EP1: Ocular Involvement In Kimura Disease
Ho Siew Lee, Norlaila Talib, Ngan KW
Department of Ophthalmology, Hospital Serdang, Selangor

Purpose:
Kimura disease is rare chronic inflammatory disorder. Ocular involvement in Kimura disease even rare. Generally limited to head and neck. To report 5 cases who ocular involvement in Kimura disease in Hospital Serdang from 2007-2011.

Method:
Case series.

Results:
CASE 1 (2007): 43-years-old female who presented with bilateral lids swelling. Incisional biopsy was taken to confirm the diagnosis. She was given multiple course of oral prednisolone of 1 mg/kg. The lesion improved initially but later progresses to involved the orbit as well.
CASE 2 (2009): 52-years-old female, left eye persistent redness with lacrimal gland enlargement for 2 months. Left orbital biopsy was taken and continue treatment in Hospital Taiping.
CASE 3 (2010): 22-years-old female. She is mentally challenged person. Multiple recurrent of right lower lid swelling. Debulking done but the lesion regrew again to involve the whole anterior segment of the right eye.
CASE 4 (2011): 45-years-female presented with right upper eyelid swelling for 1 year. Incision biopsy done but the mass recurrent.
CASE 5 (2011): 11-years-old boy presented with bilateral upper lids swelling for 4 years, right parotid gland and lymph nodes enlargement. Incisional biopsy taken from the left upper lid. He was referred to oncology, HKL.

Conclusion:
There is no definite treatment for Kimura disease. Chemotherapy, radiotherapy has been advocated but surgery is still the mainstay of treatment. However recurrence is common and may have devastating effect on visual function.

EP2: Upper Eyelid Abscess: More Than Meets The Eye
Ng Wei Loon, Umi Kalthum Md Noh, Jemaima Che Hamzah
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
We aim to report a rare case of severe frontal mucocele with orbital involvement, presenting as upper lid abscess in an elderly man.

Methods:
Case report.

Results:
A 72-year-old Chinese man with underlying hyperthyroidism complained of painful left upper eyelid swelling of 6 months duration. The swelling had rapidly increased in size since the last 3 weeks. It initially improved with intravenous antibiotic, but worsened when the intravenous antibiotic was transitioned to oral type. On examination, the left upper eyelid was severely swollen and covered almost the 2/3 of the cornea. It was tender and inflammed. There was no anterior chamber reaction and conjunctiva was fairly white. The extra ocular movement was mechanically limited on levoelevation. Computed tomography scan showed huge left frontal mucocele eroding the supereromedial orbital rim. The left globe was displaced inferolaterally but there was no extension into brain parenchyma. Referral to ortholaryngologist was made and endoscopic sinus surgery and evacuation of mucocele was done. Culture and sensitivity of the fluid showed no organism. He recovered well post-operatively with additional two weeks of antibiotics.

Conclusion:
Mucocoele frequently occur in frontal sinus. Radiological investigation is important in guiding the management and determining the extension of the mucocoele. Early surgical intervention of mucocele can prevent extension into orbit and brain. We should be aware of what can be hidden behind an innocent-looking large upper lid abscess.
EP3: A Rare Case Of Delayed Post Operative Haemorrhage Post Chalazion Surgery
Melinder K Bhupinder, Siva K Sundralingam, Fazilawati Qamaruddin
Department of Ophthalmology, Hospital Tengku Ampuan Rahimah, Klang, Selangor

Purpose:
To report a rare case of delayed post operative haemorrhage post chalazion surgery.

Methods:
Case report.

Results:
A 25-year-old gentleman with no premorbid presented to the Emergency Department with sudden onset of profuse bleeding for 3 hours over the left eye. Patient gives a history of a chalazion surgery done five days earlier over the same eye. There was no recent history of trauma over the region or consuming anticoagulant medications.

Ophthalmic examination revealed a rapid haemorrhage from a single arterial bleeder arising from the lower palpebral conjunctiva at the site of the recently done chalazion surgery. The anterior and posterior segments of both eyes were normal. The bleeding did not stop on prolonged compression using up to 3 fully soaked “Gamgee” with estimated blood loss of 600 mls. However, patient was hemodynamically stable. The bleeding vessel was identified and haemostats secured after ligating the vessel using Vicryl 6-0. Blood investigations showed no evidence of blood dyscrasia. A diagnosis of delayed post-operative haemorrhage post chalazion surgery was made.

Conclusion:
Chalazion surgery is generally a simple and common procedure. In this case, the rate of the bleeding was suggestive of an arteriolar source. Anomalous vessels are known to exist, arising from the peripheral vascular arcade, on eyelids. Therefore, surgical trauma or spontaneous necrosis to such a vessel may result in a delayed post-operative haemorrhage, as in this case.

EP4: A Healthy Child With Ocular Fungal Infection
Wan Radziah WN, Nik Nazihah NA, Azura Ramlee
Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To report a case of fungal infection of eyelid.

Methods:
Case report.

Results:
A four-year-old Indian boy presented with poor healing skin lesion with swelling at the left upper eyelid for two weeks duration. It was associated with itchiness and discharge. At the same time, he was diagnosed with tinea capitis and kerion (thickened, pus-filled spongy lesion on scalp due to response towards fungal infection of hair follicle). Skin scraping from the scalp showed positive for fungal (Nigrospora sp). He was treated with Syrup Griseofulvin 150 miligrams daily. On ocular examination, there was a scab-like lesion occupying subtotal of left upper eyelid, with surrounding skin inflammation and loss of eyelashes. There was minimal mechanical ptosis. His vision remain 6/6 in each eye. The eyes were white and the rest of ocular assessment was normal. The child was clinically well. A trial of Miconazole cream twice daily was started empirically. On review at one week, there was marked improvement seen. Treatment was then continued for the subsequent six weeks. Final review showed complete resolution of the lesion.

Conclusion:
Fungal infection of the eye can still occur in a healthy child but responds well to topical anti-fungal treatment.
Purpose:
To report a case of large upper eye lid basal cell carcinoma treated with cutler-beard surgery.

Methods:
Case report.

Results:
A 53-year-old unemployed Malay lady presented with a 4 months history of right upper eyelid mass. She had mild discomfort with on and off bleeding over the lesion. The mass was not increasing in size and no complain of blurring of vision. There was no similar problem before. On examination the vision of the right eye was 6/12 and the left eye was 6/9. The lesion measured 20mm length and 7mm height which was more than half of the eyelid margin width. The lesion was hyperpigmented with some indurated areas. There was no lymph node palpable. Incision biopsy was done and as the diagnosis was consistent with basal cell carcinoma, fresh frozen section with lid reconstruction via cutler-beard technique and contralateral tarsal plate graft was done. The patient’s eyelids were separated from each other 6 weeks postoperatively with a second operation. On follow up patient was comfortable with no upper eyelid retraction, lagophthalmos or corneal exposure.

CONCLUSION:
Cutler-beard surgery is a successful procedure for large superior basal cell.
EP6: Clinical Presentations Of Paraquat Induced Ocular Injury
Yap JY, Gan YK, Madhusudhan Paramananda, Sheena Mary Alexander
Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
Paraquat, a type of herbicide, is commonly used in agriculture based economy in developing countries. We aim to report a case to recognise the clinical presentations of paraquat induced ocular injury which is important in its management in our country definitely.

Methods:
Case report.

Results:
We describe the clinical presentations of a 46-year-old Dusun farmer who sustained bilateral ocular chemical injury after splashed by paraquat. He presented with hyperemic and chemotic conjunctiva, with worse severity on the right eye. There was associated bilateral severe pseudomembranous conjunctivitis reminiscent Steven Johnson syndrome. He was treated with topical ciprofloxacin and maxitrol (neomycin and polymyxin B sulfates and dexamethasone ophthalmic suspension) and the condition resolved after 2 weeks.

Conclusion: Paraquat induced ocular injury can be common in our country due to the easy availability of the uncontrolled herbicide. Recognition of the clinical presentation to give appropriate treatment can prevent severe ocular surface disease.

EP7: Characterisation Of Limbal Stem Cells
Bakiah Shaharuddin1,2, Charles Osei-Bempong1, Sajjad Ahmad3,4, Paul Rooney5, Simi Ali6, Rachel Oldershaw7, Annette Meeson2

1Advanced Medical and Dental Institute, Universiti Sains Malaysia, Pulau Pinang, Malaysia
2Institute of Genetic Medicine, Newcastle University, Newcastle Upon-Tyne, U.K.
3St Paul's Eye Unit, Royal Liverpool University Hospital, Prescot Street, Liverpool, UK.
4Department of Eye and Vision Sciences, Institute of Ageing and Chronic Disease, University of Liverpool, UK.
5Tissue Development Laboratory, NHS Blood and Transplant, Liverpool, UK.
6Institute of Cellular Medicine, Newcastle University, Newcastle Upon-Tyne, UK.
7Musculoskeletal Biology I, Institute of Ageing and Chronic Disease, University of Liverpool, Leahurst Campus, Chester High Road, Neston, Cheshire, CH64 7TE

Purpose:
Ex vivo expanded limbal stem cell (LSC) transplantation using amniotic membrane as a carrier system for ocular surface regeneration. The aim of this project is to isolate and characterise mesenchymal stem cells from the limbal region as an alternative cell population for cellular-based therapies.

Methods:
Cells were isolated from cadaveric corneo-scleral rims and the cells were resuspended in a MSC-growth promotion medium. Phenotypic immunolabelling was performed to define the cell population as human MSCs followed by tri-lineage cellular differentiation. Chemotaxis transwell assays were performed to study CXCL12-mediated cell migration. Cells were also plated onto cryopreserved amniotic membrane to determine if they would adhere, and proliferate on this biological scaffold.

Results:
Limbal MSC were adherent, rapidly proliferated on plastics and were positive for antibodies specific to human MSC, and negative for markers of lineage committed haematopoietic cells, expressed HLA Class I molecule and low/no expression to HLADR. They also demonstrated adipogenic, chondrogenic and osteogenic commitment. LMSC in an optimised culture conditions maintained expression of common limbal markers ABCG2, p63 and ABCB5. It demonstrated high expression of chemokine receptor CXCR4 and directed to ligand CXCL12-mediated cellular migration. LMSC were also able to grow and proliferate on cryopreserved amniotic membrane.

Conclusion: LMSC can be successfully isolated from cadaveric corneo-scleral rings using our tissue culture protocols. The potential of these cells to contribute to improved outcomes in LSC transplantation bears further investigation.
**EP8: A Surprising Manifestation Of Herpes Zoster Ophthalmicus**  
*Gan Yuen Keat, Yap JY, Madhusudhan Paramananda*  
*Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah*

**Purpose:**  
A case report of necrotizing scleritis secondary to herpes with superimosed bacterial infection in a immunocompromised patient.

**Methods:**  
Case report.

**Results:**  
A 49-year-old gentleman, background history of retroviral infection on highly active anti-retroviral therapy, presented with painful red right eye and blurring of vision for 3 days. Ocular examination revealed corneal ulceration extended to the sclera nasally. There were anterior chamber cells with hypopyon. Corneal scrapping culture and sensitivity grew pseudomonas aeruginosa. He was treated with topical fortified gentamicin, moxifloxacin, ceftazidime, homatropine and oral doxycycline. The ulceration progressively worsened and evolved to necrotizing scleritis. Ointment acyclovir was started as further examination revealed reduction of corneal sensation. A rapid clinical improvement was noted. The thinning and ulceration resolved with fibrosis.

**Conclusion:**  
Corneal ulcerations involving the sclera and necrotizing scleritis is uncommon and mixed bacterial and herpetic infection should be highly suspected especially in immunocompromised patients.

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**EP9: Moving Towards Sutureless And Fibrin Glue Free Limbal Conjunctival Autograft For Pterygium Surgery**  
*Cheng Teck Chee, Francesca Martina Vendargon, Yanti Muslikhan*  
*Department of Ophthalmology, Hospital Sultanah Nora Ismail, Batu Pahat, Johor*

**Purpose:**  
To evaluate the efficacy and safety of autologous blood limbal conjunctival autograft in pterygium surgery. Also to discuss the benefits of this new technique over the rest.

**Methods:**  
This is a case series of 7 patients with pterygium who underwent pterygium excision with conjunctival autograft using patient’s own blood coagulation. Each surgery was performed by the same surgeon. Pterygiums were excised followed by harvesting of limbal conjunctival autografts. The grafts were attached spontaneously by coagulation without sutures and fibrin glue. Post-operatively up to 2 months, each patient was given a questionnaire to evaluate their symptoms based on a set of criteria. This consisted of symptoms such as foreign body sensation, post-operative pain, photophobia, hyperaemia, chemosis and tearing which were divided into grade I to III (III being the most severe). We also looked into cost, surgical time, recurrence rate and post-operative complications such as graft dehiscence and retraction.

**Results:**  
All patients had high satisfactory level towards the outcome of the surgery. They did experienced minimal symptoms at the immediate post-operative period which eventually resolved within a short duration. The mean duration of surgery was 28 minutes. There was no added cost (free). 3 out of 7 patients had improvement over visual acuity. None of them suffered graft dehiscence or recurrence. However, 1 patient had graft retraction due to vigorous eye rubbing.

**Conclusion:**  
Autologous blood is a safe, simple, faster and cost saving procedure which promises less surgical complications, lower recurrence and yields higher patient satisfaction.
EP10: Corneal Perforation As First Manifestation Of Rheumatoid Arthritis
Khoo CL1, Nor Higrayati Ahmad Kasah1, Mohtar Ibrahim2
1Department of Ophthalmology, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Terengganu
2Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report a case of Rheumatoid Arthritis with an eviscerated eye due to perforated peripheral ulcerative keratitis with panophthalmitis, who presented to us for spontaneous corneal perforation in the fellow eye.

Methods:
Case report.

Results:
A 63-year-old lady presented to us initially with perforated peripheral ulcerative keratitis complicated with panophthalmitis which required evisceration. Her fellow eye also revealed peripheral ulcerative keratitis at that time. She was referred to the Rheumatology team who diagnosed and started treatment for Rheumatoid Arthritis. However she defaulted Rheumatology follow-up. She presented to us this episode with 4 days history of acute-onset left eye pain, redness and reduced vision. Her left visual acuity was 6/60 which improved to 6/18 with pin-hole. Examination revealed an inflamed left eye with perforated cornea and iris plugging. Laboratory results suggest an on-going active disease state. She was urgently referred to a Corneal team and cyanoacrylate glue with plastic disc was applied.

Conclusion:
Patients with connective tissue disease may present with a myriad of ocular problems. It is therefore important that ophthalmology clinicians work closely with other disciplines to optimize patients’ disease states and to avoid ocular morbidity.

EP11: Graphite Pencil Induced Corneal Toxicity
Annuar Zaki Bin Azmi1,2, Madhusudhan Paramananda1, Shuaibah Abdul Ghani2
1Department Of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah
2Department Of Paediatric Ophthalmology, Hospital Kanak-kanak Wanita Sabah

Purpose:
Graphite pencil injuries to the eye are rare and possibly hazardous to the eye as it may cause corneal toxicity secondary to aluminium released by retained graphite fragment.

Methods:
Case report.

Results:
A 7-year-old Dusun boy sustained a traumatic injury to the right eye following a graphite pencil that was accidentally thrown by his younger brother at a 1 meter distance. He sustained 4.5 mm full thickness corneal laceration with iris prolapse and an immediate primary repair was done. Cornea remained clear for the initial 2 days however gradually developed generalized stromal edema with epithelial microcyst and the vision dropped to 6/18, but with no raised intraocular pressure. Patient underwent anterior chamber washout and treated with vigorous anti-inflammatory agents and gutt hypertonic saline. Currently, 6 weeks post trauma, stromal edema slowly subsided and the vision improved to 6/9, but the condition is yet to be ideal.

Conclusion:
Graphite induced corneal toxicity is uncommon. Timely recognition of the signs with a high index of suspicion by the clinician is vital to prevent severe ocular injury, as reported in the past, ranging from asymptomatic corneal erosions to endophthalmitis.
EP12: Candy-Cane Hypopyon And Hyphema Secondary To Herpes Zoster Ophthalmicus

Katherine Seng1, Jesspal Kaur Dhillon2, Ngim You Siang2, Juliana Jalaluddin2
1Department of Ophthalmology, Pusat Perubatan Universiti Malaya, Kuala Lumpur
2Department of Ophthalmology, Hospital Pakar Sultanah Fatimah, Muar, Johor

Purpose:
We report a rare case of herpes zoster ophthalmicus (HZO) complicated by early severe neurotrophic keratitis with severe anterior chamber reaction manifested by a mixture of hypopyon and hyphema.

Methods:
Case report.

Results:
A 61-year-old lady presented with two days history of right eye redness with painful unilateral dermatomal vesicular rashes over her forehead. Hutchinson’s sign was absent. A diagnosis of herpes zoster blepharoconjunctivitis was made and she was treated with oral acyclovir and topical lubricants. One week later she developed right eye severe blurring of vision and she was found to have stage 3 neurotrophic keratitis with candy-cane hypopyon and hyphema. This was further complicated by secondary bacterial infection and secondary glaucoma. Response to treatment which consisted of oral acyclovir, topical antibiotics, lubricants, cycloplegic and antiglaucomas was poor. A temporary tarsorrhaphy was carried out in view of persistent epithelial defect, after which there were notable improvement of keratitis, resolution of hypopyon and healing of epithelial defect. However, her vision remained poor due to cornea scar and guarded visual prognosis was informed due to poor success rate of penetrating keratoplasty in this entity.

Conclusion:
Neurotrophic keratitis is usually a late complication of HZO but it manifested much earlier in this case, accompanied with severe anterior chamber inflammation. Besides, a negative Hutchinson’s sign in the early stage of HZO does not confer good prognosis, as illustrated in this case. Therefore closer monitoring and appropriate treatment for patient are essential in the early phases of the disease to prevent significant ocular morbidity.


Norfarizal Ashikin, Chua Kh, Norzana Ag, Safinaz Mk, Jemaima Che Hamzah
Department Of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
To determine the effect of edible bird’s nest (ebn) on rabbit’s cornea epithelial wound healing.

Methods:
An experimental prospective animal trial was performed using 24 New Zealand white rabbits divided into four groups consisting of six rabbits; normal saline (ns), chloramphenicol (cmc), ebn 0.05% and ebn 0.1%. A standardised central cornea epithelial defect measuring 7.5 mm diameter was done using 1-heptanol 20% for 40 seconds with application of dry sponge tax under sedation. Each drug was instilled four times a day. Immediately after cornea de-epithelisation, the cornea was photographed using topcon slit lamp. The cornea epithelial wound defect was measured every 6 hours after cornea de-epithelisation or until wound is completely healed. Epithelial defect area was measured and calculated using qims (quick imaging measurement software).

Results:
Standardised corneal de-epithelisation was achieved using 20% 1-heptanol for 40 seconds in combination with dry sponge tax. Baseline epithelium defect was $57.41 \pm 4.35 \text{ mm}^2$ in ns, $57.43 \pm 3.60 \text{ mm}^2$ in cmc, $56.41 \pm 2.20 \text{ mm}^2$ in ebn 0.05% and $57.50 \pm 2.10 \text{ mm}^2$ in ebn 0.1%. It was statistically not significant ($p=0.924$). Rate of corneal wound healing was faster in ebn 0.1% ($0.73\pm0.11 \text{ mm}^2$/hour) compared to cmc ($0.53\pm0.18 \text{ mm}^2$/hour) followed by ebn 0.05% ($0.52\pm0.15 \text{ mm}^2$/hour) and normal saline ($0.48\pm0.14 \text{ mm}^2$/hour) which was statistically significant ($p=0.03$).

Conclusion:
Ebn 0.1% hasten the corneal wound defect closure and increases the rate of corneal epithelial wound healing in rabbits. It is potential to be use as an eye drop to promote corneal wound healing.
EP14: Cornea Foreign Body Self-Removal Using Ringgit Notes: Case Series Of Occupational Hazard
Koh KL, Ch’ng Tun Wang
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

**Purpose:**
Cornea foreign body is a common occupational hazard due to inadequate eye protection during welding and metal grinding. We report on 3 cases of cornea foreign body which were self-removed and complicated with different visual sequelae.

**Methods:**
Case series.

**Results:**
Several methods have been used to remove corneal foreign body using aseptic technique to prevent secondary infection and reaction in eye clinic. However, self-removal is still a preferred initial self-treatment method in view of fast, easy availability and cost saving. A retrospective review on 3 cases of cornea foreign body self-removal using Ringgit notes noted that they were complicated with cornea ulcers and cornea perforation. Long term outcome range from poor vision result from simple cornea scar to devastating blindness due to cornea perforation. The visual sequelae were guarded for those presented late to hospital. We also describe the detailed steps of cornea foreign body self-removal. Currency as the most common circulating tool in daily economic transaction potential harbours multiple microorganisms. However, identification of causative organism remains a challenge because most of the microbiology workouts were negative.

**Conclusion:**
Workplace safety, health education and awareness to cornea foreign body are essential steps to prevent this avoidable blindness in our population of industrial workers to reduce work-related blindness.

EP15: Viral Keratouveitis With Hypopyon
Zakaria Abdollah, Norshamsiah Md Din
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

**Purpose:**
To report a case of viral keratitis with hypopyon, initially diagnosed as bacterial keratitis.

**Methods:**
Case report.

**Result:**
A 70-year-old Malay lady presented with one week history of right eye pain and redness. There was no history of trauma. She has underlying bilateral chronic angle closure glaucoma, right trabeculectomy in 1996, right herpetic keratouveitis in 2007 with subsequent corneal decompensation. Her vision has always been hand movement. Right eye examination revealed a central epithelial defect (4mm x 3mm) and superficial, well-defined white plaque with clear margin at the centre of the epithelial defect and a hypopyon level measuring 3mm height. Initial diagnosis of bacterial keratitis was made. The patient was treated with intensive course of topical antibiotic with fortified Gutt Gentamicin 1.4% and Gutt Fortum 5%. Despite this aggressive therapy for 48 hours the ulcer in the right eye persisted and did not show any improvement. Corneal scraping also revealed no organism. She was then started on oral and ointment Aciclovir in view of her previous exposure to herpetic keratitis. With antiviral therapy there was resolution of her symptoms and contraction of the white plaque and hypopyon.

**Conclusion:**
Corneal ulcer with hypopyon is always indicative of suppurative bacterial keratitis whereas viral keratitis is usually presented with sterile anterior chamber. However in severe viral keratitis, hypopyon can be present, causing confusion in the initial diagnosis as illustrated in this case.
**Purpose:**
To report a case of bacterial ulcer of a rare bacteria known as Kingella Kingae from the corneal scraping in a child with underlying vernal keratoconjunctivitis.

**Methods:**
Case report.

**Results:**
A 4-year-old boy who is underlying vernal keratoconjunctivitis, presented with right eye pain, redness and inability to open his right eye for 2 days. His mother noted a whitish opacity over his right eye on the day of presentation. During his latest eye clinic follow up for vernal keratoconjunctivitis, there was no documented shield ulcer, corneal scar, or epithelial defect. He was on daily application of his topical treatment consisting of olopatadine, and hydroxypropyl methylcellulose. On examination, the right eye conjunctiva was hyperaemic. There was presence of central corneal ulcer with fluffy edge measuring 3.6 x 4.0mm associated with dense stromal infiltrate. The anterior chamber showed intense inflammation with fibrin and a streak of hypopyon level. His right intraocular pressure was 36-37mmHg. The gram stain and chocolate agar of corneal scraping result showed gram-negative coccobacilli, *Kingella Kingae*. He was commenced on topical moxifloxacin and ceftazidime, along with intraocular pressure lowering agents; timolol and dorzolamide and continue his own topical treatment for vernal keratoconjunctivitis. The patient subsequently improved with antimicrobial topical treatment.

**Conclusion:**
*Kingella kingae* is very rare organism to cause corneal ulcer and there are only a few cases reported. Bacterial keratitis caused by this organism is generally responds well to antimicrobial treatment. A proper history and clinical evaluation is required to prevent a more devastating complication to the eye.

**EP17: Honey Supplement In Post-Menopausal Women With Dry Eye-Case Series**

**Purpose:**
To evaluate the effect of honey supplement in post-menopausal women with dry eye.

**Methods:**
This is a case series involving 2 post-menopausal women with moderate dry eye. Patients were evaluated for Schirmers I test, tear break up time and lissamine green test before honey supplement and at 3 months post honey supplement.

**Results:**
**Case 1:** Schirmers I test showed improvement from moderate to mild dry eyes, tear break up time showed improvement with few seconds increased and lissamine green test showed improvement from grade two to one.

**Case 2:** Schirmers I test showed moderate dry eye with improvement in the scoring, no improvement in tear break up time and lissamine green test.

