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ABSTRACTS OF POSTER PRESENTATIONS

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CONTENTS

CATARACT

1. 5 years retrospective epidemiological review of traumatic cataracts in Hospital Sultan Abdul Halim (HSAH)

Authors : Kee RongSheng (MBBS BMedSc), Tan Qi Xian (MBBS), Rajasudha Sawri Rajan (MSurgOphthal), Zaharidah Abdul Kadir (MSurgOpthal)
Institution : Hospital Sultan Abdul Halim, Sungai Petani

Objective: To review the epidemiology and visual outcome of traumatic cataract cases managed by Ophthalmology Department, HSAH.

Method: Retrospective study of 57 cases in 5 years (1-Jan-2012-31-Dec-2016) that underwent cataract surgery at HSAH. Data collected from hospital records included the demographics, presenting vision, post-operative best corrected vision (BCVA), laterality of cataract.

Result: The study population comprised 50 males and 7 females, with male-to-female ratio of 7:1. All patients presented with unilateral traumatic cataract (100%). Majority of the traumatic cataracts were between the working age of 21-60 years old [32 patients (56%)]. Work related traumatic cataract were 32 cases(56%); assault, 6 cases(10.5%); motor-vehicle accidents,5 cases(8.8%); sports, 3 cases(5.2%) and 10 due to miscellaneous causes(17.5%). For work related traumatic cataracts, all 32 patients (100%) did not wear protective eyewear. Duration from injury to initial presentation varied from <24 hours for 31 patients (54.4%) versus >24 hours for 26 patients (45.6%). Foreigners comprised of 5 patients (8.8%), all having work related injury (100%). Badminton contributed to 2 out of 3 sports related traumatic cataracts (66%). Post-operatively, 6 patients(10.5%) had no improvement on BCVA(Snellen), 50 patients(87.7%) had variable BCVA gain of minimum 1 line(4 patients,7%) to maximum 8 lines(1 patient,1.8%) with highest number of patients gaining 7 lines improvement(21.1%).

Conclusion: This retrospective review shows traumatic cataract cases have various causes. Visual prognosis of patient is dependent on the cause of the traumatic cataract.

2. Biometric outcome post cataract surgery – Hospital Selayang experience

Authors : Deivanai Subbiah MD, Solehah Jeffrey MBBS, Mohamad Aziz Salowi MS
Institution : Hospital Selayang

Objective: To evaluate the difference between target and actual refraction after phacoemulsification and intraocular lens (IOL) implantation in Selayang Hospital

Design: Retrospective study.

Method: Inclusion criteria: - All eyes of adults patients 18 years and above who underwent phacoemulsification with IOL implantation from January to June 2016, Exclusion criteria: -Patients less than 18 years old, eyes with ocular co-morbidity ,traumatic cataract and eyes with no documented target or achieved refraction.

Data were extracted from the National Eye Database and the Hospital Information System (CERNER). Target refraction was obtained from the measurement calculated by the biometric machine while achieved refraction was obtained from Spherical equivalence calculated by the formula sphere + 1/2 cylinder. The main outcome measure was percentage of cases achieving postoperative spherical equivalence ±1D of target refraction.

Result: A total of 754 eyes underwent phacoemulsification, in which 340 eyes did not have ocular co-morbidities. 12 patients was lost to follow up. 1 patient had follow up in another hospital. Rest of the patients had sufficient information for analysis. Out of the 327 eyes, 324 eyes achieved target refraction of ≤ ±1D (99.08%).

Conclusion: This study demonstrated that the refractive outcomes after cataract surgery in Selayang Hospital was comparably better than other international institution.

3. Outcomes of cataract surgery with residents as primary surgeons in HTAA

Authors : Nur Afiah K, Haizul I, Akmal HZ
Institution : Hospital Tengku Ampuan Afzan, Kuantan

Objective: To evaluate the cataract surgery performed, visual outcomes, and events in resident-operated cataract surgery cases.

Methodology: Retrospective Data Analysis

Summary of Results: Out of 1991 cases surgery done since January 2015 until September 2016, 360 cases were performed by the residents which give 18% of total surgery. Mean time is about 1 hour per cases. Only 1.8% cases reported for posterior capsule rent over all cases. Out of 4 cases reported as post-op endopthalmitis, 1 case was done with resident as a primary surgeon.

Conclusions: Resident-operated cases with and without events had an overall good contribution to the surgery performed as well as low complication rates. Residents should be trained more in order to gain high self-confidence with reliable surgical skills.

1st Prize

4. Visual outcome and rotational stability after implantation of toric intraocular lens in cataract surgery

Authors : H.R. Ng, MBBS (Monash University), C.H. Goh, MBBS (IMU),
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J. Jalaluddin, MBBS (UM), M.Ophthal (UM)

Institution : Hospital Pakar Sultanah Fatimah, Muar

Objective: To evaluate post-operative visual acuity, refractive status and rotational stability of toric intraocular lens (IOL) in correcting preexisting corneal astigmatism.

Methods: This is a retrospective case series involving 62 eyes of 52 patients with topographic corneal astigmatism of 1.0 Dopter (D) and above who underwent cataract surgery between June 2015 and December 2016 in Hospital Pakar Sultanah Fatimah, Muar (HPSF). All preoperative IOL calculations were performed using immersion biometry (SRK/T or Holladay 1 formula or Hoffer Q; depending on axial length). All patients undergone similar uncomplicated phacoemulsification with implantation of AcrySoft toric IOL of different powers. Visual outcome, refractive status and axis of lens were evaluated at six weeks post operation.

Summary: The mean refractive for astigmatism decreased from 1.94 D +/- 0.80 (SD) (range 1.0 to 4.0 D) to 0.99 D +/- 0.48 (SD) (range 0 to 2.25 D) at six weeks post operation. The mean postoperative spherical equivalent were at -0.49 D +/- 0.68 (SD) (range -2.87 to 1.00) in all eyes. LogMAR for uncorrected and corrected distance visual acuity (UDVA/CDVA) in six weeks postoperative patients were 0.31 +/-0.16 (SD) (range 0 to 0.7) and 0.13 +/- 0.12 (SD) (range 0 to 0.5). Intraoperative to 6 weeks of postoperative comparison of IOL axis alignment showed low levels of rotation (mean 1.28 +/- 4.63, range -17 to 11 degrees).

Conclusion: Cataract surgery with implantation of toric intraocular lens was stable and effective in improving pre-existing regular corneal astigmatism.

CORNEA AND ANTERIOR SEGMENT

5. Ankyloblepharon filiforme adnatum: A case report

Author : Ang Vyping
Co-Authors : Noor Khairul Binti Rasid, Vanessa Naseem Neoh
Institution : Penang General Hospital

Objective/Introduction: Ankyloblepharon filiforme adnatum is a rare benign congenital anomaly first described by Von Hasner in 1881. It is defined as the upper and lower eyelids are joined by thin tags.

Method: Case report

Summary of the results obtained: A male infant who was born at 40 weeks and 6 days via spontaneous vaginal delivery to a primigravid mother, weighing 3.16 kg was referred for eye examination. Antenatal history of congenital anomalies or consanguinity was unknown as the mother had abandoned the child. A detailed ocular examination revealed intermittent partial fusion of his right upper and lower eyelids by central narrow bands of tissue in 3 places. Full eyelid opening was impaired and the lids could not be easily parted. Left eye examination was normal. A detailed paediatric examination revealed other congenital anomalies such as low set of ears, cleft lip and imperforated anus.

Excision of right eyelids ankyloblepharon and examination under anaesthesia (EUA) of both eyes were planned and performed early. The 3 bands of tissue were excised with a scissor at the level of each eyelid margin with minimal bleeding. Bilateral eye examination did not reveal any other pathology and was normal.
At his follow up appointment, post surgery the eyelid opening was normal and the infant could look at objects.

Conclusion: Ankyloblepharon filiforme adnatum is a potentially amblyogenic congenital abnormality of the eyelids. Fused eyelids and inability to open the eyes, deprives the eye of visual stimulus. Early and prompt treatment should be done to reduce the risk of ambylopia.

6. Beware of toy balloon

Authors : Stephanie Fong[1], Khadijah Mustafa[1], Norhayati Abdullah[2], Shuaibah Abd Ghani[1]
Institution : [1]Department of Paediatric Ophthalmology, Hospital Wanita & Kanak-Kanak Sabah, Kota Kinabalu
[2]Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu

Introduction: To report a case of anterior segment injury following an explosion of air filled balloon.

Method: Case report

Background: A 5 year old boy with underlying bronchial asthma presented with left eye pain and redness immediately after an explosion from inflated balloon on his face while attending a birthday party. Prior to the incident both his eyes were emmetropic and had no past history of ocular trauma or past surgery. Upon examination of left eye, best corrected visual acuity was 6/7.5. Lids and conjunctiva were normal. There was a 2-mm hyphema, blood cells, fibrin, iridodialysis located at 11 o'clock and traumatic mydriasis. Intraocular pressure was 13mmHg. RAPD was not present. Fundus examination was normal. Otherwise RE findings were normal. Patient was admitted to ward. Bed rest, topical cycloplegic and steroids were prescribed. Patient was discharged on day 7 of post trauma. On further follow up, vision remains 6/6 bilaterally, hyphema resolved. Nevertheless permanent mydriasis with iridodialysis were documented.

Conclusion: Blunt eye trauma can result from a wide variety of causes even something as trivial as a balloon explosion and it is a preventable phenomenon if adequate safety measures are taken.

7. Bone in the eye - A case of osteoma cutis

Authors : Kanmani M, Gunavathy N, Ho Shu Fen
Institution : Hospital Raja Permaisuri Bainun, Ipoh

Objective: To report a case of Osteoma Cutis in 9- year- old girl

Method: Case report

Results: Osteoma cutis is a rare condition involving the formation of bone in skin or subcutaneous tissue. This may be a primary event or, secondary to an inflammatory, traumatic, or neoplastic process. There have been a few incidences of case reports of osteoma cutis in the lateral canthus and eye brow but not in other locations. We report a case in which a 9-years old Malay girl with no known health comorbidities presented with a two- months history of right superotemporal whitish subconjunctival mass. It caused her some mild irritation. Excision biopsy revealed a subconjunctival plaque like lesion with some fat globules overlying and inferior to it. Histology examination showed a fragment of dermal lesion consist of cortical bone. It is believed to be originated from inappropriate migration of pleuripotential cells in this area.

