

group A and  $-3.60 \pm 1.85$  to  $-2.80 \pm 2.19$  D group B; mean K: 44.80 to 42.50 D ( $P < 0.05$ ) and 43.98 to 43.90 D; maximum K:  $51.52 \pm 2.39$  to  $50.10 \pm 0.9$  and  $51.76 \pm 2.55$  to  $49.50 \pm 1$ , respectively). SE values decreased in group A ( $-3.4$  to  $-0.50$  D ( $P < 0.05$ )), whereas it increased in group B ( $-1.10$  to  $-1.70$  D).

### Comment

ICRS have been used to correct ectatic corneal diseases by reducing corneal steepening. CXL with riboflavin and ultraviolet A is a technique to increase corneal rigidity. Several studies showed that the association of CXL with ICRS led to better results.<sup>2–5</sup> In our study, there is no statistical difference between the two sequences: ICRS implantation followed by CXL or CXL followed by ICRS implantation. Overall, the two sequences show an improvement in UDVA, CDVA, cylinder, mean K, and maximum K.

### Conflict of interest

The authors declare no conflict of interest.

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### Sir, Efficacy and safety of patching vs bandage lens on postoperative pain following pterygium surgery

Pterygium surgery is typically performed in an outpatient setting with subconjunctival anesthesia.<sup>1</sup> Owing to the short duration of action of local anesthesia, patients may experience considerable pain and discomfort following surgery once anesthesia has worn

off. Wishaw *et al*<sup>2</sup> showed that clinically significant postoperative pain (conjunctival and corneal origin) is reportedly experienced in 60% of patients undergoing pterygium surgery.

The purpose of this prospective randomized study was to compare the postoperative pain, and symptoms of photophobia, epiphora, and foreign body sensation, with overnight patching vs placement of a bandage lens for the management of postoperative pain following pterygium surgery.

### Results

Of 30 eyes in each group, 15/30 in the patching group and 17/30 in the bandage lens group were male. All but one case in each group had nasal pterygia. The mean age of patients was  $50.1 \pm 10.6$  years in the patching group and  $49.0 \pm 16.9$  years in the bandage lens group. No statistically significant differences existed between the two groups with respect to age, laterality, pterygium location, gender, size of pterygium, size of conjunctival autograft required, or preoperative visual acuity (Table 1).

### Comment

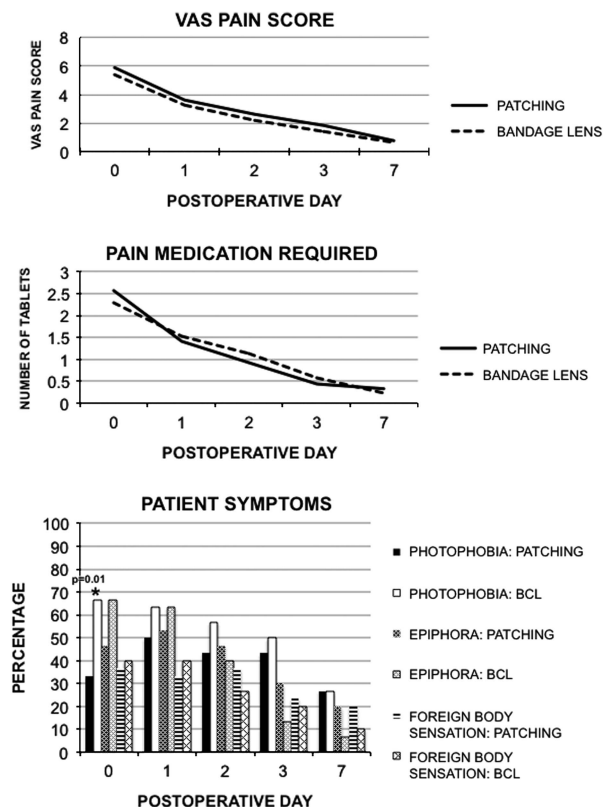
Figure 1 summarizes the results of the primary and secondary end points of the study. There was no statistically significant difference in VAS pain score or amount of pain medication taken between groups during the first week. Significantly more eyes were reported to be photophobic on POD 0 in the bandage lens group ( $P = 0.01$ ; odds ratio = 4.0). Using linear logistic regression analysis, VAS pain score predicted the amount of pain medication taken on the same day ( $P < 0.0001$ ; no significant difference between groups). On POD 0 only, VAS pain score was statistically significantly related to the graft area required ( $P = 0.023$ ). Age was noted to be inversely correlated to the amount of pain medication taken; for every additional year of age, a given patient would have taken 0.13 less tablets ( $P = 0.0009$ ). None of the clinical symptoms (photophobia, epiphora, and foreign body sensation) were predicted by any of the baseline characteristic of the groups.

