United We Stand: One Vision for Malaysia

MALAYSIAN OPHTHALMOLOGY SCIENTIFIC CONGRESS 2025

25-27 APRIL 2025

BERJAYA TIMES SQUARE HOTEL, KUALA LUMPUR, MALAYSIA

Malaysian Journal of Ophthalmology

SUPPLEMENT

KUGLER PUBLICATIONS
www.kuglerpublications.com

DOI
https://doi.org/10.35119/myjo.v7i2Supp

Published by Kugler Publications,
P.O. Box 20538, 1001 NM Amsterdam,
The Netherlands

Table of Contents

MOSC 2025 Editorial Board

Members

Chan Jan Bond

Dahvinia Devan

Haslinda A. Rahim

Ng Hong Kee

Nurul Laila Salim

Jason Allan

Rajasudha Sawri Rajan

Rohanah Alias

Sangeetha Tharmathurai

Shahidatul Adha

Siti Nurhuda

Sudhashini Chandraseka

Sujaya Singh

Syaridatul Hikmah Kamarudin

Wai Yong Zheng

Yong Meng Hsien

About MOSC 2025

MALAYSIAN OPHTHALMOLOGY SCIENTIFIC CONGRESS (MOSC) 2025
25–27 April 2025 | Kuala Lumpur, Malaysia
Theme: "United We Stand: One Vision for Malaysia"

We are proud to introduce the inaugural Malaysian Ophthalmology Scientific Congress (MOSC) 2025, a milestone event that aims to unify and advance the ophthalmology community in Malaysia and beyond. Held in the vibrant city of Kuala Lumpur, this congress is a collaborative initiative by the Malaysian Universities Conjoint Committee of Ophthalmology (MUCCO), Malaysian Society of Ophthalmology (MSO), College of Ophthalmologists Academy of Medicine Malaysia (COAMM), the Ophthalmology Services of the Ministry of Health Malaysia (MOH), and the Malaysian Armed Forces.

MOSC 2025 marks the coming together of two longstanding national meetings—the MSO Annual Scientific Meeting and the Conjoint Ophthalmology Scientific Conference (COSC)—into a single, dynamic platform dedicated to academic excellence, clinical innovation, and nationwide collaboration.

This landmark congress will feature:

- Over 46 hours of scientific content spanning 13 subspecialties in ophthalmology.
- Dedicated sessions for trainees, optometrists, paramedics, and allied health professionals.
- Expert-led debates, intervarsity quizzes, video competitions, free paper presentations, and e-poster discussions.
- Opportunities for networking, collaboration, and knowledge exchange with peers and leaders from Malaysia and the Asia-Pacific region.

Our vision is to break down silos—between public and private sectors, academia and service, trainees and consultants—by creating a vibrant space for all professionals passionate about improving eye care.

Abstracts

Free Paper Abstracts

Cataract & Refractive

ABSTRACT ID: 133

RISK FACTORS AND VISUAL OUTCOME OF CATARACT SURGERY IN HIGHLY MYOPIC PATIENTS AT A TERTIARY HOSPITAL IN SEMARANG

Edo Sun de Putra[1], Wisnu Sadasih[1]

[1]Diponegoro University, Dr. Kariadi Hospital

Purpose

The purposes of this study were to describe the visual outcome of highly myopic eyes following cataract surgery and to identify associated risk factors for poor post-surgery vision.

Methods

We carried out a retrospective, noncomparative case study at the Department of Ophthalmology, Kariadi Hospital, Semarang, Indonesia. High myopia was defined as an axial length equal to or more than 26 mm. The primary outcomes included best corrected visual acuity (BCVA), visual improvement, and complications during the first 3 months after surgery.

Results

Eighty-three eyes were enrolled from January 2024 to December 2024. A total of 74 (89.2%) eyes had good visual improvement (≥ 3 line Snellen chart), 63 eyes (75.9%) had good postoperative vision (BCVA ≥ 6/18), and 9 eyes had poor postoperative vision (BCVA < 6/60). A total of 5 patients experienced complications, including posterior capsular opacification and retinal detachment, within 3 months of follow-up. Age of the patient, pre-existing posterior segment abnormalities, and having systemic diseases such as hypertension and diabetes were risk factors that influenced postoperative vision ($P<0.001$).

Conclusion

Most of highly myopic eyes achieved good visual improvement and good postoperative visual acuity after cataract surgery. Age of the patient, systemic diseases, and pre-existing posterior segment abnormalities were risk factors for postoperative visual outcome.

Cornea & Anterior Segment Disease

ABSTRACT ID: 41
OCULAR SURFACE SQUAMOUS NEOPLASIA IN MALAYSIA: A 5-YEAR REVIEW

Ahmad Anwaar Muhammad Saifullah[1], Nor Sharina Yusof[1], Che Mahiran Che Daud[2], Rosilah Mohamad[3], Rohanah Alias[3]

[1]Hospital Raja Perempuan Zainab II (HRPZ II);[2]Hospital Sungai Buloh;[3]Hospital Kuala Lumpur

Purpose

To review the demographic profile and treatment outcomes in patients with ocular surface squamous neoplasia (OSSN) at government cornea centres in Malaysia.

Methods

This is a retrospective cohort study of patients with proven histopathological report of either corneal-conjunctival intraepithelial neoplasia (CIN) or squamous cell carcinoma (SCC). The patients were encountered from January 2016 to December 2021 at 2 government cornea centres. The patients' demographics, histopathology report, and treatment outcomes were reviewed.

Results

A total of 62 eyes involving 59 patients with proven OSSN were studied. The majority of the cases were male (76.3%), with a mean age of 65.2 ± 11.81 years old, and approximately one-third worked as farmers. Sun exposure and smoking are the predominant risk factors observed in this study. Histopathological examination revealed 69.4% were CIN, while 30.6% were SCC. The majority of the cases were treated surgically with adjunctive cryotherapy and topical mitomycin C (MMC) postoperatively. Five cases (3 CIN, 2 SCC) recurred after surgical treatment. Two cases of recurrence were treated with topical MMC and resolved completely. Another three cases required surgical excision after chemo reduction with topical MMC. Tumour pigmentation was shown to be a significant risk factor for recurrence ($p = 0.026$).

Conclusion

CIN is more common than SCC, which mainly affects the male population in Malaysia with a background history of sun exposure and smoking. Mitomycin C is a good adjunct to surgical excision, both for primary and recurrent cases. Tumour pigmentation is a predicting factor for OSSN recurrence.

ABSTRACT ID: 206

OUTCOME OF CORNEAL COLLAGEN CROSSLINKING IN KERATOCONUS: COMPARISON BETWEEN RIBOFLAVIN-M AND RIBOFAST

Chua Ter Wei[1], Safinaz Mohd Khialdin[1], Rohanah Alias[2]

[1]HUKM, Universiti Kebangsaan Malaysia;[2]Hospital Kuala Lumpur

Purpose

CXL (Corneal collagen crosslinking) is a treatment to suppress the progression of keratoconus. Riboflavin-M and Ribofast are riboflavins with permeation enhancers which can shorten CXL procedure time. This study aims to compare the outcome of CXL done with Ribofast against CXL done with Riboflavin-M.

Methods

This is a retrospective review of 99 patients with progressive keratoconus who underwent CXL at Hospital Kuala Lumpur, Malaysia. Visual acuity, refractive cylinder, spherical equivalent, maximum keratometry, simulated keratometry and astigmatism were compared at baseline, 6 months and 1-year post CXL. The outcomes between different keratoconus stages were also compared.