Conclusion: Subconjunctival mass in a child may be a maldevelopment disorder. However, excision biopsy combined with histological examination is required to rule out any malignancy.

8. Central corneal thickness in myopia and its role in corneal refractive surgery

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[2] Department of Ophthalmology, Hospital Angkatan Tentera Tuanku Mizan

Objectives: To determine the central corneal thickness (CCT) in myopic patients scheduled for SMILE/ FEMTO LASIK corneal refractive surgery.

Methods: A retrospective study of case records of myopic patients scheduled for refractive corneal surgery in HATTM from January 2015 to December 2016 was conducted to determine the central corneal thickness.

Results: A total of 130 patients (77 SMILE and 53 LASIK) were included in this study. All the patients had 6/6 vision with best correction and did not have any other anterior segment or fundus diseases in both eyes. The mean age of patients was 33.8 years (range 18-60 years). There were 73 (56.2%) males and 57 (43.8%) females; Malays 110 (84.6%), Chinese 13 (10%) and Indians 7 (5.4%).

The spherical power of myopia ranged from 0.25 to 10 D, and the cylindrical power ranged from 0.25 to 3.25 D. The mean central corneal thickness in right eye was 527.2 μ (range 283-613 μ), while in the left eye it was 527.6 μ (range 428-615 μ). Using a readymade chart provided by the Femtosecond laser manufacturer and specific formula, the residual corneal thickness (RCT) was calculated to determine whether SMILE operation can be done or not. If RCT was <250 μ, different formula for LASIK was used and RCT was calculated again. After this, if RCT was <250 μ, no surgery was advised.

Conclusion: CCT plays an important role in determining whether corneal refractive surgery can be performed in the eye and also the type of corneal refractive surgery to be performed.

9. Persistent teary bleeding post upper eyelid laceration repair

Authors : Ruknesvary S, Ho Shu Fen
Institution : Hospital Raja Permaisuri Bainun, Ipoh

Objective : To report a case of inappropriate positioning of palpebral lobe of lacrimal gland as a cause of persistent eyelid bleeding following repair of upper eyelid laceration.

Method: Case report

Results: Injury to orbital lobe of lacrimal gland is uncommon as it is usually well protected within lacrimal fossa of the frontal bone. However, palpebral lobe of lacrimal gland which located on the conjunctival surface of upper eyelid may be injured during trauma involving the superotemporal part of eyelid although such case has never been reported. Lacrimal gland, a site of intraorbital anastomosis between internal and external carotid systems, is supplied variably by lacrimal artery. We report an unusual case in which 15 years old boy who complained of persistent intermittent bleeding post primary repair of right superotemporal eyelid laceration elsewhere. The bleeding occurred simultaneously with tears coming out from the lacrimal gland. Examination under general anaesthesia revealed an incorrectly sutured palpebral lobe of lacrimal gland during primary repair onto eyelid margin leading to traction of blood vessels within lacrimal gland during eyelid opening. The lacrimal gland was repositioned and the bleeding has ceased since then.

Conclusions : Injury to palpebral lobe of lacrimal gland should be suspected when there is an injury involving the superotemporal aspect of upper eyelid. Meticulous suturing is required to ensure palpebral lobe is not malpositioned. This can lead to intermittent yet persistent bleeding from the eye as the lacrimal gland is richly supplied by both internal and external carotid system.

10. Successful treatment of epithelial downgrowth with endoscopic photocoagulation and intracameral 5-fluorouracil after prolonged limbal wound leak

Author : Zakaria Abdollah (MbBCH BAO)
Co-authors : Norshamsiah Md Din, Aida Zairani Zahidin, Amin Ahem
Institution : Universiti Kebangsaan Malaysia

Purpose*:* To present a case of epithelial downgrowth following prolong persistent limbal wound leak successfully treated with endoscopic photocoagulation and intracameral 5-fluorouracil.

Method: Case report.

Results*:* We present a case of epithelial downgrowth occurring after prolong persistent limbal wound leak at the insertion of a Baerveldt tube entrance into the anterior chamber. The epithelial invasion seemed to be growing from the limbal fistula, where the Baerveldt tube was previously placed, towards the visual axis and covering the corneal endothelium, anterior iris and pupillary margin. This case was treated with laser photocoagulation using the endoscopic cyclophotocoagulation probe (ECP), peeling of the epithelial sheet, excision of limbal fistula, a corneoscleral lamellar graft at the fistula, and intracameral 5-FU. No recurrence of epithelial downgrowth was seen up to 6 months postoperatively.

Conclusion*:* Endoscopic cyclophotocoagulation and intracameral 5-FU may be a successful combination for treatment of epithelial downgrowth.

11. The thin hot eyes

Authors : Nor Diyana Zainal Noor, Wan Haslina Wan Abdul Halim, Aida Zairani Mohd Zahidin, Umi Kalthum Mohd Noh
Institution : University Kebangsaan Malaysia Medical Centre (UKMMC)

Purpose: To report a series of corneal melting cases secondary to different inflammatory aetiologies

Methods: Retrospective case series

Results: Corneal melting syndrome is a group of inflammatory diseases consisting of marginal corneal thinning, sometimes may extend of perforation. This case series report three cases of adult with unilateral corneal melting secondary to rheumatoid arthritis (RA), atypical painless Mooren'sulcer and infective cause. Two of the patients had progressed to corneal perforation and had undergone Penetrating Keratoplasty (PK) and corneal patch graft respectively. Case that undergone PK develop recurrent corneal melting post operatively and was on systemic and topical immunosuppression. Case secondary to infective cause responded to topical antibiotics

Conclusion: Corneal melting syndrome is a rare form of ocular inflammation and most commonly associated with systemic condition. Other cause may result from infection or degeneration. It is important to recognize the causes and systemic workup is crucial in its diagnosis and treatment.

Keywords: Corneal melting, Rheumatoid Arthritis, Mooren's ulcer, Infection

GLAUCOMA

12. Anterior segment optical coherence tomography in glaucoma drainage device obstruction

Main Author : Intan Shafinaz Mohd Radzuan
Co-Authors : Ch'ng Tun Wang, Farrah Jaafar, Ahmad Mt Saad
Institution : Hospital Sultanah Bahiyah, Alor Setar

Objective: To report an imaging from anterior segment optical coherence tomography of glaucoma drainage device obstruction post penetrating keratoplasty.

Methods: A case report

Results: 40-year-old lady with left eye absolute glaucoma and right eye advanced glaucoma. She had right glaucoma drainage device (GDD) implanted for uncontrolled intraocular pressure (IOP) despite on optimum antiglaucoma eyedrops. Two years after GDD implantation she developed cornea decompensation despite good IOP control and there was no endothelial-tube touch. Therefore right eye penetrating keratoplasty was done. Two months post penetrating keratoplasty she presented with sudden onset painful right eye reduced vision. Intraocular pressure was elevated to 60 mmHg. On examination, cornea graft was hazy with shallow

anterior chamber, GDD tube was unable to visualize. AS-OCT was performed from which we detected total occlusion of GDD tube, following which RE revision and repositioning of GDD tube was performed. Her IOP subsequently remain stable.

Conclusions: AS-OCT provides valuable adjunctive tool for anterior segment imaging and useful in the presence of corneal opacity. The non contact nature of AS-OCT makes it suitable in post penetrating keratoplasty eyes where undue pressure on the cornea graft should be avoided. This is also a good case to learn from in which GDD obstruction may occur after any surgical procedures.

13. Anti-proliferative and cytotoxic profile of different concentration of ranibizumab following Mitomycin-C on human conjunctival fibroblast

Authors : Mohd Yusof Siti-Fairuz (B.Sc), Azlina Ahmad (PhD),
Hasnan Jaafar (M.Path), Ahmad Tajudin Liza-Sharmini (PhD), et al
Institution : Universiti Sains Malayia

Objectives of Study: To determine anti-proliferative and cytotoxic profile of ranibizumab following mitomycin-C on human conjunctival fibroblast.

Methods: Human conjunctival fibroblasts (HConFs) were cultured in fibroblast medium and treated with 0.4 mg/ml mitomycin-C (MMC).The cultures were then administered with ranibizumab at different concentration (0 mg/ml, 0.30 mg/ml, 0.45 mg/ml and 0.60mg/ml). Viability and proliferation of HConFs were assessed at 24, 48 and 72 hours by alamarBlue assay. At 72 hours cytotoxic effect of ranibizumab following MMC on HConFs was evaluated treatment using dual staining with annexin V-FITC and propidium iodide.

Results: 24 hours treatment of ranibizumab following MMC caused insignificant reduction of HConFs' viability in the other treatment groups compared to control except for 0.60 mg/ml. At 48 and 72 hours, the number of HConFs was significantly reduced in all the treatment groups as compared to control ($p<0.05$). Statistically, it was shown that HConFs' viability was significantly reduced by ranibizumab at concentration 0.45 mg/ml. Group of 0.60 mg/ml ranibizumab showed highest number of HConFs at 24, 48 and 72 hours. Application of MMC alone induced a high level of HConFs death (19.3-91.8%). However, addition of ranibizumab at various concentrations reduced the MMC-induced HConFs death. The lowest HConFs death was 13.1-26.1%by addition of 0.45 mg/ml ranibizumab.

Conclusion: Use of ranibizumab in addition to MMC could further inhibit the proliferation and improved the cytotoxic effect of MMC on HConFs. The optimum concentration was combination of 0.45 mg/ml ranibizumab following 0.40 mg/ml MMC.

3rd Prize

14. Evaluation of the role of dietary intake and glaucoma progression in Malay patients

Authors : Noor Asma MN (B. Optom), Rohana J (PhD), Norhalwani H (MMed), Azhany Y (MMed), et al
Institution : Universiti Sains Malaysia

Introduction: IOP is part of modifiable risk factor for management and progression of glaucoma. Identification of other potential modifiable risk factor including dietary intake is important to retard progression of the disease.

