbal epithelial cells and symblepharon release are an effective method of reconstructing the corneal surface and restoring useful vision in advanced pterygium.

Poster 24

A giant traumatic iris cyst

Tan Boon Hooi, Leow SN, Shuaibah AG
Hospital Queen Elizabeth

Introduction

To report a case of giant traumatic epithelial iris cyst and its management

Method

Case report

Results

A 52 year old gentleman presented with progressive blurring of vision in the left eye associated with redness and pain for the past one month. He gave a history of penetrating eye injury ten years ago on the affected eye. On presentation, the best corrected visual acuity was 6/15. Anterior segment examination revealed a transilluminant iris cyst superotemporally around 5 clock hours obstructing the pupil. There was also iridocorneal touch and anterior uveitis. Ultrasound Biomicroscopy showed a huge iris mass with a clear cystic cavity and iridocorneal touch. Patient underwent iris cystectomy where the anterior and posterior wall of cyst was excised. Post operatively, vision improved to 6/7.5 with resolution of uveitis. Histopathology report was consistent with a benign iris cyst. Patient was followed up regularly and no recurrence was seen to date.

Conclusion

Traumatic iris cyst is difficult to manage and has poor visual outcome with pre and post operative complications. Various treatments had been advocated including Nd: YAG laser puncture of cyst, cyst aspiration, surgical removal by cystectomy or total excision with iridocyclectomy or iris reconstruction and laser treatment with photocoagulation or cryotherapy. We describe a successful case of surgical cystectomy of traumatic iris cyst with no recurrence.

Poster 25

An overview of secondary glaucoma cases in Hospital Kuala Lumpur (HKL) from April to December 2013

Oh Kah Lay, Gan Eng Hui, Thayanithi Sandragasu, Jelinar Mohd Noor

Dept of Ophthalmology, Hospital Kuala Lumpur

Objective

To present an overview of secondary glaucoma cases presented to HKL from April to December 2013

Method

Cross sectional study

Results

A total of 330 cases of secondary glaucoma were reported during the 9-month duration between April to December 2013. Most patients had pseudoexfoliation glaucoma (20.3%), followed by neovascular glaucoma (19.7%), steroid induced glaucoma (12.7%), uveitic glaucoma (11.5%), trauma related or angle recession glaucoma (10.0%), pseudophakic glaucoma (8.8%), juvenile glaucoma (6.7%), congenital glaucoma (4.5%) and Sturge Weber syndrome (1.5%). Although juvenile glaucoma presented with the most advanced stage, with cup-disc-ratio (CDR) of 0.8, they were only on 1.5 eye drops, as compared to neovascular glaucoma which presented early with CDR of 0.5, but were on 2.1 topical medications. Pigmentary glaucoma patients had the worst visual field defect, with MD of -15.74. 93.3% of congenital glaucoma patients underwent surgical intervention, which was the highest percentage among all groups.

Conclusion

Secondary glaucoma remains a common ocular problem in HKL. Pseudoexfoliation glaucoma is reported as the commonest cause of secondary glaucoma in this centre.

Poster 26

An overview of primary open angle glaucoma (POAG) and primary angle closure (PACG) cases in HKL

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Ophthalmology Dept, Hospital Kuala Lumpur

Objective

To present an audit of POAG and PACG cases presented to Kuala Lumpur Hospital (HKL) Glaucoma clinic from April 2013 to January 2014.

Method

Cross-sectional study

Results

A total of 553 patients of POAG and 241 patients of PACG were examined during 10months period between April 2013 to January 2014. 60% of PACG patients were female but POAG shows 62% male preponderance. Majority of PACG and POAG patients were Chinese at 55% and 38% in PACG and POAG respectively. Patients more than 65years old achieved 56% and 59% of POAG and PACG cases respectively. About 28% of our POAG underwent trabeculectomy/MMC compared to 26% in PACG.

18.3% of PACG does not require any anti-glaucoma whereas only 6.9% of POAG patients not require any anti-glaucoma. 31.5% of PACG and 27.7% of POAG patients have blindness at least of 1 eye.

Conclusion

Our data showed 31.5% and 27.7% of PACG and POAG patients developed blindness. Hence active measurement should be taken and this might include regular screening programmes and early surgical intervention in order to slow the progression of the diseases and prevention of blindness.

Poster 27

Identification of genetic markers for progression of glaucoma in Malay patients with primary open angle glaucoma

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Objectives

To determine the role of genetics in progression of glaucoma in Malay patients with primary open angle glaucoma (POAG).

Method

A prospective cohort study was conducted on 108 POAG patients who were followed up for at least 5 years. Venesection was done. DNA was extracted and microarray Human Omni Express-12 platform was used for genotyping. Progression was defined based on the Advanced Glaucoma Intervention Study score (AGIS), Hodapp, Parrish, Anderson's (HPA) and Mill's criteria on Humphrey visual field 24-2 analysis from the initial recruitment period and the most recent follow up. The recruited patients were further divided into progress and non-progress groups. Genome studio was used to analyze the data. PLINK and R software's were used for further analysis to identify significant single nucleotide polymorphisms (SNPs).

Results

Out of these 108 patients, 9 showed progression of the disease using AGIS, HPA and Mills criteria. The mean progression period was 5.2(SD3.8) years. The significant loci for progression group were rs758435 in SHISA6(odds ratio (OR)=2.30; P=1.17×10e-6), rs11741204 in chromosome 5q23.3(OR 27.23; P=1.27×10e-6), rs8187890 in ALDH1A1(OR 5.98; P=4.52×10e-6), rs10511950 in chromosome 9p13.3(OR 2.36; P=4.86×10e-6), rs11744647 in DOCK2(OR 2.16; P=4.99×10e-6) and rs6580258 in chromosome 5q13.3(OR 3.99; P=5.84×10e-6).

Conclusion

There is possibility that these genetic markers play an important role in determining the progression of the disease in Malay patients with POAG. However, larger sample size is needed and other confounding factors such as IOP control should be standardized.

Poster 28

Atypical presentation of ocular toxoplasmosis in a patient with AIDS

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Introduction

Ocular toxoplasmosis is an important opportunistic infection in immunodeficiency patients since the disease can be aggressive in these patients. The diagnosis of ocular toxoplasmosis is mainly based on ocular findings, with the supportive of serological evidence. However, ocular toxoplasmosis in the immunocompromised hosts may be presented as a variety of "atypical" clinical lesions, delaying both diagnosis and treatment.

Objective

To report a case of atypical presentation of presumed ocular toxoplasmosis in a patient with AIDS and neurotoxoplasmosis, the diagnosis was supported by a resolution of intraocular inflammation after initiation of anti-toxoplasmosis drug therapy

Method

Case report

Results

A 30-year-old malay man with AIDS (CD 4 count 9 cells/ μ L) and cerebral toxoplasmosis presented with painless progressively blurring of vision in his right eye for few weeks duration. He was also diagnosed to have pulmonary tuberculosis with tuberculous lymphadenitis. However, he had defaulted the treatments, including HAART. Visual acuity was 6/9 OU. Right fundus exam revealed mild optic disc swelling, vitritis and a solitary pigmented lesion about 2-3 optic disc size surrounded by hard exudates at the peripheral inferotemporal retina. Toxoplasma serology Ig G was positive. Laboratory investigations of cerebrospinal fluid, vitreous and blood did not detect any other causative organism. Patient was treated as atypical ocular toxoplasmosis. His intraocular inflammation resolved after 1 month of anti-toxoplasmosis drug therapy in the absence of HAART and antituberculosis therapy.