**Conclusion:**
Honey intake as a daily supplement have many health benefits. This case series have shown improvement in dry eye signs. Hence, a larger sample size and longer duration of study will give a better result.
Purpose:
Methods:
Case report.

Results:
A 35-year-old gentleman presented with 6 days history of right eye pain and redness. On examination, there was a central corneal epithelial defect with disciform ring of infiltrates. The left eye was normal. He was diagnosed with disciform keratitis and started on antiviral and artificial tears. However, he started to have pain and redness in the left eye after 3 days. On examination, corneal sensation was reduced in both eyes. The epithelial defect in the right eye worsened and there was new epithelial defect with disciform ring of infiltrates in the left eye. Persistent keratopathy was observed at follow up despite adequate therapy. On further enquiry, it was discovered that he had been using topical Proparacaine 0.5% up to 1 bottle (15mls) per day for the past 2 weeks which was ‘prescribed’ by medical assistant in offshore to ease his ocular pain. Diagnosis was revised as Proparacaine related keratopathy. Patient was admitted to ensure proper supervision of treatment and abstinence of Proparacaine. Upon discharge, epithelial defect was healed with scarring resulting in vision acuity of counting finger in both eyes.

Conclusion:
The challenges in managing anaesthetic related toxic keratopathy is at diagnosis, as patients may not be forth coming or even denial of history of topical anaesthesia use. High index of suspicion in cases of persistent epithelial defect, Wessely type immune ring infiltration and disciform stromal oedema is the key to the diagnosis. We also emphasized that prescription of ocular topical anaesthetic by non-ophthalmology healthcare provider is strongly prohibited.
EP19: Review Of Cases Of Aqueous Misdirection In Ocular Surgeries In Hospital Tengku Ampuan Afzan
Nurul Shima Ismail, Shwarinin Jusoh, Mohd Aziz Husni.
Department of Ophthalmology, Hospital Tengku Ampuan Afzan, Kuantan, Pahang

Purpose:
Aqueous misdirection is an uncommon complication following an incisional ocular surgery such as cataract or filtering surgery but requires high index of suspicious and urgent attention. Few cases had occurred in HTAA and we aim to review the risk factors involved, approaches taken as management and the outcome of each.

Methods:
Case report.

Results:
We reviewed two cases of aqueous misdirection, one occurred after filtering surgery (trabeculectomy) and the other from complicated cataract surgery. First case was managed by starting patient on topical anti-glaucoma, oral Acetazolamide as well as intravenous Mannitol to control intraocular pressure (IOP). Then we proceed with Yag capsulotomy and Yag anterior hyalodotomy. Despite that, IOP was still uncontrolled therefore we proceed with pars plana vitreous aspiration and anterior chamber reformation. IOP was controlled post procedure. Patient’s vision is getting better from counting finger post trabeculectomy to 6/9. In second case, patient had also been started on topical anti-glaucoma, oral Acetazolamide and subsequently intravenous Mannitol. Similarly, due to persistent high IOP, this case was also managed operatively by doing trans pars plana vitreous aspiration, anterior chamber reformation and surgical peripheral iridectomy. IOP was controlled and vision improved from hand movement post-operatively to 6/15 currently as the best corrected vision.

Conclusion:
Aqueous misdirection is a rapidly progressing condition which requires urgent treatment and usually a stepwise approach is considered starting from medical options, laser and may proceed with surgical options such as vitrectomy depending on cases. Early recognition and diagnosis will help to prevent significant visual loss and blindness.

EP20: Surgical Outcome Of Traumatic And Non-Traumatic Subluxated Crystalline Lens In Hospital Raja Perempuan Zainab II And Its Complications
Nor Hasnida AB Gani, Nurhamiza Buang, Nor Idahriani Muhd Nor, Zamri Noordin, Norhalwani Husain
Department of Ophthalmology Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan

Purpose:
To report the postoperative outcomes and complications in non-traumatic and traumatic subluxated crystalline lens in Hospital Raja Perempuan Zainab II.

Methods:
Retrospective data of subluxated crystalline lens cases that underwent surgical intervention from January 2013 to December 2014 were collected. Fifteen eyes of 12 patients were involved. Pre and postoperative vision acuity (VA), intraocular pressure (IOP), types of surgical intervention and complications were recorded.

Results:
The mean age of the patients was 32.76 ± 24.30 yearsold, ranging from 12 to 77. Women were 50.0%. Five eyes (33.3%) were traumatic cases and 10 (66.7%) were non traumatic cases including Marfan’s Syndrome in 4 (40.0%) eyes. The surgical intervention were Intracapsular cataract extraction (ICCE)/Scleral fixated intraocular lens implant (SFIOL) (13.3%), ICCE/Anterior chamber intraocular lens implant (6.7%), plain ICCE (26.7%), Trans pars plana vitrectomy (TPPV) with plain lens capsule/scleral fixated intraocular lens implant (40.0%). Mean pre-operative logMAR vision acuity was 2.56 ± 0.60 which improved to 0.60± 0.78 post operatively in trauma cases (p = 0.004; paired t-test). For non-traumatic cases, mean pre-operative vision acuity was 1.15 ± 0.41 which improved to 0.41 ± 0.22 post operatively (p = 0.001; paired t-test).

Conclusion:
Various surgical techniques tailored according to the patients’ age and type of lens subluxation gave good visual outcomes with minimal complications.
EP21: Spontaneous Suprachoroidal Hemorrhage As A Cause Of Acute Intractable Glaucoma

Khoo CL, Nor Higrayati Ahmad Kasah, Zuraidah Mustari
Department of Ophthalmology, Hospital Sultanah Nur Zahirah, Kuala Terengganu, Terengganu

Purpose:
To report a rare case of Suprachoroidal hemorrhage in the absence of trauma or surgery in a bedbound gentleman who is on antipletelet therapy for cerebrovascular accident.

Methods:
Case report.

Results:
We report a 77-year-old man with hypertension and old right cerebrovascular accident. He is on oral Ticlopidine 250mg twice-a-day. He presented to Emergency Department for severe headache and vomiting of 3 days in duration. It was associated with acute-onset painful right eye, with blurring vision and redness. On ocular examination, right eye revealed positive RAPD, tensed eye ball with Intraocular pressure of 55 mm Hg. His anterior chamber was extremely shallow with iris almost touching the cornea. Initial diagnosis of Right eye phacomorphic glaucoma was made and he was planned for cataract surgery once stable. However his IOP remained above 50 mmHg with maximum medical treatment. His visual acuity worsened to No-perception-to-light (NPL). B-scan revealed generalized vitreous hemorrhage which filled up the whole globe and pushing the lens anteriorly. Diagnosis was revised to suprachoroidal hemorrhage and he was counseled for evisceration. Intraoperatively the eye is tensed with blood oozing out upon entering the eye. The vitreous cavity was full of dark-colored blood. No pus was noted.

Conclusion:
Spontaneous suprachoroidal hemorrhage should be considered in patients presenting with acute visual loss associated with intractable high intraocular pressure.

EP22: A Storm After Calm Weather

Tashna Evali, Pragalath Nagamuthu, Jelinar Mohamed Noor
Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur

Purpose:
Secondary angle closure glaucoma can present in various ways, even after an uneventful phacoemulsification surgery. We undertake to report 2 cases who had uncomplicated cataract surgery but developed acute secondary angle closure attack soon after. In both these cases the mechanism varied and they were symptomatic within 10 days after surgery.

Methods:
Case series.

Results:
In the first patient, secondary angle closure occurred from pupil block with underlying malignant glaucoma. The second case the attack was caused solely by pupil block. Both these cases had a cyclitic membrane covering the pupil. They responded well to treatment after proper diagnosis was made with the aid of appropriate equipment.

Conclusion:
Hence, it is important that patients are compliant to treatment after surgery. In addition, the attending ophthalmologist must have good clinical acumen so that proper management can be instituted immediately.
Purpose:
To evaluate changes in intraocular pressure after phacoemulsification among open angle glaucoma, closed angle glaucoma and normal patients.

Methods:
This is a retrospective cohort study with the subjects were extracted from the record at the Ophthalmology Department Hospital Tengku Ampuan Afzan Kuantan. The study subjects were patients with cataract either normal, open or occludable angle who underwent phacoemulsification. Intraocular pressure was recorded on three latest reading before operation and at 1st month, 3rd month and 6th month post-surgery.

Results:
There were 12 (37.5%) males and 20 (62.5%) females with total 39 eyes with 21 (53.8%) right eye and 18 (46.2%) left eye. Among 32 patients, 9(28.1%) patients with 12 eyes are open angle, 12(37.5%) patients with 16 eyes are occludable angle and 11(34.4%) are normal patients. Median pre-operative IOP in open angle, occludable and normal are 17.5, 17.8 and 14.2 mmHg respectively. Median IOP post operatively have shown reduction with 15.5, 14.3 and 13.3 mmHg respectively. The result have shown significant reduction in closed angle and normal group (p<0.05), but not in open angle. The pre-operative data shown significant different (p<0.05) between glaucomatous group and normal however post-operative data shown no significant different in intraocular pressure between this three groups.

Conclusion:
Phacoemulsification resulted in significant reduction of intraocular pressure in normal as well as closed angle eyes. There is no significant reduction in open angle group.
EP24: Subconjunctival Abscesses Exacerbated With Corticosteroid Therapy
Khai-Siang Chai, Shatriah Ismail
Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report a middle age healthy patient who developed multiple subconjunctival abscesses following a combination of oral and topical corticosteroid treatment for his severe visual threatening anterior uveitis.

Methods:
Case report.

Results:
A 55-year-old farmer presented with right eye was severe anterior uveitis and treated with topical steroid and oral steroid. However there was minimal improvement and subsequently developed multiple subconjunctival abscess. Further questioning revealed history of a tree branch hit his right eye one month prior to the onset of current illness. Incision and surgical drainage was urgently performed under local anaesthesia. The microscopic examination noted presence of yeast and fungal hyphae. Patient subsequently improved with antifungal treatment.

Conclusion:
Possibility of trauma needs a careful evaluation. Early diagnosis and prompt treatment is necessary to prevent a more devastating complication to the eye.

EP25: Dengue Maculopathy : Case Series Of Poor Vision In Dengue Fever
Ivan Cheng En Yoo, Ch’ng Tun Wang
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
An observation study of series of dengue maculopathy.

Methods:
Case series.

Results:
A retrospective analysis of poor vision in dengue fever was done to determine the clinical presentation of dengue maculopathy as there is no standard protocol to treat dengue maculopathy at this moment. Formulation of the likely treatment regime for poor vision in dengue fever is important for future reference. From January 2015 to May 2015 in Hospital Raja Permasuri Bainun Ipoh, there were 5 cases of poor vision which were painless and sudden in onset presented during the course of dengue fever and they were collectively known as dengue maculopathy after all other possible causes of poor vision are ruled out. All of them are young patients with low platelet count. The complaint of poor vision is presented during week 1 of dengue fever which is suggestive of auto-immune in origin. Vision during presentation varied from subtle visual loss of 6/9 to poor vision of counting fingers. However, majority of them resolved to good vision after 4 to 6 weeks with close monitoring and treatment. Topical NSAID and close monitoring is adequate for mild cases. However, patient with severe visual loss needed a detailed workout and systemic steroid to prevent permanent vision loss. Early detection and prompt treatment are essential for patient with visual loss in dengue fever.

Conclusion:
Maculopathy is a known complication of Dengue Fever. Early detection and prompt treatment are essential to prevent permanent visual loss.
EP26: Unilateral Anemic Retinopathy Caused By Uterine Fibroid
Khai-Siang Chai, Wee-Min Teh, Wan Hazabbah Wan Hitam, Shatriah Ismail
Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report a case of unilateral anemic retinopathy due to menorrhagia caused by uterine fibroid.

Methods:
Case report.

Results:
A 43-year-old Malay female, who has been previously diagnosed to have hypertension, presented with subacute onset of right eye central blurring of vision for one week. Her vision on presentation was counting fingers in the right eye and 6/6 in the left eye. She had pallor and a systolic murmur. There pupillary reaction was normal. She had generalised optic disc swelling, splinter haemorrhages, cotton-wool spots, roth spots and tortuous vessels with macula oedema in the right eye with normal left eye fundus. Initial diagnosis was more towards central retinal vein occlusion (CRVO).

She was investigated and found to have severe hypochromic microcytic anemia secondary to prolonged menorrhagia due to uterine fibroid. Haemoglobin on presentation was 4.7g/dl. Patient received blood transfusion, and her anemia was corrected to 12.5g/dl. Post transfusion three weeks her vision improved to 6/6 in the right eye. Optic disc swelling, cotton wool spots and macula oedema resolved. Patient has undergone fibroid removal.

Conclusion:
Unilateral anemic retinopathy is very rare and there are only a few cases reported. Anemic retinopathy is reversible and can be treated by treating the causative factor. Anemic retinopathy may present unilaterally and mimic CRVO. A proper history and clinical evaluation is required to promptly manage these cases.

EP27: Bilateral Trichosporon Asahii Choroidal Abscess in Acute Myeloid Leukemia
T.Thilakavathy, Ch’ng Tun Wang
Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a rare case of bilateral *Trichosporon asahii* choroidal abscess in Acute Myeloid Leukemia.

Methods:
Case report.

Results:
Trichosporon is fungi that commonly inhibit the soil. It also has been found as a commensal in human gastrointestinal and respiratory tract. However, it posted a risk as opportunistic infection in immunocompromise condition. Haematologic malignancy has been described as risk factor for Trichosporon outbreak. We reported a rare case of bilateral *Trichosporon asahii* choroidal abscess in a acute myloid leukemia patient. It is rare. Diagnosis of causative organism of choroidal abscess was challenging because anti-microbio was usually targeted empirically due to invasive nature of taking a biopsy.

Thus, targeting correct organism is depends on detail clinical history taking and examination. In view of immunocompromise state of blood malignancy itself has been posted as risk factor for multiple opportunistic infection, onset of eye symptom correlate with blood culture result was a crucial clue for targeting the correct microorganism. Choroidal abscess response well clinically to intravitreal and systemic anti-fungal given in our case. It shows improvement. However, there was residual visual symptom due to associated retinal sequelae of epiretina membrane and folds.

Conclusion:
Bilateral *Trichosporon asahii* choroidal abscess is rare. However, recovery is good. Detail clinical assessment is a crucial tools in targeting the correct organism by administrating the correct anti-microbial.
EP28: HIV In Disguise - A Case Of Ocular Syphilis
Abirami Shavani, Chong Mei Fong
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a case of bilateral syphilitic panuveitis in an unknown HIV-infected patient.

Methods:
Case report.

Results:
A 32-year-old gentleman presented with bilateral painless blurring of vision for 1 week associated with fever, frontal headache, and scaly skin lesion of bilateral palms and soles of 6 months duration. He admits promiscuity with unprotected sex. His visual acuity was 6/18 in the right eye and 6/9 in the left eye. On examination, noted in both eyes, presence of cells in the anterior chamber and posterior segment involvement with the evidence of chorioretinitis and vitritis.

His VDRL status was positive and also tested positive for Treponema pallidum. Further test revealed he was HIV positive. He was given IV C-Penicillin for 2 weeks and also started on Gutt Dexamethasone. His symptoms improved with visual recovery to 6/9 in both eyes with resolved ocular inflammation and residual choroidal scarring. His skin lesions also resolved completely.

Conclusion:
All ocular inflammations need to be screened for syphilis. Ocular syphilis may be the first presenting diagnosis for a patient with previously unknown HIV positive status. It usually manifests as an ocular inflammation, mainly in the posterior segment and commonest sign is usually uveitis. Prompt treatment is needed and has a good prognosis if detected and treated early.

EP29: Pregnancy - A Poisoned Chalice
Abirami Shavani, Chong Mei Fong
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a rare case of bilateral proliferative retinopathy secondary to central retinal vein occlusion in a young, pregnant lady.

Methods:
Case report.

Results:
A 30-year-old lady presented with bilateral painless blurring of vision for 1 month duration. She had gestational diabetes mellitus and was in her third pregnancy at 28 weeks with history of 2 previous miscarriages. On examination, right eye vision was 6/36 and left eye vision was 6/18. She had normal anterior segment findings however posterior segment in both eyes showed flame shaped hemorrhages in 4 quadrants. Right eye had new vessels with preretinal hemorrhage. Panretinal photocoagulation was given for her right eye. 1 week later, left eye developed new vessels with macula edema and was lasered. Her vision further deteriorated to 6/60 both eyes.

She was screened for antiphospholipid syndrome, connective tissue disease and blood hyperviscosity which were negative. Laser therapy was completed in both eyes and vision regained to 6/12 right eye and 6/9 left eye with resolution of the proliferative state and residual epiretinal membrane in both eyes.

Conclusion:
It is rare for a pregnant lady to present with bilateral central retinal vein occlusion. Any such case in a young, pregnant lady needs to be screened for antiphospholipid syndrome, connective tissue disease and blood hyperviscosity. A prompt laser therapy is needed to ensure a good visual prognosis.
EP30: Dengue Fever With Bilateral Dengue Maculopathy
Lynda L, Siva K Sundralingam, Fazilawati Qamarruddin
Department of Ophthalmology, Hospital Tengku Ampuan Rahimah, Klang, Selangor

Purpose:
To describe clinical spectrum and treatment for dengue fever-associated maculopathy.

Methods:
Case report.

Results:
A 24-year-old, Chinese, lady, admitted for dengue shock syndrome was referred to ophthalmology team on day six of fever with complaints of left eye acute onset central blurring of vision for one day. Visual acuity were 6/9 and 5/60 in right and left eye respectively. There was no relative afferent pupillary defect. Anterior segment and intra-ocular pressure for both eyes were normal. Fundus examination revealed bilateral macula oedema with presence of blot haemorrhages over the macula. Optical coherence tomography showed bilateral intra-retinal cystic fluid. Humphrey visual field demonstrated central scotoma bilaterally, with normal color vision. Her platelet counts were 46 x 10μ/L (nadir on day six). A clinical impression of dengue-related bilateral macula oedema was made.

Oral Prednisone 1mg/kg was commenced and gradually tapered over three months. Left eye visual acuity improved to 6/9 (unaided) on completion of systemic steroid. Patient retained small areas of scotoma on visual field testing at three months follow-up. Optical coherence tomography showed resolved macula oedema with minimal photoreceptor insult.

Conclusion:
Dengue fever can present with a wide degree of ophthalmic complications which can be potentially disabling. Symptoms generally occur during nadir of thrombocytopenia, at one week after onset of fever, as shown in this case. Treatment is based on postulated immune-mediated pathogenesis of the disease. Systemic steroid is proven useful in suppressing inflammatory process occurring in dengue maculopathy.

EP31: Not A Simple Oral Ulcer: Occlusive Retinal Vasculitis In Behcet's Disease
Fatin Nadia Zamawi, Juanarita Jaafar, Haslina Mohd Ali
Department Of Ophthalmology, Hospital Sultanah Bahiyah, Alor Setar, Kedah

Purpose:
Reporting a case of bilateral occlusive retinal vasculitis secondary to Behcet's disease.

Methods:
Case report.

Results:
Mr HA, a 32-year-old Malay gentleman with no underlying medical illness presented with one-year history of both eye recurrent episodes of painless blurry vision. Symptoms were associated with redness and floaters. On each occasion, both eye symptoms resolved spontaneously over weeks without medications. Apart from recurrent oral ulcers, other systemic examination was unremarkable. On presentation, both eye vision were 6/36. Both eyes demonstrated signs of anterior uveitis with retinal vasculitis and vitritis, left eye being more severe with presence of new vessels of disc. Optical Coherence Tomography of macular revealed irregular layers of retina with collection of subretinal fluid over left eye. All blood investigations were normal except positive antinuclear antibody, which was concluded insignificant by rheumatologist. Fundus fluorescein angiography showed evidence of leakage over optic disc and capillary fallout areas peripherally on both eyes.

Patient was treated with oral and topical steroids, and both eye pan-retinal photocoagulation. Both eye conditions have been stable on maintenance dose of oral steroids and second-line immunosuppressive.

Conclusion:
Behcet’s disease is an immune-mediated systemic vasculitis with multi-organ involvement. Although patient did not fulfill triad of Behcet’s disease, his clinical findings and recurrent oral ulcers highly suggestive of the disease. Early diagnosis and treatment are crucial in disease-control and hastening progression.
EP32: Red Herring In The Diagnosis Of The Red Eye  
Munirah AR, Hazlita Mohd Isa  
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur  

**Purpose:**  
To discuss a case of bilateral red eye treated as allergic conjunctivitis and acute angle closure glaucoma which turned out to be bilateral scleritis.  

**Methods:**  
Case report.  

**Results:**  
A 38-years-old woman, known case of bilateral allergic conjunctivitis with steroid induce glaucoma and trabeculectomy presented with bilateral painful red eyes and blurring of vision for two weeks. Her vision was 1/60 right eye and 6/6 left eye. Two days prior, she was diagnosed as bilateral allergic conjunctivitis with right eye acute angle closure glaucoma at another hospital, and was treated with peripheral iridectomy (PI) and subconjunctiva mydrracaine which did not improve the condition. On examination, there were deep episceral and scleral vessels dilatation seen bilaterally. The right eye had posterior synechieae, anterior uveitis and high intraocular pressure despite the PI. B-scan showed positive T-signs in both eyes indicative of active scleritis. A diagnosis of right sclerouveitis and left scleritis was made. Her symptoms resolved with oral methotrexate and oral prednisolone. Her vision subsequently improved to 6/9 over right eye and maintained 6/6 over left eye.  

**Conclusion:**  
Scleritis presents bilaterally in 50% of cases and 10% are associated with anterior uveitis. This condition may be easily missed particularly with other underlying red eye conditions. Careful ocular examination and ultrasound investigation is important for diagnosis. Prompt treatment with steroid and immunosuppressive agent ensures good outcome.  

EP33: Bilateral Atypical Optic Neuritis Secondary To Tuberculosis  
Munirah AR, Hazlita Mohd Isa  
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur  

**Purpose:**  
To discuss a case of bilateral atypical optic neuritis secondary to tuberculosis.  

**Methods:**  
Case report.  

**Results:**  
A 24-year-old healthy Malay man presented with sudden onset bilateral blurring of vision for one week preceded with two days history of high grade fever. There were no other ocular symptoms. Visual acuity was counting finger OD and 1/60 OS. Anterior segment examination was normal. Fundus examination revealed bilateral hyperemic swollen optic discs. Fundus fluorescein angiography revealed bilateral hot discs with patchy vasculitis. Investigations showed a positive Mantoux test of 15mm induration. However ESR was not raised and chest radiography was normal. TB quantiferon test show indeterminate tuberculosis antigen. CT scan brain and orbit showed no space occupying lesion and all other infectious test was normal. The patient was treated with anti tuberculosis treatment. His vision subsequently improved to 6/24 OD and 6/12 OS, with resolution of the optic disc swellings.  

**Conclusion:**  
Ocular tuberculosis has variable manifestations but commonly presents with posterior uveitis. The condition can affect healthy young individuals although rare. Tuberculous optic neuritis can be secondary to infectious infiltration or inflammation along the optic nerve. Early treatment with antituberculosis therapy usually results in good visual outcome.
EP34: Ocular Tuberculosis With Retinitis Proliferans- Is There A Role Of Vitrectomy?
Tikambari E, Wendy OCF, Aini Zahidah, Uthayarany M, Wong Chi Lun
Department of Ophthalmology, Hospital Kulim, Kedah

Purpose:
To report a case of ocular tuberculosis presenting as proliferative retinopathy in a non-diabetic patient

Methods:
Case report.

Results:
This was a healthy 45-year-old lady presented with bilateral gradual visual loss over few weeks duration associated with floaters, which worsened over the right eye 1 day prior to presentation. On examination, the visual acuity was 6/60 on right eye and 6/12 on left eye with normal anterior segments. However, fundoscopy of right eye showed a combined tractional and rhegmatogenous retinal detachment, threatening the macula. Whereas in the left eye, fibro-vascular membrane was seen, causing traction on retina but sparing the macula. Bilaterally, there was evidence of venous sheathing at the periphery but choriotreinitis or tuberculoma were absent. Blood investigations were all normal except for raised ESR (51) and a positive tuberculin skin test (18mm), highly suggesting tuberculosis infection. The 2 hours post prandial glucose level confirmed that she was not diabetic. Panretinal photocoagulation was performed for both the eyes. She also responded well to the antituberculosis medication with a good visual outcome of 6/9 in right eye and 6/12 in left eye.