Objective: To determine the association between dietary intake and glaucoma progression.

Method: A cross-sectional study was conducted in Hospital Universiti Sains Malaysia involving 242 Malay patients with primary open angle glaucoma (POAG) patients and primary angle closure glaucoma (PACG) between December 2015 and January 2017. Progression was based on four reliable Humphrey Visual Field (HVF) 24-2 standard analyses that were obtained at the recruitment period and at the initial diagnosis using Advanced Glaucoma Intervention Study (AGIS) scoring. Direct face-to-face interview on the dietary recall of food consumption pattern was conducted using food frequency questionnaire (FFQ).

Result: 116 males and 126 females with primary glaucoma were recruited with their mean age of 67.4 (SD=9.0) years. Based on the AGIS score, a total of 60 patients were found to develop visual field progression after 6.15 (SD, 4.6) years of follow up. There was significant different in coffee (p= 0.019) and egg based product intake (p= 0.037) between progress and non-progressed patients. Frequent consumption of egg reduced glaucoma progression by 1.8 folds (95% CI, 1.04, 3.13) and more frequent consumption of coffee increased the risk of glaucoma progression by 0.47 folds (95% CI, 0.25-0.88).

Conclusion: Coffee and egg based product are associated with the risk of glaucoma progression. Reduce coffee and increase egg based product consumption may reduce the risk of glaucoma progression.

15. Feasibility of eye screening among first degree relatives of primary glaucoma patients in Northeast of Malaysia

Main Author : Hanapi Maya-Sapira
Co-Authors : Siti Fairuz MY, Noor Asma MN, Yaakub Azhany, et al
Institution : Universiti Sains Malaysia

Objective: To detect glaucoma suspect or glaucoma among first degree relatives of juvenile onset open angle glaucoma (JOAG), primary open angle glaucoma (POAG) and primary angle closure glaucoma (PACG).

Methods: A pilot study involving POAG, PACG and JOAG patients who attending Glaucoma Clinic, Hospital Universiti Sains Malaysia between January 2014 and December 2015 were identified and interviewed for the pedigree chart, then followed by contact tracing of first degree relatives. First degree relatives were invited for eye screening evaluation; visual acuity (Snellen Chart), intraocular pressure (IOP) measurement (Air Puff Tonometry) and non mydriatic fundus photography conducted by trained paramedics. Detail eye examinations were performed if the visual acuity worse than 6/12, IOP measurement >21 mmHg or > 3mmHg differences between the two eyes, vertical cup-disc ratio was 0.7 or higher.

Results: 368 of first degree relatives from 70 indexed glaucoma patients were identified and contacted. A total of 41 relatives turned up and underwent glaucoma screening. 16 (39%) of first degree relatives were subjected to detail eye examination after failed the preliminary screening by trained paramedics. Another 25 relatives showed normal findings (24, 59%) and cornea problem (1, 2%). Five relatives (12 %) from indexed JOAG group were diagnosed as JOAG; three of them were treated medically and two required surgical intervention.

Conclusions: Glaucoma screening among high risk population showed beneficial outcome especially among JOAG relatives.

16. Reconsidering transcleral cyclophotocoagulation

Authors : Nur Arina MZ, Nurrul Farhanna O, Mahani MT
Institution : Hospital Putrajaya

The aim of this study was to evaluate the efficacy of diode laser cyclophotocoagulation in patients with symptomatic refractory glaucoma and to assess complications associated with this method. This is a retrospective case series from Ophthalmology clinic, Hospital Putrajaya from January until December 2014 with follow up duration of 2 years. Eleven patients with uncontrolled glaucoma, not responding to medical treatment underwent cyclodiode laser procedure. The intraocular pressure (IOP) and eye pain were the main parameters evaluated and complications were recorded. The diagnosis included neovascular glaucoma, angle recession glaucoma and pseudoexfoliative glaucoma.

The mean age of the group was 55.4 years (range 33 to 80 years). Six were males, 5 were females and all patients were Malays. All patients had poor vision when the procedure performed (from 5/60 to NPL). The mean preoperative IOP value was 34.9mmHg and the mean postoperative IOP value was 26.8mmHg. Two patients had persistent eye pain post procedure and four of them showed progression of the disease with worsening vision to NPL. One patient developed total hyphaema and one patient developed subsequent choroidal detachment. It is concluded that cyclodiode laser is a safe alternative therapy for sympotomatic refractory glaucoma who do not respond to medical treatment.

Key words: cyclodiode, glaucoma, intraocular pressure

MEDICAL OPHTHALMOLOGY

17. Acute myopia as first presentation of systemic lupus erythematosus

Authors : Salwa T[1,2], Mas EPI[1], Ng KK[1], Raja Norliza RO[1], et al
Institution : [1] Hospital Melaka, [2] Universiti Kebangsaan Malaysia

Objective: To report a rare ocular presentation of transient myopic shift in a newly diagnosed sytemic lupus erythematosus

Method: Case report

Summary of report: A 14-year-old Malay girl presented with bilateral eye blurring of vision and periorbital swelling for 5 days duration. She was not known to have refractive error. Her vision was 6/60 refracted to 6/9 bilaterally with -3.50 D, -1.00 Dx180^0 on the right and -4.00 D on the left. Humphrey visual field assessment was normal. There was no RAPD. There were periorbital edema with conjunctival chemosis bilaterally. Extraocular muscle movement were normal. The cornea, anterior chamber, intraocular pressure, lens and vitreous were normal. There were presence of macula striae bilaterally, however optic disc and retinal vessels were normal. B scan showed choroidal effusion.

On further assessment, she was diagnosed to have systemic lupus erythematosus by matching 4 of the American College of Rheumatology criteria. They were, non erosive arthritis, persistent proteinuria (1g per day), positive anti-nuclear antibody (1:640, speckled) and positive extractable nuclear antigen, anti-Ro and anti-La (>600 U/ml). After started on oral prednisolone her periorbital edema, conjunctival chemosis and myopia resolved .

Conclusion: Acute myopia should be one of the differential diagnosis of visual disturbance in systemic lupus erythematosus. The proposed mechanism of the myopic shift was anterior dispacement of lens-iris diaphgram due to choroidal effusion.

18. Case report: External ophthalmomyiasis as an eye manifestation of basal cell carcinoma

Authors : Hing ST, Ting XW, Faisal HA, Pan SW
Institution : Hospital Sibu, Sarawak

Objectives: To describe a case of basal cell carcinoma in a patient who presented with external ophthalmomyiasis in an 86-year-old lady and to emphasize on prompt treatment to prevent sight-threatening condition.

Method: Case report

Result: An 86- years-old widow with no known comorbid, presented with right periorbital swelling, redness and fever associated with nose lesion teeming with maggots four days ago. Patient is staying alone with poor socio-economic status and practicing poor hygiene. On examination noted right eye vision 3/60, left eye 3/36 with right periorbital cellulitis, chemosis and corneal epithelial defect. Other intraocular examinations were normal except bilateral cataract. Ulcerative nose lesion extending from the tip of nose to the right medial canthi and nasal cavity exposed. CECT brain and orbit showed right

nasal bridge lesion with ulceration complicated with myiasis infiltration causing right periorbital cellulitis. Twenty- seven maggots were removed with turpentine oil. Treatment immediately started with antibiotics-steroid combination therapy. Patient's eyes condition had slowly improved. However, lesion biopsy taken sent for histopathology reported as basal cell carcinoma but patient had defaulted subsequent follow up.

Conclusion: Ophthamlomyiasis externa is a superficial infestation limited to the external ocular structures. It is a rare disease and only less than 5% cases involve the eye. However, it can be complicated by fatal ophthalmomyiasis interna if not diagnosed and treated promptly. Thorough history, physical examination, radiological and laboratory investigations are all imperative in aiding the diagnosis and

19. Case series of ocular tuberculosis (TB) presentation in Hospital Sultan Abdul Halim (HSAH)

Main Author : Tan Qi Xian
Co-Authors : Kee RongSheng, Rajasudha Sawri Rajan, Mariam Ismail
Institution : Hospital Sultan Abdul Halim, Sungai Petani

Objective: To present a case series of Ocular TB with varied clinical features.

Methodology: Case series

Result: Three patients were reviewed; all presenting with blurring of vision prior to commencement of anti-TB medications. They were subsequently diagnosed with TB via different diagnostic tests (positive cerebrospinal fluid biochemistry, mantoux test and sputum culture and sensitivity). Two patients had retinal occlusive vasculitis and one had panuveitis with choroidal granuloma. Both patients with retinal occlusive vasculitis were given laser panretinal photocoagulation. All were co-managed by medical team for Directly Observed Treatment, Short-course programme (DOTS) for extended anti-TB treatment regimens (9-12 months). With Anti-TB treatment regime and laser treatment, all patients showed improved best corrected visual acuity and ocular symptoms.

Conclusion: Ocular TB is a complex clinical problem due to its wide spectrum of presentations and difficulty in diagnosis as it may not be associated with clinical evidence of pulmonary TB. Posterior segment was the common site of involvement in these patients with different presenting features. The main challenge lies in diagnosing ocular TB. The mainstay treatment of ocular TB is still completion of anti TB medications.

20. Cavernous sinus thrombosis and meningitis: A rare presentation of leptospirosis

Authors : SY Yeoh[1,2], SM Chua[1], Navpreet Sidhu[1], Raja Norliza RO[1]
Institutions : [1] Hospital Melaka , [2] University Malaya Medical Centre

Introduction: Leptospirosis involving the neurological system is often underestimated and overlooked. Cavernous sinus thrombosis (CST) syndrome and meningitis are rare complications of leptospirosis and are associated with a high mortality risk. At the time of writing, only one case of CST caused by leptospirosis has been reported.

Case Report: Here, we report a 35-year old lady who travelled to the rainforest of Borneo and developed fever soon after. A week later, she presented to the ophthalmology clinic complaining of rapidly progressive swelling of the left eye. She had no blurring of vision or double vision.