Conclusion

High index of suspicion for atypical presentations of ocular toxoplasmosis in an immunocompromised patient is critical for timely drug therapy.

Poster 29

Eales' disease - An agonizing mystery

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Dept of Ophthalmology, Hospital Kuala Lumpur

Objective

To report a case of Eales' Disease in a young patient

Method

Case study

Results

A 17-old Indian girl presented with painless blurring of vision of both eyes for six months. There were no premorbid illnesses except a positive history of contact with her late father who had tuberculosis. Best corrected visual acuity was 6/6 for the right eye and hand movement for the left eye. Fundus examination revealed retinal neovascularization, sclerotic vessels, pre-retinal hemorrhage and mild vitreous hemorrhage in both eyes. Tractional retinal detachment was seen at macula of the left eye. Fundus Florescein Angiography revealed extensive mid-periphery capillary non-perfusion with pronounced vasculitis and retinal neovascularization in both eyes. Laboratory results were within normal limits for Rheumatoid factor, ANA, ESR, VRDL and CRP. Chest X-ray showed no signs of active tuberculosis or sarcoidosis. Extensive panretinal laser photocoagulation was performed. Oral steroids with concurrent anti-tubercular therapy were administered. The visual outcome improved significantly.

Conclusion

Eales' Disease is an idiopathic, obliterative vasculitis, which typically affects the peripheral retina of otherwise healthy young people. Diagnosis is mostly clinical and requires exclusion of other systemic or ocular conditions that could present with similar retinal features. The most favoured aetiologies are tuberculosis and hypersensitivity to tuberculo-protein. These patients may not carry viable organisms, but may probably harbour nonviable organisms or DNA of *Mycobacterium tuberculosis*. The management depends on the stage of the disease which consists of medical treatment with oral corticosteroids in the active inflammatory stage and laser photocoagulation in the advanced retinal ischemia and neovascularization stages.

Poster 30

Successfully treated *Aspergillus Niger* Endophthalmitis following exposed tube of glaucoma drainage device

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Case Report

A 42 year-old Malay man was under ophthalmology follow up for his right eye neovascular glaucoma (NVG) secondary to central retinal artery occlusion. Fellow eye was normal. The right eye NVG underwent two times of trabeculectomy but failed. Baerveldt glaucoma drainage device (GDD) was implanted which complicated with tube exposure at 6 months post implantation. The exposed tube of GDD was managed with amniotic patch and resuturing. About a month later, patient reported insidious onset painless poor of vision associated with mild redness for one week duration. Eye examination showed exposed tube of GDD associated with yellowish eye discharge. The visual acuity was projection to light, the cornea was hazy and dense fibrin was noted in the anterior chamber. Intraocular pressure was 0mmHg. B scan showed vitreous opacity and choroidal detachment. Diagnosis of endophthalmitis was made. He underwent vitreous tap, intravitreal amikacin and vancomycin injection and removal of the Baerveldt GDD. Culture grew *Aspergillus Niger*. Patient was treated with intravitreal and topical voriconazole eyedrop in tapering dose for 5 months duration. Visual acuity was improved to hand movement and clearance of fibrin in the anterior chamber was noted.

Conclusion

Fungal endophthalmitis is rare but should be suspected in painless insidious onset painless case. Intravitreal and topical voriconazole is effective in treating *Aspergillus Niger* endophthalmitis.

Poster 31

Occlusive vasculitis secondary to SLE

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Objective

To report a case of Occlusive vasculitis secondary to SLE

Method

Case report

Results

A 12 year-old Malay boy presented with generalized tonic clonic seizure and sudden loss of right eye vision. He also had history of prolonged fever. Both eyes examination revealed episcleritis with pink optic disc, whitening of the retina at macula region, presence of multiple cotton-wool spots, blot and dot haemorrhages at all four quadrants of the retina. Systemic examination showed GCS 10/15, febrile, multiple vasculitic and ulcerative rashes on his face and all four limbs. Blood count showed pancytopenia. Titer for Anti-nuclear antibodies was very high and ds-DNA was positive. Patient also had proteinuria and hematuria. MRI brain showed multifocal white matter infarction and global hypoxia. MRA brain showed no stenosis, aneurysm or beaded appearance on intracranial ICA, MCA, ACA, PCA, Acom, Vertebral, basilar, SCA, PICA.

The patient was intubated for dropped of GCS and cerebral protection. He was started on IV methylprednisolone and cycle of IV cyclophosphamide by paediatric team. He was weaned off ventilator after 4 weeks. Right eye vision was hand movement and left eye was 1/60. Fundus fluorescein angiography done showed extensive right eye capillary fall out (CFO) area at all four quadrants of the retina with new vessel at the disc while left eye showed CFO at temporal peripheral retina, patchy of CFO at nasal and superior of the retina with vasculitic changes. Both eyes had large area of macula ischemia. Pan retinal photocoagulation (by LIO) done for both eyes.

Conclusion

Occlusive vasculitis in SLE can cause significant retina ischemia which leads to blindness.

Poster 32

Not just another case of central retinal vein occlusion: Waldenstrom's Macroglobulinaemia

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Objective

To report a rare case of bilateral central retinal vein occlusion (CRVO) in Waldenstrom's macroglobulinaemia

Method

Case report

Results

A 65 year old gentleman presented to an ophthalmologist with right eye (O.D.) blurring of vision and was diagnosed to have right CRVO with macular oedema. He had history of hypertension but was under control. He was given intravitreal bevacizumab but there was no improvement noted. A week later his left eye (O.S.) became blurred with vision 6/60 and noted to have left CRVO. He was then referred to our center. Blood investigation and subsequent bone marrow trephine biopsy revealed that patient had Waldenstrom's macroglobulinaemia. 3 cycles of therapeutic plasma exchange were done and followed by chemotherapy. Together with monthly injections of bevacizumab for 3 months, his visual acuity improved to 6/18 O.D. and 6/24 O.S, with reduction of central macular thickness and resolution of retinal haemorrhages.

Conclusion

A CRVO case should warrant a proper haematology investigations and not to be attributed to underlying hypertension prematurely. A bilateral simultaneous or consecutive CRVO is uncommon and could be the presenting features of an underlying serious haematology disorder. Hence, prompt recognition by every ophthalmologist cannot be over-emphasized.

Poster 33

Trilateral retinoblastoma complicated with spinal drop metastases

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Objective

We report a case of atypical trilateral retinoblastoma with spinal drop metastases.