Conclusion:
Ocular tuberculosis has various presentations; a such proliferative retinopathy in absence of other signs are not common. However, diagnosis of ocular tuberculosis continues to be presumptive and established by combination of clinical signs consistent with known patterns of ocular tuberculosis, ancillary testing such as tuberculin skin test and response to treatment.

EP35: Ocular Tuberculosis: Not To Stop At Mantoux Test
Koh YN, Chong Mei Fong
Department Of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a case of atypical Ocular Tuberculosis with underlying diabetic retinopathy diagnosed by QuantiFERON-TB Gold Test.

Methods:
Case report.

Results:
A 53-year-old Malay lady with DM and dyslipidaemia presented with gradual painless visual impairment in left eye for 3 weeks. She had Pulmonary Tuberculosis and completed treatment more than ten years ago. She denied other constitutional symptoms except for the significant loss of appetite and weight. Ocular examination revealed VA of 6/12 OD and 1/60 OS. Right eye funduscopic examination showed mild NPDR with focal maculopathy. There were features consistent with diabetic retinopathy with vascular sheathing and retinal oedema in the left eye. It has no typical lesion of ocular tuberculosis except for a vague lesion suspicious of choroiditis.

However the preliminary uveitis work up was negative except for raised ESR to 63mm. FFA of left eye revealed areas of capillary fall out at the periphery in all quadrants with suspicous NVE but no definite vasculitis seen. Hence laser treatment was started for the working diagnosis of left proliferative diabetic retinopathy with CSME. In view of unusual extensive vascular sheathing and significant past history, a QuantiFERON-TB Gold Test was ordered although the Mantoux test was negative. It reported as likely Mycobacterium Tuberculosis infection and hence patient was started on anti-TB treatment.

Conclusion:
Gamma interferon release assays (QuantiFERON-TB Gold Test) is very helpful in the diagnosis of Ocular Tuberculosis, especially in patients with features mimic other clinical entities and inconclusive investigation results.
**EP36: Ophthalmic Manifestations Of Leukaemia**

*Siti Ilyana Ghani, Nurul Ashikin, Nur Hafeela, Azian Adnan, Nor Fariza Ngah*

*Department of Ophthalmology, Hospital Selayang, Selangor*

**Purpose:**
To report a case of ocular manifestations of leukaemia.

**Methods:**
Case report.

**Results:**
A 29-year-old Malay male presented with left eye blurring of vision for 3 days. Left eye vision was 3/60 ph same. On eye examination, anterior segment unremarkable. Fundus examination revealed subhyloid hemorrhage at macula with multiple roth spots at peripheral retina. Blood investigations result revealed leukocytosis of 200 x 10⁹ /L. Full blood picture revealed features myeloproliferative disease suggestive of chronic myeloid leukemia.

**Conclusion:**
Patient with leukaemia may present with variable ocular manifestation. Recognition of the varied ocular presentations is important in diagnosing, assessing the course and prognosis of leukaemia.

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**EP37: Ocular Tuberculosis In A Healthy Young Adult**

*Fang Sin Yee, Norshamsiah Md Din, Hazlita Mohd Isa, Wong Hon Seng*

*Department Of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur*

**Purpose:**
To report a case of ocular tuberculosis (TB) with severe retinal vasculitis as the presenting feature in a healthy young individual.

**Methods:**
Case report.

**Results:**
A 17-year-old healthy male of Indonesian parentage, presented with 1 week history of bilateral eye (OU) painless progressive blurring of vision. His visual acuity was counting fingers in the right eye (OD) and 6/36 in the left eye (OS). There were anterior chamber (AC) cells of 2+ with granulomatous keratic precipitates OU. Funduscopy revealed an infero-temporal branch retinal vein occlusion (BRVO) with a partial macular star exudation OD. Both fundi showed extensive retinal vasculitis with periphlebitis and intra-retinal hemorrhages.

Fundus fluorescein angiogram showed extensive capillary fall out and leaking new vessels. Systemic examinations were normal but a Bacillus Calmette-Guerin scar was absent. The chest X-Ray was normal but his Mantoux text was 21 mm of eryhematous induration and ESR was 97mm/hour. Other uveitis workups were normal and retroviral screening was negative. This patient was started on anti-tubercular therapy with systemic corticosteroid and bilateral panretinal photocoagulation was performed. The retinal vasculitis responded well to the treatment and the patient regained 6/6 vision in both eyes after 3 months.

**Conclusion:**
Ocular TB may be the presenting feature of tuberculous infection, especially with extensive occlusive retinal vasculitis among Asians. Being a curable disease, awareness of its presentation and high index of suspicion is paramount as prompt treatment can halt the disease progression and prevent visual loss.
EP38: Sudden Visual Loss As The Initial Presentation Of Chronic Myeloid Leukaemia
Hanisah AH, Mushiahwati Mustapha, Hazlita Mohd Isa
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

**Purpose:**
To emphasize that sudden vision loss can be the only isolated symptoms for chronic myeloid leukemia (CML) without other clinical symptoms and the importance of early initiation of treatment.

**Methods:**
Case report.

**Results:**
A healthy, 26-year-old Chinese gentleman presented with sudden onset reduced vision in the right eye associated with floaters. He claimed to be lethargic for past three weeks prior to presentation. There were no other constitutional and systemic symptoms. No significant family history of malignancy or eye problems. Examination revealed right eye best corrected visual acuity (BCVA) of 6/36 and left BCVA was 6/9. Anterior segment examinations were normal. However funduscopy revealed bilateral hyperemic optic discs swelling, dilated and tortuous retinal veins and multiple dot blot haemorrhage with Roth's spots. There was also vitreous haemorrhage in right eye. Cranial nerves and systemic examinations were normal. No organomegaly noted.

Full blood count revealed white cell count of 170 x 10^9 and full blood picture was suggestive of CML in chronic phase which was later confirmed by bone marrow aspiration and trephine. Chemotherapy was commenced immediately. 3 month later, his vision improved to 6/6 both eye with resolution of optic disc swelling, vitreous haemorrhage and retinal haemorrhages.

**Conclusion:**
Ocular manifestations can be the first presentation in CML. As illustrated by this case, early diagnosis of CML and prompt treatment prevented permanent vision loss as well as avoiding patient from going into blast crisis.

EP39: A Child With Tuberculous Meningitis With Ocular Manifestation
Christina Ng WK, Shelina Oli Mohamed, Roslin Azni Abd Aziz, Nor Fariza Ngah
Department of Ophthalmology, Hospital Selayang, Selangor

**Purpose:**
Tuberculosis meningitis although rare is the most severe form of tuberculosis infection carrying a high mortality rate. It is more common in children. We report a case of Stage II tuberculosis meningitis with multiple cranial nerve palsies and concurrent multifocal choroiditis in an immunocompetent child.

**Methods:**
Case report.

**Results:**
We describe a 12-year-old immunocompetent girl who was referred by the Paediatrician with sudden onset of horizontal diplopia and profuse vomiting for 2 days. She had fever for 2 months, night sweats and weight loss. Ocular examination revealed good visual acuity, bilateral optic disc swelling with good optic nerve function, multifocal choroiditis, and a right 6th cranial nerve palsy. Urgent contrasted computed tomography of brain was normal. The following day she had altered behavior, a drop in Glasgow Coma Scale and a right surgical 3rd cranial nerve palsy. Mantoux reading at 48 hours was 15mm.

The child was treated as tuberculous meningitis based on clinical presentation, papilloedema with 6th nerve palsy, multifocal choroiditis and a positive mantoux. Anti-tuberculous treatment was commenced immediately. Magnetic resonance imaging of brain showed multiple tuberculomas scattered throughout the brain with basal meningeal enhancement. She responded to treatment and all ocular signs resolved after 3 months. Her cognitive function improved with minimal residual impairment.

**Conclusion:**
The diagnosis of childhood tuberculous meningitis is more difficult than in adults. A high index of suspicion by the Ophthalmologist may play a vital role in aiding the Paediatrician with early diagnosis. Timely initiation of treatment is essential for better outcome and survival.
**EP40: Neurosarcoidosis In A Previously Healthy Young Man**

*Nazima Shadaht Ali, Hazlita Mohd Isa*

*Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur*

**Purpose:**

Case report.

**Results:**

A 24-year-old Malay policeman presented with 1 week history of diplopia in all gazes. It was preceded by numbness of the left lips, palate and left side of the nose with left sided tinnitus for 5 months. Patient also complained of bilateral painless testicular masses associated with erectile dysfunction for 4 months. On examination, his visual acuity was 6/9, bilaterally. He had right ptosis and a 30° right esotropia on primary gaze. RAPD was negative. His conjunctiva was white bilaterally despite having fine white keratic precipitates and anterior chamber reaction of 2+ cells. Extraocular muscles (EOM) examination revealed limitation on abduction bilaterally and limited dextro and levo-elevation and depression of right eye. Fundus examination showed sheathing and cuffing of the blood vessels inferiorly.

Systemic examination revealed multiple cranial nerve involvements and 2 solid, mobile, non-tender masses above the testes. Further radiological investigations showed cavernous sinus involvement. Blood and histopathology confirmed the diagnosis of sarcoidosis. Patient was then started on immunosuppressive medications and after 3 months treatment showed improvement in extraocular muscle functions and resolution of the uveitis completely bilaterally.

**Conclusion:**

Sarcoidosis is an granulomatous inflammatory multisystem disorder. The nervous system is involved in 5–15% of patients. Neurosarcoidosis is a serious and commonly devastating complication of sarcoidosis and may manifest with variable ocular symptoms as illustrated by this case. Prognosis is good with prompt and appropriate treatment.

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**EP41: An Elderly With Cytomegalovirus Retinitis**

*Kiu Kwong Han¹,², Hanizasurana Hashim¹, Zunaina Embong²*

¹Department of Ophthalmology, Hospital Selayang, Selangor
²Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

**Purpose:**

To report a case of cytomegalovirus retinitis in an elderly immunocompetent patient.

**Methods:**

Case report.

**Results:**

A 67-year-old lady, presented with right eye pain and blurring of vision for two weeks. Her right vision was 6/60 at presentation. On examination, she had retinitis with overlying vitreous clumps and scattered retinal hemorrhages. VDRL and HIV test were negative. She was treated as for presumed Acute Retinal Necrosis (ARN). Later Vitreous sampling for cytomegalovirus polymerase chain reaction detected with high yield. Hence, the treatment was changed to intravenous ganciclovir. Vision improved dramatically to 6/24 after completion of induction course of ganciclovir.

**Conclusion:**

CMV retinitis is rare in immunocompetent but should always be considered in an elderly presented with retinitis. In doubtful cases, the availability of polymerase chain reaction for vitreous sampling helps to confirm the diagnosis.
EP42: Blurring Of Vision As The Initial Presentation Of Chronic Myeloid Leukemia

Fang Sin Yee, Malisa Ami, Jemaima Che Hamzah
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
To report a case of chronic myeloid leukemia with blurring of vision as the initial presentation.

Methods:
Case report.

Results:
A 58-year-old gentleman presented with one month history of blurring of vision on both eyes associated with lethargic, giddiness, loss of appetite and loss of weight. Presenting Visual acuity was 6/24 N24 in the right eye and 6/18 N24 in the left eye. Fundus examination revealed dilated and tortuous retinal vasculature with engorgement of veins bilaterally. There were numerous white-centered retinal hemorrhages, intraretinal hemorrhages, yellowish white elevated retinal lesions, and segmental perivascular white infiltrates scattered throughout the fundus. Some part of the vessels showed loops of sausage like dilated veins with perivascular infiltration. Both macula were edematous.

Systemic examination revealed signs of pallor and abdominal fullness due to massive hepatosplenomegaly. Full blood count revealed a leucocytosis of 500,000/mm³, along with anemia with hemoglobin level of 8.3 gm/dL but normal platelets of 476,000/mm³. Bone marrow evaluation was consistent with chronic myeloid leukemia (CML) in chronic phase. He was treated with systemic chemotherapeutic agent. The leukemic retinopathy showed marked improvement after the systemic cytoreductive therapy.

Conclusions:
Blurring of vision caused by macula edema secondary to venous engorgement and leukemic infiltration can infrequently be the initial presentation of leukemia. The knowledge regarding leukemic retinopathy may aid early diagnosis and prompt systemic cytoreductive therapy to allow preservation of vision and improve systemic prognosis.

EP43: Central Retinal Artery Occlusion Secondary To Orbital Apex Inflammation

Jaya Vani Ettikan, Hayati Abdul Aziz, Sureshkumar Vasudevan
Department of Ophthalmology, Hospital Sultanah Aminah, Johor Bharu, Johor

Purpose:
To report a case of central retinal artery occlusion secondary to inflammation at orbital apex.

Methods:
Case report.

Results:
A 69-years old man with underlying diabetes mellitus, hypertension, past history of cerebral vascular event presented with left eye blurring of vision duration for four days. The left visual acuity was no perception to light with positive relative afferent pupillary defect and restricted eye movement and mild ptosis. Fundus examination showed cherry red spot with pale retina and narrowing of blood vessels with segmental blood flow. The right eye vision is 6/9 and the anterior and posterior segment examination was unremarkable. Blood investigation revealed raised white blood cell count and high erythrocyte sedimentation rate. The connective tissue disease and infective screening was normal.

MRI orbit showed heterogenous signal intensity within left intraconal space with thickening of left extraocular muscles and optic nerve suggesting inflammation at the orbital apex. A diagnosis of central retinal artery occlusion secondary to inflammation at orbital apex was made. The patient was treated with oral prednisolone 1mg/kg/day tapering dosage over the period of fourteen weeks. His left visual acuity remained no perception to light but the extraocular eye movement and ptosis improved.

Conclusion:
We reported a case of central retinal artery occlusion secondary to inflammation at the orbital apex whereby the ophthalmoplegia improved by steroid.
EP44: Ocular Toxoplasmosis With Occlusive Vasculitis: A Case Report
Sangeetha, Wee Min Teh, Khairul
Department of Ophthalmology, Hospital Tuanku Ampuan Najihah, Seremban, Negeri Sembilan

Purpose:
To highlight a rare case of ocular toxoplasmosis with occlusive vasculitis in an immunocompetent person.

Methods:
Case report.

Results:
A 51-year-old Indian lady presented with sudden onset blurring of vision in the left eye of 1 week duration. She had a progressively increasing pain in the left eye 1 week prior to presentation. There were no other remarkable history suggestive of any infection or trauma. On examination, visual acuity was hand movement (HM) in the left eye. Anterior segment examination revealed severe left anterior uveitis. Fundus examination of left eye showed severe vitritis with generalized arteritis and 2 retinochoroiditis lesions located inferotemporally to optic disc. Left optic disc was swollen and hyperaemic. FFA showed extensive areas of capillary non perfusion of left eye suggestive of occlusive vasculitis. There was no macular oedema or foveal atrophy on OCT. C-reactive protein and ESR were raised. Her presentation was consistent with left ocular toxoplasmosis. She was treated with oral co-trimoxazole and prednisolone. Laser panretinal photocoagulation was also done over a few sessions. Her condition has improved.

Conclusion:
Occlusive vasculitis is a rare complication of ocular toxoplasmosis. Urgent treatment may prevent potentially blinding complications.

EP45: An Angry Mimicker In Immunocompromised Patient
Lathalakshmi T<sup>1,2</sup>, Nor Azita AT<sup>1</sup>, Liza Sharmini Ahmad Tajudin<sup>2</sup>
<sup>1</sup>Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur
<sup>2</sup>Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report a rare case of bilateral severe syphilitic uveitis with neurosyphilis in immunocompromised patient.

Methods:
Case report.

Results:
A 25-years-old man presented with history of recurrent eye redness and progressive blurring of vision for 6 months. He is involved in high risk sexual activity with same gender. However his retroviral status was not known. Visual acuity was 6/18 on right eye and 6/24 on left eye. There was evidence of bilateral eye panuveitis. On fundus examination, in spite of vitritis the disc appeared hyperaemic and new vessels on discs seen. There was clinical evidence of bilateral cystoid macula edema which was confirmed by OCT. Blood investigations revealed positive for VDRL with TPHA titre of 1:512 and positive retroviral status. Lumbar puncture was conducted which revealed positive csf VDRL titre of 1:2.

He was diagnosed as neurosyphilis. He was treated with intravenous antibiotics c-penicillin 4 megaunit for 14 days and serial pan retinal photocoagulation was also done. The vitritis improved. However only the left eye showed regression of new vessels on the discs. Overall there was improvement in left eye but the right eye developed vitreous haemorrhage. Right eye trans pars plana vitrectomy with endoprocedure was planned.

Conclusion:
In immunocompromised patient, a great mimicker like syphilis may delay the diagnosis. A prompt diagnosis and accurate management is important for visual rehabilitation.
**EP46: Sympathetic Ophthalmia In Uncomplicated Cataract Surgery**

*Yong Meng Hsien, Hazlita Mohd Isa, Wong Hon Seng*

*Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur*

**Purpose:**
Sympathetic ophthalmia (SO) is a diagnosis of exclusion. In our local setting, granulomatous uveitis is frequently associated with infective causes such as tuberculosis (TB). We report a case of recurrent granulomatous panuveitis that was initially treated as presumed ocular tuberculosis. Eventual investigations supported the diagnosis of SO.

**Methods:**
Case report.

**Results:**
A 75-year-old woman presented with unilateral painful red eye with features of right eye (RE) granulomatous panuveitis. The presenting visual acuity (VA) was CF. Both eyes were pseudophakic from uncomplicated phacoemulsification surgery. Her tuberculin skin test measured 25mm and ESR >120mm/hr. She was started on anti-TB medication with oral steroid. The condition improved with best VA of 6/18. However at 3-month post-treatment, she developed another episode of RE granulomatous panuveitis with VA of HM. At that point of time, it was deemed that the recurrence may be due to non-compliance to her medication. Another course of anti-TB with oral steroid was started. Her vision again improved to 6/24. However when the oral steroid was tapered, the uveitis increased in intensity. There was diffuse chorioretinal atrophy with Dalen-Fuchs nodules in her right eye. Further electrophysiology test showed diffuse photoreceptors dysfunction. She was treated with a long course of oral steroid. Her RE VA stabilized at 6/18.

**Conclusion:**
Intraocular surgery, despite of being uncomplicated and occurred years ago, is a risk factor for development of SO. It should be a differential diagnosis even in unilateral granulomatous uveitis.

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**EP47: The Association Of Ocular Tuberculosis With Eales Disease**

*Aini Mohd Azmi, Akmal Haliza Zamli, Mohd Aziz Husni*

*Department of Ophthalmology, Hospital Tengku Ampuan Afzan, Kuantan, Pahang*

**Purpose:**
To report a case of Eales disease in a patient with ocular tuberculosis (TB).

**Methods:**
Case report.

**Results:**
A 40-year-old Indonesian man with no previous medical or ocular history. Presented with two months history of progressive blurring of vision on the right eye (RE), significantly worsened in one day. Vision upon presentation was counting finger RE and left eye (LE) 6/24 pinhole 6/12. Anterior segment and posterior segment examination revealed presence of both eye panuveitis with no fundus view RE. Investigation revealed a positive Mantoux test result of 22mm and elevated erythrocyte sedimentation rate of 113mm/hour. Subsequent fundus fluorescein angiography over LE showed presence of peripheral vasculitis with capillary fallout. He was therefore treated as ocular TB and started on anti-TB. He subsequently underwent RE vitrectomy and endolaser. Intraoperative findings was consistent with Eales disease with presence of vitreous haemorrhage, dot and flame shaped haemorrhage likely old branch retinal vein occlusion secondary to vasculitis infection and neovascularisation. His best corrected visual acuity at five months post anti TB and vitrectomy were 6/9, 6/6 on RE and LE respectively with resolution of retinal neovascularisation.

**Conclusion:**
Although the exact etiology of Eales disease is unknown, this condition is considered to be a consequence of hypersensitivity reaction to tubercular protein due to previous Mycobacterium tuberculosis infection. It is therefore important to look for features of Eales disease in patient treated for ocular TB and also to rule out TB when a diagnosis of Eales disease is suspected.
EP48: Do Not Miss Out Retinal Vascular Occlusion In Systemic Lupus Erythematous Patient
Chang Hui Xin, Tan Ee Ling
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a rare case of bilateral retinal vascular occlusion in a young male patient with underlying SLE.

Methods:
Case report.

Results:
A 28-year-old man, with underlying SLE, presented with acute onset of left eye painless blurring of vision for 3 months. He has poor right eye vision for months prior to onset of left eye symptoms. On presentation, his right eye visual acuity was only perception to light, and left eye was 5/60 ph 6/36. There was a marked relative afferent pupillary defect over the right eye. Fundus examination of the right eye showed generalized pale retina, sclerosed retinal vessels and pale optic disc. Left eye fundus revealed generalized retinal hemorrhage, tortuous retinal vessels with neovascularization, hyperemic optic disc and macular edema. Fundus fluorescence angiography revealed delayed perfusion in right eye, and extensive capillary fall out area at the temporal arcades in left eye. Patient was diagnosed with right eye old central retinal artery occlusion and left eye central retinal vein occlusion. In view of his medical condition, intravitreal ranibizumab was deferred. Left eye Pan-retinal Photocoagulation was commenced. His left eye condition improved with regression of neovascularization and macular edema. There was no progression into rubeotic glaucoma.

Conclusion:
SLE is rarely presented in young male adults. Retinal vascular occlusion in SLE might be least predicted but can progress in an aggressive pace. Importance of regular eye assessment in SLE should never be overlooked.

Ep49: Ocular Manifestations Of Leptospirosis
Anhar Hafiz Silim, Raja Norliza Raja Omar, Nor Fadzillah Abd Jali
Department of Ophthalmology, Hospital Melaka, Melaka

Purpose:
To report two cases of ocular manifestations of leptospirosis.

Methods:
Case series.

Results:
The first case is an 18-year-old teenager presented with left eye redness for three-month duration. She has history of recent admission to hospital and was treated for Acute Bacterial Meningitis with Leptospirosis. Ocular examination of the left eye showed diffuse conjunctival congestion with multiple nodules. The cornea was clear with mild anterior chamber cell. The intraocular pressure and posterior segment examinations were normal. Conjunctiva biopsy revealed granulomatous inflammation with no evidence of malignancy, tuberculosis or fungal infection. The conjunctival tissue Polymerase Chain Reaction test for leptospira was positive. The second case is a 13-year-old boy presented with sudden onset of left eye inward deviation for one week. He also occasionally saw double images. The symptoms were preceded by fever but there were no other neurological symptoms. Visual acuity in both eyes was 6/6. The left abduction was restricted and bilateral optic disc were swollen. He was later diagnosed with aseptic meningitis secondary to leptospirosis and was managed by neuromedical team. With treatment, his condition dramatically improved.

Conclusion:
Leptospirosis is a zoonotic disease caused by spirochete Leptospira. Although it is one of the world’s most widespread febrile diseases, it remains underdiagnosed. Ocular manifestations can occur in the early phase of illness but they are normally noted in the second phase. These remain latent mainly because of the prolonged symptom-free period that separates the systemic manifestations from detection of ocular manifestations.
NEUROOPHTHALMOLOGY

EP50: Sphenoid Wing Meningioma
Tiong Kiew Ing¹ ², Mohamad Aziz Salowi¹, Intan Gudom¹
¹Department of Ophthalmology, Hospital Umum Sarawak, Kuching, Sarawak
²Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
Meningiomas are the second most common brain tumours. Our aim is to report a case of sphenoid wing meningioma who presented with severe proptosis and total vision loss.

Methods:
Case report.

Results:
We described a middle age female presented with right eye progressive painless blurring of vision for 6 months duration associated with swelling and redness for past 1 month. She had underlying meningioma with operation performed 10 years ago. However, she defaulted follow up. Right eye vision was no perception to light with positive relative afferent papillary defect. There were ophthalmoplegia, severe proptosis, chemosis and lagophthalmos. Intraocular pressure was 26 mmHg. Fundus showed pale optic disc with choroidal fold. Left eye examination was normal. Computed tomography of the brain and orbit revealed right sphenoid wing meningioma. She underwent craniotomy and tumour excision by neurosurgical and ENT team. Post procedure, proptosis improved and IOP became normal.

Conclusion:
Sphenoid wing meningiomas are the most common basal meningiomas. They may extend into the orbit through bone, the superior orbital fissure or the cavernous sinus. Thus, most of them will present with ocular symptoms. Meningiomas generally have a good prognosis. Thorough history taking, physical examination and investigations are mandatory in order not to miss this treatable disease.

EP51: Wall-Eyed Bilateral Internuclear Ophthalmoplegia Secondary To Multifocal Pontine Infarction
CP Siuw, Hayati Abdul Aziz, SK Vasudevan
Department of Ophthalmology, Hospital Sultanah Aminah, Johor Bharu, Johor

Purpose:
To report a rare case of WEBINO syndrome.