Results

The mean age was 25 years old (SD: 6.36), More than half of them were Malay (58.6%) & female (51.5%). There were 29 (29.3%) patients in stage 2, 31 (31.3%) patients in stage 3 and 39 (39.4%) in stage 4. At 6 months and 12 months post CXL, both riboflavin groups showed improvement in visual acuity, refractive and topographic values. However, there was a significant reduction in Kmax ($p = 0.027$) and SimK ($p=0.033$) in the Ribofast group. When comparing between different stages, Ribofast demonstrated a statistically significant reduction in refractive cylinder in stage 2 compared against stage 3 and stage 4 ($p=0.002$).

ABSTRACT ID: 254

SPECTRUM OF ANTERIOR SEGMENT DYSGENESIS IN HOSPITAL TUNKU AZIZAH: A 5 YEAR RETROSPECTIVE REVIEW

Thiranraj Ramiah[1], Sangeetha Tharmathurai[1], Norhafizah Hamzah[1]

[1]Hospital Tunku Azizah

Purpose

This study aims to report the clinical features of anterior segment dysgenesis patients evaluated at a tertiary referral center, Hospital Tunku Azizah, Kuala Lumpur.

Methods

Retrospective case review of 60 paediatric patients was conducted for patients diagnosed with ASD at Hospital Tunku Azizah from 2019-2024. Data collected included demographics, clinical presentations and ocular findings, and management strategies.

Results

Sixty children were affected with ASD in Hospital Tunku Azizah over a period of 5 years. Our study showed that most of our patient were females comprising 52%. The average age of presentation was 6 months (±3.0 SD). Majority (79%) presented with unilateral ASD. The most common clinical presentations were corneal opacity (40%), refractive error (15%) and microcornea (3.3%). Intraocular pressure (IOP) was increased in 41% of eyes. Most patient (90%) had poor visual acuity of less than 6/60. Secondary complications include cataract (3.3%), glaucoma (45%), and band keratopathy (6.7%). Treatment was mostly conservative, though 3.3% underwent lens aspiration and 5% had glaucoma surgery.

Conclusion

Early diagnosis and multidisciplinary management are essential in managing anterior segment dysgenesis (ASD) to prevent severe visual impairment in affected children.

Glaucoma

ABSTRACT ID: 122
SURGICAL OUTCOME OF TRABECULECTOMY FOR NEOVASCULAR GLAUCOMA IN HOSPITAL SELAYANG

Mohammad Syafiq Bin Yusop[1], Wan Hazabbah Wan Hitam [1], Haireen Kamaruddin[2]

[1]Universiti Sains Malaysia;[2]Hospital Selayang

Purpose

To evaluate the outcome of trabeculectomy in the eyes with neovascular glaucoma (NVG) in Hospital Selayang.

Methods

A retrospective study of NVG eyes that underwent trabeculectomy between the year 2018 and 2023 in Hospital Selayang recruited by total population sampling. Complete success was defined as intraocular pressure (IOP) <21 mmHg without antiglaucoma medications (AGM).

Results

A total of 15 eyes were included in the study which underwent Trabeculectomy with mitomycin C 0.03% and observed until 1 year post-surgery. The mean age of the subjects is 52.8 years. The cause of NVG was PDR in 10 eyes (66.7%), OIS in 2 eyes (13.3%), Occlusive vasculitis in 2 eyes (13.3%), and chronic inflammation in 1 eye (6.7%). The complete success rate of trabeculectomy done in NVG was 73.3% (11 eyes) at 1 year while the remaining eyes are categorized as qualified success achieving target IOP of <21 mmHg with AGM. No failure of trabeculectomy was noted within 1 year post-surgery.

Conclusion

Although trabeculectomy is not the surgical option of choice for NVG, a high complete success rate observed in Hospital Selayang may be attributed to the short interval from diagnosis to surgery, open angles in preoperative gonioscopy, adequate pan-retinal photocoagulation session prior to surgery, fewer postoperative complications, and multiple injections of 5-fluorouracil post-trabeculectomy.

ABSTRACT ID: 394

COMPARING PATIENTS' QUALITY OF LIFE IN TRABECULECTOMY

Muhammad Firdhaus Bin Zainudin[1] , Haireen Kamarudin[2] , Jemaima Che Hamzah[3]

[1]Hospital Canselor Tuanku Muhriz, University Kebangsaan Malaysia; [2]Hospital Selayang; [3]Hospital Canselor Tuanku Muhriz

Purpose

to compare patient's QOL before and after trabeculectomy.

Method

Total of 48 patients diagnosed with primary glaucoma underwent trabeculectomy in Hospital Selayang. Demographics including comorbids, intraocular pressure (IOP) and usage of anti glaucoma medications were collected. Two questionnaires were used in this study; World Health Organization Quality of Life Brief Version (WHO-QOL BREF) and National Eye Institute Visual Function Questionnaire 25 (NEI-VFQ-25). Scores are collected before and 3 months after operation.

Results

After 3 months operation, 95% of patients showed total score increment in both questionnaires. In addition, each questionnaires assess different aspect in patient's quality of life which include general health and vision, ocular pain, near and distance vision, peripheral vision, social functioning, and mental health. 87.5% showed improvement in IOP post-operatively. All patients showed reduction in numbers of antiglaucoma use. However, analysis revealed no statistical significance.

Conclusion

Trabeculectomy is still an operation of choice amid increment in popularity of Microinvasive Glaucoma Surgery (MIGS). It is much more cost effective and relatively safe surgery for glaucoma patients.

Medical Retina & Ocular Inflammation

ABSTRACT ID: 99

FARICIMAB IN DIABETIC MACULAR EDEMA: RESULTS FROM THE RHONE-X LONG-TERM EXTENSION TRIAL

Rajasudha Sawri Rajan[1], Dawn Sim[2], Yannan Tang[2], Arshad Khanani[3], Alex Kotak[4], Aachal Kotecha[4]

[1]Hospital Shah Alam; [2]Genentech, Inc., South San Francisco, CA; [3]Sierra Eye Associates, Reno, NV; [4]Roche Products Ltd., Welwyn Garden City, UK

Purpose

RHONE-X (NCT04432831) evaluated the long-term safety and efficacy of faricimab in patients with diabetic macular edema (DME).

Methods

RHONE-X was a 2-year, phase 3, multicenter, open-label extension trial. Patients with DME who completed either YOSEMITE (NCT03622580) or RHINE (NCT03622593) trials (parent trials) without treatment discontinuation were enrolled. All patients entering RHONE-X received faricimab 6 mg according to a treat-and-extend (T&E)-based regimen with up to Q16W dosing (based on prespecified vision and anatomic criteria per parent trials), irrespective of treatment assignment in parent trials. Patients were evaluated during masked monthly visits for the first 16 weeks of the trial; thereafter, study visits were open label and aligned with their T&E interval.

Results

RHONE-X included 1474 patients, with 81.6% (1204) completing the trial. Faricimab was well tolerated across the 2 years as demonstrated by the low rate of adverse event (AE)-related study discontinuation. Intraocular inflammation AE rates were low (1.3%). There were no cases of retinal vasculitis/retinal occlusive vasculitis. Vision gains and central subfield thickness (CST) reductions achieved during the parent trials were maintained at 1 and 2 years with faricimab T&E dosing. At RHONE-X trial conclusion, faricimab resulted in DME absence (CST <325 µm) in >90% of individuals regardless of treatment assignment in parent trials. Approximately 80% of patients were on extended dosing intervals.

Conclusion

RHONE-X shows that faricimab is well tolerated, with a safety profile consistent with parent trials. The efficacy and durability achieved with faricimab during the parent trials were maintained throughout this 2-year long-term extension trial.