Method

Case report

Results

A 2-year-old boy presented with 2 days history of headache, vomiting, lethargy and mild fever without neck rigidity. There is no family history of retinoblastoma or other malignancy. On examination, there was left eye leucocoria and strabismus. There was no hypopyon, red eye or enlargement of the globe. RAPD of the left eye was positive. Intraocular pressure was normal bilaterally. Fundus examination of the left eye revealed a roundish whitish yellow mass about 1cm in size and mild disc swelling. The right eye revealed a small whitish mass.

Both brain CT and MRI showed calcified left and right intraocular mass without optic nerve or retro-orbital extension. Brain and spine MRI also showed a suprasellar tumour with calcification which was complicated by spinal metastases and moderate obstructive hydrocephalus. Left eye was enucleated and biopsy showed retinoblastoma without optic nerve involvement. Biopsy and immunohistochemistry of the distal spinal cord tumour was consistent with metastatic retinoblastoma. Laser therapy was done for the right eye. Subsequently the child was treated with a course of vincristine, carboplatin, and etoposide.

Conclusion

This is a rare presentation of trilateral retinoblastoma because the spinal cord lesion was a drop metastases from the suprasellar tumour as a primary source of retinoblastoma rather than the ocular tumour in view of no optic nerve involvement.

Poster 34

Ocular toxoplasmosis: Complex variations on a theme

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Objective

To report three cases of ocular toxoplasmosis

Method

Case series

Results

The first case is a 23 year-old lady presented with right eye central scotoma for 4-days duration. She had similar symptoms few years back. On examination her right visual acuity was 6/60. There were presence of right vitritis, macula scar with fluffy edge and periphlebitis. While she was on course of treatment, she developed left ocular toxoplasmosis.

The second case is a 17 year-old girl with first episode of right metamorphopsia for 1-week duration. The examination showed the right visual acuity was 3/60, anterior chamber cell 2+, high intraocular pressure, vitritis, retinitis involving macula and periphlebitis. She responded well to the treatment given. However, she presented back 4 years later with the similar problem.

The third case is a 24 year-old gentleman who complained of left reduced vision for one month. He had no similar problem previously. The vision of the left eye was 6/24 with anterior chamber cell 2+ and *keratic precipitates*. There were also presence of vitritis, chorioretinitis and chorioretinal scar. Two months later while he was on treatment, he developed left rhegmatogenous retinal detachment.

Conclusion

Ocular toxoplasmosis is the most common cause of infectious posterior uveitis. Although there is no effective therapy to eradicate the organism totally, treatment aims to reduce severity of the acute inflammation and to lessen the permanent visual loss by reducing the eventual chorioretinal scar.

Poster 35

Bilateral endogenous bacterial endophthalmitis

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Hospital Taiping

Objective

To present a case of bilateral endogenous bacterial endophthalmitis resulting from *Klebsiella pneumoniae*.

Method

Case report

Results

A 57-year-old man with underlying uncontrolled Diabetes Mellitus and hypertension presented with fever and difficulty to pass urine for one week. He was admitted in private hospital and diagnosed to have prostatitis and urinary tract infection. Upon discharge, he complained of right eye sudden loss of vision associated with pain and redness. He was re-admitted for nosocomial pneumonia as he developed severe cough and chest X-ray showed pneumonia changes.

On examination, his vision was PL OD and 6/12 OS. Right eye showed chemosis, hazy cornea and dense fibrin with hypopyon (2mm) in the anterior chamber. There was no fundus view. The left eye examination showed features of proliferative diabetic retinopathy. An immediate vitreous tap and intravitreal Vancomycin and Ceftazidime injection was done. Vitreous culture yielded *Klebsiella pneumonia* sensitive to Ceftazidime, Gentamicin, Ciprofloxacin and Tazocin. Blood culture grew the same organism. He was treated with intravenous antibiotics. Subsequently he was intubated in ICU due to respiratory distress. One week later, his left eye also showed chemosis, hazy cornea with fibrin in anterior chamber. A diagnosis of both eyes endogenous endophthalmitis was made and repeated intravitreal antibiotics were given. Extensive investigations done, ultrasound abdomen showed no liver or renal abscess. CT abdomen revealed prostatic abscess. Patient was referred to surgical team for co-management. He was extubated two weeks later. However, his vision in both eyes remained NPL.

Conclusion

Bilateral endogenous bacterial endophthalmitis is a rare but devastating condition which results in poor visual outcome.

Poster 36

Central retinal vein occlusion in dengue fever

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Objective

To report a case of central retinal vein occlusion in a patient with dengue fever.

Method

Case report

Results

A 41 years old Malay female presented to our clinic with right eye blurring of vision since day 2 of dengue fever. Ocular examination revealed visual acuity of 1/60 and central retinal vein occlusion.

Conclusion

Dengue viral infection causes hypercoagulability which can result in vein occlusion. With the increasing incidence of dengue viral infection, we should be more aware of its blinding complications

Poster 37

Choroidal metastases - First sign of breast carcinoma recurrence

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Background

Intraocular metastases is the most common malignancy of the eye but yet it is rarely seen. Apart from lung carcinoma, breast carcinoma commonly metastasize to the uvea and accounts for 39-49% of uveal metastases. In view of rapid progression after diagnosis, survival period ranges from 10 to 23 months.

Objective

To report a case of choroidal metastases from invasive ductal carcinoma, course of the disease and current modalities of treatment.

Method

Case report

Results

A 65 year old female was diagnosed with left human epidermal growth factor receptor 2 (HER2) positive invasive ductal carcinoma in mid 2012. She underwent radical mastectomy and chemotherapy. Patient was symptom free for 1 year till she presented with sudden onset of painless blurring of right vision. On ocular examination, her right visual acuity was counting fingers with presence of relative afferent pupillary defect. Funduscopy examination revealed multiple white choroidal lesions occupying a circumference of 2.5 disc diameter located 1.5 disc diameter temporal to fovea. B-scan showed a lesion with 3mm elevation. Her left visual acuity was 6/9 and both anterior and posterior examinations were normal. Two weeks after ocular manifestation patient developed shortness of breath. She was diagnosed to have lung and liver metastases. Unfortunately, prior to commencement of chemotherapy patient succumbed to the disease.

Conclusion

Various methods of treatment for choroidal metastases include radiotherapy, chemotherapy, laser photocoagulation, transpupillary thermotherapy, and the latest monoclonal antibody therapy for HER 2 positive cancers. Breast carcinoma with choroidal metastases is very aggressive and early commencement of treatment can prolong survival rate. However, in this case, the disease progression was too rapid for her to receive any treatment.

Poster 38

Retinoma: A benign variant of retinoblastoma

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Aim

To report a case of retinoma and the importance of frequent ophthalmic examination.