Methods:
Case report.

Results:
A 58-year-old gentleman with underlying of diabetes mellitus, hypertension and dyslipidemia presented with diplopia for 2 days duration. It was associated with lips and anterior tongue numbness, vomiting and giddiness. Ocular examination revealed bilateral exotropia in primary gaze and adduction deficit in both eyes. There was nystagmus in the contralateral eye while attempting adduction in both eyes. The convergence was absent. The vertical gazes were also limited with vertical gaze-evoked nystagmus. Fundoscopy showed normal optic disc and retina. Other systemic neurological examinations were normal. Magnetic resonance imaging of the brain and orbits showed multifocal infarction in the pons and medulla oblongata. Right vertebral artery signal was absent in angiography. The patient was diagnosed as wall-eyed bilateral internuclear ophthalmoplegia secondary to multifocal pontine infarction. He was treated as ischemic stroke and anticoagulant was started.

Conclusion:
WEBINO is a rare syndrome. We report a case of WEBINO due to multifocal pontine infarction.
EP52: Orbital Apex Syndrome Caused By Tuberculous Meningitis
Chong Soh Yee, Ch'ng Tun Wang, Chong Mei Fong
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
Orbital apex syndrome is a syndrome involving of the optic nerve in addition to some or all of the cranial nerves within the carvenous sinus or superior orbital fissure. We here to describe a case of orbital apex syndrome caused by tuberculous meningitis.

Methods:
Case report.

Results:
A 31-year-old lady presented with right sided headache for 3 months, associated with right eye blurring of vision and right eye ptosis for 2 weeks. On examination, visual acuities were 5/60 over right eye and 6/9 over left eye. There was right eye complete ptosis, fixed and dilated pupil with total ophthalmoplegia. Right pterional craniotomy and biopsy was performed and showed caseating granulomatous inflammation. The magnetic resonance imaging orbits revealed presence of thickened lobulated markedly enhancing leptomeninges over right temporal region extending to right orbital fissure and right optic canal and also into the apex of right orbit. As such, patient was treated as tuberculous meningitis and she was started on anti-tuberculous treatment. With the treatment, there was full recovery of extraocular movement after 5 months.

Conclusion:
Orbital apex syndromes can be caused by inflammatory, infectious, neoplastic, traumatic or vascular causes. The investigations including pterional craniotomy and biopsy, neuroimaging such as computerized tomography scan and magnetic resonance imaging are important to rule out the underlying causes. The treatment of the orbital apex syndrome is based on the underlying cause and combined management with other specialities is necessary.

EP53: Right Superior Oblique Myokymia
Lim I-Liang, Alice Gan KC, Nor Fadzillah Abd Jalil, Raja Norliza Raja Omar
Department of Ophthalmology, Hospital Melaka, Melaka

Purpose:
To report on a rare case of right superior oblique myokymia with an abnormal complaint of binocular diplopia. A well-documented Hess test captured this rare episode, which maybe a useful reference.

Methods:
Case report.

Results:
A 44-year-old Chinese gentleman complained of sudden intermittent binocular double vision for two days. It occurs multiple times unpredictably on a daily basis which lasted around one minute each episode. On orthoptic assessment, the cover test for distance showed a right hypertropia, and the prism cover test revealed a 16△ right over left which was evidenced by Hess test. The rest of ocular and physical examination were unremarkable. The imaging and blood investigations were also unremarkable. He was treated conservatively via observation and the symptoms resolved after two weeks. The subsequent Hess test was normal.

Conclusion:
Superior oblique myokymia is an unusual disorder of ocular motility characterized by rapid, small amplitude, rotary oscillations limited to one eye. The etiology is unknown. Dynamic viewing is the best way to recognize these movements. Even with attentive investigation, it can be difficult at best to identify some cases other than with a good case history. For patients who notice symptoms but yet can function adequately, simple observation and reassurance for the patient may be all that is required. Other form of treatment includes pharmacological therapy and extraocular muscle surgery.
EP54: Atypical Presentation Of Idiopathic Bilateral Optic Perineuritis In Young Patient
Khai-Siang Chai, Jessica MPT, Wan Hazabbah Wan Hitam, Shatriah Ismail
Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report a case of atypical presentation of idiopathic bilateral optic perineuritis in a young patient.

Methods:
Case report

Results:
A previously healthy 27-year-old Malay male presented with sudden onset of right eye blurring of vision associated with headache and vomiting for one week. Patient had reduced vision bilaterally more on the right compared to the left. There was relative afferent pupillary defect (RAPD) present in the right eye and reduced optic nerve function in the affected eye. Patient also had bilateral generalised optic disc swelling, splinter haemorrhages and tortuous vessels. Initial diagnosis was more towards a space occupying lesion with raised intracranial pressure or optic nerve sheath meningioma. With the help of magnetic resonant imaging (MRI) typical features of bilateral optic perineuritis (OPN) was seen and the diagnosis of Idiopathic Bilateral OPN was made in the presence of negative connective tissue and infective screening. Patient was treated with high dose corticosteroids and oral steroids to which he responded well with full recovery of his vision and optic nerve function.

Conclusion:
Bilateral Idiopathic OPN is a very rare entity in a young patient. Diagnosis is made based on MRI findings. One should suspect bilateral OPN in an atypical presentation as seen in our case, where the MRI findings are more beneficial than that of the computed tomography scan. Their presentations can vary and clinicians should have a high index of suspicion as these patients need prolonged treatment with steroid for better visual outcome and prevention of relapses.

EP55: Suprasellar Arachnoid Cyst: A Rare Cause Of Visual Impairment
K Sarojini, S Stella, F Jane, Zabri Kamaruddin
Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To report a case of bitemporal hemianopia due to optic nerve compression by suprasellar arachnoid cyst.

Methods:
Case report.

Results:
A 66-year-old lady with underlying hypertension, presented with gradual visual field defect bilaterally for 2 months. Otherwise, there were no symptoms of increased intracranial pressure and neurological deficit. Visual acuity was RE 3/60 PH 6/36, LE Counting fingers 3 feet. On examination, there was no relative afferent pupillary defect. Bilateral anterior and posterior segments were normal. Confrontation and subsequent Bjerrum examination confirmed bitemporal hemianopia. Systemic examination was unremarkable. CT Brain and MRI brain revealed a suprasellar cyst measuring 2.4 x 1.8 x 3.0 cm extending to the suprasellar region which compressed the optic chiasm superiorly and pituitary gland inferiorly. On MRA, there was a wide neck saccular aneurysm at the supraclinoid part of the left intracranial internal carotid artery. Therefore, this patient was referred to neurosurgical team and urgent right supraorbital craniotomy and excision of cyst was done due to compressive optic neuropathy.

Conclusion:
Suprasellar cyst may present with ocular complaints without any other neurological signs or symptoms. A high index of suspicion is crucial in establishing early diagnosis for prompt treatment.
EP56: Optic Disc Swelling – A Diagnostic Dilemma
Aini Zahidah, Tikambari E, Wong Chi Lun
Department of Ophthalmology, Hospital Kulim, Kedah

Purpose:
To report 3 cases of optic disc swelling from various causes - 1 case of bilateral eye involvement and 2 cases of unilateral.

Methods:
Case series.

Results:
First patient was a 58-year-old gentleman with uncontrolled type 2 diabetes mellitus, presented with right eye painless blurring of vision for 4 months. Vision was 6/18. Right eye fundus showed hyperemic optic disc swelling, with scattered hemorrhages at periphery and normal macula. Blood investigations for infectious screening, CT brain and lumbar puncture were all normal. Diagnosis of diabetic papillopathy was made.

Second patient was a 41-year-old lady with primary glomerulonephropathy admitted for hypertensive urgency, presented with bilateral eye painless blurring of vision. Vision was counting finger on right eye, and 5/60 on left eye. Both fundi showed optic disc swelling with dilated capillaries, extensive macula edema and generalized exudates. Blood investigations and neuroimaging again were normal except for sky-rocketting blood pressure in ward which was inadequately controlled despite maximal medical therapy. She was diagnosed with grade 4 hypertensive retinopathy.

Last patient was a 51-year-old lady who came for cataract screening, but incidentally noted right optic disc hyperemia with blurred disc margin but absence of vascular changes. Her vision was 6/60 in the right eye. When blood investigations were normal, CT scan and MRI findings on contrary were consistent with right optic nerve meningioma.

Conclusion:
Optic disc swelling is a pathological condition with myriad causes. Diagnosing optic disc swelling remains challenging and requires many different pieces of evidence through thorough history, complete systemic examination and ancillary testing.

EP57: Atypical Presentation Of Optic Neuritis
Ng Wei Loon, Othmaliza Othman, Jemaima Che Hamzah, Hazlita Mohd Isa
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
We aim to report an atypical visual field presentation of optic neuritis in a young adult with associated medical problems.

Methods:
Case report.

Results:
A young gentleman presented with sudden progressive unilateral visual loss for one week. Ocular examination revealed right visual acuity of 6/12 with optic nerve dysfunction. The right optic disc was hyperaemic with blurred disc margin. Visual field test detected an Inferior altitudinal field defect in the right eye. The left eye was unremarkable. Further systemic examinations and blood investigations showed him to have young hypertension and hypercholesterolemia. Based on the ocular and systemic findings, a diagnosis of non-arteritic anterior ischaemic optic neuropathy (NAION) was made.

Unfortunately his vision continued to worsen despite optimal control of his medical condition. The diagnosis was then revised to optic neuritis (ON) and high dose corticosteroid was commenced. He subsequently showed good response to steroid where vision as well as optic nerve function returned to normal.

Conclusion:
Inferior altitudinal field defect are typically seen in NAION particularly with concurrent medical diseases and rarely presents in optic neuritis. This case also highlights the importance of close monitoring of disease progress to ensure proper diagnosis and intervention is made.
EP58: Fixed Dilated Pupil After Cataract Surgery
Teo Bin Hoo, Francesca Martina Vendargon, Yanti Muslikhan
Department of Ophthalmology, Hospital Sultanah Nora Ismail, Batu Pahat, Johor

Purpose:
Urrets-Zavalia syndrome was first established following penetrating keratoplasty for keratoconus in 1963. Besides, this fixed dilated pupil condition was subsequently proposed in other intraocular surgery e.g. lamellar keratoplasty, trabeculectomy and argon laser peripheral iridoplasty. We would like to report a case of left eye fixed dilated pupil following uneventful cataract extraction and posterior chamber intra-ocular lens (IOL) implantation which was done under local anaesthesia.

Methods:
Case report.

Results:
A 63-year-old man with underlying hypertension had undergone left eye phacoemulsification and posterior chamber IOL implantation under local anesthesia. No mydriatic eye-drops were instilled after the surgery. Topical anti-inflammatory and antibiotic were given. One week post-operatively, left eye pupil became fixed and dilated despite reducing inflammation and normal-range intra-ocular pressure (IOP). He was then monitored closely. The fixed dilated pupil started to constrict after eight weeks and returned to natural state at week 16.

Conclusion:
Multiple theories have been proposed for Urrets-Zavalia syndrome, but the exact aetiology is not known. Urrets-Zavalia syndrome can develop even in uneventful cataract surgery.

EP59: Never Too Severe, Never Too Late
Lim Thiam Hou, Alisa Victoria Koh
Department of Ophthalmology, Hospital Miri, Sarawak

Purpose:
Traumatic optic neuropathy occurred following ocular, orbital or head trauma as a sudden visual loss which could not be explained by other ocular pathology. We aim to report a case of indirect traumatic optic neuropathy with substantial vision improvement despite initial non perception of light, after a high dose steroid treatment initiated even beyond the golden hour.

Methods:
Case report.

Results:
A 54-year-old lady sustained loss of vision to non-perception of light after her right eye was hit by a fist-sized stone. There was traumatic hyphema with high intraocular pressure noted on the affected eye. Radiological investigations revealed no significant findings. The patient’s intraocular pressure normalised with medications. High dose systemic steroid was started 48 hours post injury and the patient responded markedly to the therapy with improved vision to 6/36 PH 6/18.

Conclusion:
High-dose corticosteroid treatment in this case of indirect traumatic optic neuropathy showed marked benefit despite initial severe loss of vision. Patients should be offered this treatment option versus conservative management in the absence of medical contraindication for high dose steroid therapy.
EP60: Bilateral Horizontal Gaze Palsy In Multiple Sclerosis
Logesvaran A/L Murugan, Tai PY, Fazilawati Qamaruddin
Department of Ophthalmology, Hospital Tengku Ampuan Rahimah, Klang, Selangor

Purpose:
To report a rare case of bilateral horizontal gaze palsy secondary to bilateral paramedian pontine reticular formation (PPRF) lesion in a patient with multiple sclerosis.

Methods:
Case report.

Results:
A 30-year-old Malay lady presented with diplopia for 2 weeks. There was no blurring of vision, no trauma and no symptoms of increased intracranial pressure. She had a history of left eye optic neuritis in 2013 that resolved with steroid therapy. On examination, visual acuity was 6/6 bilaterally and there was no relative afferent pupillary defect. Both eye anterior segments and posterior segments were normal. The extraocular movement was normal for vertical gaze but restricted in horizontal gaze in both eyes. The weakness of adduction is more than the abduction in both eyes. There was also presence of gaze-evoked horizontal nystagmus on attempted abduction of each eye. Otherwise, no other neurological deficit noted. T2-weighted images and flair of magnetic resonance imaging showed multiple hyperintense lesions at periventricular region, juxtacortical white matter of right frontal and temporal lobes, corpus callosum and left cerebral peduncle that was consistent with multiple sclerosis.

Conclusion:
Multiple sclerosis is a demyelinating disease that can have variety of neurological manifestations. Complete lesion of bilateral pprf usually produces horizontal palsy and slow vertical saccade. This patient has a normal vertical saccade and weak horizontal gaze with nystagmus of abducting eye most probably due to partial involvement of PPRF.

EP61: No Second Chance
Koh YN, Thilakavathy T, Chong Mei Fong
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a case of right posterior communicating artery aneurysm with ocular presentation at eye clinic.

Methods:
Case report.

Results:
A 75-year-old Malay lady with underlying DM and Hypertension, presented with drooping of right upper lid associated with painless progressive visual impairment for 2 months duration and intermittent occipital headache for a month. She had history of mild right-sided limbs weakness before. Ocular examination revealed right complete ptosis with restriction in upward, downward and medial gaze. Right pupil was 5mm in size and non reactive to light. An Urgent CT scan brain showed a mild hyperdense area in right posterior communicating artery suggestive of resolving haemorrhage with a vague aneurysm, measured about 10X10mm in size. CT Angiography confirmed the diagnosis of right posterior communicating artery aneurysm. The presence of teat sign without evidence of other intracranial haemorrhage implying the possibility of impending rupture of the aneurysm. However the patient insisted on traditional treatment instead of an urgent neurosurgical intervention despite counselling. When the patient finally changed her mind after few weeks, an earliest next available date of operation was given. Unfortunately patient collapsed and passed away while waiting for the operation at home.

Conclusion:
Patients with surgical third nerve palsy necessitates an urgent neurosurgical attention would be referred to eye clinic instead due to their ocular presentation. Prompt diagnosis and intervention should be done to these “walking time bomb” to prevent a devastating outcome.
EP62: Bilateral Optic Neuritis In Pregnancy  
Fang Sin Yee, Norshamsiah Md Din  
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

**Purpose:**  
To report a case of bilateral optic neuritis in pregnancy.

**Methods:**  
Case report.

**Results:**  
A 42-year-old gravida 5 para 4 woman at 31 weeks gestation with no prior history of medical illness, autoimmune disease, or recent viral infection presented with rapidly deteriorating left eye (OS) visual acuity (VA) to perception of light over 7 days followed by deteriorating right eye (OD) VA to 6/36 over 2 days. It was associated with pain on eye movement. She has had one episode of similar episode OS 2 years ago, visual acuity OS improved following treatment with systemic corticosteroid. Fundus examination revealed palish optic disc OS and hyperaemic and swollen optic disc with blurred disc margin inferiorly OD. Humphrey 24-2 visual field showed diffuse central scotoma OS and inferior arcuate defect OD. Visual evoked potential was normal. Preeclampsia workout and blood investigations were all normal except erythrocyte sedimentation rate of 60mm/hour. She was immediately started on intravenous Methylprednisolone 250 mg QID for 3 days followed by oral prednisolone 1mg/kg body weight for 11 days and slowly tapering off. VA improved to 6/36 OS and 6/6 OD.

**Conclusions:**  
Bilateral optic neuritis can occur during pregnancy although third trimester is considered to be protective against multiple sclerosis attack. Treatment with steroids is generally safe and efficacious in pregnancy as for management for optic neuritis in non-pregnant ladies.

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Tan Chew Yong, Shelina Oli Mohamed  
Department of Ophthalmology, Hospital Selayang, Selangor

**Purpose:**  
To report a case of seronegative neuromyelitis optica with tremendous visual recovery despite a delay in treatment.

**Methods:**  
Case report.

**Results:**  
We describe a case of a 10-year-old Malay girl who presented with reduced vision in both eyes due to bilateral optic neuritis who subsequently developed myelitis during her admission. Her vision at presentation was hand movement in the right eye and light perception in the left eye. She was diagnosed as NMO based on the 2006 revised diagnostic criteria by Wingerchuck. However, her NMO-IgG was negative.

She was treated with intravenous methylprednisolone pulse therapy 1 week after presentation, followed by a combination of oral prednisolone and oral azathioprine. The delay in treatment was due to a suspected systemic infection in view of spiking temperature but septic workout was negative. With treatment, the patient showed significant vision improvement to 6/9 in both eyes.

**Conclusion:**  
In this case, seronegative NMO is being illustrated in a young patient with good outcome despite a delay in the treatment.
EP64: Bitemporal Hemianopia In A Young Lady: What Can It Be?
Ainal Adlin N, Safinaz MK, Bastion MLC, Jemaima Che Hamzah, Othmaliza Othman
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
To report a case of multiple sclerosis with bitemporal hemianopia.

Methods:
Case report.

Results:
A 17-year-old female student presented with both eyes blurred vision and visual field defect for 1 month duration. Visual acuity for OD was 6/24 and OS was 6/60. There was no relative afferent pupillary defect and fundoscopy was normal. Visual field examination showed bitemporal hemianopia. Neurological examinations were unremarkable. MRI revealed small focal enhancing lesion within the optic chiasm, with no pre-and post chiasm involvement. There were multiple hyperintense foci lesion found in periventricular, pericallosal and juxtacortical region, as well as within the cerebrum, cerebellum and brainstem. Diagnosis of multiple sclerosis was made after fulfillment of McDonald criteria. High dose intravenous corticosteroid therapy was commenced and there was significant improvement of visual acuity and visual field defect post treatment.

Conclusion:
Although rare, chiasmal multiple sclerosis is one of the diagnoses that we should entertain in a young patient presented with bitemporal hemianopia.

EP65: Menorrhagia: Could It Bleed Until Blind?
Koh KL, Chong Mei Fong
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report on a rare case of unilateral anterior ischaemic optic neuropathy (AION) solely caused by severe anemia secondary to menorrhagia.

Methods:
Case report.

Results:
A 20-year-old lady with an episode of severe menorrhagia developed syncope and hypotension with blood pressure of 83/42 mmHg. She had sudden onset of right eye visual impairment. Her vision deteriorated to 6/60 especially in the superior field with presence of relative afferent pupillary defect. Funduscopy examination revealed right pale swollen optic disc with venous tortuosity and cotton-wool spots in both eyes. Humphrey perimetry confirmed the right superior altitudinal visual field defect. Her hemoglobin level dropped to 3.6 g/dL. Full blood picture and haemoglobin electrophoresis confirmed the iron deficiency anemia. Coagulation profile and connective tissue screening were normal. She was diagnosed to have dysfunctional uterine bleeding for which hormonal therapy and tranexemic acid were started.

Despite understanding the risk of AION in the fellow eye she refused blood transfusion for religion reason. Her anemic condition was corrected gradually to 10.5g/dL with hematasics supplement. Unfortunately the right superior visual field defect persisted with inferior sectoral optic atrophy although the anemic retinopathy resolved completely.

Conclusion:
AION may occur in iron deficiency anemia solely due to menorrhagia with no systemic comorbid. Risk factors that predispose to developing AION in severe anemia include associated hypotension which reduces perfusion pressure to the posterior ciliary artery, resulting in hypoxia of prelaminar optic nerve; and anatomically small and crowded optic disc.
EP66: Big Onodi Air Cell Causes Optic Neuropathy
Wendy See Yen Nee, Neoh YL, Ruqqayah Ahmadshah, S.Kala
Department of Ophthalmology, Hospital Umum Sarawak, Kuching, Sarawak

Purpose:
To report a case of compressive optic neuropathy secondary to enlarged onodi air cells.

Methods:
Case report.

Results:
A middle-aged gentleman presented to the eye clinic with complaints of left eye sudden painless dropped of vision upon waking up. He claimed that it was preceded by history of low grade fever two weeks ago. Visual acuity was counting finger in the left eye with a positive relative afferent pupillary defect (RAPD) and red desaturation. Dilated fundus examination was normal except a pale optic disc.

A diagnosis of left optic neuropathy was made. He underwent computed tomography (CT) of orbit and brain. The imaging reported that a big left sphenoid sinus impinged on the left optic canal. The left sphenoid air cells was big with onodi-cell-like projection on left superior margin of left optic canal. Both the optic nerves and chiasm were normal on the CT. He was referred to the ENT team and subsequently underwent left optic nerve decompression.

Conclusion:
There are many causes of optic neuropathy. Compressive optic neuropathy occurring due to pneumotized sphenoid sinus with enlarged onodi air cells is unusual. Prompt diagnosis, early referral with co-management and surgical intervention by the ENT team is vital to prevent permanent damage to the adjacent optic nerve.

EP67: Empty Sella Syndrome; Is It Pseudotumor Cerebri?
Syaridatul Hikmah Kamarudin, Nor Fadhilah Mohamad, Azida Juana Wan Abd Kadir
Department of Ophthalmology, Pusat Perubatan Universiti Malaya, Kuala Lumpur

Purpose:
To describe a case with incidental finding of empty sella syndrome with rare presentation of unilateral optic nerve swelling.

Methods:
Case report and literature review.

Results:
This patient, 47-year-old woman, 1st presented to neuro-medical clinic with chronic headache on left side without symptoms of raised intracranial pressure, aura or visual disturbance. She is recently diagnosed with hypertension, not diabetic. She also had history of spinal surgery for prolapsed intervertebral disc many years ago. CT scan shows no abnormal findings. Months later she came to us with unresolved headache.

She is plump, clinically has no neurological deficit, vision was 6/9 on both eyes, no RAPD. There is unilateral disc swelling, absent of venous pulsation on both eyes. MR imaging shows an empty sella turcica but no hydrocehalus or space-occupying lesion. MRV investigation also found normal venous sinuses. Further history revealed recent menstrual disturbance. Laboratory findings of pituitary status are unremarkable. Lumbar puncture was suggested to her but patient was not keen.

Conclusion:
Empty sella refers to radiological appearance of an enlarged sella turcica; filled with cerebrospinal fluid, thus pituitary gland appears flattened. Primary empty sella syndrome is not precipitated by surgery, trauma or radiation. It commonly affects obese women with idiopathic intracranial hypertension (IIH). IIH is commonly presented with headache and rarely with very asymmetrical optic nerve swelling which this patient has, plus being hypertensive. Unfortunately, definite diagnosis of IIH cannot be made without a lumbar puncture to determine the opening pressure. She is on azetolamide for medical therapy.
EP68: Bilateral Atypical Optic Neuritis Secondary To Herpes Zoster Infection
New Sze Hui, Hayati Abdul Aziz, SK Vasudean
Ophthalmology Department, Hospital Sultanah Aminah, Johor Bharu, Johor

Purpose:
To report a rare case of bilateral atypical optic neuritis secondary to Herpes Zoster in a 78-year-old lady.

Methods:
Case report.

Results:
A 78-year-old lady presented with sudden reduced vision of the right eye for 5 days duration, which was followed by left eye sudden reduced vision 5 days later. Patient has underlying hypertension and trigeminal neuralgia with previous history of herpes zoster infection. The right eye vision was ‘counting finger’ while the left eye vision was 2/60 (Snellen). Relative afferent pupillary defect was positive in the right eye. There was presence of moderate cataract in both eyes. Fundus examination revealed a swollen optic disc in the right eye and hyperemic disc in the left eye. Erythrocyte sedimentation rate, connective tissue disease, infective screening and Serum for aquaporin 4 were negative. Magnetic resonance imaging revealed enhancement of bilateral optic nerve with optic chiasm involvement.