On examination, she appeared lethargic. Her right vision was 6/24 (6/12) and left vision 6/36(6/24). Left RAPD was present. There was proptosis with lid edema over the left eye. There was limitation of movement of her left extraocular in all directions. Her optic disc was pale and her retinal arteries were attenuated. Her right eye was normal. Cranial nerves examination showed impairment of left cranial nerves 2,3,4,5 and 6. Kernig's and Brudzinki's sign were positive.

She was co-managed with the medical team. Urgent CT brain and orbit showed left cavernous sinus thrombosis with meningitis and cerebral oedema. Leptospira serology was positive. She was started on intravenous antibiotics and fully recovery after a week

Conclusion: A strong index of suspicion is important for early diagnosis of neurological manifestations and complications of leptospirosis. Prompt treatment is mandatory as it is life and sight saving.

21. Endogenous endophthalmitis in Kota Bharu, Kelantan: A 5 year retrospective study

Authors : Michael Ngu DB MBBS, Shakiran Gunaseelan MBBS,
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Institution : Hospital Raja Perempuan Zainab II, Kota Bharu

Purpose : The aim of this study was to profile the predisposing factors, microbial profiles, source of infection, and visual outcome of endogenous endophthalmitis (EE) in Hospital Raja Perempuan Zainab II (HRPZ II) Kelantan.

Methods : We reviewed data from 18 eyes of 17 patients diagnosed with EE that were admitted to eye ward in HRPZ II from 2012 to 2016. Data was collected from parameters including age, source of infection, visual acuities, microbial profiles and treatment outcome.

Results : The mean age of patients reviewed was 53.2 years. There was only a single case involving bilateral eyes with a preponderance of left eye (70.6%) compared to right (23.5). All the patients studied had at least one preexisting predisposing condition the most common at which was diabetes mellitus(82.4%). A source of infection was identified in 12 of the 17 patients with urinary tract infections leading the way (29.4%). Organisms were successfully isolated in 55.6% of cases with an edge to gram negative organism (35.3%) versus gram positive (23.5%). Every patient presented with a visual acuity of worse than 6/60. 52.9% of patients underwent vitrectomy surgery. Only 17.6% had a final visual acuity of better than 6/60 while 64.7% were non perceptive to light. 4 of these patients underwent an evisceration

Conclusion : Endogenous endophthalmitis is a rare but often devastating ocular condition. Early diagnosis and intervention might lead to relatively good visual outcome.

22. Endogenous endopthalmitis secondary to cerebral abscess in abandoned baby

Main Author : Neshalene Ratna Krishnan
Co-Authors : Mohamad Fathi Ismail, Suresh Kumar Vasudevan
Institution : Hospital Sultanah Aminah, Johor Bahru

Objective: To report a case of endogenous endopthalmitis secondary to cerebral abscess in a neonate.

Method: A case report

Result: An abandoned female neonate, day 6 of life, with sepsis was referred from neonatal ICU for left eye swelling and redness for 1 day duration. Examination revealed left periorbital oedema and erythema with proptosis, extensive chemosis and a tight eyeball. There was a total anterior chamber hypopyon with no fundal view. No laceration wound noted. She was diagnosed as left endogenous endopthalmitis secondary to sepsis.Vitreous tap and intravitreal antibiotics was performed. Clinical improvement of the eye, however, was only noted after second intravitreal antibiotics injection. Culture and sensitivity showed no growth. Computed tomography of brain/orbit revealed cerebral abscesses with associated edema, left eye proptosis with scleritis, and retro-orbital inflammation. Although the eye was initially responding well to treatment, she had a recurrent with full hypopyon after third week of treatment. Further intravitreal antibiotics was given. Repeated CT showed worsening of cerebral abscess. Systemic antibiotics was substituted. Subsequent magnetic resonance imaging of brain/orbit showed improvement in cerebral abscess. The eye was slowly healing but already in pre-phthisical stage.

Conclusion: Prompt diagnosis and treatment of endopthalmitis is always essential at any stages of life. Closed collaboration with other medical disciplines could not be overemphasized in managing patient with endogenous endopthalmitis.

23. Chronic Myelomonocytic leukemia with leukemic cutis associated with ocular surface disease due to meibomian gland dysfunction

Authors : Yeo Kai Chi (MBBS), Kursiah Bt Mohd Razali (MS)
Institution : Hospital Raja Permaisuri Bainun, Ipoh

Objective: To report a case of Chronic Myelomonocytic Leukemia with Leukemic cutis and severe ocular disease.

Method: Case report

Result: Mr. L is a 74 year old, Chinese, male, known case of hepatitis B carrier, presented with extensive erythematous papules and nodules with haemorrhagic crusted skin erosion over the face, trunk, limbs, associated with skin itchiness for 6 weeks duration. It was associated with bilateral eye redness, discharge and blurring of vision. Ocular examination revealed bilateral severe ocular surface disease, blepharitis and conjunctivitis. No other significant ocular diseases seen. Treatment was initiated and clinically improved.

Conclusion: Chronic Myelomonocytic Leukemia with Leukemic Cutis is a relatively rare, heterogenous syndrome, classified as a myelodysplastic syndrome according to the French-American-British classification system. Only 12 cases of leukemic cutis in chronic Myelomonocytic have been reported. The diagnostic criteria for Chronic Myelomonocytic Leukemia include a peripheral blood monocytosis of 1000 / mm3, peripheral blood blasts of less than 5%, and the absence of Auer rods. In addition, Chronic Myelomonocytic leukemia bone marrow samples shows dysplasia of the erythrocytic, megakaryocytic, granulocytic lines, a blast count of 5% to 20%, increased in monocytic precursors.

In this case, this patient also presented with bilateral severe ocular surface disease, blepharitis and conjunctivitis which was not reported before. Therefore, further study needed to ascertain whether there is any correlation between the Chronic Myelomonocytic leukemia with Leukemic Cutis and severe ocular surface disease, blepharitis, conjunctivitis.

24. Multiple Myeloma: Uncommon Immunogammopathy Maculopathy

Main Author **:** Mohd Syafiq Azman
Co-Authors : Shawarinin Jusoh, Akmal Haliza Zamli
Institution : Hospital Tengku Ampuan Afzan, Kuantan

Objective: To report a case of symptomatic immunogammopathy maculopathy in multiple myeloma despite lower level of Ig M (<7000 mg/dl).

Method: Case report

Summary: Multiple Myeloma is a plasma cell malignancy that destroys renal, skeletal and neurological function. An unusual macular detachment with or without subretinal precipitates or fundus signs of serum hyperviscosity, such as retinal hemorrhages and distended retinal veins, may be observed in patients with immunogammopathy such as multiple myeloma. Normally an immunogammopathy maculopathy becomes symptomatic when Ig M level exceed 7000 mg/dl (non-diabetic patient). We examined a 53-year-old Malay man with underlying hypertension and known multiple myeloma, complained of progressive blurring of vision in both eyes over 2 months. Visual acuity with best correction was 6/36 in both eyes. No relative afferent pupillary defect. Slit lamp biomicroscopy showed minimal nuclear cataract in both eyes. No evidence of cornea crystals. Funduscopic examination revealed bilateral macula neurosensory detachment with yellow-white subretinal precipitates. The retinal veins also appeared distended. Fluorescein angiography showed no evidence of macula hyperflorescence from the retinal vasculature or retinal pigment in either eye. Laboratory evaluation revealed microcystic anaemia, thrombocytopenia and abnormal serum protein electrophoresis Ig M Kappa paraproteinemia of 5890 mg/dl.

Conclusion: Symptomatic immunogammopathy maculopathy in multiple myeloma is still possible despite lower level of Ig M therefore prompt treatment is necessary to prevent irreversible visual loss.

25. Mycotic aneurysm - A rare complication of a common disease

Author : Dharshini Balasubaramaniam[1], Praveen Selvarajah[1], Shuaibah Ab Ghani[2]
Institutions : [1] Dept of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu
[2] Dept of Pediatric Ophthalmology, Hospital Wanita & Kanak-Kanak Sabah, Kota Kinabalu

Objective: To describe a rare case of mycotic aneurysm as a sequelae of orbital cellulitis

Method: Case report

Results: A 4-year old Filipino boy who was immunized and pre-morbidly healthy, presented with right periorbital swelling, red eye and discharge for 5 days, associated with low grade fever. Parents denied history of ocular trauma and upper respiratory tract symptoms. On examination, the child was septic and lethargic. Ocular examination revealed bilateral periorbital swelling and erythema with right eye proptosis and chemosis. Relative afferent pupillary defect was negative. Visual acuity and extraocular movements were not assessed as his Glasgow Coma Scale was 10/15. CT Brain and Orbit showed bilateral orbital cellulitis with subperiosteal abscess. Patient was treated with intravenous cefotaxime and clindamycin.

Unfortunately, his condition deteriorated and he subsequently developed bilateral surgical third nerve palsy. Urgent MRI brain and orbit revealed bilateral cavernous sinus thrombosis, cerebritis and mycotic aneurysms at the anterior and middle cerebral arteries. Blood culture and eye swab grew Methicillin-Resistant Staphylococcus Aureus. He was then commenced on intravenous linezolid. However, despite resolution of the infection, the neurological deficit as a sequel was irreversible.

Conclusion: Mycotic aneurysm, although a rare sequelae of orbital cellulitis, should not be dismissed as early detection and timely treatment is crucial in optimizing patient's outcome.

26. Ocular manifestations of leptospirosis patients following endemic at Beruas River

Main Author : Azima Binti Ahmad Shahrudin, MD (CSMU)
Co-Author : Fadzillah Mohd Tahir, MMED Ophthalmology (USM)
Institution : Hospital Taiping

Objectives: To study the ocular manifestations among commando-in training infected by Leptospira treated at Hospital Taiping.

Methods: 13 males commando-in-training with clinical and laboratory (ELISA IgM) diagnoses were subjected to ophthalmological examination.

Results: We observed anterior uveitis in all 13 patients. None with subconjunctival haemorrhage. No cataract formed. One patient with optic disc swelling. None with retina involvement. All treated with Gutt. Dexamethasone 0.1% every 8 hours and Gutt. Ciprofloxacin 0.3% every 2 hours for two weeks. Majority regain best corrected visual acuity of 6/6 following one week course of treatment.