Method

Case report

Result

A 3-year old boy with underlying G6PD deficiency presented with left eye squint of 1 year duration. He had no other medical illness and no family history of eye diseases or malignancy. On presentation his visual acuity (VA) as 6/9.5 on the right eye and 6/19 on the left eye. Ocular examination and anterior segment findings were normal. Fundus examination of the left eye revealed an elevated, greyish translucent retinal lesion involving papulomacular bundle with areas of calcifications. Fundus examinations of both parents showed no abnormalities. The patient underwent a series of examinations under anaesthesia (EUA) over 1 year, and the lesion was found to be non-progressing.

Conclusion

The case shows presentation of a retinoma. Repeated initial follow-ups are essential to confirm this diagnosis.

Poster 39

Retinitis pigmentosa with unilateral Coat's Disease complicated with bilateral retinal astrocytoma

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Objective

To report a case of retinitis pigmentosa associated with left eye Coats' disease, complicated with bilateral retinal astrocytoma.

Method

Case report

Results

A 20-year-old female presented with progressive both eyes blurring of vision for 4 years and subsequently developed nyctalopia. She has menstrual irregularities. Ophthalmologic examination revealed visual acuities of 6/36 in right eye and counting finger in left eye. Systemic examination showed tiny nodules on nose, hirsutism, prominent maxillary bone and short fingers. IQ is normal. Ophthalmologic examination revealed left eye old keratic precipitates with early posterior subcapsular cataract. Bilateral fundus noted pallor of optic disc with grayish white matter nearby, peripheral bony spicules, telangiectasias and attenuated vessels. Left eye showed paramacular pigmentary changes with chronic exudative retinal detachment on inferotemporal region. Routine blood investigations were normal. Chest X-Ray, computed tomography brain and orbit, ultrasound of liver and kidney showed normal findings. Left eye peripheral lesion cryotherapy was planned.

Conclusion

The association of retinitis pigmentosa, Coats' disease, and both eyes retinal astrocytoma has been described. The association of Coats' disease and retinal astrocytoma is rare. Retinitis pigmentosa is an inherited retinal dystrophy. Although in Coats' disease no genetic predisposition has been proven, the growing list of genetic diseases associated with Coats' disease should be considered in patients presenting with this retinopathy. The combined clinical scenario leads to the possible diagnosis of tuberous sclerosis complex but was not supported by radiological findings.

Visual acuity and refractive changes post vitrectomy in non-accidental injury

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Purpose

To assess the visual acuity and refraction of children who had undergone pars plana vitrectomy for pre-macular haemorrhages secondary to non-accidental injury.

Method

A total of 40 paediatric cases of suspected non-accidental injuries that were referred to the Ophthalmology Department, Hospital Kuala Lumpur for management of retinal haemorrhages were evaluated. 29 eyes that had persistent pre-macular haemorrhages for around 1 month were subjected to lens sparing pars plana vitrectomy to evacuate the haemorrhage. Visual acuity and refractive changes were assessed at 1 month and 6 months post vitrectomy.

Results

The mean age for all the children at diagnosis was 5.99 months. Out of the 40 children, 25 (62.5%) were males and 15 (37.5%) were females. 34 cases (85%) had bilateral haemorrhages at presentation. 47 (58.75%) eyes had pre-macular haemorrhages out of which 29 eyes underwent vitrectomy. 19 eyes had acceptable visual acuity at 6 months post-operative period. 10 eyes had poor visual acuity that can be attributed to macular fibrosis, macular holes and extensive intracranial injuries. Post-operative refractive findings revealed a significant myopic shift from the normal expected refractive error for age (p value < 0.001).

Conclusion

Timely pars plana vitrectomy for removal of pre-macular haemorrhages may be beneficial in preventing visual deprivation amblyopia and to avoid any permanent toxic effects of haemoglobin on the macula. Close monitoring of the vision and the refractive status is essential as a part of visual rehabilitation in these children.

Poster 41

Intravitreal dexamethasone implant – Dramatic improvement in recalcitrant CMO of CRVO eye

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Objectives

To describe the safety and efficacy of intravitreal dexamethasone implant- Ozurdex™ in a case of recalcitrant macular oedema secondary to central retinal vein occlusion (CRVO)

Method

A case report with literature review, focusing on the management and treatment response by serial monitoring modalities (fundus photo and OCT).

Results

A 53-year-old Malay man with history of dyslipidaemia, presented with sudden onset painless loss of left eye (LE) vision. Visual acuity (VA) was 6/24 OS, 6/9 OD. Clinically the LE showed signs of CRVO, associated with macular edema. Central macular thickness (CMT) was 526µm. He developed rubeosis iritis with intraocular pressure (IOP) 34mmHg in subsequent follow-up. Patient received extensive pan-retinal photocoagulation and 6 injections of intravitreal Lucentis monthly. However, despite resolution of rubeosis and retinal hemorrhage, his LE VA deteriorated to 6/60 with increasingly severe macular oedema. Serial OCTs showed CMT increasing to 699µm. Change of treatment to intravitreal dexamethasone implant was therefore decided. Patient's LE VA improved dramatically at first follow-up to 6/24 and CMT improved to 365µm. Three months after, his VA remained at 6/24, CMT improved to 334 µm. Monitoring of IOP showed increasing trend to 22mmHg, but well controlled with topical anti-glaucoma. Monitoring of cataract otherwise remained unremarkable.

Conclusion

Intravitreal steroid implant Ozurdex™ was a safe and efficacious treatment for recalcitrant macular oedema secondary to CRVO that had been resistant to repeated anti-VEGF therapy with single agent. Monitoring of intraocular pressure and cataract formation is mandatory in view of these common side effects of steroid.

Poster 42

An enthralling case of lipaemia retinalis

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Purpose

To report a case of lipaemia retinalis.

Method

Case report

Results

This is a rare case of 30-day-old full term infant who presented with elevated level of cholesterol and triglycerides and also ocular manifestation portrayed as lipaemia retinalis. His elder sibling had metabolic disease which whom was suspected to have GM-1gangliosidosis and died at the age of 1 year 5 months. On examination, anterior segment was normal with unremarkable external signs of hyperlipaemia. Both fundi shows creamy vessels with difficult differentiation between arterioles from veins and palish disc, the extravasation of the lipid material from the vessels were not prominent. Retina had salmon coloured appearance with no retinal hemorrhages. Systemically the child was active with no life-threatening signs. Strict low fat diet (<10-15% of total daily caloric intake) has proven tremendous improvement.

Conclusion

Lipaemia retinalis is an important and reliable parameter of high levels of cholesterol and triglycerides. It can occur in all types of hyperlipoproteinaemia most commonly in familial hyperchylomicronemia and diabetes patient. Early recognition of lipaemia retinalis can save child's vision and life. Ultimately, to observe the progression, RetCam imaging engages a vital role.

Poster 43

Discover the red island

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Introduction

We reported a case of Valsalva maculopathy in pregnancy and highlight possible parameters that could predispose to it.

Method

Case report

Results

A 28 year-old primigravida at 33 weeks of gestation presented with acute onset of painless central scotoma in the left eye. She denied any recent strenuous activity. On examination, her left eye visual acuity was counting finger at 2 feet. Fundus examination showed a large pre-retinal haemorrhage of 5DD involving the fovea. Blood investigations were within normal range and optical coherence tomography showed a huge pre-retinal haemorrhage. Patient was co-managed with obstetrician. Her scan and uterus parameters are up to date.