A diagnosis of bilateral atypical optic neuritis secondary to herpes zoster infection was made. Patient was started on intravenous methylprednisolone sodium succinate which was followed by oral prednisolone tapering dose. Despite treatment, right eye vision progressed to ‘no perception of light’ meanwhile left eye vision improved to 6/60.

Conclusion:
This is a case of atypical optic neuritis presenting in an uncommon age group which showed poor response to steroid. Herpes zoster infection as a cause of atypical optic neuritis has to be considered.

Dharshini B, Madhusudhan Paramananda, Sheena Mary Alexander
Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
To report a case mimicking a medical 3rd nerve palsy.

Methods:
Case report.

Reports:
We present a 40-year-old Malay lady with a subacute onset of diplopia and ptosis over the right eye which was progressively worsening over a course of 1 month. She was a known case of diabetes and hypertension and there was no history suggestive of a space occupying lesion. Examination revealed exotropia and ptosis of the right eye with defects in extraocular movement. The pupil was not involved and other cranial nerve examinations were unremarkable. She was diagnosed with vasculopathic (medical) third nerve palsy. 2 months later during a routine review, there was significant improvement in extraocular movements and ptosis, but to our surprise the pupil was mid- dilated and non reactive. On close examination, there were subtle evidence demonstrating aberrant regeneration of the oculomotor nerve. An urgent MRI of the brain revealed a large lobulated midline sella lesion involving the cavernous sinus with local compression of the optic chiasm. A differential of chondroma, chondrosarcoma or metastasis was made. She was subsequently placed under the expert care of the neurosurgical unit.

Conclusion:
It is evident that surgical third nerve palsies may not always present with the typical history and pupillary involvement as commonly described. Therefore, clinicians should be more vigilant in approaching these patients, without dismissing the possibility of a surgical third nerve palsy as overlooking this may prove detrimental.
EP70: Recurrent Optic Neuritis: Dilemma in Management

Thilakavathy T, Tan Ee Ling
Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a case of recurrent optic neuritis.

Methods:
Case report.

Results:
A 24-year-old female presented with 2 days history of progressive left eye blurring of vision with pain on eye movement. She had recurrent bilateral optic neuritis since 2014 with 4 episodes in right eye, with presenting vision worse than 6/60. She responded well to corticosteroid at each attack and vision improved, except during the last episode of recurrence, she never seek medical treatment, rendered her right eye vision 1/60. In 2015, she first presented with similar symptoms in left eye with vision 6/24 and she responded to corticosteroid. At presentation, she had reduced contrast sensitivity over left eye with vision of 6/9. Right eye vision was 1/60 with presence of relative afferent pupillary defect and impaired optic nerve function. Both eye anterior segments were normal. There was right optic atrophy. Left fundus was normal. Visual field test showed central scotoma in left eye. Magnetic Resonance Imaging (MRI) of brain was normal with no evidence of multiple sclerosis or optic perineuritis. Anti-Aquaporin 4, infective and connective tissue screening were negative. In view of recurrence and poor visual acuity in fellow eye with multiple attacks, she was given longer duration of corticosteroid. Her left eye recovered with improved optic nerve function. She is currently followed up closely due to the multiple episodes of optic neuritis.

Conclusion:
Recurrent optic neuritis is always a challenge to treat. Prompt investigations are needed to rule out underlying causes. Recurrent cases should be closely monitored and may need longer duration of corticosteroid treatment.


Tan CK, Praveen Selvarajah, Wan Hazabbah Wan Hitam
Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report a case of optic neuritis exacerbation in pregnancy.

Methods:
Case report.

Results:
A 25-year-old Malay lady presented with progressive blurring of vision in the right eye for 4 days. It was associated with pain on eye movement. She delivered her second child 4 weeks ago. Patient had history of bilateral recurrent optic neuritis since 2002. She had 3 episodes of optic neuritis from 2002 to 2006. Patient remained asymptomatic for 6 years. In 2012, during her first pregnancy, she developed 3 episodes of optic neuritis. The first 2 attacks were 2 months apart and the third was 6 months later, in post-partum period. This is the third episode of optic neuritis in the current pregnancy, the first being at 17 weeks of gestation involving the right eye, and the second at 25 weeks gestation involving the left eye.

She responded well to corticosteroid treatment. Overall, a total of 6 episodes were in the left eye and 2 episodes in the right eye. One episode was bilateral. Her visual acuity was impaired in both eyes. The optic nerve functions were also markedly reduced in both eyes with no relative afferent pupillary defect. Both anterior segments were unremarkable. Fundoscopy revealed bilateral pale discs. Magnetic Resonance Imaging brain was normal with no evidence of multiple sclerosis. Lumbar puncture showed no oligoclonal bands in the cerebrospinal fluid. Anti-Aquaporine 4, infective and connective tissue screening were negative. Patient was treated with corticosteroid regime according to the Optic Nerve Treatment Trial. She responded well and the optic nerve functions improved.

Conclusion:
Exacerbation of optic neuritis in pregnancy is a rare condition. Close monitoring and early diagnosis enabled us to treat early and prevent further progression of the disease.
EP72: Optic Neuritis Occurring After Intensive Phase Of Anti-Tuberculosis Treatment  
Nazihatul Fikriah Abd Halim, Wan Hazabbah Wan Hitam  
Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:  
To report a case of Optic Neuritis secondary to tuberculosis which developed in a pulmonary tuberculosis patient who was already on treatment.

Methods:  
Case report.

Results:  
A 63-year-old lady who was diagnosed as pulmonary tuberculosis (sputum AFB positive) was 4 months into treatment when she presented with painless blurring of vision on both eyes of 4 days duration. The visual acuity reduced more markedly on her left eye. She also had scotoma involving upper part of her left visual field. On admission, patient had positive relative afferent pupillary defect over her left eye and fundus examination showed bilateral optic nerve swelling which was worse on the left. Both anterior segments were normal. An urgent CT scan showed no evidence of space occupying lesion and MRI examination was normal.

She was started on intravenous methylprednisolon 250mg QID for 5 days and anti-tuberculosis (TB) treatment was continued. She was discharge with oral prednesolone of 1 mg per kg daily on tapering dose over 8 weeks. Her optic nerve functions improved markedly since the third day of intravenous methylprednisolon and bilateral optic disc swelling reduced. Her anti TB treatment will be continued for a year.

Conclusion:  
Optic neuritis occuring in a patient who was already half way into treatment of anti-tuberculosis is not common. It is important to differentiate between anti-tuberculosis drug induces optic neuritis and optic neuritis as a manifestation of extra-pulmonary tuberculosis as the treatment is different. Prompt treatment should be given to minimise damage and restore optic nerve function.

EP73: Ocular Bartonellosis Mimicking Optic Neuritis In Early Presentation  
Noorlaila B, Zunaina Embong, Wan Hazabbah Wan Hitam  
Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:  
To report an early presentation of ocular bartonellosis.

Methods:  
Case report.

Results:  
A 13-year-old boy presented with sudden onset painless blurring of vision in the right eye for five days. He had history of fever prior to that. Patient recalled history of being scratched by cat a month ago. There was presence of right cervical lymphadenopathy. VA in the right eye was 6/120 with deranged optic nerve functions. There was swollen hypereamic right optic disc during his initial presentation suggesting of optic neuritis. He was started on intravenous Ceftriaxone 1gram per day. However there was no improvement after four days on treatment. A short course of corticosteroid was given. On day four of admission there was an appearance of a macular star.

A diagnosis of cat scratch disease was made. His antibiotic regime was changed to intravenous Azithromycin 500mg. Later the bartonella serology showed an elevation of Ig M and Ig G titre. OCT of macula showed intraretinal fluid collection. Patient was discharge after one week with improvement of the condition. On follow up his VA improved to 6/24 with resolving optic disc and macular swelling. A repeat OCT at one month showed a flat macula. Patient completed 6 weeks course of antibiotic.

Conclusion:  
Macular star in ocular bartonellosis may present later. Early presentation may mimick optic neuritis. A combination of corticosteroid and anti microbial therapy may be need for good outcome.
EP74: Pituitary : Expect The Unexpected
Raajini Devi Krishnan, Rajasudha Sawri Rajan, Azizi Abu Bakar, Hazlita Mohd Isa
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
To report a case of pituitary apoplexy presenting with 2nd and 3rd Nerves involvement

Methods:
Case report.

Results:
A 61-year-old lady with underlying Diabetes Mellitus, presented with a sudden right visual loss with droopy eyelid of 3 days duration. Examination showed no perception of light of the involved eye with a near complete ptosis, restricted extraocular movements and pupillary involvement. Right afferent pupillary defect tested positive. She had 6/60 vision in the left with no visual field defect. Fundus revealed presence of mild right disc pallor. Left fundus was unremarkable. Investigative Computed tomograph (CT) brain revealed right caudate nucleus and internal capsule infarcts with no signs of space occupying lesions. Magnetic Resonance Imaging confirmed a haemorrhagic pituitary macroadenoma compressing the Optic Chiasma.

She underwent transphenoidal excision which showed a retrochiasmatic, well encapsulated necrotic pituitary tumor. Post-operatively right ptosis improved with no anisocoria. Vision remained same bilaterally. A temporal field defect was noted on the left.

Conclusion:
This case illustrates an uncommon manifestation of pituitary tumor with a combination of 3rd and 2nd nerve dysfunctions as its presentation.

EP75: Recurrent Optic Neuritis As Early Presentation Of Idiopathic Hypertrophic Cranial Pachymeningitis: A Case Report
Suraida Abd Rashid¹, Norhayati Samsudin¹, Chui Yain Chen⁴, Azhany Yaakub¹, Win Mar Salmah², Adil Hussein¹, Lakana Kumar³, Wan Hazabbah Wan Hitam¹, Mohtar Ibrahim¹
¹Department of Ophthalmology, ²Department of Radiology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan
³Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
Hypertrophic cranial pachymeningitis is an uncommon chronic inflammatory process results in thickening of the dura mater. We report a rare case of recurrent optic neuritis as early presentation of idiopathic hypertrophic cranial pachymeningitis.

Methods:
Case report.

Results:
A 44-year-old Malay lady presented with recurrent episodes of optic neuritis, four episodes in the left eye and one episode in the right eye over a period of 12 years. It was associated with headache. MRI showed no meningeal thickening during the first attack. Thickened leptomeningeal was only detected on imaging seven years after the initial presentation. The last relapse showed involvement of right cranial nerve III, IV, V and VI. Subsequent MRI revealed progression of the meningeal thickening with involvement of the right orbital apex and cavernous sinus. Blood investigations for infectious and autoimmune disorders were normal. She was diagnosed to have idiopathic hypertrophic cranial pachymeningitis. She was treated with systemic corticosteroids. Her condition remained stable despite deficit in vision in the left eye due to optic neuropa thy.

Conclusion:
Idiopathic hypertrophic cranial pachymeningitis may present as recurrent optic neuritis in the early phase. MRI may remain normal for some years. Systemic corticosteroid is the mainstay treatment during acute attack of optic neuritis and also for idiopathic hypertrophic cranial pachymeningitis.
EP76: Temporary monocular Total Loss Of Vision In Cassion Disease With Underlying Anterior Cerebral Artery A1 Segment Hypoplasia
Ahmad Razif Omar, Loo Wan Wei, Adil Hussein
Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report a case of temporary monocular severe loss of vision in Caisson disease with underlying anterior cerebral artery A1 segment hypoplasia.

Methods:
Case report.

Results:
A 28-year-old Malay gentleman, presented with left eye painless, total loss of vision 4 hours after scuba diving. It was associated with headache, right hemiparesis and decrease sensation on the right upper and lower limb. His left eye acuity was NPL in all quadrants with positive RAPD, right eye acuity was 6/6. Posterior segment examinations of both eyes were normal with no focal arterial narrowing and no cherry red spot. Intraocular pressure was normal. Neurological assessment revealed mild motor and sensory deficit in right upper and lower limbs.

Urgent CT brain done was normal. The initial diagnosis was decompression sickness syndrome with left eye central retinal artery occlusion. He was started on hyperbaric oxygen therapy (HBOT) on D3 post-illness. Visual symptom had remarkably improved from NPL into CF 2 feet after first HBOT therapy. Throughout the admission, he completed seven times HBOT therapy and his left visual acuity had returned to 6/6 with no RAPD. His neurological symptoms had also improved with no residual motor and sensory deficit.

Magnetic Resonance Angiography showed left anterior cerebral artery A1 segment hypoplasia (normal variant) with normal cerebral vasculature and ophthalmic artery. Patient was discharged well and given follow up under ophthalmology and medical clinic.

Conclusion:
Most significant symptoms were total monocular loss of vision in the left eye and contralateral motor sensory deficit of right upper and lower limb preceded by scuba diving. All symptoms were reversible to premorbid condition by HBOT alone. This condition could be due to Caisson disease with possible insult of right carotid artery which had caused anterior circulatory ischemia. The developmental variant hypoplastic left A1 ACA segment might increase the risk of carotid artery occlusion in this case.
**EP77: Bell's Palsy Post Embolization Of Carotid-Cavernous Fistula**

*Tiong Kiew Ing*¹, *Mohamad Aziz Salowi*¹, *Intan Gudom*¹
¹Department of Ophthalmology, Hospital Umum Sarawak, Kuching, Sarawak
²Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

**Purpose:**
We report a case of Bell's palsy post transarterial embolization of carotid-cavernous fistula.

**Methods:**
Case report.

**Results:**
We describe a young female presented with unilateral red eye and swelling for 2 weeks duration. There were left eyelid puffiness, proptosis, and engorged corkscrew episcleral vessels with increased intraocular pressure. Cerebral Digital Subtraction Angiogram demonstrated left indirect carotid-cavernous fistula. She was on maximum anti-glaucoma medications. She underwent left transarterial embolization with 0.5 ml glue lipiodol as she failed medical treatment and repeated scan showed more dilated left ophthalmic vein. Obliteration of fistula was successful. However, she developed left-sided facial numbness and asymmetry, with mildly slurred speech post procedure. She was diagnosed to have Bell's palsy by a neurologist and was started on oral prednisolone 60 mg for 1 week plus physiotherapy.

**Conclusion:**
Endovascular embolization is the method of choice for carotid-cavernous fistula as it has high success rate with low mortality and morbidity. However, our patient developed Bell's palsy post procedure. To the best of author's knowledge, there is no available case report regarding Bell's palsy post transarterial embolization of carotid-cavernous fistula. It was thought to be related to pressure palsy due to venous engorgement around the internal auditory meatus which was connected to the inferior petrosal sinus. Prompt identification and management with early physiotherapy should be given for a better treatment outcome.

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**EP78: Dysthyroid Optic Neuropathy In Pregnancy**

*Tiong Kiew Ing*¹, *Mohamad Aziz Salowi*¹, *Intan Gudom*¹
¹Department of Ophthalmology, Hospital Umum Sarawak, Kuching, Sarawak
²Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

**Purpose:**
We aim to report a case of dysthyroid optic neuropathy in pregnancy.

**Methods:**
Case report.

**Results:**
We describe a multigravida female presented with both eyes progressive painless blurring of vision for 3 months at second trimester. She had underlying Grave's disease on treatment. Her right visual acuity was counting finger and left eye was 6/36. There were ptosis, ophthalmoplegia, swollen eyelid and caruncle with elevated intraocular pressure. Blood investigations revealed normal free T4 with reduced thyroid stimulating hormone. Plain Computed Tomography of orbit showed hypertrophy of muscle belly of extraocular muscles with sparing of tendons. There was presence of orbital apex crowding, with possible optic nerve compression bilaterally. Patient was co-managed with the obstetric team and endocrinologist. She was started on intravenous methylprednisolone for 3 days, followed by oral prednisolone subsequently. Visual acuity improved to 6/24 in the right eye and 6/9 in the left eye. Ptosis and extraocular muscle movement improved. She had a safe delivery with a normal baby.

**Conclusion:**
The most common cause for thyroid eye disease in pregnancy is Grave's disease. Although dysthyroid optic neuropathy is rare, it should not be overlooked as it is a sight threatening condition. It requires medical decompression with steroid or surgical decompression subsequently if indicated. The teratogenic effect of corticosteroids in pregnancy seems to be very low. Early identification and proper treatment is mandatory to avoid irreversible blindness.
EP79: Unique Paediatric Oculoplastic Trauma Cases In Penang General Hospital
Tan Chew Ean¹, Chan Hui Tze², Adeline Khaw Mae Li³, S. Periyathamby², JH Lau², Vanessa N.Mansurali²
¹Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah
²Department of Ophthalmology, Hospital Pulau Pinang
³Department of Ophthalmology, Pusat Perubatan Universiti Malaya, Kuala Lumpur

Purpose:
To report 3 cases of unique paediatric oculoplastic trauma cases.

Methods:
Case series.

Results:
Case 1: A 9-years-old boy was kicked over left-sided face, experienced headache and diplopia. He was treated for cerebral concussion and left internuclear ophthalmoplegia by private ophthalmologist but was referred as symptoms persisted. CT orbit revealed left medial orbital wall fracture with medial rectus trapdoor entrapment. Transcaruncular repair of medial wall with bioabsorbable implant was performed and adduction of left eye improved.
Case 2: An 11-year old boy, referred for cavernous sinus thrombosis, presented with red proptosed left eye. Fundus showed venous stasis retinopathy. Further questioning revealed history of head trauma. Cerebral angiogram revealed arterio-venous fistula between branch of middle meningeal artery and vein. Transarterial embolization was performed with good outcome.
Case 3: A 5-year old boy hit by a cradle hook then sustained avulsion wound to his right upper eyelid involving canaliculi. Toilet and suturing and bicanalicular intubation yielded good outcome.

Conclusion:
Paediatric trauma cases can pose a diagnostic dilemma and can be surgically challenging.

EP80: A Perfect Decoy
Lim I-Liang, Nor Fadzillah Abdul Jalil, Raja NORliza Raja Omar
Department Of Ophthalmology, Hospital Melaka, Melaka

Purpose:

Methods:
Case report.

Results:
A 44-year-old lady complained of sudden onset of painless reduced left vision for a day associated with redness and central scotoma. It was preceded by headache for two months. She has history of poorly controlled diabetes mellitus. The left vision was no perception to light and the left eye’s movements were restricted. It was proptosed. The left fundus examination revealed an extensive subretinal scar with hemorrhage obscuring the whole posterior pole. The B-scan captured a solid lesion arising from the left macula. The contrasted CT of paranasal sinus/neck/brain revealed a soft tissue mass at the posterior nasal space with local invasion of left sphenoid, left orbit and eyeglobe. It was highly suggestive of nasopharyngeal carcinoma. The initial histopathological examination of nasopharyngeal mass via nasal endoscopy showed no granuloma or malignancy. A repeat biopsy of the same site revealed fungal infection suggestive of aspergillosis. It was confirmed by a positive fungal polymerase chain reaction and the fungal culture and sensitivity which grew Aspergillus fumigatus. Subsequently, her left fundus examination showed a total retinal detachment with subretinal and vitreous haemorrhage. Topical and systemic antifungals were commenced. A debulking surgery of the nasopharyngeal mass by the ENT team was performed. Unfortunately, the patient defaulted her subsequent follow-up.

Discussion:
Aspergillus fumigatus presents a significant threat to immunocompromised hosts; the mortality rate from disseminated aspergillosis with cerebral involvement may be as high as 70%. Treatment of invasive aspergillosis involves chemotherapy with antifungal agents, principally amphotericin B and surgical debridement.
**EP81: Dural Carotid-Cavernous Fistula Presenting As Isolated Third Nerve Palsy**

**Ho Fui Li, Mohamad Aziz Salowi**  
Department of Ophthalmology, Hospital Umum Sarawak, Kuching, Sarawak

**Purpose:**  
Isolated third nerve palsy is an uncommon presentation of dural carotid-cavernous fistula. We aim to report a case of dural carotid cavernous fistula which presented as unilateral isolated third nerve palsy without orbital congestion.

**Methods:**  
Case report.

**Results:**  
A 58-year-old lady with underlying diabetes and hypertension presented with right sided sudden onset third nerve palsy with pupillary involvement. Neuroimaging excluded the presence of posterior communicating artery aneurysm and intracranial mass. Suspicion of carotid-cavernous fistula arose when early opacification of right cavernous sinus seen on cerebral angiography. Digital subtraction angiography revealed that it was an indirect right carotid-cavernous fistula. She was managed conservatively and her condition gradually improved.

Manifestation of dural carotid-cavernous fistula is dependent on the direction of drainage. This patient had a fistula that drained posteriorly to posterosuperior portion of cavernous sinus and then to inferior petrosal sinus. This caused compression of oculomotor nerve against the roof of cavernous sinus. Absence of anterior drainage to superior ophthalmic vein resulted in quiet white eye.

**Conclusion:**  
Dural carotid-cavernous fistula can present with isolated third nerve palsy and hence should be considered as a differential diagnosis. Clinical manifestations are dependent on the direction of fistula drainage.

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**EP82: Unilateral Orbital Epidermal Cyst With Eyelid Hemangioma**

**Lim ZD, Viona Lai MS, Fayyaz A, Nortalia Talib, Jaafar SM, Chiang Wai Siang**  
1Department of Ophthalmology, Hospital Duchess of Kent, Sandakan, Sabah  
2Department of Ophthalmology, Hospital Serdang, Selangor  
3Department of Pathology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

**Purpose:**  
To illustrate a rare case of orbital epidermal cyst with eyelid hemangioma.

**Methods:**  
Case report.

**Results:**  
A 39-year-old, gentleman, presented with right upper eyelid huge swelling associated with complete mechanical ptosis leading to visual disturbance and cosmetic derangement for 20 years. On elevation of upper lid manually, visual acuity of right eye was 6/9. No proptosis and no limitation of extraocular movement. A palpable non tender firm mass measuring 3.5cm x 4cm at superolateral region of upper lid mimicked lacrimal gland tumour and dermoid cyst clinically. In addition, there was a 1cm x 1cm reddish fleshy mass seen on the right lower lid. Left eye examination was normal.

CT scan Orbit showed right superolateral orbital hypodense lesion suggestive of cystic mass. Open orbitotomy to remove right upper lid mass and excision biopsy of right lower lid mass were done. Histopathological examination revealed right orbital epidermal cyst with right lower lid hemangioma. Post operatively, there was slight ptosis due to residual redundant skin.

**Conclusion:**  
 Orbital epidermal cyst with eyelid hemangioma is rare. Surgical excision is recommended to provide definitive histological diagnosis and to yield good visual and cosmetic outcome.
**EP83: Unilateral Proptosis With Trichophyton Rubrum In Thyroid Eye Disease**

_Viona Lai MS, Lim ZD, Fayyaz A, Omar H, Chiang Wai Siang_

_Department of Ophthalmology, Hospital Duchess of Kent, Sandakan, Sabah_

**Purpose:**
To illustrate a rare devastating complication of Thyroid Eye Disease with Trichophyton Rubrum.

**Methods:**
Case report.

**Results:**
A 53-year-old Bugis lady, presented with left eye painful swelling associated decreased vision for 2 days. Visual acuity of left eye was hand movement and right eye was 6/18 (6/9 with pinhole). Pupillary reflex was equal and reactive in both eyes. No relative afferent pupillary defect detected. There was left proptosis, conjunctival chemosis and limitation of extraocular movement in all direction. Left eye showed extensive corneal abscess with feathery infiltrates, thinning inferior nasally and hypopyon. Right eye examination was normal. Left corneal scrapping was positive for Trichophyton Rubrum.

Biochemical investigation showed hyperthyroidism. She was given topical Fluconazole, topical Amphotericin B and oral carbimazole. Post treatment, left cornea abscess was resolved. Her left eye visual acuity was remained hand movement because cornea scarring.

**Conclusion:**
Trichophyton Rubrum infection is a rare and severe sight threatening sequelae in Thyroid Eye Disease. Prompt management is important to prevent permanent blindness.

**EP84: Right Orbital Apex Syndrome Secondary To Metastatic Right Breast Carcinoma**

_Yih Chian Yew, Cheng Imm Lee, Ee Ling Ang_

_Department of Ophthalmology, Hospital Pulau Pinang_

**Purpose:**
Orbital apex syndrome (OAS) is a collection of cranial nerves deficit (CN III, IV, VI, and V1, with optic nerve dysfunction) associated with a mass lesion near the apex of orbit. We report a rare case of right OAS caused by metastatic breast carcinoma to skull and facial bones and extending into orbital cavities.