ABSTRACT ID: 114

FARICIMAB FOR POLYPOIDAL CHOROIDAL VASCULOPATHY: WEEK 16 RESULTS FROM THE PHASE 3B/4 SALWEEN TRIAL

Datuk Dr Nor Fariza binti Ngah[1], Gemmy Cheung[2], Timothy Y.Y. Lai[3], Tomohiro Iida[4],Ruobing Bai[5], Philippe Margaron[6]

[1]Hospital Shah Alam; [2]National University of Singapore; [3]The Chinese University of Hong Kong; [4]Tokyo Women's Medical University; [5]Roche Products Ltd., Welwyn Garden City, UK; [6]F. Hoffmann-La Roche Ltd., Basel, Switzerland

Purpose

SALWEEN (ISRCTN69073386) is a phase 3b/4 multicentre, open-label trial evaluating effectiveness, safety, and durability of faricimab in patients with polypoidal choroidal vasculopathy (PCV) from Asian countries. Here, we present interim, week 16 results.

Methods

Patients with symptomatic macular PCV (N=135) received 4 initial every-4-week (Q4W) doses of faricimab 6.0 mg, followed by faricimab Q8W, Q12W or Q16W based on disease activity assessments at weeks 20/24. At weeks 44/48 through 104, patients will follow a treat-and-extend-based regimen with treatment intervals ranging from Q8W–Q20W. Primary endpoint: change from baseline best-corrected visual acuity (BCVA) averaged over weeks 40–48. Week 16 analyses: change from baseline BCVA and central subfield thickness (CST), proportion of patients with no intra- and subretinal fluid (IRF and SRF), resolution of polypoidal lesions (PL), as assessed by Indocyanine Green Angiography, and safety.

Results

Mean (95% CI) BCVA and CST changes from baseline at week 16 were +7.8 letters (+6.4, +9.3) and -144.6 µm (-167.0, -122.2), respectively. The proportion of patients with no IRF/SRF at week 16 was 80.3%. Amongst patients with baseline PL as confirmed by the central reading centre (CRC) and who attended week 16 visits (n=100), 51.0% had complete regression of PL. Faricimab was well tolerated. There was 1 reported case of retinal vasculitis, however, this was not supported by the independent CRC on review of images.

Conclusion

Dual angiopoietin-2/vascular endothelial growth factor-A inhibition with faricimab resulted in robust improvements in vision and anatomy, and regression of PL, after the loading period in patients with PCV from Asian countries.

ABSTRACT ID: 126

KEY CLINICAL OUTCOMES WITH FARICIMAB IN TREATMENT-NAÏVE PATIENTS WITH NEOVASCULAR AGE-RELATED MACULAR DEGENERATION (NAMD): RESULTS FROM THE TENAYA/LUCERNE TRIALS AND REAL-WORLD FARETINA/FARWIDE STUDIES

Amelia Lim Lay Suan[1], David Tabano[2], Ming Yang[2], Gloria Chi[2], Aachal Kotecha[3], Philippe Margaron[4]

[1]Gleneagles Penang Hospital; [2]Genentech, Inc., South San Francisco, CA; [3]Roche Products Ltd., Welwyn Garden City, UK; [4]F. Hoffmann-La Roche Ltd., Basel, Switzerland

Purpose

To summarize clinical pearls from phase 3 TENAYA/LUCERNE and real-world FARETINA/FARWIDE studies in treatment-naïve nAMD patients treated with faricimab.

Methods

Patients in TENAYA/LUCERNE (NCT03823287/NCT03823300; N=1,329) received faricimab 6.0 mg up to every 16 weeks (Q16W) or aflibercept 2.0 mg Q8W. Outcomes were assessed monthly through Week 112. FARETINA and FARWIDE, two retrospective studies utilizing 2022–23 data from the IRIS Registry (US), and NHS sites using Medisoft EHRs (UK), respectively, assessed patients receiving faricimab for ≥12 months. Analysis focused on treatment-naïve eyes.

Results

In TENAYA/LUCERNE, patients always on ≥Q12W or only Q16W achieved stable functional/anatomical outcomes; >50% met pre-specified criteria for potential Q20W dosing. Central subfield thickness (CST) reduction, retinal fluid resolution and decrease in maximum serous pigment epithelial detachment thickness were greater with faricimab vs aflibercept during head-to-head dosing. In FARETINA (n=2,368) and FARWIDE (n=176), mean (standard deviation [SD]) number of faricimab injections during Months 1–6 vs 7–12 was 4.1 (1.3) vs 2.4 (1.6), and 4.7 (0.6) vs 2.0 (1.1), and mean (SD) change in visual acuity from baseline to Month 12 was +3.9 (16.4) and +4.6 (1.1) letters, respectively. Mean (SD) CST improvement in FARETINA (n=196 eyes) after 12 months was –49.3 (10.1) µm ($p<0.001$).

Conclusion

These clinical pearls from TENAYA/LUCERNE demonstrate the robust disease control and extended durability with faricimab. Various biomarkers showed greater anatomical improvements with faricimab vs aflibercept during head-to-head dosing. Stable outcomes in patients on extended dosing intervals suggest potential for further interval extension. These data with faricimab are supported by increasing real-world data.

ABSTRACT ID: 128

GREATER REDUCTION IN HARD EXUDATES WITH FARICIMAB VERSUS AFLIBERCEPT IN PATIENTS WITH DIABETIC MACULAR EDEMA: BIOMARKER RESULTS FROM THE PHASE 3 YOSEMITE/RHINE TRIALS

Wong Hon Seng[1], Roger Goldberg[2], Michael Ip[3], Kara Gibson[4], Andreas Maunz[5], Diane Uschner[5]

[1]OasisEye Specialists Centre; [2]Bay Area Retina Associates, Walnut Creek, CA, USA; [3]University of California, Los Angeles, CA, USA; [4]Roche Products Ltd., Welwyn Garden City, UK; [5]F. Hoffmann-La Roche Ltd., Basel, Switzerland

Purpose

Exploratory analysis of YOSEMITE/RHINE (NCT03622580/NCT03622593) trials evaluated if dual inhibition of angiopoietin-2 (Ang-2) and vascular endothelial growth factor A (VEGF-A) with faricimab reduces hard exudates (HE) in patients with diabetic macular edema (DME) compared with aflibercept.

Methods

Patients with DME were randomized 1:1:1 to receive intravitreal faricimab (6.0 mg every 8 weeks [Q8W] or treat-and-extend [T&E]) or aflibercept (2.0 mg Q8W). HE presence was evaluated by a central reading centre using color fundus photography within the Early Treatment of Diabetic Retinopathy Study grid at screening and weeks 16, 52, and 96. HE volumetric analyses on optical coherence tomography (OCT) will be performed.

Results

HE was evaluated in 1870 patients (faricimab Q8W=626, faricimab T&T=628, aflibercept=616). HE proportions at baseline were similar across the three treatments (80.8-81.6%) and decreased over time. In patients with baseline HE, HE proportions at week 16 were similar between faricimab and aflibercept. By weeks 52 and 96, fewer faricimab (Q8W/T&E) patients had HE vs aflibercept-treated patients (79.0%/75.8% vs 86.2% and 52.8%/55.9% vs 64.5%, respectively). This corresponded to a difference (95% confidence interval) of -7.2% (-12.2%,-2.2%; nominal P=0.0058) and -10.5% (-15.6%,-5.4%; nominal P<0.0001) at 52 weeks and -11.7% (-18.6,-4.8; nominal P=0.0013) and -8.9% (-15.7,-2.1; nominal P=0.0124) at 96 weeks for faricimab Q8W and T&E over aflibercept, respectively. Retinal segmentation and quantification of HE volume on OCT will be presented.