Conclusions: We observed a high incidence of keratouveitis in second phase of leptospirosis. Leptospiral uveitis can be treated with topical steroid and topical antibiotic only without the need of systemic antibiotic. However, involvement of optic disc in leptospirosis patient may need systemic steroid and antibiotic. In cases of suspected leptospirosis, prompt referral to Ophthalmology department render early detection of uveitis, hence, higher probability of the inflammation still confine in a milder stage and would possibly carries good visual outcome.

27. Ocular tuberculosis masquerading as ocular tumour

Authors : Izwan KT, Safinaz MK, Norshamsiah MD
Institution : Hospital Canselor Tuanku Muhriz

Objective: To describe a case of ocular tuberculosis (OTB) that had initially presented with ocular manifestations that simulate intraocular malignancy.

Method: case report

Result: A 30-year-old medical officer presented with 3 months history of right eye progressive blurring of vision, associated with pain, redness and photophobia. He had multiple episodes of similar complaints over the past 3 months which subsided following application of steroid eyedrops. His visual acuity was hand movement OD and 6/6 OS. The anterior chamber showed cells of 3+ with granulomatous keratic precipitates, rubeosis iridis, posterior synechiae from 3-9 o'clock and ectropion uveae; gonioscopy showed whitish mass at the angle with neovascularisation. The lens was cataractous precluding fundal view. Ocular examinations were unremarkable OS. Systemic examinations were normal and Bacillus Calmette-Guerin scar was present. The chest X-ray was normal but a Mantoux test read 24 mm of erythematous induration. The erythrocyte sedimentation rate was 48mm/hour. B scan and ultrasound biomicroscopy showed retrolental mass at the ciliary body. Magnetic resonance imaging showed an intraocular mass with no optic nerve or extraorbital extension. Based on his highly positive mantoux test, he was diagnosed with OTB. He was co-managed with the chest physician and was started on anti-tubercular therapy.

Conclusion: OTB simulating as intraocular tumor is rare and requires a high index of suspicion to diagnose this curable disease especially in high risk groups such as medical personnel and immigrants.

28. Orbital apex syndrome secondary to orbital cellulitis with central retinal artery occlusion

Main Author : Michele SY Tey
Co-Authors : Calvin CY Lim, Suresh Kumar Vasudevan
Institution : Hospital Sultanah Aminah, Johor Bahru

Objective/Introduction: An unusual presentation of left central retinal artery occlusion following left orbital cellulitis.

Method: A 60-year-old Indian man with hypertension and poorly-controlled diabetes, presented with diplopia for two days. It was associated with fever, frontal headache and severe left eye pain. On examination, there was inability to abduct the left eye. His best corrected visual acuity was 6/9 both eyes with no afferent pupillary defect. Imaging performed demonstrated left maxillary and ethmoid sinusitis, with no evidence of carvenous sinus thrombosis. Admission was warranted and he was commenced on intravenous antibiotics. Subsequently, he developed left eye chemosis and proptosis with partial ptosis and progressive limitation of extraocular movement at all gaze. These quickly advanced to complete ptosis and total ophthalmoplegia. His left eye vision deteriorated to no perception to light. Fundus examination was unremarkable with no evidence of vaso-occlusion at that point. A functional endoscopic sinus surgery with septoplasty and endoscopic orbital decompression was done by ENT team. Mucormycosis was ruled out upon obtaining culture result from the sinus surgery. Post-operatively patient was found to have a cherry red spot with pale retina on fundoscopy examination. At a follow up of 3 months post operatively, there were spontaneous resolution of ptosis and ophthalmoplegia. However, his vision remains at no perception to light.

Conclusion: Central retinal artery occlusion following an orbital apex syndrome and orbital cellulitis is unusual and has poor visual outcome despite commencement of systemic antibiotics.

Keywords: orbital apex syndrome, orbital cellulitis, central retinal artery occlusion

29. Resolved Vincristine Induced Bilateral Ptosis Following Pyridoxine and Thiamine Combination Therapy in a Child

Main Author : Chai Khai Siang
Co-Author : Shatriah Ismail
Institution : Universiti Sains Malaysia

Objective: To describe a case of child develop bilateral eye severe ptosis induced by vincristine

Method: Case report

Results: A 2-year-old child with underlying common B-cell acute lymphoblastic leukaemia presented with bilateral ptosis 7 months ago. Prior to presentation, she had been receiving UKALL regime A protocol chemotherapy including oral dexamethasone (6.5mg/m^2/day), intramuscular L-asparaginase (6000U/m^2), intravenous vincristine (1.5mg/m^2), intrathecal Arabinosylcytosine (50mg) and intrathecal methotrexate (10mg) therapy. She had completed a total of 5 doses of vincristine, which is equivalent to a cumulative dose of 3.5mg vincristine (0.36mg/kg).

The child was able to pick up small objects and follow objects with steady gaze. On inspection, bilateral ptosis was noted with right upper lid at upper pupillary margin while the left upper lid was covering the visual axis. On palpation of abdomen noted hepatospleenomegaly.

Patient was treated with syrup gabapentin 100mg twice a day subsequently increased to three times daily, syrup folic acid 0.25mg once a day and one tablet Neurobion which consists of 100mg thiamine disulfide (5mg/kg), 200mg pyridoxine hydrochloride (10mg/kg) and 200mcg cyanocobalamin (10mg/kg) once a day. Despite continuation of chemotherapy, bilateral ptosis markedly improved after 1 week of combination of pyridoxine and thiamine treatment and completely recovered after 1 month.

Conclusion: Side effect of vincristine are reversible and close monitoring is essential to prevent undesired complications. Pyridoxine combined with thiamine has equal effectiveness compared to combined pyridoxine and pyridostigmine therapy in neuropathy induced by vincristine. Nevertheless such combination treatments accelerate recovery of ptosis. Observation can be considered in mild ptosis.

30. Sight threatening branulas

Authors : Dheveya S (MBBS), Nazrah MR (MDUKM)
Institution : Hospital Tuanku Ja'afar, Seremban

Objectives: To report two rare cases of patients who had endophthalmitis following intravenous cannulation.

Methods: Observational case series.

Results: We report two cases of endogenous endophthalmitis following intravenous cannulation during the same admission period. A 43 year old Malay female and a 73 year old Chinese male were admitted to medical ward and treated for acute cardiac condition. Both patients had branula inserted over their upper limb. During admission, both patients presented with acute signs and symptoms of endophthalmitis following thrombophlebitis and abscess from the branula site.
On examination, there were anterior chamber inflammatory changes with hypopyon and vitreous loculations in both the patients. The male patient's vitreous tap and infected branula site revealed *Staphylococcus aureus.* Both patients were treated as endogenous endophthalmitis and given intravitreal as well as intravenous antibiotics.
Unfortunately the male patient had no improvement in vision upon discharge. Patient eventually underwent trans pars planar vitrectomy under local anaesthesia in view of poor cardiac status.However the female patient had resolved inflammation with improved vision up to 6/9.

Conclusions: It is essential to ensure the hygiene of intravenous cannulation site as infection from the branula site is proven to cause endogenous endophthalmitis.

31. SLE with variability of ocular posterior segment manifestations

Main Author : Muharliza Musa
Co-Authors : Ling Kiet Phang, Haslina Mohd Ali, Roslin Azni Abd Aziz
Institution : Hospital Sultanah Bahiyah, Alor Setar

Objectives : To describe the ocular posterior segment and systemic manifestations associated with systemic lupus erythematosus (SLE) in Hospital Sultanah Bahiyah, Alor Setar Kedah.

Methods: Retrospective study from 2014 to 2016, indentified 5 new cases of ocular posterior segment involvement in patients with active SLE were described. 673 published cases of lupus-related ocular posterior segment were summarized.

Results: There have been 1case of optic nerve involvement, 2 cases with vaso-occlusive retinopathy and 2 cases with choroidopathy. All 5 patients (100%) had active systemic vascular disease at the onset of their ocular disease; none (0%) had central nervous system (CNS) lupus vasculitis. All but 2 of the patients had a known diagnosis of SLE at the onset of ocular posterior segment involvement. 7 of the involved eyes had presenting visual acuity of 20/200 or worse; 4 eyes showed improvement in visual acuity with therapy. 1 patient had resolution of their choroidopathy when their systemic disease was brought under control.

Conclusions: The eye manifestations in SLE are variable. The eye findings may be the presenting sign of the systemic disease. In addition, these findings may serve as an indicator of active systemic disease. Careful assessment by the ophthalmologist is mandatory to prevent sight-threatening complications. SLE is a multisystem disease which requires the collaboration between the rheumatologist and the ophthalmologist to provide adequate treatment and prevent complications.

32. Various ocular inflammation in patient with positive anti-nuclear antibody

Authors : Mun Wei Lam[1], Hayati Abdul Aziz[2], Su Ngein Leow[2], Suresh Kumar Vasudevan[2]

Institutions : [1]Hospital University Sains Malaysia[1], Kota Bharu
[2]Hospital Sultanah Aminah[2], Johor Bahru

Objective: To report 2 cases of chronic ocular inflammation in patients with positive Anti-Nuclear Antibody.

Method: Retrospective, Case series

Results: Case 1: A 34-year-old lady presented with recurrent right eye redness for 3 years duration. The right eye visual acuity was 6/18 while the left eye was 6/9. Ocular examination of the right eye showed sectoral scleritis nasally and corneal stromal opacity with ghost vessels. Fundus examination of the right eye showed optic disc swelling. The optic nerve function tests were intact. B scan showed no evidence of 'T' sign but the right sclera was thickened. The Anti-Nuclear Antibody test was positive with speckled pattern. Infective screening and other autoimmune test were negative. We diagnosed her as right sclerokeratitis with component of posterior scleritis. Oral prednisolone and topical steroid were commenced. The patient responded well to the treatment.