Discussion

Valsalva retinopathy is typically reported in young males but cases have been reported in pregnant women. In pregnant women, the main contributor to increased intraabdominal or intrathoracic pressure is the uterus rather than the straining activity itself. Therefore, uterus size should be taken into account and parameters such as symphysio-fundal height, abdominal girth, estimated fetal weight and amniotic fluid index measured for monitoring. To date, no study had identify the cut off limit. Generally, those at higher end of percentile chart should avoid strenuous activity

Conclusion

Valsalva retinopathy is a cause of morbidity. However, due to the uncommon presentation, it is impossible to carry out a prospective study. Therefore, we propose that the four parameters to be included in future case reports or study to guide clinicians for best clinical practice.

Poster 44

A case series of incontinentia pigmenti

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Purpose

To report 2 cases of Incontinentia Pigmenti presented to Ophthalmology Department Hospital Kuala Lumpur.

Method

Case report

Results

CASE 1 : A 2 months old girl was referred for eye assessment after she was diagnosed to have incontinentia pigmenti. Examination revealed that the left eye had fan shaped retinal abnormal vasculature, while her right eye examination was normal. Left indirect laser photocoagulation treatment was given. The eye responded well to treatment.

CASE 2 : A 3 months old Malay girl presented to ophthalmology clinic with buphthalmic left eye after she was diagnosed to have incontinentia pigmenti from dermatology department. Examination under anaesthesia revealed that her left eye had total retinal detachment while her right eye had areas of avascular retina. Photocoagulation treatment was given to the right eye. However it was poorly responded to the treatment as the right eye subsequently developed tractional retinal detachment with fibrovascular membrane. These problems lead to blindness of both eyes.

Conclusion

Incontinentia Pigmenti, also known as Bloch-Sulzberger syndrome, is a rare X-linked dominant disorder that affects mostly female patient. It is a multisystem disorder that effects the eyes, central nerves system, skin and teeth. Visual problems develop when retinal ischaemia occurs and manifest reactive neovascularisation and fibrovascular scarring. Early referral to ophthalmology is needed once the diagnosis was established. Early treatment may prevent retinal detachment and blindness.

Poster 45

Five-year audit on retinopathy of prematurity screening in Seri Manjung Hospital

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Gideon Khaw Keat Ween
Hospital Seri Manjung

Objective

To conduct an audit on the retinopathy of prematurity (ROP) screening in Seri Manjung Hospital from 2009 to 2013.

Method

A retrospective review of hospital records was performed on all babies who underwent ROP screening from 2009 to 2013.

Results

A total of 208 babies were screened (30 in 2009, 35 in 2010, 49 in 2011, 52 in 2012 and 42 in 2013). 39.4% of them had very low birth weight (<1500g) and 12.9% had extremely low birth weight (<1000g). 15.8% were born less than 28 week, 60.1% within 28 to 32 week whilst 14.4% above 32 weeks. Overall 20 (9.61%) babies were diagnosed with ROP. Seven developed Stage I ROP, six with Stage II and seven with stage III ROP. There were none with stage IV or V ROP. Seven babies required indirect laser photocoagulation. All babies had resolution of ROP. With regards to the trend of ROP, there was an increase in the number of extremely low birth weight over these years (2 in 2009, 2 in 2010, 4 in 2011, 8 in 2012 and 11 in 2013), corresponding with the greater need for treatment (none prior to 2012, 1 in 2012 and 6 in 2013).

Conclusion

ROP screening allows early detection and appropriate treatment of the disease. The prevalence of ROP in our centre was 9.6%.

Poster 46

CMV Retinitis in aids patient with high CD4 count

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Introduction

Cytomegalovirus (CMV) retinitis is commonly seen in HIV-positive patients; it typically occurs in the setting of severe immune suppression (CD4 count less than 50 cell/ μ L). We present a case report of HIV-infected patient in whom CMV retinitis developed even with high CD4 counts.

Method

Case report

Results

34-years old Chinese bachelor presented with bilateral progressively blurring of vision over 10 days duration. He was a homosexual and diagnosed to have retro viral positive a year ago. Patient was taking aesthetic supplements for his well being. Ocular examination, visual acuity on the right eye was 6/60 while left eye was 6/48. The funduscopy were characteristic of cytomegalovirus (CMV) infection with white opaque granular of retinal necrosis, vessel sheathing and hemorrhages in both eyes. Patient was treated with intravitreal ganciclovir twice per-week until resolution of active lesions. Adjuvantly intravenous ganciclovir 350mg twice daily was given. Later anti-retroviral therapy of efavirenz and tenofovir also initiated.

Discussion

This case report underscores that CMV retinitis may occur despite high CD4 counts among patients who experience only partial immune reconstitution. This occurrence may have been attributed to the hormonal therapy (dehydroepiandrosterone (DHEA), hydrocortisone, high dose systemic Vitamin C and testosterone) that the patient has been taking pass 2 years. The high circulating DHEA in this patient could mask the immunosuppression and offset protein catabolism induced by elevated cortisol.

Conclusion

Bilateral retinitis with falsely high CD4 count secondary to exogenous hormonal therapy is potentially sight threatening disease. Early interventions prevent severe morbidity.

Poster 47

Macular holes surgery in Perak: A retrospective review

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Introduction and Objectives

Full thickness macular hole (MH) is a common maculopathy, usually idiopathic, which could be managed with pars plana vitrectomy (PPV) and internal limiting membrane (ILM) peeling. Nonetheless, the outcome of surgical management is dependent on many factors. This retrospective review looked into the MH profile and surgical outcome of MH surgery in Perak.

Method

This study is a retrospective review of all idiopathic macular holes surgery performed in Raja Permaisuri Bainun Hospital in 2012.

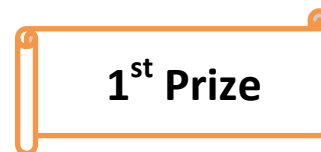
Results

15 eligible patients were included in the study. The mean age was 69.13 ± 7.54 year-old with mean duration of symptoms of 40.53 ± 43.39 months. 3(20.0%) patients presented with best corrected vision acuity (BCVA) worse than 1/60, 5(33.3%) patients between 1/60 and 3/60 while 7(46.7%) patients between 4/60 and 6/60. None had BCVA better than 6/60. Mean macular holes size was $607.67 \pm 149.78 \mu\text{m}$. All patients had 23G pars PPV with ILM peeling and gas endotamponade. Mean post-operative follow-up time was 6.80 ± 2.81 months. Primary macular holes closure was achieved in 12(80.0%) patients and 10(66.7%) had improvement of their visual acuity. Eight (53.3%) patients had BCVA better than 6/60, 5(33.3%) patients between 4/60 and 6/60 and 2(13.3%) patients between 1/60 and 3/60. Of the 3 unclosed holes, 1 patient underwent a repeat surgery with subsequent closure of the macular hole.

