Management of macular epiretinal membrane secondary to accidental globe perforation during retrobulbar anesthesia

Dear Editor,

We read with keen interest the article management of macular epiretinal membrane secondary to accidental globe perforation during retrobulbar anesthesia by Dhananjay Shukla describing the successful management of macular epiretinal membrane secondary to accidental globe perforation during retrobulbar anesthesia, but we have a few points and questions to make the article more pertinent.[1]

In the era of phacoemulsification and instant visual rehabilitation, how is it that the patient complained of poor post-operative visual recovery 1 month after "successful" cataract surgery? What is the hospitals protocol for examining

patients after cataract surgery? Isn't the vision recorded earlier than 1 month post op? If the patient had to be checked in detail earlier, then this complication could have been recognized and treated earlier.[2]

What was the pre-operative status of the retina? Since the author has revealed the other details it would be easy to find out whether there was some pre-existing epiretinal membrane (ERM). There is no doubt that there was an inadvertent perforation, but our concern is whether the ERM developed de novo or was it worsening of a pre-existing ERM. It usually takes more than 4 weeks for an ERM to develop after trauma and the membrane seen in this case seems too thick and mature-considering it developed in 4 weeks and with no other ill effects of the perforation.[3] The author himself has made note of this fact that "missed" perforations may lead to an incorrect diagnosis of a pre-existing ERM secondary to say chorioretinitis. It would be helpful to know the pre-operative retina status.

What would be the author's recommendation for the management of an ERM developing after an in advertent perforation? How is it different from the management of an idiopathic ERM? In our opinion, the management of any ERM remains the same, whatever the cause. The prognosis would change depending on the pre-operative condition and central macular thickness on optical coherence tomography.[4] Macular retinal pigment epithelium scarring would portend a worse prognosis. Could the author also give an algorithm for the management of inadvertent perforations? How soon a vitrectomy should be done in case the retina is not visualized due to vitreous hemorrhage. Would an early vitrectomy in this case have prevented the formation of the ERM?

Lastly the author mentions that patients should be warned about risks and potential complications of injectable regional anesthesia. All standard consent forms do have this complication listed, but it is very seldom told to the patient or his relatives as it is a very rare complication and in our opinion to highlight it in every case with an exception in high risk cases would only increase the apprehension of the patient.[5]

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