Interestingly, postoperative pain and requirement for pain medication (acetaminophen with codeine tablets) was similar after POD 1, when the patch was removed. The bandage lens during the first postoperative week did not appear to improve comfort. These results suggest that both modalities help in reducing the postoperative

**Table 1** Clinical characteristics in patients with primary pterygium undergoing excision followed by patching or bandage lens

	Patching	Bandage lens	P-value
No. of eyes	30	30	
Laterality (right:left)	13:17	16:14	0.45
Pterygium Location (nasal:temporal)	29:1	29:1	1
Age (years)	$50.1 \pm 10.6$	$49.0 \pm 16.9$	0.77
Gender (male:female)	15:15	17:13	0.60
Size of pterygium (mm <sup>2</sup> )	$12.29 \pm 7.65$	$15.9 \pm 12.76$	0.19
Size of CAU required	$43.83 \pm 16.86$	$49.67 \pm 24.48$	0.29
Preoperative visual acuity (logMAR)	$0.157 \pm 0.168$	$0.17 \pm 0.166$	0.76

Abbreviation: CAU, conjunctival autograft.



**Figure 1** VAS pain score, amount of pain medication taken, and clinical symptoms in patients following pterygium surgery with postoperative patching or bandage lens.

pain following pterygium excision, although overnight patching may provide further relief from the symptoms of photophobia.

Either overnight patching or the placement of a bandage contact lens is safe and effective in the management of postoperative pain following excision of primary pterygia with CAU. In cases where overnight patching would interfere with the visual needs of the patient, the placement of a bandage lens is preferable.

**Conflict of interest**

The authors declare no conflict of interest.

**References**

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**Sir,**  
**Intraocular xanthomatous tumor presenting as fulminant uveitis**

We report a case of xanthomatous tumor presenting as uveitis, which improved after surgery and immunosuppressive treatment.

**Case report**

A 52-year-old male with normal serum lipoproteins has blurred vision and dull pain for 5 months OS. His best-corrected visual acuity (BCVA) was 6/600. Hypopyon and posterior synechiae occurred. Intravenous methylprednisolone was given. After posterior synechiae was lysed, a retrolental mass was found and confirmed by magnetic resonance imaging (Figure 1). Phacoemulsification, external transscleral tumor resection and partial lamellar cycloectomy were performed. GEN-PROBE amplified *Mycobacterium Tuberculosis* direct test and Mantoux test were negative. The pathology (Figure 2) showed negative staining of synaptophysin and chromogranin-A, which excluded paraganglioma. The negative staining of S-100 protein and melan-A eliminated melanocytic lineage. The negative staining of melan-A and desmin precluded perivascular epithelioid cell tumor. Granular cell tumor was unlikely due to the absence of typical granular eosinophilic cytoplasm and negative S-100 protein staining. The positive staining of CD68 confirmed its histiocytic lineage. Differential diagnosis included xanthoma,<sup>1</sup> juvenile xanthogranuloma,<sup>2</sup> reticulo-histiocytoma,<sup>3</sup> Malakoplakia or Rosai–Dorfman disease.<sup>4</sup> No specific pathogen is identified under periodic Acid–Schiff and acid-fast stains. A xanthomatous tumor was diagnosed. After treatment, his BCVA maintained 6/6.

**Comment**

Xanthomas are usually related to abnormal metabolism of lipids. Histology of xanthoma showed a diffuse proliferation of foamy histiocytes with occasional Touton giant cell.<sup>1</sup> The reported non-malignant tumors causing uveitis include juvenile xanthogranuloma<sup>2</sup> and adenoma of the ciliary body.<sup>5</sup> Juvenile xanthogranuloma is a benign non-Langerhans cell histiocytic proliferation of skin and soft tissue.<sup>2</sup> It can be differentiated from xanthoma by the distribution of lesion and the absence of lipid abnormalities. Reticulohistiocytoma usually presents as a firm, skin colored, yellowish or reddish