Conclusion

Most of the cases presented late with large macular holes and very poor baseline visual acuity, therefore affecting the prognosis and visual outcome. Nonetheless, hole closure rate was achieved in 80% of cases and 67% of patients had some improvement of BCVA.

Poster 48



The effect of low-concentration Atropine combined with Auricular Acupoint Stimulation in Myopia Control

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Objectives

To compare the effect of myopia control between patients treated with low-concentration atropine eye drops combined with auricular acupoint stimulation and those treated with atropine alone.

Method

This was a single-blinded randomized controlled clinical trial performed in a regional teaching hospital. The patients received either topical 0.125% atropine nightly plus auricular acupoint stimulation (0.125A+ACU group) or topical 0.125% atropine alone nightly (0.125A group). The changes in spherical equivalent (SE), axial length (AL), anterior chamber depth (ACD), and intraocular pressure (IOP) per year were compared between the two groups.

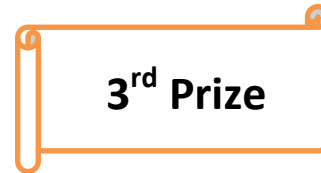
Results

Seventy-three of 110 total patients (66.4%) completed at least 6 months of follow-up. Patients in the 0.125A+ACU group had less myopic progression and AL elongation (-0.35 diopter and 0.24 mm/year) than those in the 0.125A group (-0.60 diopter and 0.30 mm/year) (mean follow-up 14.7 months, $p < 0.0001$ and $p = 0.01$, respectively). The ACD increased more in the 0.125A+ACU group than in the 0.125A group (0.078 mm vs. 0.023 mm/year, $p = 0.0004$). IOP decreased more in the 0.125A+ACU group than in the 0.125A group (-1.00 mmHg vs. -0.13 mmHg/year, $p = 0.04$). A decrease of 1 mmHg of IOP correlated with a decrease of myopic progression of 0.021 diopter/year ($p = 0.006$).

Conclusions

Patients treated with 0.125% atropine eye drops plus auricular acupoint stimulation had less myopic progression, less axial length elongation, more anterior chamber deepening, and greater IOP reductions than those treated with 0.125% atropine alone. Patients with a lower IOP tended to have less myopic progression.

Poster 49



Role of anti-aquaporin antibody assay in diagnosis of neuromyelitis optica

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Introduction

Neuromyelitis optica (NMO), also known as Devic's disease, is an idiopathic, inflammatory demyelinating disease (IIDD) of the central nervous system. In the past, the diagnosis of NMO was often confused with its counterpart, multiple sclerosis (MS). In recent years, the availability of anti-aquaporin 4 (AQP4) antibody ((NMO-IgG) immunoassays has facilitated distinction between NMO and MS, thus allowing us to initiate early and appropriate treatment.

Objective

To emphasize the role of NMO-IgG in making an accurate and timely diagnosis of NMO.

Method

This was a retrospective case series of all cases of NMO seen in Hospital Universiti Sains Malaysia (HUSM) from January 2013 to December 2013.

Results

Our series consisted of five female patients, all of whom were initially misdiagnosed as multiple sclerosis (MS). Their ages at presentation ranged from 22 to 63 years of age. Three of them presented with unilateral optic neuritis, which became bilateral in one case. The remaining two presented with both optic neuritis and transverse myelitis. The revised diagnosis of NMO was facilitated by detection of AQP4 antibodies in these patients. The time delay between the initial diagnosis of MS and the correct diagnosis of NMO ranged from one to four years, being longer in the cases which presented with optic neuritis alone.

Conclusion

Aquaporin-4 antibody (NMO-IgG) testing is indispensable in the workup of NMO. An early and correct diagnosis of NMO may reduce the morbidity associated with the natural course of this relapsing disease.

Poster 50

Common neuro-ophthalmic conditions at Hospital Universiti Sains Malaysia

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²Hospital Universiti Sains Malaysia

Objective

To review the common neuro-ophthalmic conditions presented to Ophthalmology Clinic Hospital Universiti Sains Malaysia, Kelantan.

Method

Retrospective case review of patients with neuro-ophthalmic conditions presented to Ophthalmology Clinic, Hospital Universiti Sains Malaysia during the period of January 2005 to December 2012.

Results

A total of 849 case records of neuro-ophthalmic conditions were reviewed. Neuro-ophthalmic conditions affected all age groups. The five most common conditions were ocular motor disorders, such as cranial nerve palsies (double vision) (27.9%), pituitary tumours (12.5%), optic neuritis (8.2%), ischaemic optic neuropathy (7.5%), traumatic optic neuropathy (6.2%). For cranial nerve palsies, the 6th nerve palsy (55%) and the 3rd nerve palsy were the 2 common presentations. Other neuro-ophthalmic conditions were papilloedema, optic nerve compression, cerebrovascular disorders, thyroid eye disease, myasthenia gravis, pupillary abnormalities and hereditary optic neuropathies. Only one case suspected to be Giant Cell Arteritis but the biopsy was not conclusive.

Conclusion

In our series, the most common neuro-ophthalmic conditions presented to our neuro-ophthalmology division are cranial nerve palsies, mainly 6th and 3rd nerve palsies followed by pituitary tumours, optic neuritis, ischaemic optic neuropathy and traumatic optic neuropathy.

Poster 51

Optic neuritis exacerbation in pregnancy: A case report

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²Hospital Universiti Sains Malaysia

Objective

To report a rare case of optic neuritis exacerbation in pregnancy.

Method

Case report

Results

A 25-year-old Malay lady presented with progressive blurring of vision in the right eye for 1 week. It was associated with pain on eye movement. She was pregnant at 17 weeks for her second child. Patient had history of bilateral recurrent optic neuritis since 2002. She had 3 episodes of optic neuritis from 2002 to 2006. Patient remained asymptomatic for 6 years. In 2012, during her first

pregnancy, she developed 3 episodes of optic neuritis. The first 2 attacks were 2 months apart and the third was 6 months later. She responded well to corticosteroid treatment. Overall, a total of 5 episodes were in the left eye and 1 episode in the right eye. Her visual acuity was 6/6 in both eyes. However, the optic nerve functions were markedly reduced in the left with presence of relative afferent pupillary defect. Both anterior segments were unremarkable. Fundoscopy revealed bilateral pale discs. MRI brain was normal with no evidence of multiple sclerosis. Anti-Aquaporin 4, infective and connective tissue screening were negative. Patient was treated with corticosteroid regime according to the Optic Nerve Treatment Trial. She responded well and the optic nerve functions improved. Patient was followed up closely due to her past history of optic neuritis exacerbation in pregnancy.

Conclusion

Exacerbation of optic neuritis in pregnancy is a rare condition. Close monitoring and early diagnosis enabled us to treat early and prevent further progression of the disease.

Poster 52

Weber syndrome secondary to cerebral tuberculosis

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Objective

To report a case of Weber Syndrome caused by cerebral tuberculosis.