**Methods:**
Case report.

**Results:**
A 44-year-old woman presented with 2-week history of blurring of vision of right eye associated with partial proptosis. She was diagnosed with stage 2 right breast carcinoma in 2006, and right mastectomy was done. Chemotherapy was commenced but she defaulted subsequent cycles of chemotherapy. In 2013, she had recurrence with extensive bone, liver and lung metastases. Despite palliative chemotherapy, her disease progressed. She presented in May 2015 with the eye symptoms. Her visual acuity was: right eye 6/24, pinhole 6/18; left eye 6/18, pinhole 6/12. There was positive RAPD on right eye, with proptosis. Her right eye extraocular movement was restricted over all quadrants. Fundus examination showed bilateral swollen optic discs, right more than left. Brain/orbit CT showed right eye proptosis, with extensive bony metastases in skull and facial bones with soft tissues extending into both orbital cavities.

**Conclusion:**
Metastatic breast carcinoma involving the orbital cavity is a rare cause of OAS. Interestingly, this patient presented with OAS of right eye, corresponding to the same side of the primary tumour at right breast. Imaging by CT/MRI plus detailed history of underlying illness are important in determining the aetiology of OAS.
EP85: Crouzon Syndrome With Bilateral Dacryoadenitis
Ng Chun Wai¹, Norhalwani Husain¹, Sharifah Intan Hosnaliza Syed Osman²
¹Department of Ophthalmology, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan
²Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur

Purpose:
To report a case of Crouzon syndrome with bilateral dacryoadenitis with exposure keratopathy and left eye corneal ulcer. He was successfully co-managed together with Ophthalmology departments of Hospital Kuala Lumpur.

Methods:
Interventional case report.

Results:
The patient is a 17-year old boy, known case of Crouzon syndrome presented with severe proptosis with bilateral eye exposure keratopathy and left eye corneal ulcer. It was complicated with bilateral dacryoadenitis and conjunctival prolapsed due to lagophthalmos. Ocular imaging suggestive of bilateral dacryoadenitis. He was treated with intensive topical antibiotic eye drops, oral prednisolone and intravenous antibiotic. He was then referred to Hospital Kuala Lumpur for ocularplastic surgery in view of extensive exposure keratopathy. Bilateral conjunctiva repositioning and intermarginal tarsorrhaphy was performed. The proptosis improved postoperatively. His right eye exposure keratopathy healed with best corrected vision of 6/9. His left eye corneal ulcer healed leaving a scar involving visual axis with best corrected vision of 6/60.

Conclusion:
This case illustrates the rare case of bilateral dacryoadenitis in Crouzon syndrome. The case also shows that surgical correction for proptosis with lagophthalmos together with anti-inflammatory treatment are able to fasten the recovery of this condition. Early recognition and treatment is mandatory to avoid visual loss and worsening complications.

EP86: Solitary Orbital Tumor: A Rare Case Of Orbital Tumor
Hanisah AH, Munirah AR, Nazima SA, Gaayathri N, Hazlita Mohd Isa
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
To report a case of solitary orbital tumor; a mesenchymal tumour, which rarely arise in the orbital area.

Methods:
Case report.

Results:
A 35-year-old Malay lady presented to PPUKM with six months history of painless, slow progressing swelling of the left upper eyelid. On examination, visual acuity was 6/6 OD and 6/9 OS. She was found to have left eye 4mm, non-axial proptosis. A firm, non-tender palpable mass at left upper eyelid laterally was noted and globe was displaced inferonasally. Extraocular movements were full bilaterally and she denied any diplopia. Anterior segment examination and intraocular pressures of both eyes were normal. On funduscopy, there was evidence of choroidal folds superotemporally in the left eye. However, optic disc and macula were normal. Her right fundus and other systemic examinations were unremarkable.

CT scan of the brain and orbit was performed which showed a solitary, left extraconal mass superotemporally pressing the globe. The tumour was successfully removed via lateral orbitotomy. Histopathology showed areas of hyper and hypocellular regions with patternless proliferation of spindle shaped cells. Immunohistochemically, the tumor was positive for both CD34 and Vimentin leading to the diagnosis of left solitary orbital tumour. Patient has been well since.

Conclusion:
Solitary tumour rarely occurs in orbit. Nevertheless, it should be considered as one of the differential diagnosis for orbital tumours. Adequate sample for histology and appropriate immunochemical testing is important to confirm the diagnosis.
Purpose:
To report a case of orbital cellulitis secondary to paranasal sinusitis.

Methods:
A case report.

Results:
A 28-year-old Malay gentleman was prescribed oral antibiotics after presenting with 4 days history of fever, chills and rigors at a district hospital. He was referred to eye clinic after developing right eyelid swelling and diplopia the next day. Unfortunately, he only came 2 days later. No pain on eye movement. There was history of frequent nasal congestion and cacosmia for 1 year. On examination, vision of right eye was reduced (3/60) but no relative afferent papillary defect (RAPD) was present. There was significant right upper eyelid swelling with proptosis and severe conjunctival chemosis. Fundus examination was unremarkable. Extraocular movement was restricted in all directions. Diplopia present on left gaze. Computer tomography (CT) scan orbit and paranasal sinus showed acute sinusitis of both frontal, right anterior ethmoid and right maxillary sinus with right orbital extension causing right eye proptosis. No intracranial extension. Total white cells was 21.83. Surgical drainage of was performed by the ENT team. As patient did not improve, a repeat CT scan was done and showed remaining sinusitis of both frontal sinus. Surgical drainage was repeated. Patient improved after the procedure.

Conclusion:
Orbital cellulitis is a life threatening soft tissues infection behind the orbital septum with multifactorial etiology and need to be differentiate between preseptal cellulitis as it can cause severe complications such as cavernous sinus thrombosis and brain abscess. This case highlighted the importance of early treatment of orbital cellulitis.

Purpose:
To report a missed complication of head trauma- carotid cavernous fistula (CCF).

Methods:
Case report.

Results:
A 17-year-old, Malay, gentleman sustained severe head injury that left him unconscious after a motor vehicle accident last year. Computed tomography (CT) showed left temporal subdural haemorrhage and multiple facial and skull vault fracture. His first ophthalmological examination, performed one day after the injury while the patient was intubated for cerebral protection, revealed a left periorbital hematoma, conjunctival chemosis, and mid-dilated pupil. No reverse relative afferent pupillary defect (RAPD) was present. His subsequent examination was performed two weeks later. The examination revealed a left RAPD with loss of light perception. There was proptosis of the left eye with partial ptosis, conjunctival chemosis, but no orbital bruit. Total ophthalmoplegia of the left eye was present. The intraocular pressure (IOP) and fundus were normal. CT angiogram brain and orbit showed features are suggestive of left CCF (Type A). Therefore, patient was referred to neurosurgery Hospital Kuala Lumpur (HKL) for embolization. During follow-up after embolization, the symptoms gradually have improved.

Conclusion:
A CCF is an abnormal communication between the carotid arterial system and the venous cavernous sinus. Direct CCF consists of direct connection between intracavernous carotid artery and the surrounding cavernous sinus and the symptoms may develop days or weeks after the head injury. This case highlights the importance of early recognition in preventing ophthalmic and neurologic morbidity.
EP89: Recurrent Optic Neuropathy In Thyroid Ophthalmopathy Despite Prior Orbital Wall Decompression

Wu SY\textsuperscript{1,2}, Nazila AA\textsuperscript{1}
\textsuperscript{1}Department of Ophthalmology, Hospital Selayang, Selangor
\textsuperscript{2}Department of Ophthalmology, Pusat Perubatan Universiti Malaya, Kuala Lumpur

Purpose:
To report a rare case of recurrent orbitopathy in Thyroid Ophthalmopathy despite prior orbital wall decompression surgery.

Methods:
Case report.

Results:
50-year-old lady, presented with 6 months bilateral lid swelling and 10 days left eye blurring of vision. She had thyrotoxicosis with prior radioactive iodine therapy, currently euthyroid on L-thyroxine. Left vision dropped from 6/9 to 6/18 with RAPD positive, impaired colour vision and reduced red desaturation. Extraocular movements (EOM) were restricted with increased intraocular pressure and hyperaemic disc. Thyroid function test was deranged. CT orbit showed thyroid orbitopathy involving all recti muscles, with orbital apex crowding. She was given intravenous methylprednisolone total of 6g. Her treatment response was fluctuating. With time, her right eye developed optic neuropathy with worsening vision of 6/6 to 6/18 while left vision worsened to 6/36. Optic discs were swollen bilaterally with impaired optic nerve function and restricted EOM. She underwent bilateral medial and lateral orbital wall was decompression. Post operatively bilateral vision initially improved but later developed recurrent orbitopathy with a significant vision dropped to 6/60, hyperaemic swollen discs and impaired optic nerve function test. She was treated with intravenous methylprednisolone, followed by oral prednisolone. Her vision subsequently improved and optic nerve swelling regressed.

Conclusion:
Visual threatening orbitopathy may recur despite prior orbital decompression. Recurrent orbitopathy may be attributed to insufficient bone removal, enlarged recti muscle and prolapsed frontal sinus mucocele. Sight threatening optic nerve compression in thyroid eye disease should be treated urgently to restore good vision and prevent grave consequences.

EP90: A Surprising And Devastating Cause Of Endophthalmitis

Gan Yuen Keat, Chua SW, Madhusudhan Paramananda, Anis Farhad, Sheena Mary Alexander
Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
To report 2 rare cases of endogenous endophthalmitis secondary to Toxocara infestation in immunocompromised patients.

Methods:
Case series.

Results:
This a case of 2 immunocompromised patients with a surprising ocular toxocariasis infestation. The first is a 23-year-old girl who is a known case of SLE, presented with both eyes progressive blurring of vision for the past 3 months. Examinations showed bilateral panuveitis with posterior pole granuloma. She was treated as endogenous endophthalmitis as per protocol, but with limited improvement. To our surprise and with high index of clinical suspicion, toxocara serology was positive. She was then started on oral Albendazole for 4 weeks. The second case is a 51-year-old lady with ESRF undergoing regular dialysis and on immunosuppressive therapy. She was warded for long duration for sepsis secondary to candidal fungal infection. Examinations revealed right peripheral and posterior pole granulomas almost exactly similar to the 1st patient. She was treated for endogenous endophthalmitis and again in close succession a positive serology was confirmed. Both cases since then showed gradual clinical improvement.

Conclusion:
Both patients may have been more susceptible to this condition because of their immunocompromised state or due to their immunosuppressive therapies respectively. Clinicians should have a heightened sense of awareness, in view that, even the rarest cause could inflict a devastating endophthalmitis.
EP91: Double Trouble: Bilateral Endogenous Endophthalmitis
Anhar Hafiz Silim, Raja Norliza Raja Omar, Nor Fadzillah Abd Jalil
Department of Ophthalmology, Hospital Melaka, Melaka

Purpose:
To report a case of bilateral endogenous endophthalmitis.

Methods:
Case report.

Results:
A 39-year-old gentleman complained of fever for five days associated with reduced oral intake and abdominal pain. He was an active intravenous drug abuser. On the day of admission, he developed bilateral sudden onset of reduced vision associated with floaters, eye discomfort and photophobia. Ocular examination showed intense signs of inflammation in both anterior and posterior segments of both eyes. There were fully packed cells in the bilateral anterior chambers with hypopyon, dense vitritis as well as macula abscess in the right eye.

He later was diagnosed with bacteraemia secondary to infective endocarditis by the evidence of positive vegetations at mitral valve on echocardiogram findings and Streptococcus dysgalactiae subspecies equisimilis were isolated from blood cultures. However the vitreous cultures were negative. With prompt administration of intravenous and intravitreal antibiotics as well as topical medications, the patient's condition dramatically improved.

Conclusion:
Endogenous endophthalmitis constitutes a potentially devastating intraocular inflammation, caused by the migration of the pathogen from a distant primary site of infection to the eye where it crosses the blood-ocular barrier. Bilateral involvement is only seen in 14 to 25% of patients. The majority of patients with endogenous endophthalmitis suffer from underlying medical problems such as immunocompromised, intravenous drug abuse and prolonged stay in intensive care. S. dysgalactiae subspecies equisimilis on the other hand is a rare cause of sinusitis, pharyngitis, pulmonary infections, septic arthritis, endocarditis as well as endophthalmitis.

EP92: Necrotizing Fasciitis Of Orbit: A Case Report And Review Of Literature
Nur Aisyah Binti Zakaria, Madhusudhan Paramananda, Sheena Mary Alexander
Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
Necrotizing fasciitis (NF) is a devastating rapidly progressive soft tissue infection. Rarely its involvement of the face and orbits are seen in immunocompromised patients, who inadvertently have a higher rate of mortality. We aim to report a rare case of necrotizing fasciitis with unexpected involvement of the orbit.

Methods:
Case report.

Results:
A 71-year-old gentleman with multiple co-morbidities was admitted and treated for sepsis secondary to hospital-acquired pneumonia. Unfortunately he developed blackish discoloration over the right medical canthal region associated with restriction of the right eye movement. Initially he was treated as right eye orbital cellulitis and treated accordingly but during a follow up after 2 weeks, patient was noted to have gangrenous lesion affecting both the upper and lower lid margin. Extensive surgical debridement and a right eye enucleation was done, in view of spread of necrotizing tissue invading the eye ball. Culture and sensitivity of the necrotic tissue grows Aspergillus sp. Patient however passed away due to septicemia.

Conclusion:
Necrotizing fasciitis involving the orbit is rare. Prompt treatment and early recognition of this rare presentation is beneficial to improve the mortality rate.
**EP93: Rare Presentation Of Orbital Apex Syndrome Secondary To Optic Chiasm Tumour**

*Somasundranayaky, Kosyilya, Chui Yin Chua, Rohana Taharin*

*Department of Ophthalmology, Hospital Bukit Mertajam, Pulau Pinang*

**Purpose:**
To report a rare case of orbital apex syndrome secondary to optic chiasm tumour.

**Methods:**
Case report.

**Results:**
A 32-year-old male with no known medical illness presented with sudden painless right blurring of vision and squint. He was otherwise well. His right visual acuity was HM and 6/9 in the fellow eye. There was mild right proptosis. Right RAPD was positive and there were limitation of right medial, inferior, superior and lateral gazes. Other cranial nerves and systemic examinations were unremarkable. A diagnosis of RE orbital apex syndrome was made and urgent imaging was scheduled.

Patient however sought alternative treatment and came back two weeks later with RE vision of NPL. Other examination findings remained the same. MRI showed an enhancing irregular lesion at the optic chiasm on the right which extended inferiorly involving the right hypothalamus, pituitary gland and right cavernous sinus, suggestive of infiltrative optic chiasm glioma. Biopsy was planned to confirm the diagnosis but patient refused.

**Conclusion:**
Orbital apex syndrome secondary to infiltrative optic chiasm tumour is uncommon. Tumour e.g. glioma involving the visual pathway in adulthood is very rare and is often associated with poor prognosis due to its aggressive nature.

**EP94: Unusual Clinical Presentation Of Idiopathic Orbital Inflammatory Disease Mimicking Carotid Cavernous Fistula**

*Nurhayati AK, Syed Shoeb Ahmad, Shuaibah Abd Ghani*

*1Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah*

*2Department of Paediatric Ophthalmology, Hospital Wanita dan Kanak-Kanak Sabah*

**Purpose:**
We aim to report a case of idiopathic orbital inflammatory disease in an elderly gentleman who presented with clinical features suggestive of carotid cavernous fistula.

**Methods:**
Case report.

**Results:**
Our patient presented with protrusion of the right eye, diplopia and redness for a month. There was no systemic disease or trauma. Examination revealed proptosis, ophthalmoplegia and cockspur conjunctival vessels which became more prominent on Valsalva manoeuvre. Pulsation and bruit were absent. Fundus showed dilated tortuous retinal vessels. Thus, clinically the condition resembled carotid cavernous fistula.

Computed tomography scan showed an ill-defined enhancing mass in intraorbital space involving medial-, inferior-recti and inferior oblique muscles. Cavernous sinuses were normal. Magnetic resonance imaging showed hypointense lesion in the orbit. Trans-nasal endoscopy biopsy of the mass showed lymphocytic inflammatory infiltrates with fibrosis. Thus, a final diagnosis of idiopathic orbital inflammatory disease was made with the evidence from radio-imaging and histopathologic studies.

**Conclusion:**
Idiopathic orbital inflammatory disease is a good mimicker of other orbital disorders and the diagnosis is by exclusion. Our case mimicked carotid cavernous fistula, but it was ruled out by the radiology and histology examinations. Thus, a diagnosis of idiopathic orbital inflammatory disease was made.
EP95: A Rare Association Of Herpes Zoster Ophthalmicus With Orbital Apex Syndrome And Complicated Secondary Bacterial Keratitis

JJ Lim, YM Ong, Wan Zalina Mohamed Zain
Ophthalmology Department, Hospital Sultanah Bahiyah, Alor Setar, Kedah

Purpose:
To report on a rare case of herpes zoster ophthalmicus (HZO) with orbital apex syndrome and neurotrophic ulcer.

Methods:
Case report.

Results:
A 77-year-old Malay lady with underlying hypertension, was referred by Private Ophthalmologist with complete ptosis. Three weeks prior to presentation, she had vesicular skin lesions over left periorbital region and forehead, associated with left eye pain, redness and progressive blurring of vision. Visual acuity over left eye was perception to light. Left eye was proptosed, ptotic with complete ophthalmoplegia and presence of relative afferent pupillary defect. Cornea was hazy with presence of epithelial defect, and reduced cornea sensation as compared to right eye. Posterior segment view was obscured. B-scan ultrasonography showed no posterior segment involvement.

She was diagnosed left HZO with orbital apex syndrome and neurotrophic ulcer. She was treated with oral acyclovir and corticosteroids in combination with artificial tears and topical steroids. Her symptoms improved slowly. She was discharged after two weeks, with residual smaller epithelial defect. She was on close monitoring as outpatient. Unfortunately, she developed secondary bacterial keratitis. Following treatment, the bacterial keratitis resolved. However, her vision remained at perception to light.

Conclusion:
HZO can be presented as a spectrum of conditions. Orbital apex syndrome is rare but severe complication. Mainstay of treatment is combined administration of systemic acyclovir and steroids. Systemic steroid use may decrease severity of disease, however, there is a risk for secondary bacterial infection. Early and careful follow up is needed to prevent progression of infection.

EP96: Complete Recovery Of An Almost-Missed Caratico-Cavernous Fistula

Wendy See Yen Nee, S.Kala
Department of Ophthalmology, Hospital Umum Sarawak, Kuching, Sarawak

Purpose:
To report the complete recovery of an almost-missed case of direct high flow carotid cavernous fistula following a basal skull fracture post accident.

Methods:
Case report.

Results:
A 32-year-old lady presented with progressive painless vision loss and pulsatile proptosis in her right eye. She had history of road-traffic accident (RTA) a month ago, which she sustained basal skull fracture, right-sided facial laceration and multiple cranial nerves palsies. Her right vision was 6/60 with positive relative afferent pupillary defect (RAPD). Ocular examination revealed right proptosis with orbital bruit, congested conjunctival vessels and increased intraocular pressure. Computed tomography (CT) and magnetic resonance imaging (MRI), immediate and one-month post trauma respectively, did not reported suspicious signs of carotid-cavernous fistula (CCF). She was diagnosed CCF solely based on a clinical diagnosis and subjected to diagnostic cerebral angiogram. A high flow direct carotid cavernous fistula was confirmed. She was immediately referred to interventional radiologist Hospital Universiti Kebangsaan Malaysia for embolisation. All the signs resolved post embolisation with improvement of vision to 6/9.

Conclusion:
This article is to highlight the importance of suspecting CCF in post trauma patients presented with classical pulsatile exophthalmus. Direct high flow CCF is an ophthalmic emergency and when diagnosed, should be promptly referred to interventional radiologist. CCF is a well documented but uncommon complication of head injury. Its presentation is usually delayed.
EP97: Rare Extraconal Orbital Mass; A Benign Schwannoma
Syaridatul Hikmah Kamarudin, Ong Chin Tuan, Azida Juana Wan Abd Kadir
Department of Ophthalmology, Pusat Perubatan Universiti Malaya, Kuala Lumpur

Purpose:
To report a rare case of orbital Schwannoma, its presentation and management.

Methods:
Case report.

Results:
A 23-year-old female presented with slow, painless proptosis of the right eye without symptoms of diplopia or blurring of vision. Examination showed unilateral non-axial proptosis, right eye was hypertrophic, and optic nerve function is intact. No restriction of eye movement. CT scan showed extracanal, well-defined, enhancing oval-shaped mass in the orbit which displaced the globe anteriorly. Excision biopsy noted well-encapsulated mass posterolateral to the globe, ruptured during manipulation showing the yellowish, cheesy-like content. Histopathological examination showed Schwannoma with Antoni A pattern.

Conclusion:
Schwannoma or neurilemmoma is a benign tumor of arising from Schwan cells of peripheral or cranial nerve; with orbit is a site of rare occurrence. However patient may lose her vision due to optic nerve compression and atrophy if not recognised and treated early. Imaging studies like computed tomography help to identify this lesion as well as ruling out possible malignant causes.

EP98: Unilateral Globe Subluxation And Its Causes
New Sze Hui
Department of Ophthalmology, Hospital Sultanah Aminah, Johor Bharu, Johor

Purpose:
To report two cases with rare, benign neoplastic cause of unilateral proptosis: fibrous dysplasia and sphenoid meningothelial meningioma grade I.

Methods:
Case series.

Results:
Case A: A 46-year-old female, who was presented with right severe proptosis, with intermittent globe subluxation and painless blind eye for 2 years. Ophthalmic examination revealed right non-axial proptosis with partial ophthalmoplegia and compressive optic neuropathy. Computed tomography scan showed fibrous dysplasia involving sphenoid, frontal and right temporal bone causing stretching of the right optic nerve.

Case B: A 45-year-old male, who was presented with left painful persistent globe subluxation, severe conjunctival chemosis, exposure keratopathy and blindness for 1 year. Ophthalmic examination revealed axial proptosis with partial ophthalmoplegia and compressive optic neuropathy. Patient was diagnosed with left greater wing sphenoid meningothelial meningioma grade I with multiple recurrences. Magnetic resonance imaging revealed a temporal extra-axial lesion involving intraorbital, sphenoid sinus, carvenous sinus encasing the left internal carotid artery and retro-orbital extension causing compression of the left optic nerve and infiltration of left superior, inferior and lateral recti muscles.

Conclusion:
Case A is a monostotic fibrous dysplasia presenting in an uncommon age group. The extensive involvement of the craniofacial bones makes surgical resection challenging for severe disfigurement. Case B is an atypical meningioma which has high recurrence rate. The extensive extracranial tissue involvement indicates its biological aggressiveness. Early surgery to address progressive sensory disturbance is recommended in both cases so as to avoid permanent visual disability.
EP99: Choroidal Mass In Severe Staphylococcus Aureus Related Orbital Abscess
Lathalakshmi T1,2, Nor Azita AT1, Liza Sharmini Ahmad Tajudin2
1Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur
2Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan

Purpose:
To report an unusual presentation of orbital cellulitis caused by staphylococcus aureus.

Methods:
Case report.

Results:
A 32-year-old man presented with history of left eye pain, redness and swelling of 4 days duration. He had history of minor trauma to left eye 1 week prior to it. Visual acuity was 6/6 on the right and 6/12 on the left eye. There was no RAPD. Moderate restrictions of ocular motility in all gazes with minimal lagophthalmos in left eye. Left conjunctiva was chemotic with no lid swelling and there was non-axial proptosis. Left eye fundus examination revealed elevated choroid temporally about the size of 5 disc diameter with choroidal striae. Bscan showed scleral thickening with fluid in subtenon space and T sign. Urgent CT orbit showed large left multiloculated orbital abscess; measuring 1.2APx 1.6W X 3.3CC cm causing compression to the adjacent globe and lateral rectus. He was started on intravenous co-amoxiclav. However, the left eye proptosis worsened with presence of pus discharge on the conjunctiva. Incision and drainage was performed. Culture and sensitivity result showed Staphylococcus Aureus. Retroviral status was negative. Subsequently there was marked reduction in proptosis and choroidal mass effect flattened. He regained his premorbid vision of 6/6.

Conclusion:
Low common virulent organism is able to cause severe orbital abscess even in immunocompetent individuals. High index of suspicious and prompt treatment will salvage the globe and vision.

EP100: Orbital Cellulitis With Cavernous Sinus Thrombosis
Nurul Zulaikha Wahab, Sakinah Zakariah
Department of Ophthalmology, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan

Purpose:
To report a case of cavernous sinus thrombosis (CST) as a potentially fatal complication of facial skin infection with orbital cellulitis.

Methods:
Case report.

Results:
A 14-year-old boy, previously healthy. Presented with 3 days history of left eye swelling, proptosis, pain, redness and reduced vision. He gave history of infected acne at left frontal facial area which partially treated with oral antibiotic for past one week. Ophthalmology examination showed severe left orbital cellulitis with proptosis, chemosis, ophthalmoplegia, exotropia and hypotropia.