Case 2: A 54-year-old lady presented with recurrent left eye redness with floaters for 6 months duration. The left eye vision acuity was 6/12 pinhole 6/9. Ocular examination of the left eye showed quiet anterior chamber. However, anterior vitreous cells were seen. There were vitreous clumps seen inferiorly at the posterior segment. The left optic disc was not hyperemic. The Anti-Nuclear Antibody test was positive with nucleolar pattern. Infective screening and other autoimmune test were negative. We diagnosed her as left intermediate uveitis. The patient was started on topical steroids alone and was responded well clinically.

Conclusion: A patient with Anti-Nuclear Antibody positive alone without demonstrated positivity to other autoimmune markers can presented with chronic ocular inflammation as seen in our case series. Hence, it is advisable for Rheumatologists to send patient with Anti-Nuclear antibody test positive for eye screening. Prompt diagnosis and treatment will prevent vision-threatening complications.

33. Venom ophthalmia caused by black spitting cobra: A report of twelve cases in a District Hospital

Main Author : Ju Juen Chin
Co-Authors : Krishnalatha Buandasan, Francesca Martina Vendargon
Institution : Hospital Sultanah Nora Ismail, Batu Pahat

Objectives: We present twelve cases of ocular injury following entry of snake venom by the Equatorial spitting cobra (*Naja sumatrana*). To highlight the importance of copious eye irrigation for decontamination of venom toxins.

Case Series: Out of twelve cases, five occurred at the workplace and seven in and around village homes. All patients experienced immediate intense burning pain (pain score 10 using the 0-10 Numeric Pain Rating Scale), watery red eyes, blepharospasm and transient blurring of vision. Five patients sustained corneal epithelial defects and seven patients had punctuate epithelial erosions.

Management & Outcome: First aid eye irrigation was performed on all patients and titrated according to the pain score. Seven patients needed 2 litres of eye irrigation, one patient required 3 litres and four patients required 5-7 litres. Pain score improved significantly post-irrigation. All patients were prescribed eye lubricants, prophylactic topical antibiotics and oral analgesics. Vision improved to 6/9 and 6/6 after a day for ten patients and after two days for two patients. None developed corneal scarring or permanent visual disability.

Conclusion: Venom ophthalmia by *Naja sumatrana* may cause permanent blindness but most of our patients only experienced mild ocular signs. "Dry spit"- spitting with low venom content might be the reason for such minimal reactions. Immediate copious eye irrigation is crucial in decontaminating the eye of venom toxins and cannot be over-emphasized.

MEDICAL RETINA

34. A rare case report of unilateral acute retina pigment epithelitis (ARPE) associated with hand, foot and mouth disease (HFMD)

Main Author : Tan Qi Xian
Co-Authors : Josephine Lee En Hui, Rajasudha Sawri Rajan, Mariam Ismail
Institution : Hospital Sultan Abdul Halim, Sungai Petani

Objective: to report a case of unilateral acute retina pigment epithelitis associated with hand, foot, and mouth disease

Method: Case report

Result: We report a 30 year old gentleman who presented with left eye sudden central scotoma for 1 week duration with no other ocular complaints. He had history of hand, foot, and mouth disease 2 weeks prior to presentation and treated symptomatically by his general practitioner. Visual acuity upon presentation was LE unaided 6/36 pinhole 6/36. RAPD was negative. Confrontation test and Amsler chart showed left eye central field loss with no metamorphopsia. Anterior segment was normal. Fundoscopy showed a left eye large diffused area of spotty yellowish discolouration in posterior pole involving macula. Fundus Autofluorescence (FAF) showed mottled, patchy hypofluorescence at macula and papillomacula bundle extending from superior arcade to inferior arcade with Fundus Fluocescence Angiography (FFA) shows no evidence of leakage. Optical Coherence Tomography (OCT) of left eye reported irregularities and thinning of RPE. In view of no improvement after 3 weeks of observation and patient's occupation, he was started on low dose oral prednisolone (0.5mg /kg) and tapered down over 1 month. His left eye vision improved to 6/12.

Conclusion: ARPE is a benign, self-limiting idiopathic inflammatory disease which can be seen in post viral infection. Treatment is usually not required however this case highlights the use oral steroid proved to be helpful to reduce inflammation.

35. A tale of two – chronic myeloid leukemia and diabetic retinopathy

Main Author : Rupini Yogesvaran
Co-Author : Ong Poh Yan
Institutions : Universiti Kebangsaan Malaysia/Hospital Selayang

Objective: To report a case of rapid progression of proliferative diabetic retinopathy as an initial manifestation of chronic myeloid leukemia

Method: Case report

Results: An 18-year-old girl with good control of her insulin dependent diabetic mellitus, initially presented with bilateral painless blurring of vision for 6 months duration. At presentation, visual acuity was 6/36 in both eyes, with normal intraocular pressures (IOP) and anterior segments. Both fundi showed presence of moderate non-proliferative diabetic retinopathy. However, a week later, both vision deteriorated, right eye to 2/60 and left eye to counting fingers. IOP was 36mmHg and 52mmHg respectively, in the right and left eye. Both eyes had florid rubeosis iridis and a streak of hypopyon was seen in the left anterior chamber. There were florid retinal neovascularisation in both eyes. Vitreous haemorrhage with fibrovascular membranes overlying the optic disc was noted in the left fundus. Her full blood picture demonstrated leucocytosis of 281,000/mm3, and subsequently she was diagnosed to have Chronic Myeloid Leukemia. Intensive topical steroids treatment led to resolution of the hypopyon. Multiple sessions of laser panretinal photocoagulation were given to address the neovascularisation. IOP in the right eye improved but left eye remained uncontrolled despite maximum anti-glaucoma medications, micropulse cyclophotocoagulation and transcleral cyclophotocoagulation. She is planned for further surgical intervention for the left eye after completing her chemotherapy and when fit for operation.

Conclusion: In unexpected or rapidly progressing retinopathy in well-controlled diabetic patients, other possible pathologies should be excluded. These patients should be treated promptly and aggressively with the appropriate treatment for the underlying systemic disease.

36. Beware of Cats!

Main Author : Lim Jie Jie
Co-Author : Hanizasurana Hashim
Institution : Hospital Selayang

Purpose : To report on a case of bilateral neuroretinitis secondary to Bartonella henselae.

Results: A 31-years-old Malay lady, with no known medical illness previously, presented with bilateral painless central blurring of vision over 1 week duration. She also had fever on and off over 2 weeks time. She had history of cat scratch about 1 month ago in her workplace. On examination, her both eye vision are 6/9. Right eye red saturation reduced than left eye. No relative afferent pupillary defect. Fundus examination showed bilateral optic nerve swelling with macular striations and multiple choroiditis lesions at the periphery. Optical coherence tomography both eyes showed presence of bilateral subretinal fluids. A diagnosis of neuroretinitis and choroiditis secondary to cat scratch disease was made. Serologic testing of Bartonella henselae IgM and IgG were both positive. Patient was treated with intravenous ceftazidime for 2 weeks. Her symptoms and ocular findings improved with treatment. Patient was discharged with oral Doxycycline for 6 weeks.

Conclusions: Cat-scratch disease with associated neuroretinitis is getting common in Malaysia. It should be suspected in any patient that manifests an abrupt loss of visual acuity together with the finding of disc swelling and macular star exudates, especially in the presence of the history of cat contacts.

37. Case report on retinal capillary hemangioblastoma - To treat or not to treat

Authors : Lam CS, Bastion MLC
Institution : Universiti Kebangsaan Malaysia Medical Center

Objectives: To report a case of retinal capillary hemangioblastoma (RCH) and the treatment dilemma.

Methods: Retrospective case report

Summary: A 31-year-old Malay policewoman presented with left eye floaters for 1 year. She denied blurring of vision, flashes of light, eye redness or pain. There was no prior history of trauma. She was otherwise healthy with no family history of note. Her vision was 6/6, N5 bilaterally. The right eye examination was normal. On fundus examination of the left eye, an elevated vascular lesion measuring one disc diameter (1.5mm) in size with overlying vitreous condensation and dilated feeder and drainage vessels was noted in the superotemporal quadrant. There was no retinal haemorrhage, exudate or retinal detachment seen. The optic disc and macula looked normal. The appearance was consistent with a solitary RCH in von Hippel-Lindau disease, a systemic condition characterized by multiple cysts of the cerebellum, pancreas and kidney.

The patient proceeded with ocular and systemic investigations for VHL including macula optic coherence tomography, fundus fluorescein angiogram, brain and abdominal ultrasound and MRI scans. The ocular treatment dilemma for asymptomatic RCH with good vision which are smaller than 3 mm is whether to observe or treat with laser photocoagulation or cryotherapy. This will be discussed.

Conclusion: Treatment for RCH can be complex; mode of treatment mainly depends on the size of RCH, its location, and associated retinal changes.

38. Cat scratch disease (CSD) with posterior segment involvement

Authors : Hanan binti Feisal Bamadhaj, Ayesha Mohd Zain, Zairah binti Zainnal Abidin, Rusnah binti Hussain
Institution : Hospital Ampang

Objective: To report a case of cat scratch disease presented with bilateral neuroretinitis.

Method: Case Study

Summary: A 24 year old Malay gentleman with history of eczema. He presented with both eye redness and left eye reduced vision for 2 days duration. Symptoms associated with fever for one week. There was history of contact with cat. Visual acuity was 6/9 over the right eye and 6/24 ph 6/18 over the left eye with no relative afferent pupillary defect. Anterior segment findings were unremarkable except for bilateral localised subconjunctival hemorrhage. Fundus examination on the right eye revealed multiple retinitis over the posterior pole. Left optic disc was swollen with macula star. Bjerrum visual field showed enlarged blind spot on the right eye and left eye central scotoma. Right eye colour vision was normal, the left eye was not able to be tested due to central scotoma. CT scan brain showed no evidence of intracranial space occupying lesion or orbital abnormality. Further laboratory investigations, IgM for Bortenella Henselae confirmed the diagnosis of cat scratch disease. Patient was started on antibiotic and after a few days followed by oral steroid therapy . Upon completed treatment, left eye vision improved to 6/15 while right eye vision remained at 6/9. On subsequent follow up, OD swelling and retinitis resolved.