Method

Case report

Results

A 46-year-old lady with recently diagnosed to have diabetes mellitus and hypertension presented with sudden loss of consciousness. On admission, patient had complete left 3rd nerve palsy with pupil involvement and right sided hemiparesis. Patient also had altered cognitive functions. Both anterior segments and fundi were normal. An urgent CT scan revealed a left thalamus and external capsule infarct. MRI showed post contrast ring enhancement in the left thalamus and midbrain. A magnetic resonance spectroscopy (MRS) was performed and revealed elevated lipid peak at the site of the lesion. Mantoux test was highly positive with elevated ESR of 74mm/hr. CSF profile was normal. Patient was diagnosed to have Weber Syndrome secondary to cerebral tuberculosis. Anti-tuberculosis (TB) treatment was started immediately and she was also given a course of oral prednisolone for two months. Patient showed good improvement in her cognitive functions and right hemiparesis. The left 3rd nerve palsy also showed partial recovery. Anti TB treatment was continued for a year.

Conclusion

Weber Syndrome caused by cerebral tuberculosis is not common. MRI and MRS play an important role in diagnosing cerebral tuberculosis thus prevent invasive investigation.

Poster 53

Tolosa-Hunt syndrome and Bell's Palsy, are they coincident?

Lim I-Liang, Nor Fadzillah Abdul Jalil, Raja Norliza Raja Omar, Anusiah Selvathurai
Hospital Melaka

Objective

To report a case of Tolosa-Hunt Syndrome (THS) which later developed Bell's palsy

Method

Case report

Results

A 43-year-old Malay lady, known case of diabetes mellitus, presented with sudden progressive drooping of left upper lid for 2 weeks associated with left periorbital pain and double vision. It was precipitated by 2 months history of left-sided headache. Examination showed paralysis of left third cranial nerve with an intact left second cranial nerve. The fasting blood sugar was impaired and no significant abnormality of other blood investigations. The impression of posterior communicating artery aneurysm was ruled out by normal findings of computer tomography and magnetic resonance angiography of the brain. Three days later, she showed involvement of her left IV, V₁ and VI cranial nerve without other neurological deficits. She was treated conservatively with the impression of mononeuritis multiplex with multiple cranial nerves involvement secondary to diabetes mellitus. However, elective magnetic resonance imaging of brain revealed an enhanced soft tissue thickening within the left cavernous sinus suggestive of inflammation (Tolosa-Hunt Syndrome). Spontaneous remission of the condition was observed, however, she came back 2 months later with right Bell's palsy which responded well with systemic steroid.

Conclusion

THS is a rare idiopathic granulomatous inflammation of the cavernous sinus or superior orbital fissure; whereas Bell's palsy is an idiopathic inflammation facial nerve within the facial canal. In this case, are they related, or purely coincident? A literature review found that this is the second reported case of these 2 syndromes coexisting.

Poster 54

Childhood optic neuritis in Hospital Tengku Ampuan Afzan, Kuantan

Aliff Irwan, Noor Diana, Wan Norliza, Mohd Aziz
Hospital Tengku Ampuan Afzan

Objective

To document aetiology, clinical presentations, visual outcome of childhood optic neuritis in Hospital Tengku Ampuan Afzan, Kuantan

Method

Retrospective review of children diagnosed with optic neuritis aged less than 12 years old admitted at Hospital Tengku Ampuan Afzan, Kuantan from July 2012 till January 2014

Results

There were 3 patients (5 eyes) with optic neuritis identified in which all patients were female. Two patient had bilateral ocular involvement and 1 patient had unilateral involvement. All cases were preceded by history of post viral infection while the isolated bilateral optic neuritis was associated with Clinically Isolated Syndrome - Multiple Sclerosis. All of the patients appear with profound visual loss at presentation. Intravenous corticosteroid treatment was commenced in all cases and the final vision improved to 6/18 (2 eyes), 2/60 (1 eye) and 4/60 (2 eyes).

Conclusions

In children with optic neuritis, profound visual loss is a common clinical presentation but with favourable visual recovery. Corticosteroid treatment appeared to be beneficial on the visual outcome.

Poster 55

Leptospirosis: The unusual presentation

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Hospital Tuanku Jaafar Seremban

Objective

To report an unusual leptospirosis case with primary ocular presentation.

Method

Case report

Results

A 33 year-old lady, no known medical illness, presented with left eye reduced vision for 1 month associated with high grade fever. She had history of going for a picnic 1 week prior to symptom. There was no other significant history. General and systemic examinations were normal. Ocular examination revealed left eye (OS) visual acuity hand movement and 6/6 in right eye (OD). Slit-lamp examination of both eyes (OU) no abnormality in the anterior segment. There was no relative afferent pupillary defect. Funduscopy and optical coherent tomography (OCT) of OS showed optic disc and macula oedema with minimal macula star, OD was normal. Fluorescein angiography of OS was characterized by leakage from disc margin, OD revealed no abnormality. A diagnosis of neuroretinitis of OS was made. Haematological investigations revealed mild leucocytosis with raised ESR. Serological test showed positive for leptospira serology with raising titre. She was on oral doxycycline. After 3 weeks on follow up, best corrected visual acuity of OS improved with funduscopy and OCT of OS showed resolution of optic disc and macula edema with prominent macula star.

Conclusion: Leptospirosis should be ruled out in every case of neuroretinitis and referred for detailed ophthalmological evaluation, to detect the full spectrum of the disease.

Poster 56

A rare case of cat scratch disease

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Dept of Ophthalmology, Universiti Malaya

Objective

To report a case of neuroretinitis cause by Bartonella Henselae and to show that relevant investigations and prompt treatment with antibiotics leads to a good visual outcome.

Method

Case report

Results

A 57 year old Malay gentleman with history of hypertension, type 2 diabetes mellitus and right eye optic atrophy (AAION) diagnosed in 2011 presented with left eye painless blurring of vision sudden in onset for the past 2 weeks with no history of fever prior to visual symptoms. Visual acuity over the right eye was the same. He was a retired government officer with no history of pets at home especially cats and denied being bitten or scratched by cats.

On examination, visual acuity was 6/60 in the affected left eye with relative afferent pupillary defect. Anterior segment examination was unremarkable with an intraocular pressure of 12 mmHg bilaterally. Fundus examination of left eye revealed optic disc swelling with haemorrhages inferonasally and a partial macular star of hard exudates with edema nasal to the macula. He was diagnosed to have left eye neuroretinitis. There was no lymphadenopathy. Blood investigations - FBC, RP, LFT, RBS, ESR, CRP, Hepatitis B, Hepatitis C and HIV was normal. CT Brain/orbit done urgently was normal. He was referred to neuromedical - lumbar puncture and Mantoux test was normal. Serology for Borrelia burgdorferi and Bartonella was sent. Blood investigations for Cryptococcus, Leptospira, Toxoplasmosis and Syphilis were negative. IgM and IgG titre for Bartonella henselae came back as positive. He was immediately started on oral Trimethoprim / Sulfamethoxazole (Bactrim) 2 tablets BD for 2 weeks with excellent response. His left eye vision improved within 2 weeks to 6/6 and neuroretinitis resolved.

