



A CASE REPORT: ANTERIOR CHAMBER FOREIGN BODY WITH AN INCONSPICUOUS CORNEAL ENTRY WOUND

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ABSTRACT **Introduction-** Intraocular foreign bodies (IOFBs) resulting from penetration into eye chambers, accounted for 18-41% of all open injuries. The cases of ocular injuries with intraocular foreign body may lead to partial visual loss to complete blindness. There have been very few reports on iris intraocular foreign body and we reported one such case. **Material and methods-** 15 years old male Presented with complaint of diminution of vision in left eye for 1½ months, insidious in onset and gradually progressive, with history of injury to left eye while playing Gulli danda about 1½ months back following which he developed pain, redness for which he sought treatment locally and he was prescribed some unknown medication. The patient was thoroughly examined. It was decided to remove the foreign body. **Conclusion-** Every case of ocular trauma whether seems to be blunt or penetrating, should be ruled out for any intraocular foreign body. Also every case of intraocular foreign body need to be dealt cautiously and the decision to remove foreign body should be taken wisely

KEYWORDS :

INTRODUCTION

In India being an agricultural country, we often come across the cases of ocular injuries with intraocular foreign body which may lead to partial visual loss to complete blindness. Intraocular foreign bodies (IOFBs) resulting from penetration into eye chambers, accounted for 18-41% of all open injuries.¹ The common type of foreign bodies leading to perforation are thorns, twigs, metallic and non-metallic etc. Out of these twigs and thorns usually lead to perforation causing infection. also the cases of ocular trauma are quite common in children specially the children living in rural areas as the games like tipcat (gilli danda), seven stones (pitthu) are quite common among them which can cause various accidents leading to ocular trauma, particularly the globe rupture. We encountered a rare case of intraocular foreign body over iris in a child while he was play gilli danda.

Case Report

A 15 years old male referred to the ophthalmology department with complaint of diminution of vision in left eye for 1½ months, which was insidious in onset and gradually progressive. He gave the history of injury to left eye while playing Gilli danda about 1½ months back following which he developed pain, redness for which he sought treatment locally and he was prescribed some unknown medication. On examination, the BCVA in right & left eye was 6/36 & less than 6/60, respectively. He was found to be a case of ocular albinism, which was an incidental finding.

On slit lamp examination of left eye, there was a small corneal scarring, measuring 0.8mm at 4 o'clock position in paracentral cornea. On anterior segment examination, there was an elongated foreign body at around 3 O'clock position over iris, apparently measuring about 4.3 mm, adhering partly to anterior capsule of lens with anterior capsular opacification at 3 O'clock position with granulation tissue over & around FB with posterior synechiae from 12 O'clock to 3 O'clock (fig. 1, 2.). Pupil was irregular and sectorally reactive to light due to posterior synechiae. No aqueous reaction was evident.

It was planned to remove FB. To our surprise, the size of FB was actually about 3.6 mm in length and around 1mm in width (after clearing the granulation tissue over it) (fig. 3). A decision to remove the partly cataractous lens was taken intra operatively. The surgery was uneventful (fig. 4). The foreign body was then sent for culture sensitivity, though the reports were negative for any microbial organism. Post-op topical antibiotic, cycloplegic and topical steroid

were started. No post-operative complication were noted.

DISCUSSION

In case of any type of ocular trauma, history regarding the mode of injury and injury with any flying object should be elicited. IOFB account for upto 40% in open globe injuries.[1] The most common mechanisms of injury include hammering metal on metal, power tools and gunshots or explosives.[2],[3] Most common IOFB is metallic.[4] IOFB should be ruled out with proper clinical examination and using various diagnostic modalities- x- ray, B scan USG, CT scan, MRI if required and suspicion is high).

The extent of trauma from IOFBs is associated with the size, shape, speed, density and velocity of the object as well as the composition of the penetrating or perforating material.[1]

Visual outcome is based on the mechanism of injury, type of foreign body and subsequent complications.[5] Vision loss can be devastating as a result of endophthalmitis, retinal detachment or metallosi.[6]

CONCLUSION

Every case of ocular trauma whether seems to be blunt or penetrating, should be ruled out for any intraocular foreign body. With an incomplete and improper ocular examination, one can miss out an intraocular foreign body. This can further lead to growth of microorganism associated with the foreign body and further poor consequences. Also every case of intraocular foreign body need to be dealt cautiously and the decision to remove foreign body should be taken wisely.

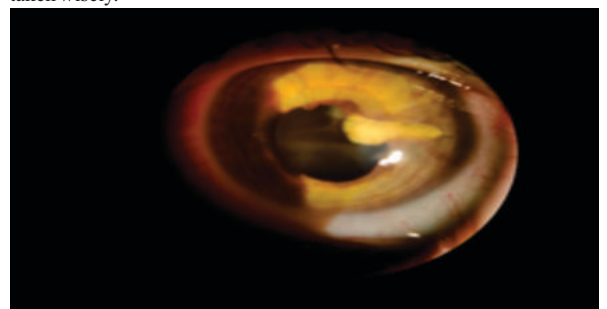


Fig.1 Foreign body in anterior chamber seen on slit lamp examination



Fig.2 Foreign body in anterior chamber seen on slit lamp examination



Fig.3 Foreign body with granulation tissue (magnified view)

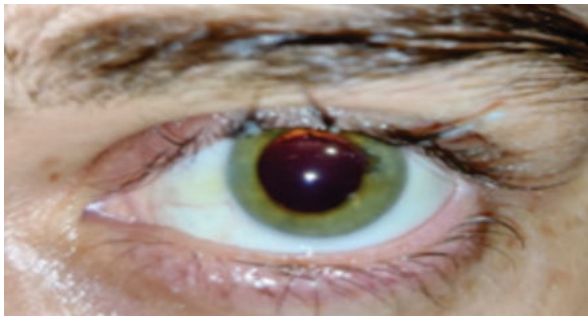


Fig.4 Post-op day 2 (foreign body removed and IOL implantation)

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