Conclusion

Faricimab showed greater HE reduction than aflibercept in patients with DME and may reflect improved vascular stability with dual Ang-2/VEGF-A inhibition, as demonstrated in other biomarker analyses.

Miscellaneous

ABSTRACT ID: 470
EFFECT OF MYOPIC DEFOCUS ON ON-OFF VISUAL PATHWAYS IN YOUNG ADULTS

Woi Pui Juan[1], Nur Syafika Natasha Muhamad Kamarul Azman[1], Mohd Izzuddin Hairol[1]
[1]Universiti Kebangsaan Malaysia

Purpose

To investigate how different levels of myopic defocus affect ON-OFF visual pathways in young adults using a psychophysics approach.

Methods

Sixteen participants (mean age = 21.75 ± 1.69 years) with best-corrected visual acuity (BCVA) of at least 0 logMAR were recruited. ON and OFF visual pathway functions were assessed using a digital iOS application on a tablet. Myopic defocus at near vision was induced using convex lenses, with randomized defocus levels (0.5, 0.6, 0.7, and 0.8 logMAR). Participants identified 1 to 3 bright (ON pathway) or dark (OFF pathway) targets against a binary-noise background as quickly as possible by tapping a touchscreen button. Reaction time (s), accuracy (%), and performance index [(1/reaction time) × accuracy] were recorded.

Results

Reaction time was shorter ($p < 0.001$) and accuracy higher ($p < 0.05$) for dark targets than for bright targets, regardless of defocus levels ($p > 0.05$). No significant interaction was found between target type and defocus level for reaction time or accuracy ($p > 0.05$). The performance index was higher for dark targets ($p < 0.001$) and increased with greater defocus levels for both bright and dark targets ($p < 0.05$).

Conclusion

The shorter reaction time and higher accuracy for dark targets suggest that the OFF visual pathway outperforms the ON visual pathway in young adults. Additionally, myopic defocus appears to enhance performance in both pathways, as indicated by the performance index. These findings provide insights into the differential processing of visual stimuli under defocus conditions and may have important implications for myopia management and the development of optical interventions leveraging myopic defocus principles.

ABSTRACT ID: 478

TOPICAL INSULIN REVISITED: REPORTING THE PHYSICOCHEMICAL AND MICROBIOLOGICAL STABILITY OF TOPICAL INSULIN 25 IU/ML UNDER SHORT-TERM DAILY USAGE AND LONG-TERM STORAGE AT ROOM AND REFRIGERATED TEMPERATURES

Giovani Faustine[1], Mae-Lynn Catherine Bastion[1], Wan Haslina Wan Abdul Halim[1], Mazlina Mohd Said[1], Azura Abdul Ghani[1], Birinder Kaur[2]

[1]Universiti Kebangsaan Malaysia; [2]Hospital Canselor Tuanku Muhriz @ Universiti Kebangsaan Malaysia Medical Centre (UKMMC)

Purpose

To report physicochemical and microbiological stability of topical insulin 25 IU/ml with normal saline (TI-NS) or sodium hyaluronate 0.18% (TI-AT) (Vismed multi™, TRB Chemedica International SA, Switzerland) in the short- (1 month) and long-term (6 months) at two temperatures.

Methods

This laboratory study involved TI-NS and TI-AT in low-density polyethylene (LDPE) bottles. Forced degradation exposed samples to high temperatures (70°C for 24 hours). Insulin was quantified using stability-indicating high-performance liquid chromatography (HPLC) with diode-array detection (HPLC/DAD) and RP-C18 column, o-nitrophenol as an internal standard, and UV detection at 214 nm. In the first month, the formulations were kept at identical temperatures of room temperature (30°C ± 2°C) or refrigeration temperature (5°C ± 3°C) under simulated conditions of daily expression. For the long-term experiment, the two formulations were unopened till testing. Chemical and physical changes were analysed and observed weekly in the first month, then at 3 and 6 months. Stability was set according to the British Pharmacopoeia, with 90–110% of initial concentration (95% CI) considered acceptable. Microbiological stability was assessed until month 1.

Results

Samples were stable for all parameters of visual inspection, turbidity, UV spectral absorption, osmolality and pH, and culture growth at all time points, at both temperatures for both formulations.

Conclusion

Topical insulin eyedrops can be prescribed for 1 month at room or refrigeration temperatures and stored till 6 months with excellent physical, chemical, and microbiological stability. This has an impact on prescribing protocols for this novel medication to treat epithelial defects and dry eye in diabetes mellitus.

Neurophthalmology

ABSTRACT ID: 481
CASE SERIES OF OPTIC NEURITIS IN YOUNG ADULT MALES FROM HOSPITAL SULTANAH AMINAH, JOHOR BAHRU

Cheong Yik Yin[1], Hayati Abdul Aziz[1]

[1]Hospital Sultanah Aminah

Purpose

To report a case series of optic neuritis among young adult males at Hospital Sultanah Aminah, Johor Bahru.

Methods

Case series.

Results

Case 1: A 32-year-old male presented with one week of right eye pain and blurred vision. Examination revealed right visual acuity of 3/60 and impaired optic nerve function. Fundus examination showed right optic disc swelling. The contrast-enhanced CT (CECT) of the orbit revealed a bulky right optic nerve but patient refused lumbar puncture. He was treated for right optic neuritis with intravenous steroids.

Case 2: A 32-year-old male presented with painless left eye blurry vision for one week. Examination revealed left visual acuity of 3/60 with optic nerve dysfunction. Left eye fundus examination showed a hyperemic disc, and CECT demonstrated a bulky left optic nerve. Cerebrospinal fluid (CSF) analysis was normal. The patient was treated for left optic neuritis with intravenous steroids.

Case 3: A 46-year-old male with retroviral disease and a history of treated neurosyphilis presented with left eye pain and blurred vision. Left visual acuity was 1/60 with impaired optic nerve function. Fundus examination showed a pink, non-swollen disc. Rapid plasma reagin showed a 1:16 titer. CECT and CSF were otherwise normal. The patient was treated for retrobulbar optic neuritis with intravenous steroids and antimicrobial therapy for ocular syphilis.

Conclusion

This series highlights the varied presentations and underlying causes of optic neuritis, as well as the challenges in their management. Visual improvement was noted in all cases after treatment.

Orbit & Oculoplastic

ABSTRACT ID: 444

A DIAGNOSTIC DILEMMA IN PEDIATRIC PROPTOSIS: FROM SUSPECTED MALIGNANCY TO BENIGN ORBITAL CAVERNOUS HEMANGIOMA

Mohd Asyraaf Bin Abdul Kadir[1], Adzura Salam[2], Akmal Haliza Zamli[3]

[1]Unimas; [2]International Islamic University Malaysia (Iium); [3]Hospital Tengku Ampuan Afzan

Purpose

To report a case of a 3-year-old boy with rapidly worsening unilateral proptosis, initially diagnosed as rhabdomyosarcoma, later suspected to be orbital lymphangioma on imaging, but ultimately confirmed as cavernous hemangioma after surgical excision. This case highlights the diagnostic challenges in pediatric orbital tumors.

Methods

A case report.

Results

A 3-year-old boy presented with a one-month history of progressive left eye proptosis, which worsened significantly over two weeks. He was initially diagnosed with rhabdomyosarcoma at a district hospital, but further evaluation with magnetic resonance imaging (MRI) suggested an orbital lymphangioma. Due to the rapid progression and concern for vision-threatening optic nerve compression, an anterior orbitotomy with tumor debulking was performed. Histopathological examination (HPE) of the excised lesion confirmed the diagnosis of cavernous hemangioma. Postoperatively, the patient showed significant cosmetic improvement with reduced proptosis. However, due to the rapid disease progression and preoperative optic nerve compression and severe exposure keratopathy, his visual outcome remained suboptimal. No recurrence was noted on follow-up.