He was treated with broad spectrum empirical antibiotics. CT scan showed left orbital cellulitis with small facial abscess, left superior ophthalmic vein and left cavernous sinus thrombosis. Blood C&S showed Staphylococcus aureus. Intravenous antibiotics were changed according to sensitivity. His eye condition markedly improved with proper administration of intravenous antibiotics with visual acuity of 6/6 both eyes.

Conclusion:
This case illustrates any facial infection can lead to CST as a potential fatal complication. The comprehensive management of patient includes early diagnosis as well as a proper management of primary infection site with both empherical and definitive treatment of intravenous antibiotics.
EP101: Intraocular Osseous Metaplasia
MR Abd Hadi, Suriana Suaiubn, Sharifah Intan Hosnaliza Syed Osman
Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur

Purpose:
To report on a rare case of post-traumatic intraocular osseous metaplasia seen in Eye Clinic, Kuala Lumpur Hospital

Methods:
Case report.

Case report:
A 26-year-old female presented with left phtihical eye for the past 7 years. She gave history of childhood trauma in which her left eye was poked with a stick. Evisceration of left eye with medpor implant was performed. Difficulty encountered in attempt to remove the blackish, hard and gritty ocular tissue; resembling a hard coconut shell. No bleeding encountered during procedure.

Specimen was sent for histopathological examination and revealed fragments of loose fibrocollagenous stroma containing numerous melanocytes and bone trabeculae with no malignant change. The finding was consistent with osseous metaplasia.

Conclusion:
Intraocular osseous metaplasia is a rare finding which can occur in a post-traumatic case in association with pthisis bulbi as in this case. It has a unique pathogenesis in which it is believed that the choroidal layer has undergone bony transformation.

EP102: Rare Lacrimal Gland Swelling As Presenting Features Of Grade IV Disseminated Malignant Lymphoma
Nurhayati AK, Syed Shoeb Ahmad, Shuaibah Abd Ghani
Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
Malignant lymphoma of the lacrimal gland is rare. We aim to report a case of patient of disseminated grade IV lymphoma presented with lacrimal gland swelling.

Methods:
Case report.

Results:
A 80-years-old gentleman presented with progressive painful left periorbital swelling associated with protrusion of the eyeball and drooping of the eyelid for ten months associated with bilateral parotid glands swelling. He denied of constitutional symptoms. Examination showed diffuse upper eyelid swelling with enlargement of lacrimal gland causing hypoglobus and significant of non-axial proptosis. The conjunctiva was chemosed and injected with dilated vessels superiorly. Both parotid glands were enlarged but no signs of inflammation. Bilateral cervical, supraclavicular and axillary lymph nodes were enlarged with hepatomegaly. Other systemic examination were unremarkable. Peripheral blood film suggestive of reactive changes.

Computed tomography scan revealed enlargement of left lacrimal gland, both parotid glands and both cervical lymph nodes. Right supraclavicular lymph node biopsy suggestive of marginal zone B-cell lymphoma. Lumbar puncture showed no malignant cells seen and bone marrow trephine biopsy showed no marrow involvement. Staging examination revealed Stage IV disseminated malignant lymphoma.

Conclusion:
This is a case of Stage IV disseminated malignant lymphoma which had an unusual presentation of a lacrimal gland swelling.
EP103: Chorioretinitis Sclopetaria : A Rare Complication Of Ocular Blunt Injury
Wan Radziah WN, Nik Nazihah NA, Zabri Kamaruddin
Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To report a case of chorioretinitis sclopetaria.

Methods:
Case report.

Results:
A 29-year-old male was referred to Vitreoretinal Unit, Selayang Hospital for giant tear with retinal detachment. He presented with right eye acute reduced vision following a blunt trauma two days prior. He was initially treated for upper lid laceration and conjunctival abrasion at the referring centre. On examination, his visual acuity was counting finger at 3 feet in the right eye and 6/6 in the left eye. There was right relative afferent pupillary defect, and localized subconjunctival haemorrhage seen. Fundus revealed extensive preretinal haemorrhages with retinal whitening at superotemporal retina extending towards the macula, and inferior vitreous haemorrhage. No retinal detachment noted. Examination of the left eye was unremarkable. Diagnosis of chorioretinitis sclopetaria was made. He was also treated for traumatic optic neuropathy. In the following review, his vision dropped further to counting finger at 1 foot. There was generalised diffuse vitreous haemorrhage obscuring the fundus view. B scan showed attached retina. At two months follow up, there was presence of subretinal and preretinal fibrosis at superotemporal retina and macula region. Subsequent review at six months post trauma showed extensive scarring. His vision remain counting finger at 1 foot.

Conclusion:
Chorioretinitis sclopetaria is a rare complication of blunt trauma to the eye. Despite extensive choroidal and retinal injury, surgical intervention is not required. A high index of suspicion is warranted to avoid unnecessary vitreoretinal surgery.

EP104: Chronic Central Serous Chorioretinopathy Treatment Modalities: A Case Report
Tan Wen Hsia, Zabri Kamaruddin
Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To study the various modalities of treatment for CSCR.

Methods:
Case report.

Results:
A 42-year-old gentleman, presented with bilateral eye floaters for 3 months. He had history of taking traditional medication for 4 months. On examination, visual acuity (VA) on his right eye (RE) is hand movement, and left eye (LE) is 6/24. Intraocular pressure is 20 bilaterally. Anterior segment is normal bilaterally and lenses are clear. Right fundus showed inferior exudative retinal detachment (RD). Left fundus showed multifocal subretinal pigment epithelial defect (PED) and inferior exudative RD. B scan showed bilateral serous RD. Ocular coherent tomography (OCT) was not done on the RE due to poor view. LE showed multiple PED with subretinal fluid (SRF). RE Fundus Fluorescent Angiography (FFA) and Indocyanide Green (ICG) shows masking due to large exudative RD. LE FFA showed multiple areas of leakage and ICG shows multiple areas of dilated choroidal vessels corresponding to areas of leakage. An external subretinal fluid drainage was done for the RE. Focal laser and sequential photodynamic therapy was done for the LE. On subsequent follow up, there was improvement of VA, RE counting finger at 1 foot and LE 6/36. OCT showed bilateral SRF reducing. Fundus examination showed RE resolved exudative RD and LE inferior exudative RD.

Conclusion:
There are many modalities of treatment for CSCR, such as medical treatment, laser photocoagulation, photodynamic therapy, transpupillary thermotherapy, micropulse yellow laser therapy and external SRF drainage is an option to facilitate definitive treatment.
EP105: Large Intraocular Foreign Body Causing Retinal Infarction: A Case Report
Tan SE, Selvaraja Vengadasalam, Zabri Kamaruddin
Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To report a case of a large ceramic intraocular foreign body in a 49 years old male tile layer with a history of trauma to the left eye while breaking kitchen tiles.

Methods:
Case report.

Results:
Primary repair of the large corneal entry wound was done on the same day of the injury. Presence of an unusually large IOFB in the posterior segment was confirmed with CT scan. His visual acuity in the left eye was perception to light. There was a sutured corneal entry wound with subtotal hyphaema and iridodialysis.

He underwent pars plana vitrectomy and foreign body removal. A large ceramic IOFB with sharp edges was grabbed with intraocular FB forceps and removed through the same corneal entry wound. The impact site was at the supero-temporal retina resulting in an impact site retinal tear and massive supero-temporal retinal infarct resulting from transected major vessel bundle. The retinal tear was laser barricaded and supero-temporal sectoral retinal laser photocoagulation was given. Surgery was concluded with silicone oil endotamponade.

His best corrected vision had improved to counting finger in an oil filled eye. Poor vision was attributable to the presence of a corneal scar, supero-temporal macula scar and previous retinal infarct.

Conclusion:
IOFB injury is a potentially devastating condition with a high risk for complications and permanent visual impairment.

EP106: Prognosis Of Traumatic Submacular Hemorrhage Managed Conservatively
Gan YK, Yap JY, Florence S, Sheena Mary Alexander
Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
To report a case of traumatic submacular hemorrhage managed conservatively. Extensive traumatic submacular hemorrhage could result in very poor visual prognosis. Various treatments have been reported including pneumatic displacement, vitreoretinal surgery, intravitreal recombinant plasminogen activator (r-TPA) and intravitreal ranibizumab injection. Yet, there is no standard treatment at present.

Methods:
Case report.

Results:
We describe a 26-year-old Dusun gentleman, who was punched by a stranger over his left eye 2 days prior to presentation. He complained of blurring of vision with central scotoma. His vision on presentation was 3/60 with no improvement with pinhole. Anterior segment examination was normal. However, upon funduscropy, he was found to have extensive submacular hemorrhage. Optical coherence tomography (OCT) macular revealed possible choroidal break, retinal pigment epithelium rip with submacular hemorrhage. He was then given topical Ketorolac tromethamine 5 mg/mL 4 times a day. One week post trauma we noted there was no improvement in vision and remained at 3/60. However, OCT macular showed resolving macular haemorrhage. We will continue to monitor the possible complications of traumatic submacular haemorrhage for this patient.

Conclusion:
We have yet to have sufficient studies done on the management of traumatic submacular hemorrhage. More research on intervention should be done for traumatic submacular hemorrhage as appropriate intervention can help improve the visual prognosis. Careful monitoring of the complications of traumatic submacular haemorrhage is important for the long term visual prognosis as well.
EP107: Bilateral Crystalline Lens Dislocation And Ocular Decompression Retinopathy

Tan Chai Lee¹,², Khairuddin Othman¹, Ng Chun Wai², Zamri Noordin², Zulkifli Abdul Ghani², Wan Hazabbah Wan Hitam¹, Raja Azmi Mohd Noor¹

¹Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan
²Department of Ophthalmology, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan

Purpose:
To report a rare case of traumatic bilateral crystalline lens dislocation post mild head injury, treated surgically, however complicated with decompression retinopathy.

Methods:
Case report.

Results:
A 50-year-old man presented with painful, blurring of both eyes vision of 5 days duration. Patient had history of sustained a knock on the head on table after tripped and fall due to imbalance 1 week prior to presentation. There was no loss of consciousness and no treatment sought for the head trauma. Examination revealed visual acuity of CF in the right eye (RE), HM in the left eye (LE). There was presence of bilateral posterior lens dislocation with high intraocular pressure (IOP). He was treated with IOP lowering and anti-inflammatory agent. He then underwent pars plana vitrectomy and removal of crystalline lens with scleral fixed IOL (SF-IOL) of RE, and subsequent pars plana vitrectomy and lensectomy of the LE. Post-operatively he developed iris prolapsed with eventually extrusion of SF-IOL of the RE. Both eyes became hypotony and developed decompression retinopathy with choroidal and retinal detachment. The RE was treated surgically, while LE was treated conservatively. On follow up, patient was on aphakic glasses with RE visual acuity of HM, and LE 6/60. Retina in both eyes was flat.

Conclusion:
Traumatic posterior lens dislocation may associate with secondary high IOP, choroidal and retinal detachment that might give great challenges in management.

EP108: Optic Disc Pit With Central Serous Chorioretinopathy

S Stella, K Sarojini, Devaraj Supramaniam, Selvaraja Vengadasalam

Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To report a case of optic disc pit related central serous chorioretinopathy which underwent vitrectomy, ILM peel and C3F8 Tamponade.

Methods:
Case report.

Results:
A 22-year-old healthy male with no comorbid, presented with left eye sudden painless blurring of vision for 1 month. Otherwise, no other symptoms. Visual acuity was Right eye 6/9 , Left eye 6/60 pin hole same. On examination, there was no relative afferent pupillary defect, bilateral anterior segment was normal, lens were clear. Right eye posterior segment was unremarkable, left eye medium was clear, enlarged cup disc ratio of about 0.7 associated with optic disc pit temporally and serous macula detachment, Optical Coherence Tomography showed persistent subretinal fluid with macula pucker, therefore proceeded with left eye vitrectomy, ILM peel and C3F8 Tamponade .

3 months post-operatively, left eye vision was remain 6/60 but Optical Coherence Tomography showed decrease in subretinal fluid. There was an improvement in the macula thickness from 733 preoperatively to 338 um.

Conclusion:
Optic disc pit usually seen in association with other abnormalities and in 50% of cases, it might be associated with serous macula detachment. In view of persistent subretinal fluid, vitrectomy may show improvement in reduction in subretinal fluid.
**EP 109: Fraser Syndrome: The Hidden Eye**

*Hanisah AH, Munirah AR, Nazima SA, Gaayathri N, Hazlita Mohd Isa*

*Department of Ophthalmology, Pusat Perubatan UKM, Kuala Lumpur*

**Purpose:**
To report a rare autosomal recessive disorder known as Fraser syndrome.

**Methods:**
Case report.

**Results:**
A 6-month-old baby girl born with bilateral fused eyelids was referred to PPUKM for further intervention. Upon presentation, she was noted to have bilateral cryptophthalmos, syndactyly, a large laryngeal web and abnormal genitalia. She was born full term via cesarean section due to prolonged labour. Her birth weight was 3.3kg. Antenatal was uneventful. Her parents are healthy and non-consanguineous. She is the third child of the family. Her parent claimed that their first child, a baby girl, was also born with the same condition and died soon after birth due to renal agenesis. The second child is a boy who is normal and healthy.

Further chromosomal studies performed confirmed her to have Fraser Syndrome. MRI of the brain and orbit showed bilateral hypoplastic eyeballs with posteriorly located larger colobomatous cysts. Both optic nerves were noted to be hypoplastic and medially displaced. Based on the MRI findings, a high possibility of no visual potential following surgery was explained to parents and a conservative management was decided for the baby.

**Conclusion:**
Cryptophthalmos is one of the major criteria for diagnosing Fraser Syndrome. Baby born with this condition must be examined thoroughly to look for other fatal malformation like renal agenesis. Early genetic counselling is important to educate the parents with regards to the probability of them conceiving another child with Fraser syndrome.

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**EP110: Clinical Profile And Efficacy Of Supratarsal Injection Of Triamcinilone Acetonide And Dexamethasone Sodium Phosphate (Corticosteroid) In Treating Severe Vernal Keratoconjunctivitis: 5 Years Review**

*Punitan Rajendran, Haslinda Md Said, Shatriah Ismail*

*Department of Ophthalmology, School of Medical Sciences, Universiti Sains Malaysia, Kelantan*

**Purpose:**
To describe the demographic, clinical manifestation, treatment efficacy and complication of supratarsal corticosteroid injection for severe vernal keratoconjunctivitis (VKC) patients at Hospital Universiti Sains Malaysia (Hospital USM) over 5 year's period, and discuss the literature of supratarsal steroid injection in treatment of refractory VKC.

**Methods:**
We conducted a retrospective review of medical records for VKC who were treated with supratarsal corticosteroid injection at Hospital USM from January 2010 until December 2014. Total of 15 records were traced and reviewed and 5 patients were excluded from this study due to missing and inadequate data. Total 18 eyes were treated with a combination of supratarsal injection of triamcenolone acetonide and dexamethasone sodium phosphate. These patients were monitored for minimum 8 to 12 months.

**Results:**
Majority of them were male (90%). All these patients were between the ages of 4-16 years. All our patients presented with itchiness and giant papillae. We observed 100 percent improvement in symptoms and signs at one month after the treatment. All patients showed significant visual acuity improvement of at least 2 lines on Snellen visual acuity. The main side effect was increased intraocular pressure (4 patients, 22.2%). Four of these patients had recurrences as early as two month post supratarsal injection and received a second injection.

**Conclusion:**
The clinical improvement of combination supratarsal corticosteroid injection in VKC patients from our center is fairly similar to single supratarsal corticosteroid injection in published other studies. Increased intraocular pressure is the main drawback in our series.
EP 111: Familial Exudative Vitreoretinopathy - Clinical Profile And Management
Anis Baidura Azal, Lau Sui Ching, Sunder Ramasamy, Jamaliah Rahmat, Joseph Alagaratn
Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur

Purpose:
To report our experience with the diagnosis and management of FEVR in paediatric population.

Methods:
Retrospective interventional and descriptive case series of 5 patients (10 eyes) affected by FEVR evaluated and treated in our hospital.

Results:
Patients were all male with a mean birth weight of 2.3 kg (range 1.4kg -2.8kg) and mean gestational age of 37.4 weeks (range 33weeks-39weeks) and mean age at presentation is 3.4 years old (range 2 days of life-10 years old). A positive family history of FEVR was obtained in 40% of patient. Prophylactic photocoagulation and cryocylotherapy was done in all patients. During follow up, all eyes retained stable vision.

Conclusions:
A high index of suspicion, family screening and early prophylaxis are recommended to prevent avoidable blindness from this underdiagnosed disease.

EP112: Series Of 3 Cases With Varied Retinal Presentations In Incontinentia Pigmenti
Lau Sui Ching, Anis Baidura Azal, Sunder Ramasamy, Jamaliah Rahmat, Joseph Alagaratn
Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur

Purpose:
Ocular involvement occurs in at least one quarter to one third of cases, typically in the form of proliferative retinal vasculopathy. Rapid progression leads to total retinal detachment and retrolental membrane formation within the first few months of life. We aim to report case series of three patients with incontinentia pigmenti

Methods:
Retrospective case series.

Results:
This retrospective case series describes three cases with very varied retinal presentations in infants with incontinentia pigmenti at Hospital Kuala Lumpur. The first case presented with an avascular periphery retina which required and was managed with laser therapy. The second case showed very advanced tractional retinal detachment in both eyes which was not amenable to treatment. The third case presented with essentially normal retinas.

Conclusion:
Retinal screening at the earliest is essential in infants confirmed with incontinentia pigmenti.
EP113: A Case Of Successful Squint Corrective Surgery For Right Eye Traumatic Superior Oblique Muscle Palsy
Yih Chian Yew, Vanessa Neoh
Department of Ophthalmology, Hospital Pulau Pinang

Purpose:
Isolated superior oblique muscle palsy is rare and may occur after trauma. Patients usually suffer from diplopia and tend to tilt their head. We report a case of successful corrective surgery for superior oblique muscle palsy after 40 years from the causative traumatic event.

Methods:
Case report.

Results:
A 63-year-old man sustained right superior oblique muscle palsy after a motor vehicle accident in 1974. He suffered from diplopia for years since the incidence. Examination revealed tilted head position to left, right hypertropia and mild exotropia in primary position. His right eye has limitation of depression in adduction. After almost 40 years, patient came for eye consultation and he agreed for a corrective surgery to improve his symptom. Superior oblique tuck surgery was not considered as it may cause Brown syndrome. Oculoplastic surgery with 8 mm myomectomy of right inferior oblique muscle was performed for him. Post-operatively, he showed improvement of his symptom, with only slight diplopia of left gaze. Hess chart showed minimal residual right superior rectus over-action. He is currently on prism glass (1 prism dioptre Base up) of left eye. He has no more diplopia on all gaze.

Conclusion:
This case demonstrated that even though a superior oblique muscle palsy has occurred years ago, oculoplastic surgery still have a role and can improve patient's symptom and quality of life.

EP114: Dangers Of Cradle!
E Anushia, B Nor Akmal, YC Voon, Suriana Suain, Sharifah Intan Hosnuliza Syed Osman
Department of Ophthalmology, Hospital Kuala Lumpur, Wilayah Persekutuan Kuala Lumpur

Purpose:
To evaluate the incidence of eyelid laceration in children presented in Hospital Kuala Lumpur due to cradle injury.

Methods:
Two case series of eyelid laceration in children caused by cradle injury which presented to Eye Clinic in Kuala Lumpur Hospital between Jan 2015 to May 2015.

Results:
The 1st case was a 4-year-old boy whom was taken care by his grandmother presented with injury to his left upper eyelid due to trauma caused by cradle hook. During the incident, his grandmother was taking a shower. He presented to us with left upper eyelid avulsion wound of medial one third involving canalicular injury. Other ocular examination was unremarkable. Eyelid toilet and suturing with bicanalicular intubation using Crawford tube were performed.

The 2nd case was a 2-year-old boy, who was nursed in a cradle and upon getting out of it, the edge of the cradle accidentally hooked his left eyelid. Examination under anaesthesia revealed full thickness laceration wound of the middle third of left upper and lower eyelids involving the lid margin. Other ocular examination was unremarkable. Eyelid toilet and suturing was done.

Conclusion:
Cradle may appear harmless but may pose unsuspected injury to children. Public should be made aware of these risks and exercise extra caution and supervision while using it.
EP115: Pupillary Block Glaucoma Following Penetrating Eye Injury

Valarmathy Vaiyavari, Tanusha Dorairaja, Selvaraja Vengadasalam, Devaraj Supramaniam, Choo Swee Ying

Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
Case report.

Methods:
A 26-years-old Malay gentleman sustained a penetrating right eye injury with traumatic cataract by a metal wire. His presenting vision was hand movement only. There was no relative afferent pupillary defect. Orbital x-ray and B-scan were negative for intraocular foreign body. He underwent a primary right corneal toilet and suturing. This was subsequently followed by cataract extraction during which was noted that he had pre-existing anterior capsule tear and a large posterior capsule tear resulting in retained cortical matter in vitreous with clouding of vitreous phase. Postoperatively noted that he had complete pupillary block by the anterior prolapse of the intact anterior hyaloid phase. Intraocular pressure (IOP) remained dangerously high (ranging 47-50mmHg) despite full medical anti-glaucoma treatment. Pars plana vitrectomy was then performed to relieve the pupillary block, following which there was normalization of IOP without any further medical treatment.

Conclusion:
Aphakic pupillary block glaucoma can result following cataract extraction in cases of traumatic cataract. This can be possibly prevented by creating a functional Peripheral iridotomy and performing Vitrectomy when necessary.

EP116: The iron in the eye

Ivan Cheng En Yoo, Ch’ng Tun Wang

Department of Ophthalmology, Hospital Raja Permaisuri Bainun, Ipoh, Perak

Purpose:
To report a rare case of quiet metallic intraocular foreign body.

Methods:
Case report.

Results:
A 53-year-old Malay gentleman presented to eye clinic for diabetic retinopathy. Incidentally noted a metallic foreign body at the inferior angle of left eye. Minimal rust ring formed at the endothelium adjacent to the foreign body. However, ocular examination shows 6/9 vision with no anterior chamber reaction and no symptoms of siderosis. Further history revealed that he had an ocular injury 15 years ago when he was grinding metal. Patient refused for surgical intervention as his vision is good. The foreign body is likely an iron piece as there is localized formation of rust ring.

Conclusion:
We report a rare case of quiet intraocular iron without siderosis formation.
EP117: Siderosis Bulbi As A Result Of Retained Metallic Intraocular Foreign Body
Wilson Wong Jun Jie, Pall Singh
The Tun Hussein Onn National Eye Hospital, Petaling Jaya, Selangor

Purpose:
Siderosis bulbi is a complication that can occur after an injury involving an iron intraocular foreign body. We aim to report a case of siderosis bulbi in a patient with intraocular foreign body which was presumed to be organic.

Methods:
Case report.

Results:
We describe a gentleman who presented with an intraocular foreign body as a result of a workplace related trauma. Conservative management was chosen as the intraocular foreign body appeared non-metallic in nature which also did not appear as opaque on the orbital X-ray. The patient eventually underwent cataract extraction with vitrectomy when he presented one year later with siderosis bulbi. However, his condition progressed despite the surgical intervention.

Conclusion:
Siderosis bulbi can occur between 18 days to 8 years following an ocular trauma involving metallic intraocular foreign body. A very high index of suspicion is required when it comes to management of a workplace related ocular trauma. Early surgical intervention is vital to prevent the onset of siderosis bulbi as there is no definitive treatment once this condition has set in.

Tan Wen Hsia, Zabri Kamaruddin
Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To understand and manage a case of traumatic sclopetaria.

Methods:
Case report.

Results:
A 29-year-old gentleman presented with sudden blurring of vision. A grinder head broke and hit his right eye while he was grinding metal at home. On examination, his right eye visual acuity is counting finger at 1 foot. Intraocular pressure is 16. Relative afferent pupillary defect is positive. There is periorbital hematoma, temporal superficial subconjunctival abrasion and subconjunctival haemorrhage. His lens is clear. Fundus examination shows vitreous haemorrhage, optic disc is pink with cup-disc ratio of 0.3. There is pre-retinal haemorrhages surrounding the optic disc. There is also a superotemporal macular detachment with oedema and the macula is off.

B-scan ultrasonography showed a flat retina and no retinal detachment seen. He was then reassured and followed-up monthly. On the last review, his vision improved to counting finger at 3 feet.