Conclusion

Detailed history and investigation should be performed in patients with neuroretinitis to rule out infective causes. Cat scratch disease should be ruled out since 2/3rd of patients with neuroretinitis have been shown to have cat scratch disease. Development of macular star is variable in cat scratch disease and can be partial or incomplete usually nasal to macula as seen in this patient. Early and appropriate antibiotic treatment, oral Trimethoprim / Sulfamethoxazole proved to be an excellent treatment in this case.

Poster 57

Red Herring for a space-occupying lesion (SOL)

Minaksisundram Muthappan, K. John Mathen
Hospital Sungai Buloh

Objective

To report a case of suprasellar mass extending to right cerebellopontine angle leading to right 2nd and 3rd with left 7th and 8th cranial nerve palsy with limb weakness causing frequent falls in a child.

Method

Case report

Results

A 7-year-old Malay male who was previously well, presented with sudden onset of blurring of vision in the right eye following a fall at school. He had history of frequent falls previously. Systemic examination noted that patient had right 2nd and 3rd with left 7th and 8th cranial nerve palsy with poor posture as well as left upper and lower limb weakness. His visual acuity was 6/24 and 6/18 with pinhole in the right eye and 6/18 and 6/9 with pinhole in the left eye. There was relative afferent pupillary defect in the right eye. Fundoscopy of the right eye showed palish optic disc temporally. The left fundus was normal. Within 2 days of presentation, patient's vision further deteriorated to no light perception in the right eye and perception to light in the left eye. Other findings remained the same. MRI revealed a suprasellar mass extending to cerebellopontine angle with mass effect and obstructive hydrocephalus. Patient was referred to Neurosurgery for co-management .

Conclusion

Patients occasionally do not realise that they may have an underlying disease that tend to present initially with milder symptoms. It is important to always observe patient as a whole and treat them as such as to prevent undiagnosed conditions which can be life threatening.

Poster 58

Fish hook injury to the eye

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Hospital Sungai Buloh

Objective

To report an uncommon case of Ocular fish hook injury and different methods of fish hook removal.

Method

Case report

Results

Fish hook injury to the skin is common among people who fish for recreation. Due to the barbed nature of the hook, they possess a unique challenge to remove without causing further tissue damage. Ocular fish hook injuries however, are less common. We report a case of a penetrating ocular fish hook injury involving the cornea which was removed with the "advance and cut" method on a 7 year old child. We also describe the different methods of fish hook removal recorded in literature. Ultimately, the technique of choice will depend on the findings at presentation. As this constitutes a contaminated wound, the tetanus status of the patient should also be assessed and treated accordingly.

Conclusion

In the light of this case report, we advise people who go fishing should take protective measure to wear goggle for eye protection. In addition to that, understanding the nature of fishhook injury, anatomy of fishhook and all various methods of removing fishhook are essential to the practice of ophthalmologist in managing fishhook injury to the eye.

Poster 59

Sling shot injury causing preseptal cellulitis in a toddler

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¹ Hospital University Sains Malaysia

² Hospital Sultanah Bahiyah

Purpose

To report a rare presentation of preseptal cellulites following a sling shot injury in a toddler

Method

Case report

Results

A 11-month old Malay child presented with a 'gun shot like injury' over the forehead and swelling of the left eye. On examination, he had a deep laceration wound over the forehead measuring 2.0cm in diameter with minimal bleeding. No palpable foreign body. There was no relative afferent pupillary defect. The left upper lid was swollen and erythemathous. Anterior segment showed subconjunctival hemorrhage superiorly with chemosis. Posterior segment was unremarkable. He was treated with intravenous antibiotic for preseptal cellulitis. His skull xray showed white opaque foreign body on the frontal bone. CT face and orbit revealed left comminuted fracture of left orbital wall and frontal bone with prelesional edema. He underwent wound exploration under general anesthesia revealing 1.5cm unshattered marble embedded in the left frontal bone, which was removed. He responded well to intravenous antibiotic.

Conclusion

It was an unexpected surprise to find a marble embedded in the frontal bone and to the best of our knowledge there have been no similar case reported. Most injuries in children are preventable with parents/adult supervision during play and by making sure toys are age-appropriate.

Poster 60

Delayed treatment of chemical ocular burns and its effect

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Introduction

Ocular chemical injury is serious ophthalmology emergency that is often not given adequate attention by primary caregivers, due to lack of awareness of the urgency of treatment, progress of disease severity and its long term complications.

Objective

To report progression and severity of ocular chemical burns with delayed treatment.

Method

Case report

Results

A 26-year-old Bangladeshi man, presented to Accident and Emergency department, UMMC complaining of blurring of vision, redness and painful left eye. He reported a history of exposure to cement liquid one day prior to presentation. He sought treatment at a private clinic and given ointment chloramphenicol and discharged home. Upon examination, his vision was 2/60 in the left eye. Cement specks were still present in bulbar conjunctiva and both upper and lower fornix of left eye. Left eye's pH was 8-9, obtained with the Universal pH Indicator paper strip. The Patient was admitted for regular irrigation, daily removal of pseudomembrane and cleaning and pH monitoring. The patient was admitted for 11 days and discharged with left eye vision 6/12, 60% corneal epithelial defect.

Conclusion

Ocular chemical injury first line treatments need copious irrigations and thorough examination to remove all injurious leftover chemical material. Without proper treatment, disease severity will progress. Complications, which can arise include prolonged hospitalization.

Poster 61

Imaging of intraocular foreign body resulting in surgical surprise

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Method

An observational and interventional case report

Results

A 33-year-old Myanmar construction worker presented with blurring of vision in right eye, associated with pain and redness following an alleged injury to right eye at work place duly hit by a small flying piece of metal. On presentation his visual acuity in right eye was 6/120 and 6/6 in left eye. There was no relative afferent pupillary defect. The conjunctiva was injected. A sclero-limbal lacerated wound measuring 2.4 mm located at 2 o'clock with prolapsed iris at the wound. The fundal view was hazy. B-scan showed a localized medium echodense area and hyperechoic shadow suggestive of intraocular foreign body (IOFB), just superior to the optic nerve head. The left eye was normal. Orbital X-ray and CT orbit showed a perforated right globe with a radioopaque rod-like image of foreign body. Examination under anaesthesia, wound exploration with primary scleral toilet and suturing was performed on the day of presentation. Right eye combination procedure of trans pars plana vitrectomy with phacoemulsification, lens implantation and IOFB removal was performed. Intra-operatively IOFB was located superotemporal to fovea, running obliquely and superonasally into the coats of the eye. The IOFB was actually lying obliquely within the coats of the globe and not located in the vitreous cavity and did not extend beyond the globe as shown in the images.

Conclusion

Most of the times, CT scan is a reliable investigation to localize IOFBs in ocular injuries. However, clinical evaluation and correlation of all the images and careful intra-operative observations is more important. Intraocular foreign body removal can be a surgical surprise many times.