Conclusion

This case underscores the diagnostic challenges of pediatric orbital tumors, where overlapping clinical and radiological features can lead to misdiagnosis. Although rhabdomyosarcoma is a key differential in rapidly progressive proptosis, benign vascular tumors such as cavernous hemangioma and lymphangioma should also be considered. Histopathological confirmation remains essential for accurate diagnosis and appropriate management. Early intervention is crucial in preventing irreversible visual loss, highlighting the importance of a multidisciplinary approach in pediatric orbital tumor evaluation.

Paediatric Ophthalmology & Strabismus

ABSTRACT ID: 175

The Very First Malaysian Made Squint Surgery Simulation Model: Low - Cost, Simple to Make, and Realistic for Training

Lim Qiu Yip[1], Ng WL[1]

[1]Hospital Pulau Pinang

Purpose

Proficiency in surgical procedures involving the extraocular muscles in ophthalmic surgery training is important especially in squint and ocular trauma surgery. In Malaysia, there are significant challenges for ophthalmology trainees and newly practicing ophthalmologist to achieve mastery of this skill as there are lack of hands-on-training, surgical exposure opportunity. Surgical simulation training will be able to bridge the gap of mastery and we would like to introduce Malaysia's very first squint surgery model that is simple to make and affordable, yet at the same time realistic to practice squint surgery skill. No animal or cadaveric globe is needed to build this simulation model.

Methods

We developed a squint surgery simulation model by using various art and crafts materials, plumbing as well as tailoring material. The model consists of a base, eyeball with extraocular muscle and conjunctiva.

Results

The simulation model is tried and tested by paediatric ophthalmologists and found to be able to replicate the key steps of the squint surgery procedure with high degree of realism and accuracy.

Conclusion

Mastery of surgical procedure involving extraocular muscle is important in ophthalmology practice especially in squint and ocular trauma surgery. In order to accelerate the growth and mastery of the skill. Simulation training is able to effectively aid novice who are learning the skill as our simulation model is a good tool to serve as a teaching aid as it is affordable, simple to make as well as realistic.

Surgical Retina

ABSTRACT ID: 486
INCIDENCE AND CLINICAL PATTERNS OF ELEVATED INTRAOCULAR PRESSURE FOLLOWING PARS PLANA VITRECTOMY

Chew Chang Feng[1], Ng Hong Kee[1]

[1]Hospita Raja Permaisuri Bainun Ipoh

Purpose

To investigate the incidence and clinical patterns of elevated intraocular pressure (IOP) following pars plana vitrectomy (PPV) in rhegmatogenous retinal detachment (RRD).

Methods

A retrospective observational study.

Results

A total of 294 patients without prior glaucoma or ocular hypertension who underwent PPV with gas tamponade for RRD were enlisted. Patients were followed for one month, and IOP was assessed at immediate, one-week, and one-month post-vitrectomy. Patient characteristics were compared and analyzed between those with and without elevated IOP.

At one month postoperatively, 98 patients (33.3%) developed elevated IOP, peaking at one week (51.02%). Patients younger than 50 years had a higher incidence (49.3%) compared to those aged 50 years or older (27.9%, $p<0.001$). Males were more frequently affected (38.5%) than females (25.8%, $p=0.023$). Chinese patients had the highest incidence (45.9%, $p<0.001$). Eyes without proliferative vitreoretinopathy (PVR) had a higher incidence (41.6%) than those with PVR (26.1%, $p=0.005$). Other factors were not statistically significant. Elevated IOP occurred in 35.0% of pseudophakic/aphakic eyes and 28.4% of phakic eyes ($p=0.296$). The incidence was similar between perfluoropropane (33.2%) and sulfur hexafluoride (34.5%, $p=0.890$) gas tamponade. Scleral buckling was associated with a 40.7% incidence of high IOP, compared to 30.5% in non-buckled eyes ($p=0.097$). 23-gauge PPV had a 34.8% incidence, while 25-gauge PPV had 31.5% ($p=0.561$). Fellow-led surgeries had a higher incidence (40.0%) than consultant-led surgeries (32.3%, $p=0.369$)

Conclusion

Elevated IOP is a common post-vitrectomy complication, peaking at one week. Younger age, male gender, Chinese ethnicity, and absence of PVR were significantly associated with elevated IOP, while other surgical and clinical factors were not. Close postoperative monitoring is essential.

ABSTRACT ID: 566

FACTORS AFFECTING VISUAL OUTCOME POST PARS PLANA VITRECTOMY IN POSTERIOR SEGMENT INTRAOCULAR FOREIGN BODY IN TERTIARY CENTRE

Jamuna Lachumanan[1], Inderpreet Kaur[1], Low Yi Huey[1], Azhan Azman[1], Zabri Kamaruddin[1]

[1]Hospital Selayang

Purpose

To describe factors affecting visual outcome post Pars Plana Vitrectomy (PPV) in patients with posterior segment intraocular foreign body (IOFB) injuries

Methods

Retrospective case series

Result

A total of 11 eyes with posterior segment IOFB injuries from January 2024 to January 2025 were analyzed. One patient was excluded due to chronicity. All 10 patients were males with mean age of 32.3 years and majority of them had penetrating injuries at workplace. None wore protective eyewear. Seven foreign bodies were metallic. The site of penetrating injury was at sclera in one patient, cornea in six patients and corneo- sclera in three patients. The mean duration from onset of trauma to PPV and IOFB removal was 6 days. The mean preoperative LogMAR improved from 2.01 to 1.75 postoperatively at final visit. Anatomic success was obtained in 80% of eyes after the first surgery. Five eyes had improvement of visual acuity (VA) postoperatively, two had no improvement and three had worsening vision. Presence of relative afferent pupillary defect (RAPD), vitreous hemorrhage (VH), endophthalmitis, lens injury and retinal detachment at presentation were associated with worsened or no change in VA. There was no correlation of poor vision on presentation, type of work injuries (welding or hammering) , time between trauma and IOFB extraction and wound location with improvement in visual outcome.

Conclusion

Poor visual prognostic factors for IOFB removal post PPV includes presence of RAPD, VH, lens injury, RD and endophthalmitis. Postoperative visual outcome remains poor generally.

ePoster Discussion Abstracts

Cornea & Anterior Segment Disease

ABSTRACT ID: 48
IT IS NOT ALWAYS ACANTHAMOEBA KERATITIS: A CASE SERIES OF CORNEAL RING INFILTRATE

Chin Cheau Wei[1], Sujaya Singh[1], John Mathen[2]

[1]Universiti Malaya; [2]Oasis Eye Specialists, Kuala Lumpur

Purpose

Corneal ring infiltrate (CRI) is a ring-shaped corneal intrastromal reaction resulting from an immune response to foreign antigens.

Methods

Case series.

Results

Case 1: A 28-year-old lady who is a contact lens (CL) user presented with left eye pain and redness. Examination showed left eye CRI at the paracentral cornea. She was started on gutt Ceftazidime and fortified Gentamicin. A few days later, the corneal scraping culture returned negative, but the CL case culture isolated Serratia marcescens, Stenotrophomonas maltophilia, and Pseudomonas aeruginosa. She was added on gutt fluorometholone. Subsequently, the CRI scarred up with peripheral vascularization. Case 2: A 35-year-old gentleman who works as an electrician, alleged plastic piece entered his left eye. Upon examination, there is presence of an embedded foreign body (FB) in the deep epithelial layer, located paracentrally at 4 o'clock. Computed tomography of the orbit ruled out the presence of intraocular FB. He was offered surgical removal of the FB but he refused. The next day he developed CRI with epithelial defect. Intensive topical antibiotics were commenced. The cornea scraping culture returned negative and topical steroid was added on. The CRI scarred up after 2 weeks.