Conclusion: Recognizing specific eye manifestations with high index of suspicion is crucial in making a clinical diagnosis of cat scratch disease. Commencing an appropriate ocular and systemic treatment of cat scratch disease is crucial in securing good visual potential.

39. Combination of serpiginous choroidopathy and multifocal choroiditis in a patient with presumed ocular tuberculosis

Main Author : Lim Jie Jie
Co-Author : Hanizasurana Hashim
Institution : Hospital Selayang

Purpose: To highlight combination of presentation with serpiginous and multifocal choroiditis in a presumed ocular tuberculosis

Methods: Case Report

Results: A 44-year old indian man, presented with right eye painless, progressive blurring of vision for 3 weeks. Visual acuity over the right eye was 6/36, left eye was 6/9. Examination showed right serpiginous choroidopathy with bilateral multifocal choroiditis. Fundus fluorescein angiography confirmed the findings of active choroidal lesions in both eyes. Although he denied of exposure to tuberculosis but Mantoux test was strongly positive. Anti tuberculosis course was given for nine months. Visions and the choroidal lesions gradually improved.

Conclusions: Ocular tuberculosis can manifest with simultaneous combination of serpiginous choroidopathy and multifocal choroiditis

40. Criswick-Schepens syndrome

Authors : Farhana I, Nor Akmal B, Sunder R, Jamalia R
Institution : Hospital Kuala Lumpur

Purpose : To report a case with strong family history of Familial Exudative Vitroretinopathy (FEVR)

Method : Case report

Introduction : Criswick-Schepens syndrome (former name for the autosomal dominant form of the disease), or FEVR is relatively rare vitreoretinal disorder that is clinically similar to Retinopathy of Prematurity[3]. It is a potentially blinding eye disorder caused by mutations in genes that play a crucial role in the development of the normal retinal vasculature[1]. It leads to incomplete vascularization of peripheral retina[5]. Most cases of FEVR are autosomal dominant, but autosomal recessive, X-linked and sporadic cases are also known[5].

Result : A term 1 month old baby with a good birth weight presented to eye clinic Hospital Kuala Lumpur after referred by paediatric team as he has a strong family history of FEVR. This baby is the only child in the family. His father was diagnosed to have FEVR at the age of 7 year old. Besides his father, the other family members that are blind are his uncle, auntie, grandfather, grandfather's brother and his grand grandfather.

He has prolonged jaundice which still under paediatric clinic follow up. During examination under anaesthesia, anterior segment was normal bilaterally. Media was clear. Fundus examination revealed 360 degree area of avascular retina at mid-periphery bilaterally. Examination of the right eye showed a falciform fold extended from optic disc to the ciliary body. There was area of neovascularization. The left optic dics and macula dragged temporally with areas of neovascularization and preretinal haemorrhage. Both retina appears flat. Indirect laser photocoagulation treatment was given to avascular area bilaterally. Patient was prescribed gutt Nevanac and Pred Forte post laser treatment.

Conclusion : The mode of heritance in this child is likely an autosomal dominant. Molecular genetic testing for FZD4 and LRP5 is helpful for confirmation. Regular fundus evaluation for detection of neovascularization and complication is crucial. Family screening and genetic counselling, are important consideration[1].

41. Disseminated cytomegalovirus (CMV) infection in chronic myeloid leukaemia (CML): South to the North

Authors : Mohd Fariz MA, Zairah ZA, Ayesha MZ
Institution : Hospital Ampang

Introduction: Chronic Myeloid Leukaemia (CML) is a type of myeloproliferative disorder characterized by proliferation of mature granulocytes and their precursors that is associated with the Philadelphia Chromosome translocation.

Objective: To report a case of a patient with chronic myeloid leukaemia presented with disseminatedCMV infection.

Method: Case report

Result: A 55 year old Chinese lady with underlying CML on multiple immunosuppressants presented with 4 months history of bilateral painless blurring of vision, worse on the right. One month prior to the eye symptom, patient was treated for stomach CMV infection.
On examination, best corrected visual acuity on the right eye was hand movement with positive afferent pupillary defect and the left eye was 6/24. There were bilateral diffuse pigmented fine keratic precipitates with anterior chamber reactions and cataractous lens. There was no fundal view on the right eye due to dense vitritis. B scan revealed multiple retinal elevation at the area of macula. Funduscopy of the left eye showed areas of retinitis with haemorrhages characteristic of tomato-ketchup appearance seen in CMV retinitis, sparing the zone I.
Patient was given intravenous Foscarnet and biweekly intravitreal ganciclovir on the right eye. Vitreous sample polymerase chain reaction (PCR) positive for CMV supported our clinical diagnosis. Improvement was noted on the left eye with resolution of the retinitis and improvement of vision. Unfortunately, right eye vision deteriorated due to vitreous hemorrhage.

Conclusion: Patients with haematological malignancy on multiple immunosuppressants render them vulnerable to opportunistic infections. The infection can be severe and may involve multiorgan. Accurate clinical diagnosis and immediate treatment are crucial. Not to be ignored is the proper counseling on the treatment side effects, prevention of infections, and the emphasis on early seeking of medical attention.

42. Pre-retinal haemorrhage successfully treated with intravitreal ranibizumab

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Objective: To report a case of pre-retinal haemorrhage secondary to aplastic anaemia that succesfully treated with intravitreal ranibizumab.

Method: Case report

Result: A 39-year-old man with a diagnosis of severe aplastic anaemia presented with bilateral pre-macular haemorrhages in both eyes. His right eye vision was 6/45 and counting finger in the fellow eye. He was treated with intravitreal ranibizumab once to the right eye and twice to the left eye. Right eye showed complete resolution of pre-macular haemorrhage and minimal residual pre-macular haemorrhage in the left eye at 3 months after initial presentation.

Conclusion: This cases had favourable outcome with intravitreal ranibizumab and can be considered as non-surgical treatment option in treating pre-macular haemorrhage.

NEURO-OPHTHALMOLOGY

43. Bilateral optic neuritis secondary to ocular tuberculosis in immunocompetent adults: A case series

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Institution : Hospital Cancelor Tuanku Muhriz (HUKM)

Purpose: To report series of bilateral optic neuritis cases secondary to ocular tuberculosis in immunocompetent adult.

Methods: A retrospective case series

Results: Ocular tuberculosis (TB) has been associated with optic neuritis but bilateral cases in healthy immunocompetent individuals are rarely seen. We report a case series of three young healthy adults with bilateral painless optic neuritis as the presenting feature of ocular TB. Two of the patients had bilateral optic disc swelling at presentation and one presented with unilateral optic disc swelling which progressed to involve the fellow eye. Clinical examination, tuberculous tests and angiographic studies supported the diagnosis of bilateral optic neuritis secondary to ocular TB. All patients were started on anti-tubercular medication followed by oral prednisolone and all of them had visual improvement a few weeks after treatment.

Conclusion: These cases highlight a new trend of ocular TB presentation in young healthy individuals and thorough investigation is pertinent to preserve the visual function.

44. Bilateral optic perineuritis occuring in a preschooler - A diagnostic conundrum

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Objectives: Optic perineuritis is an uncommon cause of progressive vision loss usually occurring in adults. It represents a rare form of orbital inflammatory disease in which the specific target tissue is the optic nerve sheath. As it can mimic optic neuritis, it is important to consider this disease entity for early treatment and to prevent relapses. Our aim of this case report is to increase awareness of an atypical presentation of optic perineuritis occurring in a child presented with an acute severe bilateral vision loss with disc edema, its management and clinical outcome.

Case report: A 4-year old girl with no prior medical illness presented to us with an acute onset of bilateral blurring of vision for 3 days duration, following an episode of upper respiratory tract infection 2 weeks prior. Clinical examination revealed bilateral optic disc swellings with tortuous retinal vasculatures. She was started on high dose intravenous methylprednisolone for 5 days followed by a course of oral steroids for a total duration of 6 weeks. Her initial evaluation was suggestive of optic neuritis; however brain magnetic resonance imaging (MRI) showed evidences of optic perineuritis such as tram track and doughnut sign. Following treatment, vision improved remarkably in both eyes with recovery of optic nerve function to normal.

Conclusion: Although optic perineuritis occurring in a child with bilateral optic disc swelling is rare, a high index of suspicion of this disease is essential as a differential to optic neuritis. Early diagnosis is important to guide treatment duration, conferring better prognosis and visual outcome.

45. Cosmetic catastrophe: Ischemic optic neuropathy and orbital myositis following dermal hyaluronic acid filler injection

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Introduction: To report a case of unilateral ischemic optic neuropathy with orbital myositis after hyaluronic acid (HA) filler injection for cosmetic nasal augmentation.

Case report: A 31-year-old Chinese woman presented with sudden onset of right visual impairment associated with diplopia. Patient had received a HA-containing filler injection into the glabella for dorsal augmentation twelve hours prior to presentation. Visual acuity of the right eye was counting finger while that in the left eye was 6/9. A right relative afferent pupillary defect was demonstrated with exotropia on primary gaze. There was limitation of right extraocular movement especially upon adduction, depression and elevation. The site of injection showed reticulated skin discoloration. Right anterior segment and fundus examination revealed no abnormalities detected. Humprey visual field test disclosed a right inferior altitudinal field defect with impairment of colour vision. Computed tomography of orbit revealed mild enlargement of the right medial and inferior recti muscles. A diagnosis of right ischemic optic neuropathy and orbital myositis was made based on the radiological findings. Our patient showed a tremendous improvement of vision after a subcutaneous hyaluronidase injection with complete visual recovery within two weeks. Opthalmoplegia and visual field defect resolved three months post treatment.

Conclusion: We report a case of a reversible visual loss following cosmetic facial filler injection. Early recognition and appropriate treatment may preclude this potentially disastrous clinical entity. Therefore, physicians should be aware of the possibility of accidental intravascular injection and a good understanding of facial vasculature anatomy is crucial to prevent this catastrophic event.

46. Optic neuritis: A rare manifestation of nasopharyngeal carcinoma (NPC)

Main Author : Abdul Hadi Rosli
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Institution : Hospital Serdang

Purpose: To report the symptoms of blurring of vision as initial presentation of nasopharyngeal carcinoma (NPC).

