Cryptophthalmos is a rare disorder first reported in 1872 by Zehender[2] and is most commonly observed in patients with Fraser syndrome. Fraser syndrome is named after George R. Fraser, who first described the syndrome in 1962.[3] Thomas et al.[1] described 4 major criteria and 8 minor criteria for this syndrome (Table 1). A diagnosis of Fraser syndrome can be made from the presence of 2 or more major criteria and 1 minor criterion.

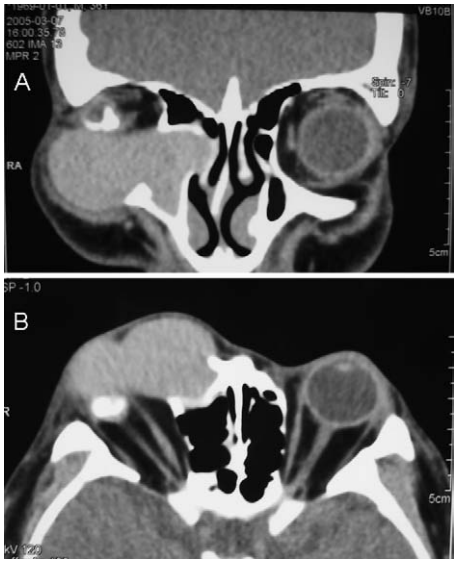

Fig. 2—A CT scan revealed a dumbbell-shaped cyst that was situated anterior to the globe and extended into the right ethmoidal sinus (A). All extraocular muscles and the optic nerve were found to be present. A calcified mass was identified within the right microphthalmic eye (B).

Table 1—Diagnosis criteria for Fraser syndrome according to Thomas et al.[1]

Major criteria	Minor criteria
Cryptophthalmos	Congenital malformation of nose
Syndactyly	Congenital malformation of ears
Abnormal genitalia	Congenital malformation of larynx
Sibling with Fraser syndrome	Cleft lip and (or) palate
	Skeletal defects
	Umbilical hernia
	Renal agenesis
	Mental retardation

Mocan et al.[4] reported a case of Fraser syndrome associated with bilateral complete cryptophthalmos and bilateral orbito-palpebral cysts. Amrith et al.[5] reported a case of congenital orbito-palpebral cyst associated with Fraser syndrome. To the best of our knowledge, this is the first case report of a unilateral, complete cryptophthalmos combined with an orbito-palpebral cyst in a patient without Fraser syndrome. Since there is a possibility that a neoplasm exists in the orbit in a patient with complete cryptophthalmos, it is recommended that whenever symptoms such as paresthesia and (or) swelling are present in complete cryptophthalmos, the patient should be referred to an ophthalmologist immediately for detailed examination to rule out potential neoplasm or any other abnormalities in the orbit.

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Intraocular framycetin sulphate ointment after sutureless clear corneal section phacoemulsification

We report two cases of possible intraocular ingress of antibiotic ointment (framycetin sulphate) after sutureless clear corneal section phacoemulsification without any adverse reaction. One of these resolved spontaneously, while the other necessitated surgical removal.

Two patients had uncomplicated sutureless clear corneal section phacoemulsification with foldable silicone posterior chamber implants (Allergan SI 40-NB). Both patients had a superior corneal section (3.0 mm) with a side port

(2.25 mm) and inferior stab (3.0 mm) with topical application of framycetin sulphate (Soframycin + plasibase 30W) eye ointment at the end of the surgery. The superior corneal section and inferior stab were made using a 3-step construction, and the side port was made using a 1-step construction. Stainless steel keratomes were used for all wounds.

On the first day postoperatively, 1 patient showed a lump of whitish-opaque material located on the surface of the intraocular lens with full occlusion of the visual axis; visual acuity was at the counting fingers level, compared with 6/12 preoperatively. There was no inflammation, and the intraocular pressure was found to be normal. No resolution at 1 week prompted surgical intervention and removal of the ointment only. The material was semisolid and greasy in consistency, which caused surgical difficulty both during scraping, and irrigation and aspiration.

The 3-week routine postoperative examination of the second patient showed a small lump floating in the anterior chamber, which did not completely occlude the visual axis (Figs. 1 and 2; patient consent was obtained for the use of images); visual acuity was 6/24–1 compared with 6/18 preoperatively. There was no increase in the anterior chamber activity over what would be expected at this stage postoperatively. This patient was observed.

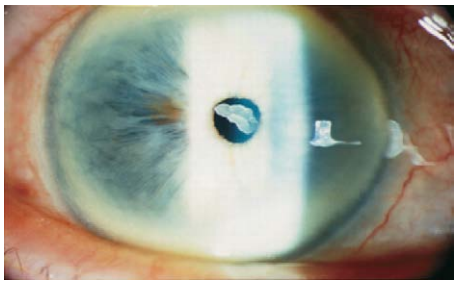

Fig. 1—Anterior chamber slit-lamp photograph of the second patient, showing an opaque blob floating in the anterior chamber without an increase in anterior chamber activity.

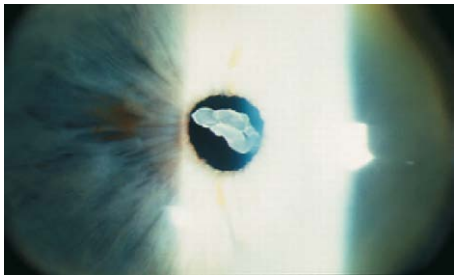

Fig. 2—Anterior chamber slit-lamp photograph showing a lump in the anterior chamber of the second patient consistent with framycetin sulphate ingress.

