TARSAL STRIP PROCEDURE

I enjoyed "Refinements of the Tarsal Strip Procedure" by Weber et al.1 I too have found it sometimes useful to bend the needle in performing this and other procedures; however, I must take exception to the authors’ suggestion that the needle be bent with the fingertip. Doing so unnecessarily increases the risk of an accidental needle stick. The same objective can be accomplished using a hemostat rather than the fingertip.

REFERENCES


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SLIT-LAMP ADAPTATION

I read with interest the letter by Cutino, "Adaptation of the Slit Lamp for Patients With Large Breasts," in the October 1991 issue of Ophthalmic Surgery.1 I would like to point out, however, that Leatherbarrow and I suggested this simple idea earlier.2

We have since been told by many fellow ophthalmologists that they have found our suggestion helpful in slit-lamp examinations as well as in laser procedures; many noted that they simply place a light plastic or metal sheet between such patients and the slit lamp almost routinely.

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CORTICOSTEROID VEHICLE TOXICITY

We read with interest the article "Inadvertent Penetrating Injury to the Globe With Periocular Corticosteroid Injection" by Jain and colleagues.1 The authors rightly raise questions regarding the role of the vehicle vs steroid toxicity to the retina. Hida and colleagues, in 1986, demonstrated that four of six vehicles for commercially-available corticosteroids (Celestone Soluspane, Depo-Medrol, Decadron, and Decadron L.A.) showed obvious toxicity to the region after intravitreal injection in rabbits.2 We recently demonstrated, by means of ERG and VEP responses, that the preservative used in Depo-Medrol, myristyl-gamma-picolinium chloride, was toxic to the rabbit retina.3 The results of our study prompted us to stop using Depo-Medrol for periocular injection.

We urge pharmaceutical companies to find nontoxic vehicles to make corticosteroid preparations safer for periocular use. We wonder if it is necessary to include preservatives in steroid preparations intended for single-dose use.

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LEVATOR APONEUROSIS RECESSON

Drs Harvey and colleagues article, "Modified Levator Aponeurosis Recession for Upper Eyelid Retraction in Graves’ Disease,"1 was excellent. However, I would like to point out that the procedure they describe was presented by Malca Guevara and myself2 This procedure was originally introduced before the 1980s.

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CORNEAL TRACTION SUTURE VS MATTRESS-TYPE EPICLERAL SUTURE

I read with interest the Letter to the Editor by Conklin et al., Corneal Traction Suture in Trabeculectomy.1 The technique they described is very similar to that described by Cohen,2 and by Salz and Reader.3 I wish to comment on a complication associated with the corneal traction suture.

After reading the Salz and Reader article, I was experimenting with a mattress-type episcleral suture inferiorly to control globe position during phacoemulsification. As I was somewhat unhappy with the frequency of subconjunctival hemorrhage associated with placing this suture, I decided to move it into the cornea. I had good results with the corneal suture until I used it in an operation on an 86-year-old woman who underwent uneventful two-handed phacoemulsification on March 14, 1990.

In the first few days after surgery, the patient developed a stromal infiltrate along one of the suture tracks inferomedially. The lesion grew Streptococcus veridans. The patient was placed on intensive topical