Conclusion

Although CRI is highly suggestive of Acanthamoeba keratitis, it could be caused by bacterial keratitis and foreign body. Therefore we emphasize the importance of identifying the underlying cause of CRI and treating it accordingly.

ABSTRACT ID: 274
EXPLORING CORNEAL ULCERS: OUTCOMES AND INSIGHTS FROM A CASE SERIES

Tharishini Chandra Segaran[1], Juanarita Jaafar[1]

[1]Hospital Sultanah Bahiyah

Purpose

To provide an overview of various clinical presentations , course and outcome linked to different etiologies of corneal ulcers.

Methods

A case series of 11 eyes with confirmed corneal cultures of different causative organisms who required hospital admission, with reference to morphological features, management and follow up. The main outcome measure was the final visual acuity.

Results

Organisms isolated include Fusarium, Aspergillus, Acanthamoeba, Streptococcus pyogenes, Streptococcus pneumoniae, Pseudomonas aeruginosa and Mycobacterium abscessus. 27% presented within 3 days following the onset of symptoms but showed no significant correlation with the final visual outcomes, suggesting that the etiological agents might have a more substantial role. Gram negative bacteria was the most prevalent causative organism, followed by the protozoa Acanthamoeba and were associated with poor visual outcomes. Paracentral cornea was involved with highest frequency in fungal and Gram positive bacteria, whereas central cornea was involved in the other causative agents. Patients who presented with hypopyon, infiltrate size ≥4mm and required therapeutic interventions such as corneal gluing, tarsorrhaphy and penetrating keratoplasty had poorer vision. 72.7% achieved a final visual acuity of ≤2/200 despite early empirical treatment.

Conclusion

Corneal ulcer is a major ocular morbidity globally that has various biological etiologies. Our study emphasizes the significance of early diagnosis, investigation, and initiation of therapy to prevent devastating consequences. This study also highlights the poor prognosis of ulcers caused by different organisms despite early empirical treatment. Hence, identifying the causative organism and treating them promptly should take precedence above all.

ABSTRACT ID: 311

SUBCONJUNCTIVAL 5-FLUOROURACIL (5FU) INJECTION AS ADJUNCT FOR POST-SURGICAL EXCISION OF RECURRENT PTERYGIUM: A CASE SERIES

Aiman Ifwat Samsolbari[1], Lam Chenshen[1], Wan Haslina Wan Abdul Halim[1], Mazaya Mahmud[2]

[1]Universiti Kebangsaan Malaysia; [2]*Universiti Putra Malaysia*

Purpose

To report cases of recurrent pterygium treated with subconjunctival 5FU injection post pterygium excision.

Methods

Case series

Results

We report 3 cases of recurrent pterygium who underwent consecutives 5 fluorouracil (5FU) subconjunctival injection post pterygium excision. Case 1: AHA, a 41 years old (YO) female underwent pterygium excision and conjunctival autograft (CAG) with topocryl glue, which was widely used in cutaneous lesion rather than in pterygium surgery. Signs of recurrence was noted at 3 months post operation and was subsequently treated with 3 subconjunctival 5FU injections of monthly interval. Case 2: MA, 64 YO female is a patient who had recurrence pterygium with symbpleharon after multiple pterygium excision surgery. She underwent pterygium excision, symblepharon release and amniotic membrane transplant (AMT). Signs of recurrence were noted at 3 months post-operation. She was then treated with total 6 injections of subconjunctival 5FU alternate with intralesional Bevacizumab in monthly interval. Case 3: NM, 62 YO female underwent initial pterygium excision with bare sclera, who then presented with signs of recurrence 2 months post operatively. She received 3 injections of subconjunctival 5FU at monthly interval. All patients showed no sign of worsening nor progression of recurrence pterygium up to 6 moths after completed treatment with no side effect from 5FU.

Conclusion

This report highlights the efficacy and safety of 5FU injection as adjunct therapy to pterygium excision in recurrent pterygium.

ABSTRACT ID: 427

THE CLINICAL CHARACTERISTIC OF KERATOCONUS PATIENTS: A YEAR DESCRIPTIVE STUDY

Bellakusuma Nurdianningrum[1], Fatimah Dyah Nur Astuti[1]

[1]Diponegoro University, Kariadi Hospital

Purpose

Keratoconus is a progressive corneal disorder characterized by thinning and bulging of the cornea, leading to visual impairment. This study aims to describe the clinical characteristics of keratoconus patients in Dr. Kariadi Hospital, including the risk factors, examination results, and treatment.

Methods

A descriptive retrospective study was conducted in Dr. Kariadi General Hospital Semarang, Indonesia. The clinical data of patients with keratoconus were obtained from medical records from January to December 2024.

Results

The data is collected from 12 (24 eyes) patients' medical records. Keratoconus was more commonly found in men than women (56.25% vs. 43.75%). The mean age of patients with keratoconus was 22 (13-38). The most common risk factors of the patients are the habit of rubbing their eyes (67%), atopic/allergy history (0.17), family history of keratoconus or refraction error (0.08), and history of using contact lenses (0.08). Regarding the severity based on the Amsler-Krumeich Classification, 33% (4 patients) were classified as stage I, 42.5% (5 patients) were stage II, 0.08% (1 patient) were stage III, and 17% (2 patients) were stage IV. Throughout the period, 58% of patients were referred to do corneal crosslinking, 8% were treated using contact lenses, and 17% of patients chose spectacles as the treatment.

Conclusion

This study showed that keratoconus patients in Dr. Kariadi Hospital were predominantly men and of a young age. The most common risk factor is the habit of rubbing their eyes. Corneal cross-linking is the most common treatment choice to treat keratoconus.

ABSTRACT ID: 554

CONGENITAL CORNEAL STAPHYLOMA POST-PENETRATING KERATOPLASTY

Wee Xu Zhen[1], Rohanah Alias[1]

[1]Hospital Kuala Lumpur

Purpose

To report three cases of congenital corneal staphyloma post-penetrating keratoplasty with different treatment outcome.

Methods

Case series.

Results

The first case is a child referred to us at 4 months old with bilateral Peter's anomaly with anterior staphyloma (right eye corneal diameter 16mm, left eye 13mm). Right eye evisceration done at 4 months old while left eye proceeded with sclerokeratoplasty at 9 months old. Post-operatively, corneal graft remains clear for 1 year and child is able to fix and follow object, visual acuity (VA) as least counting finger (CF). The second case concerns a child with bilateral congenital corneal opacity, presented to us with right microphthalmia and left eye anterior staphyloma with progressive corneal thinning and descematocele, ultimately leading to corneal perforation requiring penetrating sclerokeratoplasty at 1.5 months old. Post-cornea transplant at 3 months, child is doing well with graft remains clear, VA at least light perception (PL). The next case involves a child born with bilateral congenital corneal opacity with left eye anterior staphyloma unable to close eyelids, requiring sclerokeratoplasty at day 12 of life. Unfortunately in this case, graft has since turned hazy during post-operative review at 2 months, with VA at least PL.

Conclusion

The reported cases described variable presentation of congenital corneal staphyloma in different time-frame and severity. Although born term with uneventful antenatal history, these children with congenital corneal staphyloma all required surgical intervention as definitive management. These patients end up with different outcome.