Method: A case report

Result: A 54 year old Chinese gentleman with underlying sinusitis complained of painless blurring of vision of the left eye for 5 months. He had no other symptoms in particular suggestive of NPC. He had CT scan brain and orbit done in private hospital. It showed sinusitis. On his presentation to us, his right eye vision was 6/6 and left eye was counting finger 1 feet. Relative afferent pupillary defect (RAPD) was present over the left eye. However his fundus examination particularly optic disc appeared normal. Other cranial nerves examinations were intact. He was investigated for underlying medical illness to cause left eye reduce vision. The blood result only showed elevated level of cholesterol and triglyceride. 2 months later, he complained of pain upon opening the mouth and persistent blocked nose. The examination revealed left sided cheek swelling and restricted mouth opening. In addition there were palsy of V,VI, VIII, IX and X cranial nerves. Eye examination revealed left optic disc pallish compare to before. Hence, patient was referred to ENT. Nasoendoscopy by ENT team showed fungating mass over left Foramina of Rotundum. CT parasinus and brain showed left nasopharyngeal mass with extension to adjacent structures. Biopsy of the mass revealed undifferentiated NPC WHO type 3. He was referred to Institut Kanser Negara for radiotherapy.

Conclusion: NPC typically present to Opthalmology clinic with 5^{th} and 6^{th} cranial nerves involvement. Nevertheless, involvement of 2^{nd} cranial nerve might the only and the first clinical sign in NPC.

47. Why does my eyelid droop whenever I get a fever?

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Introduction: Recurrent benign third nerve palsy in the paediatric age group is uncommon, but has been described following viral infections. It is important to rule out other etiologies with a thorough history, examination and investigation.

Case Report: A 5 year old girl presented with sudden onset of drooping of the left eyelid. Prior to that, she had history of fever, vomiting, abdominal pain and sore throat. There was no central nervous system symptoms otherwise.

On examination, there was left ptosis covering her visual axis. There was no anisocoria. Her left eye had limitation of adduction, elevation and depression. She had no visual impairment and the rest of her ocular examination was normal. The rest of her cranial nerves were normal. CT brain/orbit and MRI brain were normal. She was treated conservatively and made full recovery.

She presented again yearly for three consecutive years with similar episode as in her first presentation. Each time, she had a history of fever prior to the ptosis episode and her ptosis resolved completely within a week. She was otherwise completely well in between episodes.

Conclusion: This case points towards a viral etiology as she had fever in all her episodes. The majority of benign third nerve palsies do not have a sinister cause and have an excellent prognosis, with recovery expected in most cases. The exact pathophysiology is unknown, although third and sixth nerve palsies have been reported following Measles Mumps Rubella vaccination, which also point towards a viral etiology.

48. Young lady with left oculomotor nerve palsy secondary acute focal left midbrain infarction

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Introduction: Midbrain infarction involving oculomotor nerve palsies are usually associated with elderly patient. Here we report a case of a young patient presented with left oculomotor nerve palsy secondary to acute focal left midbrain infarction which is rare.

Case report : A 29 year old, nulliparous, heavy smoker with no background history of any medical illness, presented with one day history of sudden onset deteriorating vision of left eye and associated with double vision. She was noted to have dextroelevation and laevodrepression preceded with severe headache. Her best corrected visual acuity on the right eye is 6/6 and left eye 6/7.5. Slit lamp examinations for anterior and posterior segment are normal. Neurological examinations reveal unsteady gait and abnormality in Cranial Nerve III. Cholesterol level noted to be high. CT brain reported enhancing rounded lesion just above the pituitary gland, appears continues with the anterior communicating artery, suspicious of aneurysm. We then proceeded with MRI and resulted in acute focal left midbrain infarct. She was then referred to Neuromedical team for further management and was started on Aspirin.

Conclusion: Oculomotor nerve palsy secondary to acute focal left midbrain infarct in a young patient is rarely reported. This case underlines the importance of early diagnosis and immediate management. Possible causes that could contribute to the brain infarct of a young patient are also discussed.

OCULOPLASTIC

49. Dacryocystectomy, is it still an option in managing tearing?

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Institution : Hospital Serdang

Introduction: Dacryocystectomy(DCT) is a complete surgical extirpation of lacrimal sac. Even though it was described as an act of surgical despair, a useless and barbaric mutilation and a malpractice, it still has its place in managing patients with tearing.

Method: Case series

Results:
Case 1: 39 years old gentleman, who had history of trauma in 2009, where he sustained bilateral Le Fort II Fracture and severe crushed nasal bone fracture. He underwent bilateral Open Reduction and Internal fixation(ORIF) with multiple plates and screws. Post operatively patient developed tearing on Left eye. He was counseled for surgical intervention but he defaulted. This patient presented again 7 years later with left worsening epiphora and foul smelling discharge. CT imaging reveals bilateral nasolacrimal duct obstruction with mucosal thickening. Eventually he underwent left dacryocystectomy in which intraoperatively noted presence of multiple screws and plate with entrapment of medial canthal tendon by the screws.

Case 2: 18 years old male with history of trauma in 2013, sustained Le fort fracture II on left side and underwent ORIF with plating and screws. Since then for the past 2 years he developed recurrent left medial canthal swelling with tearing and pus discharge. This patient was subjected for left external DCR with intubation. Intraoperatively noted fibrosed tissue with displaced fracture bones, hence ledt DCT was performed. Post operatively patient became less symptomatic.

Conclusion: Although DCR is the standard treatment to improve lacrimal outflow, this case series showed that DCT is a useful alternative in treating patients with tearing.

PAEDIATRIC OPHTHALMOLOGY

50. A rare clinical entity: Bilateral persistent fetal vasculature

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Objective: To describe a case of bilateral persistent fetal vasculature

Method: Case report

Results: A 7-year-old boy presented with right leukocoria and poor vision. Family history and medical history were negative. On examination, the best-corrected vision of the right eye was NPL and left eye was 1/60.There was a right corneal opacity, shallow anterior chamber and dense cataract with no fundus view. Left eye had a localized lens opacity posteriorly, and a persistent hyaloid membrane extending from the optic disc to the lens. Intraocular pressure was normal bilaterally.

Computed tomography with contrast showed right microphthalmia and features suggestive of persistent fetal vasculature bilaterally. There were also calcifications seen along the globe contour, which warranted further evaluation to rule out retinoblastoma. Magnetic resonance imaging showed features of bilateral persistent fetal vasculature with tubular structures seen coursing from the posterior aspect of the lens to the optic disc heads. There was also right retinal detachment. There was no evidence of retinoblastoma.

Discussion: Persistent fetal vasculature occurs due to failure of regression of the embryological primary vitreous and hyaloid vasculature. Our patient had a combined anterior and posterior subtype of persistent fetal vasculature. He presented late with poor vision. Thus, visual prognosis is poor. He was treated conservatively and referred for low vision aid, special school arrangement and application of disability registration.

Conclusions: Bilateral persistent fetal vasculature is rare. Majority with posterior involvement never obtain useful vision despite surgical intervention or treatment. However, retinoblastoma, a life-threatening condition, needs to be ruled out.

SURGICAL RETINA

51. Case series of late onset recurrent retinal detachment post retinal reattachment surgery

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Objective: To describe the occurrence of late onset recurrent retinal detachment years after vitrectomy

Method: Case series

Result: 3 cases from ophthalmology clinic in Hospital Canselor Tuanku Muhriz were studied.

Case 1: A 73 year old Chinese gentleman presented with sudden onset of flashes in his right eye for 3 days' duration. He denied any preceding ocular trauma. Visual acuity was 6/9. Fundoscopy revealed shallow retinal detachment inferonasally. He was previously treated for rhegmatogenous retinal detachment (RRD) and underwent trans pars plana vitrectomy (TPPV) 8 years prior.

Case 2: A 71 year old Chinese lady presented with sudden onset of flashes and floaters in her left eye for 4 days' duration. She denied any preceding ocular trauma. Visual acuity was 4/60. Fundoscopy revealed retinal detachment inferiorly with an inferonasal tear. She was previously treated for RRD and underwent TPPV 7 years prior.

Case 3: A 44 year old Malay lady presented with sudden onset of inferior visual field defect for 1 weeks' duration. Visual acuity was 6/18. Fundoscopy revealed superior retinal breaks. She was previously treated for RRD and underwent TPPV 12 years prior.

Conclusion: Recurrent retinal detachment in previously vitrectomized eyes varies between 6% and 28%, and occur more commonly within 5 months postoperatively. Late onset of redetachment is rare. Patient education is essential to prevent further complications.

52. Ocular siderosis

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Purpose: Reporting a case of ocular siderosis

Method: Interventional case report

Results: Mr MY, a 58 years old Malay gentleman with no underlying medical illness presented with five-month history of left eye gradual onset, painless blurry vision. Symptoms were preceded by history of high-velocity foreign body entered right eye while cutting grass with rotating blade cutter without eye protection, of which was self-treated with over-the-counter topical medications. No history of eye redness or floaters. Systemic examination was unremarkable. On presentation, vision was 6/6 OD and 6/36 OS. Left eye demonstrated rusty pigments on anterior lens capsule with anterior subcapsular cataract with retrolental streak vitreous opacity and underlying flat retina. Right eye was normal.

CT orbit showed radio-dense foreign body in left globe over posterior and inferolateral to lens. Patient underwent left eye phacoemulsification and vitrectomy surgery. Intraoperatively noted siderosis of lens capsule with no intraocular foreign body (IOFB) found. Repeated imaging showed retained IOFB. Subsequently, he underwent endocyclophotocoagulation which retrieved fibrosis-covered IOFB inferotemporal to posterior capsule. Post-operative recovery was uneventful, however left eye vision remained poor at 6/36. Full-field electroretinogram showed generalized diminished amplitudes suggesting of poor prognosis.

Conclusion: Ocular siderosis is a vision-threatening complication of retained iron-containing IOFB. A careful evaluation is mandatory in patient with history suggestive of penetrating ocular injury and timely removal of IOFB is crucial to prevent this fatal condition.