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TRAUMATIC CHOROIDAL DETACHMENT - ONE BABY RETINA SURGEON'S NIGHTMARE

Poster

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Purpose:

I would like to report that I have had difficulties with vitrectomy due to traumatic choroidal detachment and have resolved it.

Methods:

A 65-year-old man was hit in the right eye by a rubber hose and addressed the vision loss that had occurred. The visual acuity was HM and the intraocular pressure was 12 mmHg. Along with conjunctival lacerations, prolapsed vitreous and traumatic hyphema, traumatic mydriasis were observed in the anterior chamber, and traumatic lens dislocation into vitreous cavity was observed. Fundus was not observed, and there was no RD peak by USG. Since surgery was not immediately possible due to corneal edema, a delayed vitrectomy was decided.

Results:

3 cannulas were plugged in first and anterior vitrectomy and blood clot removal were performed in the anterior chamber. After connection of the infusion cannula and during vitrectomy, the eyeball was not maintained and persistent choroidal detachment was occurred. It was found that there was traumatic choroidal detachment in the area where the infusion cannula was located, so that no fluid entered. Despite repeated sclerotomy in other areas, no fluid entered the vitreous cavity due to choroidal detachment. I made 6 o'clock corneal incision and located infusion cannula. Finally, I could perform the vitrectomy.

Conclusions:

When operating on trauma patients, traumatic choroidal detachment must be kept in mind. When performing a vitrectomy, the tip of the infusion cannula must be checked.