No postoperative corneal edema was noted in either case. Both patients received standard postoperative topical betamethasone and neomycin sulphate (Betnesol-N, UCB Pharma Ltd, Brussels, Belgium) 4 times a day for 4 weeks. Neither patient required an increase in the frequency or duration of the topical steroids or required any other form of steroid therapy.

Six months postoperatively, there were no adverse reactions in either patient, and the material had completely disappeared spontaneously in the second patient. Vision was 6/18+2 in the first patient with evidence of retinal pigment epithelial detachment and 6/9 in the second patient.

Incidental entry of antibiotic ointment into the anterior chamber after sutureless clear corneal section with various adverse reactions has been previously reported.[1–3] We report a possible ingress with a different eye ointment base (Plastibase 30W). The surgical technique could be a reason for the incidents in our cases. We did not observe any adverse reactions after 6 months of follow-up.

We were unable to get our sample analyzed to confirm our clinical findings, but the appearance, consistency, and the surgical behaviour of this substance are consistent with our clinical diagnosis.

There is increasing evidence of the instability of sutureless clear corneal section phacoemulsification with postoperative ingress of ocular surface fluid into the anterior chamber and increased risk of endophthalmitis.[4,5] Our cases demonstrate this worrying issue.

We conclude that sutureless clear corneal section phacoemulsification may hold an increased risk of antibiotic ointment ingress into the anterior chamber. In the absence of visual axis obscuration, surgical removal may not be necessary and careful observation is appropriate. In addition, this particular composition of framycetin sulphate ointment appears to be inert to the anterior chamber. In view of current recommendations of the European Society of Cataract and Refractive Surgeons,[6] we have adopted the use of intracameral cefuroxime intraoperatively and have stopped using ointments at the end of surgery.

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Giant spontaneously regressed retinoblastoma

Spontaneously regressed retinoblastoma (Rb) is a well-documented condition representing 5% of all Rbs.[1–3] In the literature, most spontaneously regressed Rbs are small, with a mean basal dimension of 5 mm. In this report, we document a massive spontaneously regressed Rb of 20 mm in diameter.

A 4-year-old Caucasian boy, with no family history of Rb, manifested right eye exotropia for 1 month. On examination, the visual acuity was counting fingers in the right eye and 20/20 in the left eye. The left eye was normal. The right eye showed 10 prism diopters of exotropia. Fundus evaluation revealed a giant yellow-white retinal mass partially overhanging the optic disc and involving the macula, with extension to the ora serrata inferonasally, measuring 20 mm in diameter. There was extensive surrounding retinal pigment epithelial (RPE) hyperplasia and atrophy (Figs. 1A and 1B). The surface of the lesion displayed 10 intratumoural cavities, which were confirmed on ultrasonography and optical coherence tomography (Fig. 1C). There was no subretinal fluid; nor were there dilated feeder vessels, vitreous seeds, or subretinal seeds. Ultrasonography showed a large calcified retinal mass measuring 4.4 mm in thickness (Fig. 1D). These findings were consistent with spontaneously regressed Rb. Genetic testing revealed no evidence of germline mutation. At 1-year follow-up, the tumour was stable (Fig. 2) and visual acuity improved to 20/150 with amblyopia patching.

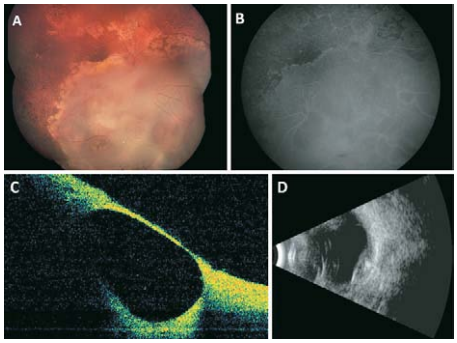

Fig. 1—A 4-year-old boy with lazy eye presented with a giant spontaneously regressed retinoblastoma measuring 20 mm in diameter. (A) The large white retinal tumour showed numerous surface cavitary changes and surrounding retinal pigment epithelial alterations. (B) Fluorescein angiography showed looping random intrinsic vessels without leakage. (C) Optical coherence tomography demonstrated a surface cavity. (D) Ultrasonography showed a partially calcified retinal mass of 4.4 mm thickness.

Clinically, spontaneously regressed Rb appears as a grey translucent retinal mass with varying degrees of calcification, vascular loops, a broad surrounding zone of chorioretinal atrophy, and RPE alterations.[1–3] There is a notable lack of dilated tortuous feeder vessels, subretinal fluid, and related vitreous or subretinal seeds. In some cases, intralesional cavities are found.[4]

Histopathologically, spontaneously regressed Rb shows a characteristic appearance, with haphazardly arranged neuronal cells showing photoreceptor differentiation, few axons, and smaller numbers of Müller fibres and astrocytes, with no immature neuroblastic elements.[5]

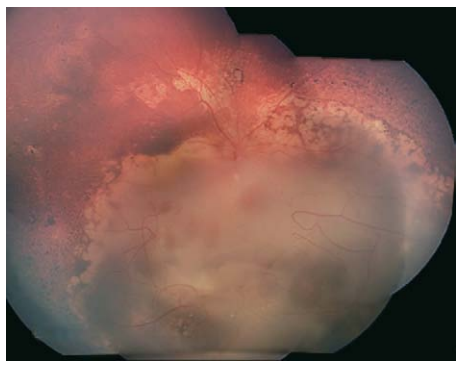

Fig. 2—On follow-up 1 year later, the mass was stable.