Conclusion:
Sclopetaria is a rare event that can occur when a high-velocity missile strikes the globe without penetrating it. It has a characteristic choroidal and retinal appearance. Observation alone is adequate as the risk of retinal detachment is low.
EP119: A Case Of Red Eye That Is Not To Be Missed
Tang Seng Fai, Ng Wei Loon, Hazlita Mohd Isa
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
To report a rare case of traumatic middle meningeal arteriovenous fistula that presented with chronic “red eye”.

Methods:
Case report.

Results:
A 74-year-old lady with history of minor head trauma was referred for persistent left eye redness of one month duration despite being treated by her general practitioner. Clinical examinations revealed presence dilated corkscrew episcleral vessel in the left eye. All other ocular examination of the left eye including visual acuity, extra ocular movement, intraocular pressure, optic nerve functions and fundus was normal. The right eye examination was unremarkable. CT scan of the brain showed features suggestive of ocular venous outflow disturbance. Subsequent cerebral angiogram showed a rare fistula formation between middle meningeal artery and sphenoparietal sinus. This lead to sphenoparietal sinus dilatation which drained into left cavernous sinus. Concurrently outflow occlusion in the left cavernous sinus was noted causing reflux of blood into left superior and inferior ophthalmic vein. Transarterial endovascular embolisation was performed to close the fistula and the “red eye” resolved.

Conclusion:
Traumatic middle meningeal arteriovenous fistula (MMAF) is an uncommon condition. Cases with MMAF usually manifest with severe symptoms and rarely presents with ocular symptom alone as seen in this case. Thorough and careful ocular examinations will lead to the proper diagnosis. Prompt investigation and intervention is crucial to prevent further ocular damage.

EP120: Traumatic Lens Capsular Breach Without Progressive Lens Opacification
Jacob Danasamy, Nazri Omar
Department of Ophthalmology, Hospital Serdang, Selangor

Purpose:
The crystalline lens is enveloped by capsular tissue and breach of this capsule is usually followed by cataract formation. Other possible complications include lens swelling and lens-induced uveitis. We aim to report a case of penetrating corneal injury with anterior lens capsule breach which did not result in lens associated complications.

Methods:
Case report.

Results:
A 43-year-old gentleman presented with discomfort and blurring of vision after a staple pin entered his eye a day earlier. Examination revealed a full thickness corneal laceration with surrounding corneal oedema. The anterior chamber was slightly shallow with positive Seidel’s sign. The pupil was round and reactive. Upon dilatation of the pupil, a vertical breach of the anterior lens capsule was noted with minimal haze.

Surgical repair of the corneal wound was performed and the anterior chamber was reformed. Post operative management included topical steroid, antibiotic and a mydriatic agent along with oral analgesics. The patient was monitored for lens complications during the immediate post-operative period. Subsequently, he was reviewed at a week and a month intervals. Apart from the localised fibrosis over the breached capsule and the associated iris pigment deposition, the lens remained clear. There were no posterior synechiae and other lens associated complications seen. The final unaided vision was 6/9 with N5.

Conclusion:
Anterior capsular breach may not necessarily lead to other lens complications. In cases where adequate monitoring and treatment can be guaranteed, surgical lens removal is avoidable thus preventing premature presbyopia in young patients.
EP121: Management Of Traumatic Macular Hole: A Case Report
Uthayarany M, Wendy OCF, Tikambari E, Kalatheran S, Wong Chi Lun
Department of Ophthalmology, Hospital Kulim, Kedah

Purpose:
To report a case of macular hole following a blunt trauma in a young adult and subsequent management.

Methods:
Case report.

Results:
A 29-year-old Malay gentleman presented with alleged history of blunt trauma to left eye after hit by fishing metal ball while fishing on the same day. Vision on presentation was 1/60 in the affected eye, and examination revealed conjunctival laceration with no scleral penetration, traumatic mydriasis and iritis, iridodialysis extending from 8-10 o’clock with angle recession up to 270 degree. Reverse relative afferent pupillary defect was negative and intraocular pressure was normal. Fundoscopy revealed Berlin’s edema with a central macular hole. There was also choroidal rupture nasal to optic disc.

Following resolution of conjunctival laceration and iritis, he was referred for vitreoretinal opinion in Hospital Sultanah Bahiyah and subsequently planned for pars plana vitrectomy.

Conclusion:
Macular hole occur relatively infrequent after blunt ocular trauma. The exact pathophysiology is still unclear. Since spontaneous closure is possible; options of early vitrectomy versus close follow up remain a subject of debate.

EP122: Traumatic Optic Neuropathy Following A Jet Spray Injury
Nur Aqilah Salleh, Wong Hon Seng
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
Traumatic optic neuropathy (TON) is a common complication of high velocity blunt injury. We report a case of TON that was not detected during the initial presentation.

Methods:
Case report.

Results:
We describe a man who sustained jet spray blunt trauma to his right eye eight months ago. He was discharged well from his primary hospital and was referred to our centre for unexplained visual lost. At presentation to us, his best corrected visual acuity was 6/24 OD, 6/6 OS. He complaint of loss of stereopsis and relatively blurred vision in his right eye. Examination revealed no afferent pupillary defect with normal anterior segment. His right optic disc was pink and peripheral retina had no break.

He underwent electrophysiology tests including ffERG and VEP, which were normal. CT scan orbit showed no significant abnormality of the optic nerve. Suprisingly, Humphrey visual field (HVF) revealed a dense scotoma in his right visual field.

Conclusion:
Detection of optic neuropathy is vital especially post trauma. This case highlighted the value of a simple perimetry test like HVF, which can guide us in establishing the diagnosis of TON. VEP results can be normal as there are lot of factors that may influence the result of an electrophysiology test.
Huwaina AS, Nor Sharina Yusof, Bashkaran Karuppannan
Department of Ophthalmology, Hospital Kuala Krai, Kelantan

Introduction:
Orbital penetrating injury is the most devastating injury which may be associated with retained foreign bodies. Wooden or bamboo foreign bodies within the orbit are difficult to diagnose in the clinical setting. This case report outlines the clinical presentation and radiological findings in chronic retained intraorbital foreign body.

Methods:
Case report.

Results:
A 32-year-old Bangladeshi man, presented with persistent painless right eye redness associated with blurring of vision for 6 months duration. There was a history of penetrating right eye injury by a wooden stick 2 years ago with removal of the foreign body done. Initial CT scan was unremarkable. Recent eye examination revealed visual acuity 6/45 in the right eye with chemotic conjunctiva and restricted ocular movement medially. A repeat CT scan orbit was done showed a retained intraorbital foreign body extending to the sphenoid sinus with chronic inflammation.

Conclusion
Detection of retained intraorbital foreign bodies requires a high index of suspicion in clinical management. A CT scan of the orbit is the imaging modality of choice for detection and localization of the foreign body. Early detection of retained intraorbital wooden foreign body is crucial to prevent severe orbital infection.

EP124: Calcium Oxide Desiccant Ocular Chemical Injury
Tan CY, Liew OH, Azura Ramlee
Department of Ophthalmology, Hospital Selayang, Selangor

Purpose:
To report a case of chemical injury to the eyes following exposure to calcium oxide (lime) obtained from a desiccant packet found in dried seaweed.

Methods:
Case report.

Results:
A 10-year-old boy presented to the emergency department 5 hours after both his eyes were accidentally splashed with a chemical solution at school. The patient and his friends were ‘experimenting’ the reaction of the granules obtained from a desiccant packet taken from dried seaweed when mixed with tap water. The bottle of water exploded after being shaken and the heated chemicals splashed into his eyes. The granules in the desiccant packet were later proven to be calcium oxide. The pH in the eyes was 8.0 at presentation. Assessment after irrigation revealed Roper-Hall grade I alkaline injury in the right eye and Roper-Hall grade III in the left eye. His right vision was counting finger 3 feet which improved to 6/24 with pinhole and left vision was counting finger 3 feet. He also had a second degree burn over the face.

He was treated with topical steroids, antibiotics, and artificial tears, as well as oral doxycycline and vitamin C. He gradually improved and at 6 months post injury his BCVA in each eye was 6/6 with only a remaining faint paracentral corneal scar in the left eye.

Conclusion:
Desiccant packets are commonly found in food products. The public should be made aware of the danger of calcium oxide desiccant and these products should be strictly kept away from children.
EP125: Trapdoor Fracture
Punithamalar V, Nandini V
Department of Ophthalmology, Hospital Tuanku Ja’afar, Seremban, Negeri Sembilan

Purpose:
To report a case of trapdoor orbital fracture which improved with observation.

Methods:
Case report.

Results:
A 13-year-old student presented to eye clinic with right eye pain and double vision for 1 day duration. He sustained trauma during a rugby game in school. A co-player had accidentally elbowed his right eye. On examination, visual acuity in both eyes were 6/9, pinhole 6/6. The right eye adduction and abduction were markedly reduced. Diplopia was present in all quadrants. Forced duction test was negative. There was no relative afferent pupillary defect (RAPD). Anterior and posterior segments of both eyes were normal. CT scan orbit revealed a linear crack in right lamina papyrecea without displacement – trapdoor fracture without tissue entrapment. The student was closely monitored for any deterioration of visual symptoms. The extraocular movements dramatically improved over a period of three months.

Conclusion:
Sports injury is the third most common cause of trapdoor fractures in young patients. Trapdoor fractures with obvious clinical or radiological evidence of tissue entrapment will require timely surgical intervention to prevent muscle ischaemia. In our patient, he had diplopia which gradually improved with observation. Close observation is an option in patients without clinical or radiological evidence of entrapment.

EP126: Do Not Tick Me Off
Goh Yew Jen1, Mohd Aziz Husni2
1Department of Ophthalmology, Pusat Perubatan Universiti Malaya, Kuala Lumpur
2Department of Ophthalmology, Hospital Tengku Ampuan Afzan, Kuantan, Pahang

Purpose:
To report two cases of lower lid infection caused by tick (Ixodes Ricinus) bite and to show that careful inspection is vital in its diagnosis and treatment

Methods:
Case series.

Results:
A 44-year-old lady without systemic comorbidities, presented with painful right lower lid swelling for five days. History revealed she was hit by a foreign body over the right eye at a fruit plantation 5 days ago. Right lower lid swelling was accompanied with red eye and blurring of vision. Visual acuity was 6/18 on the right eye and 6/9 on the left. Right periorbital region was swollen and erythematous with a lower lid mole-looking lesion.

A 50-year-old lady with bilateral eye diabetic macula oedema, presented with painful right lower lid. She was hit by a foreign body while riding a motorcycle two days prior. Visual acuity was 5/60 bilaterally. Right lower lid showed a mole looking lesion with minimal erythema surrounding it. On slit lamp examination, noted that the lower lid ‘mole’ was in fact, moving, and found to be a tick. The arachnid was removed using non-tooth forceps, under local anaesthesia and treated with Maxitrol ointment. Visual acuity improved to 6/9 bilaterally for the first patient and symptoms resolved for both patients.

Conclusion:
Careful examination should be carried out in cases with alleged foreign body contact. In this case, an unsuspecting ‘mole’ turned out to be a tick. Detailed inspection can reveal its diagnosis and prompt treatment can then be carried out to achieve full recovery.
Purpose:
Methods:
Results:
A 26-year-old Chinese lady complained of right eye pain and blurring of vision after her husband threw a power bank 2 weeks prior to presentation. Patient initially went to another hospital, where she was treated for traumatic hyphema with high intraocular pressure (IOP). She was discharged after 1 week with 4 antiglaucoma eye drops.

On presentation, the right eye vision was hand movement with positive RAPD. There was subconjunctival hemorrhage, hazy cornea and deep anterior chamber with pigmented cells of 4+. There was iridodonesis but no iridodialysis. IOP was 50 mmHg. Mild phacodonesis was present with suspicious cleft in the middle of the intumescent lens, suggestive of posterior capsule rent. B scan showed vitreous hemorrhage with flat retina. IOP was optimised prior to surgery. She underwent lens aspiration and anterior vitrectomy. During surgery, a large posterior capsule rent was seen and patient was left aphakic. 3 weeks post operatively, her vision is 6/60, ph 6/24, RAPD negative. IOP is 15 mmHg with minimal AC cells. Optic disc is pink, CDR 0.3, with cotton wool spots and splinter hemorrhages at the macula with minimal vitreous clump. Patient is planned for secondary IOL implantation later.

Conclusion: An object as small as the power bank can cause significant blunt ocular trauma. Domestic violence has been reported as the second most common cause of blunt ocular trauma and it is preventable.

Purpose:
Methods:
Results:
An unfortunate 18-year-old gentlemen was referred from the emergency department. The patient was reported riding a motorbike under alcohol influence before skidded and hit a stationary car. He was found unconscious by the roadside with his right globe found nearby the scene. On examination, there was a large orbital hematoma presence but no evidence active bleeding or CSF leaks. Apart from laceraion wound over the scalp there was no lacerations over both lids. The right complete evulsion of the globe and optic nerve was noted. Bedside primary suturing was done before he was transferred to neurosurgical centre for further management of intracranial bleed.

Conclusion: Complete avulsion of globe and optic nerve has worse prognosis. However due to absence of visual function, a variety approaches have been proposed to discuss strategy to reposition globe and suture muscle back to their normal anatomical position mainly for cosmesis reason.
Ainal Adlin N, Aimy MZ, Norshamsiah Md Din, Safinaz MK, Mushawiaht Mustapha
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:
To report a case of mild form of traumatic anterior optic neuropathy from a blunt trauma.

Methods:
Case report.

Results:
A 67-year-old gentleman presented with left eye blurred vision for 1 week duration after alleged blunt trauma. His OS vision was counting finger. However, with +10D lens, his vision improved to 6/18. Reverse RAPD was positive. Anterior segment showed traumatic mydriasis with absence of crystalline lens at the pupillary plane. Gonioscopy revealed 360º angle recession. Intraocular pressure (IOP) was between 26-30mmHg. Posterior segment examination revealed inferiorly dislocated crystalline lens. Optic disc was mildly hyperemic and the retina was flat.

Patient was treated for high IOP and topical anti-inflammatory agent was also prescribed. Patient underwent left eye trans pars planar vitrectomy and lensectomy. Intraoperatively, there was inferior retinal tear with shallow retinal detachment. Endolaser was given then C3F8 18% was injected. Initially, he was planned for scleral fixated intraocular lens implantation, however patient was left aphakia due to intra-operative findings mentioned. He is planned for secondary intraocular lens implantation in 2-months time.

Conclusion:
Although less common, anterior traumatic optic neuropathy with indirect mechanism of injury carries a better visual prognosis.

EP130: Clinical Presentations Of Intraorbital Foreign Body Secondary To Trauma
Mohd Ihsan Jamaludin, Madhusudhan Paramananda, Premadeva S, Shuaibah Abd Ghani, Sheena Mary Alexander
Department of Ophthalmology, Hospital Queen Elizabeth, Kota Kinabalu, Sabah

Purpose:
Marble air gun is a widely used tool for hunting small animal especially in Sabah. Managing these associated ocular injuries should comprise of a thorough assessment with an occasional multidisciplinary care.

Methods:
Case report.

Results:
We describe a case of a 4-year-old girl who accidentally fired her uncle’s air gun which hit her left eye. On examination, a retrobulbar foreign body with optic nerve avulsion was seen but the globe was intact. Surgical removal through the superior orbital rim approach was done with liaison between ophthalmology, neurosurgery and maxilo-facial unit. The surgery was successful and a single marble was delivered out. The globe was intact and child recovered post operatively but her vision remained no perception of light.

Conclusion:
Intraorbital foreign body usually are associated with penetrating high velocity injury. In this case, we will describe how the injury resulted in a retrobulbar foreign body with an intact globe and how the approach from the superior orbital rim that is rarely but successfully done in comparison with other approach such as lateral orbitotomy that are commonly used to remove retrobulbar foreign body.
Azhan Azman, Shawarini Jusoh, Khairul Azhar, Mohd Aziz Husni
Department of Ophthalmology, Hospital Tengku Ampuan Afzan, Kuantan, Pahang

Purpose:
To report an unusual ocular trauma of retroorbital penetrance by fishing bullet weight (sinker).

Methods:
Case report.

Results:
A 32-year-old male Indonesian presented to casualty clinic with right eye injury claiming a fishing bullet weight entered the eye while fishing. He presented with acute right eye pain without reduced of vision. Anterior segment examination showed no evidence of penetration to the globe but a thorough examination revealed a small opening at lateral end of lower lid above the lower orbital groove. Posterior segment examination showed a retina commotio at inferotemporal region with normal optic disc appearance. Computed tomography demonstrated a radio opaque foreign body lied in the retro orbital area close to the optic nerve. Emergency surgical intervention was performed using transnasal approach (Ethmoidectomy) and succesfully removed the 2x1cm sinker. Vision was preserved post operatively.

Conclusion:
There is an increased risk of optic neuropathy and motility disturbance when removing a retro orbital foreign body. Therefore, it is important to accurately localize the foreign body and to choose the safest and appropriate surgical approach.

EP132: Spectrum Of Ocular Trauma Following Hit By Flying Living Object Onto The Eye During Motorbike Riding
Siti Husna Hussein, Nurhamiza Buang, Norhalwani Husain, Azma Azalina Ahmad Alwi
Department of Ophthalmology, Hospital Raja Perempuan Zainab II, Kota Bharu, Kelantan

Objective:
To report a spectrum of ocular trauma following being hit by flying living object onto the eye during motorbike riding.

Methods:
Case series.

Results:
This case series involved 3 patients with similar mechanism of ocular injury with different spectrum of presentation. All cases were seen in eye clinic. The first case was a 44 year old male, with history of being hit by a bat on the right eye. He sustained scleral laceration of 6.5mm and uveal prolapse at 2 o'clock position. He developed orbital cellulitis and retinal detachment post operatively. The second case was a 19 year old male with history of alleged stung by a bee in the left eye. He sustained superficial stromal foreign body. Removal of foreign body was done under slitlamp but complicated with toxic keratouveitis. The third case was a 24 year old male with history of alleged stung by a bee on the right eye. He sustained deep seated endothelial foreign body. Removal of foreign body was done in the operation theater via anterior chamber approach. He then developed toxic keratouveitis with melting cornea.

Conclusion:
These three cases illustrate the similar mechanism of injury which is being hit by flying living object onto the eye during motorbike riding. This high impact collision can result in a variety of ocular trauma. Therefore, the use of protective helmets with facial covering for motorcyclists should be enforced. Early prevention and treatment is mandatory to avoid serious complications and to ensure good visual prognosis.
Objective:
To report a case of a spitting snake (Naja Sumatrana) venom attack on the eyes, its effects and to show that prompt treatment as it is with all chemical injuries, is vital in its management.

Methods:
Case report.

Results:
A 61-year-old lady without systemic comorbidities, presented with bilateral painful red eyes 40 minutes after she was spat on by a snake. Initial pH was 8. Her eyes were irrigated with 8 pints of normal saline each, with final pH 7. Further history revealed a failed attempt to chase a hiding black snake away as it suddenly sprang up and spat venom on her face. Bilateral eyelid swelling was accompanied with red eye, photophobia, pain and blurring of vision. Visual acuity was 6/36 both eyes. On slit lamp examination, bilateral conjunctivas were injected. Cornea showed scattered punctate epithelial erosions, streak and inferior epithelial defects. There were no corneal opacities nor limbal ischaemia. No other significant anterior segment findings. Two hourly topical steroids bilaterally were initiated, along with topical chloramphenical, preservative free artificial tears, topical homatropine and oral vitamin C. She was seen over the course of 3 weeks. Epithelial defect healed, visual acuity improved to 6/9 bilaterally and symptoms resolved.

Conclusion:
In this case of spitting snake venom attack, treatment was initiated as per corneal chemical burns protocol. Chemical injuries of the eye can produce extensive damage to the ocular surface, anterior segment and limbal stem cells, and represent potentially blinding ocular injuries. Immediate assessment and initiation of treatment should then be carried out to achieve good final visual outcome.
EP134: Iris Metastasis Secondary To Breast Carcinoma
Ho Fui Li, Mohamad Aziz Salowi
Department of Ophthalmology, Hospital Umum Sarawak, Kuching, Sarawak

Purpose:
Iris metastasis is rarely encountered in clinical practice. We aim to report a case of iris metastasis secondary to breast carcinoma.

Methods:
Case report.

Results:
A 44-year-old lady with history of treated breast carcinoma presented with two-week history of white mass in right eye. On examination, there was a whitish mass measuring 6mm x3mm with superficial vascularisation on the superior iris. Mild anterior chamber activity seen. Gonioscopy showed the mass was occluding anterior chamber angle. Intraocular pressure and fundus assessment were normal. Presence of iris metastasis alerted us to screen for metastasis elsewhere. She was noted to have lung and mediastinal lymph node metastases. Chemotherapy was reinitiated but she passed away during the treatment course.

Breast cancer is the commonest malignancy that metastasizes to uvea where it accounts 39-49%. Uvea is the commonest site of metastases and iris metastasis constitutes 5-11% of uveal metastases. Prognosis of patients with iris metastasis is generally poor.

Conclusion:
Iris metastasis is a late sign as patient would have systemic spread of malignancy at the time of presentation. Hence, the prognosis in them is grave with 5-year survival rate of only 5-7%. It is crucial to exclude other metastases in patient with iris metastases.

EP135: The Hidden Salmon Patch: Ocular Lymphoma Mistaken As Vogt Koyanagi Harada Disease
Nazima Shadaht Ali, Hazlita Mohd Isa
Department of Ophthalmology, Pusat Perubatan Universiti Kebangsaan Malaysia, Kuala Lumpur

Purpose:

Methods:
Case report.

Results:
A 65-year-old male was referred to HUKM Eye Center with a provisional diagnosis of Vogt Koyanagi Harada disease which worsened despite oral Prednisolone treatment. On presentation at our centre, his visual acuity was 6/9 N5 OD and CF N48 OS. His left eye appeared proptosis with fullness of the upper lids bilaterally. Upon lifting the eyelids, a conjunctiva salmon patch lesion was detected underneath them. Funduscopy revealed multiple choroidal infiltrations and hyperaemic optic disc swelling. B-scan examination showed thickened choroid with retinal detachment. CT scan showed a left axial proptosis with a homogenous enhancing mass at the posterior aspect of the globe. Conjunctival tissue biopsy revealed marginal Zone B cell (MALT type), low grade, non-Hodgkin's lymphoma. He was referred to the Haematology team and was decided for conservative management initially. After 6 months, the conjunctival lesions worsened, optic discs were more hyperaemic and swollen and there was inferior exudative retinal detachment seen. He was then was started on chemotherapy which subsequently improved his ocular condition.

Conclusion:
MALT Lymphomas constitute the majority of orbital and periorbital non-Hodgkin's lymphoma. Early surgical biopsy and adequate imaging studies is essential. MALT Lymphomas are not usually aggressive and remains localized to mucosal surfaces.
EP136: A Rare Case Of Kaposi’s Sarcoma

Withdraw presentation

EP137: Primary Vitreoretinal Lymphoma: A Case Report

Primary Vitreoretinal Lymphoma: A Case Report

Siti Zakiah MK, Raja Norliza Raja Omar, Nor Fadzillah Abd Jalil, Kavitha P
Department of Ophthalmology, Hospital Melaka, Melaka

Objective:
To report a case of posterior uveitis secondary to PVRL.

Methods:
Case report.

Results:
A 59-year-old Malay lady, complained of sudden onset of seeing floaters over the left eye associated with painless blurring of vision for 2 weeks duration. The contralateral eye was blind following a penetrating injury 10 years back. On examination, the right vision was NPL and the left vision was 6/12. The anterior segment of the left eye was quiet and the posterior segment showed vitritis with an inactive chorioretinal scar at the superonasal quadrant. The investigations were not conclusive of any diagnosis and therefore she was treated as sympathetic ophthalmia initially and then the diagnosis was revised to ocular toxoplasmosis. Despite on two weeks of oral prednisolone and azithromycin, her condition had worsened. She had developed multiple choroiditis and vasculitis. She was treated as ocular tuberculosis (TB) based on clinical grounds. A mantoux test, TB PCR and TB quanteferon test were negative. Anti-TB medication was started and she responded well for the first 6 weeks. The choroiditis and vasculitis had completely resolved. Several retinal lesions had appeared over the macula. A second sample of TB and viral PCR were sent and the results were negative. Anti TB medication was stopped. She was finally treated as PVRL based on clinical suspicious and resistance to treatment. She received intravitreal injection of methotrexate. The retinal lesions completely resolved after 9 injections over 6 weeks. Unfortunately she developed corneal toxicity secondary to the methotrexate and therefore the injection was withheld.

Conclusion:
PVRL should be suspected in elderly patients who present with posterior uveitis with negative workup for common causes of posterior uveitis. Sub RPE infiltrates are the most distinct feature. Intravitreal methotrexate is amongst one of the most effective treatment.