Glaucoma

ABSTRACT ID: 15
THE SILENT COMPLICATION: CASE SERIES OF OCULAR DECOMPRESSION RETINOPATHY FOLLOWING GLAUCOMA FILTERING SURGERY

Fadhilah Khairunnise Poerwoko[1], Maharani[1]

[1]Diponegoro University

Purpose

To report clinical characteristics of ocular decompression retinopathy (ODR) following glaucoma filtering surgery.

Methods

This is a prospective case series of five cases of ocular decompression retinopathy following glaucoma filtering surgery that were performed between January-October 2024.

Results

There were five cases of retinal hemorrhages, four cases following trabeculectomy combined with phacoemulsification and one case following trabeculectomy with 5-fluorouracil combined with pars plana vitrectomy. Three cases showed ODR since one day after surgery, while the other two was seen in 1 month after surgery due to limited posterior segment examination caused by corneal edema. Retinal hemorrhages in three cases resolved one month after surgery, while the other two resolved around 2 months after surgery. All cases had pre operative intraocular pressure (IOP) above 50 mmHg without medications, after surgery all achieved >20% IOP reduction from baseline. Post operative visual acuity of case 1-4 were optotype, while case 1 only improved from light perception to counting fingers. All of the patients had no marked systemic risk factors and none of the patients used anticoagulants medications, only one patient (case 2) had comorbids of hypertension consuming amlodipine and all had normal coagulation lab results.

Conclusion

Higher pre operative IOP filtering surgery can be one of the risk factor of ODR. While ODR is a relatively rare complication, early recognition of ODR is crucial to avoid unnecessary investigations or misdiagnoses as the condition may raise concern for more serious pathologies. Despite having this complication, all five cases still achieved IOP control and improved VA post operatively.

ABSTRACT ID: 105

OUTCOMES OF BLEB NEEDLING WITH 5-FLUOROURACIL (5-FU) POST TRABECULECTOMY AMONG GLAUCOMA PATIENTS IN KELANTAN

Premalatha Marthay[1], Norhalwani Husain[2], Mohd Azmi Suliman[3]

[1]Ministry of Health, Malaysia; [2]Hospital Raja Perempuan Zainab II; [3]National Institue of Health

Purpose

To evaluate the outcomes of bleb needling with 5-FU among glaucoma patients in Kelantan over a one-year period, focusing on success rates and complications.

Methods

Retrospective review was conducted on 24 patients who underwent bleb needling with 5-FU between January 2020 and December 2023 at Hospital Raja Perempuan Zainab II.

Results

The median age of the patients was 54 years old, with 54.2% being men. Among the patients, 12.5% had primary angle-closure glaucoma (PACG), 45.8% had primary open angle glaucoma (POAG), and 41.7% had secondary glaucoma. The median interval between trabeculectomy and needling was 14 weeks. Before needling, 37.5% of patients were not on anti-glaucoma medication (AGM), 33.3% were on one AGM, and 29.2% required two to four AGMs. The median preoperative intraocular pressure (IOP) was 22 mmHg. Postoperatively, the median IOP reduced to 16 mmHg at 3 months, 13 mmHg at 6 months, and 12 mmHg at 12 months, with a median reduction of 10 mmHg at 12 months. Most patients (45.8%) underwent one needling session, while 33.3% required two sessions. After a year, 62.5% of patients were off AGMs, 25% used two, and 12.5% used three. Compared to pre-needling, 45.8% reduced their medications, 29.2% stayed the same, and 25% needed more. Most patients (62.5%) had complete success, 20.8% had qualified success, and 16.7% were failures. The most common complication was subconjunctival hemorrhage (87.5%), followed by bleb leaking (12.5%), hypotony (12.5%) and hyphaema (4.2%).

Conclusion

Bleb needling with 5-FU is an effective and safe intervention to restore bleb function after trabeculectomy, achieving significant IOP reduction with minimal complications.

ABSTRACT ID: 139

THREE-MONTH OUTCOMES OF PAUL GLAUCOMA IMPLANT IN REFRACTORY GLAUCOMA: A CASE SERIES

Noor Izzati Akhmal Zulkefli[1], Tan Chai Keong[1], Haireen Kamaruddin[1], Ayesha Md Zain[2]

[1]Hospital Selayang; [2]Hospital Universiti Kebangsaaan Malaysia

Purpose

The Paul Glaucoma Implant (PGI) is a non-valved device gaining recognition for its potential to manage refractory glaucoma by providing sustained intraocular pressure (IOP) control. This case series explores the three-month outcomes of PGI implantation in six eyes with refractory glaucoma.

Methods

Six eyes from six patients with refractory glaucoma, unresponsive to maximum medical therapy, underwent PGI implantation. Preoperative data, including IOP and medication burden, were recorded. Postoperative outcomes, including IOP reduction, changes in medication use, and complications, were assessed at 1 week, 1 month, and 3 months.

Results

The PGI demonstrated effective intraocular pressure (IOP) reduction at three months, compared to preoperative levels. The average number of glaucoma medications also decreased markedly. In most eyes, however, a period of hypertension was noted within six weeks of surgery, necessitating the removal of the stent to restore adequate IOP control. Post-intervention, all eyes achieved stable IOP without significant adverse events such as hypotony, tube exposure, or severe vision loss during the follow-up period.

Conclusion

Early findings suggest that the Paul Glaucoma Implant effectively lowers and maintains intraocular pressure while reducing reliance on glaucoma medications in refractory glaucoma. Further research is needed to assess long-term outcomes and optimize postoperative management strategies.

ABSTRACT ID: 159

OUTCOMES OF PHACOEMULSIFICATION COMBINED WITH HYDRUS MICROSTENT IMPLANTATION IN PRIMARY OPEN-ANGLE GLAUCOMA

See Woan Shian[1], Lim Zhi Yiu Hiang[1], Tan Chai Keong[1], Haireen Kamaruddin[1]

[1]Hospital Selayang

Purpose

Hydrus Microstent is a microinvasive glaucoma surgery (MIGS) device designed to reduce intraocular pressure (IOP) by acting as an intracanalicular scaffold. This case series aims to report the surgical outcomes for patients with primary open-angle glaucoma who underwent phacoemulsification combined with the implantation of Hydrus Microstents.

Methods

This is a retrospective, non-comparative, single-center case series involves six phakic eyes with mild to moderate glaucoma that underwent phacoemulsification and implantation of the Hydrus Microstent. The primary objective was to evaluate IOP outcomes by comparing preoperative and postoperative IOP measurements. Additional observations included adjunctive medication usage, potential complications, and the overall patient response to the procedure.

Results

Overall, all patients experienced a reduction in mean IOP. Postoperative mean IOP showed a significant reduction compared to preoperative levels. All patients were able to taper their medical therapy, with four of them becoming drop-free. Additionally, all patients demonstrated improved vision and stable visual fields.

Conclusion

The combination of Hydrus Microstent implantation with phacoemulsification is a safe procedure for reducing IOP and the need for glaucoma medications. Advances in glaucoma surgery have significantly impacted the field, and continued research and development will further incorporate these techniques into clinical treatment protocols.

