Suprachoroidal hemorrhage: a devastating complication of the eye

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DESCRIPTION

Suprachoroidal haemorrhage is a rare and devastating complication in any ocular surgery. Its diagnosis is stress provoking, both for patient (because of extreme pain) and for doctor (because of unforeseen events). Herein, we report a case of intraoperative suprachoroidal haemorrhage while doing a penetrating keratoplasty. A 43-years-old woman presented with a history of pain, redness and diminution of vision in her left eye, following history of fall of an insect into her eye. The presenting visual acuity was ‘no perception of light’. Patient was clinically diagnosed with right eye perforated corneal ulcer. The patient was a known case of primary open-angle glaucoma in both eyes. Systemically patient was hypertensive with controlled blood pressure, on medication. The patient was admitted with a corneal perforation (4*4 mm), with lens plugging the perforation site. Patient was planned for therapeutic keratoplasty. Injection mannitol 10% solution was given intravenously (according to body weight), preoperatively to decrease the intraocular pressure. After adequate local anaesthesia, the host cornea was cut including 1 mm clear margins of corneal ulcer.

Video 1 Showing suprachoroidal hemorrhage in full-thickness keratoplasty.

Learning points

► In our case, the history of glaucoma, hypertension and local anaesthesia was contributing factors for suprachoroidal haemorrhage.
► Early diagnosis of suprachoroidal haemorrhage with prompt management intraoperatively as well as postoperatively are key factors in handling this devastating complication.

Cataractous lens was removed. Sudden hypotonus of the eye lead to suprachoroidal haemorrhage. Posterior capsule gave way and a clear vitreous mound can be seen rising from the wound site simulating volcanic eruption (as in video 1). The surgeon was novice, the diagnosis of suprachoroidal haemorrhage was delayed till she can see whole vitreous outside the eye along with retina and choroidal mounds and haemorrhage. Digital pressure was applied for 30 min to control suprachoroidal haemorrhage following which surgeon tried to place the ocular contents back inside, on failing the attempt the vitreous and retina along with choroid was excised with conjunctival scissors. The donor cornea was sutured with host after controlling the suprachoroidal haemorrhage.

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