Medical Retina & Ocular Inflammation

ABSTRACT ID: 71
EXPLORING CMV RETINITIS: A CASE SERIES IN IMMUNOCOMPROMISED PATIENTS

Teh Shunzhor[1], Tan Kuan Sze[1]

[1]Hospital Sultan Idris Shah, Serdang

Purpose

To report 2-cases of cytomegalovirus retinitis(CMV) in single centre

Methods

Case series

Results

Case-1: A thirty-years-old gentleman, a retroviral disease defaulter with CD4-count 16, presented with two-months history of right eye(RE) floaters followed by one-week painful generalized blurring of vision. Vision RE perception-of-light(PL) and left eye(LE) 6/9. Examination revealed non granulomatous acute anterior uveitis, extensive retinitis with intra-retina haemorrhage, frosted branch angitis and retinal detachment(RD) over RE while LE showed superior retinitis with retina haemorrhage within one-disc-diameter from optic disc(OD). Bilateral intra-ocular pressure(IOP) normotensive. Patient underwent RE pars-plana-vitrectomy(PPV), endolaser(EL) and silicon-oil, alongside with biweekly bilateral intra-vitreal(IVT) Ganciclovir(2mg) for two-to-three-weeks, IV ganciclovir 5mg/kg BD(induction phase) for three-weeks and topical steroids and antibiotics. Highly-active-antiretroviral-therapy(HAART) was planned to restart after completing IV ganciclovir. On 3rd-week of treatment, vision RE PL with recurrent RD. Patient defaulted on further treatment.

Case-2: A thirty-eight-years-old gentleman, underlying hypertension and immune-mediated membranoproliferative glomerulonephritis on imunnosupression therapy for one-year, presented with recurrent RE redness, painful generalized blurring of vision for few-weeks with elevated IOP. Bilateral vision was 6/9. Examination revealed non granulomatous acute anterior uveitis, infero-nasal retinitis with intra-retina haemorrhage one-disc-diameter from OD over RE. He was planned for biweekly RE IVT Ganciclovir for atleast two-weeks, IV ganciclovir 2.5mg/kg BD(renal dose) for two-three-weeks with topical steroids and anti-glaucoma. Immunosupression therapy was tapered accordingly by nephrology team. After 2-weeks of treatment, vision remained 6/9, bilateral IOP normotensive and retinitis and retina haemorrhage was less dense.

Conclusion

CMV retinitis is an opportunistic infection affecting immune-compromised patients, particularly HIV/AIDS patients who are not on HAART. Prognosis poorer with presence of RD.

ABSTRACT ID: 95

EARLY FLUID RESOLUTION IS ASSOCIATED WITH SHORT- AND LONG-TERM EXTENDED DURABILITY IN PATIENTS WITH NEOVASCULAR AGE-RELATED MACULAR DEGENERATION TREATED WITH FARICIMAB: A POST HOC ANALYSIS OF THE TENAYA/LUCERNE TRIALS

Lee Mun Wai[1], Roberto Gallego-Pinazo[2], Manuel Amador[3], Nicholas Dagincourt[3], Ivo Stoilov[3],Philippe Margaron[4]

[1]LEC Eye Centre; [2]University and Polytechnic Hospital La Fe, Valencia, Spain ; RETICS Oftared, Health Institute Carlos III , Madrid, Spain; [3]Genentech, Inc., South San Francisco, CA, USA; [4]*F. Hoffmann-La Roche Ltd., Basel, Switzerland*

Purpose

The head-to-head phase of TENAYA (NCT03823287)/LUCERNE (NCT03823300) trials demonstrated greater retinal fluid (intraretinal [IRF]/subretinal fluid [SRF]) resolution with faricimab, a dual angiopoietin-2/vascular endothelial growth factor-A inhibitor, than aflibercept in neovascular age-related macular degeneration. This post hoc analysis assessed the association between early fluid resolution and extended treatment intervals with faricimab.

Methods

Patients in TENAYA/LUCERNE randomized trials received 6.0 mg faricimab up to every 16 weeks (Q16W) after initial loading (4 doses). Following weeks 20/24 assessment, patients received fixed dosing up to Q16W until week 60 and then a treat-and-extend–based regimen. This pooled analysis evaluated the association between rapid fluid resolution (defined as absence of fluid [IRF/SRF] at weeks 4, 8 and 12) and durability at weeks 20/24 (short-term extended durability) and end of study (long-term extended durability).

Results

Patients with IRF/SRF at baseline with rapid fluid resolution through week 12 (n=538) had twice the odds (odds ratio [OR] 2.00; 95% confidence interval [CI]: 1.24-3.25; P=0.0047) of extending to Q16W vs every 8 week (Q8W) dosing immediately after loading (weeks 20/24). Patients with a rapid resolution of fluid (IRF/SRF) through week 12 (n=474) had approximately 80% higher odds (OR 1.80; 95% CI: 1.11-2.89; P=0.0161) of being on Q16W vs Q8W dosing at the end of the study (week 112).

Conclusion

This post hoc analysis from the TENAYA/LUCERNE trials demonstrates that rapid fluid resolution through week 12 with faricimab may be associated with short- and long-term extended durability (Q16W) supporting dual pathway inhibition impact on early disease control and vascular stability.

ABSTRACT ID: 202
OCULAR SYPHILIS: WHY IT IS NOT?

Nor Azimah binti Abd Aziz[1], Nurul Ashikin Abdullah[2], Siti Zaitihani Hamdan[2], Nazima Shadaht Ali[2], Hanizasurana Hashim[2]

[1]Universiti Teknologi MARA; [2]*Hospital Selayang*

Purpose

Syphilitic uveitis is rare and accounts for up to 2.5% of uveitis cases and about 0.5% to 0.65% of syphilis cases. The non-treponemal test (NTT) is the standard screening tool for syphilis and is essential for diagnosing patients with suggestive signs and known sexual contacts, assessing reinfections, and monitoring treatment. However, it can produce false negative results that delay diagnosis. This report highlights three cases of ocular syphilis misidentified as non-syphilitic uveitis due to initial negative screening.

Methods

Case Series

Results

All patients had intermediate uveitis (IU) and/or panuveitis. Cases 1 and 2 involved HIV-positive young adults, while Case 3 was an older immunocompetent adult. Initial rapid plasma regain (RPR) tests were negative in all cases. Case 1 was treated as presumed endophthalmitis but refractory to treatment. Case 2 experienced recurrent episodes of progressing IU. In Case 3, his condition deteriorated after the commencement of oral steroids. Tumour markers and computed tomography (CT) scan of the brain were normal. Repeated RPR tests with dilution were done in all cases, revealing a positive high titre. Each case demonstrated remarkable improvement after the initiation of penicillin therapy.

Conclusion

Early diagnosis of ocular syphilis is crucial to avoid potentially devastating ocular consequences. This case series illustrated the importance of repeating NTT with dilution in all high-risk groups and in refractory uveitis. False negative NTT is mainly attributed to the prozone phenomenon when an overwhelming antibody response occurs, often associated with early stages of syphilis, secondary syphilis, HIV co-infection, and pregnancy.

ABSTRACT ID: 334
THE BURDEN OF UVEITIC GLAUCOMA IN PAHANG, MALAYSIA: A TWO-YEAR RETROSPECTIVE ANALYSIS

Mohd Asyraaf Bin Abdul Kadir[1], Adzura Salam[1], Wan Norliza Wan Muda[2]

[1]University Malaysia Sarawak; [2]Hospital Tengku Ampuan Afzan, Kuantan

Purpose

To evaluate the prevalence, clinical profile, and management strategies of uveitic glaucoma (UG) among patients with uveitis at Hospital Tengku Ampuan Afzan (HTAA), Kuantan, Pahang, from 2023 to 2024.

Methods

A retrospective review of 98 consecutive uveitis cases was conducted. Data on demographics, laterality, anatomical classification, etiology, intraocular pressure (IOP) fluctuations, steroid-induced ocular hypertension (sOHT), UG incidence, use of anti-glaucoma medications, and surgical interventions were analyzed.

Results

Of the 98 cases, 61.2% were female, and 62.9% had bilateral involvement. The mean age at presentation was 44.47 years. Final visual acuity (decimal Snellen) ranged from 0.001 to 1, with a mean of 0.45. Panuveitis (45.9%) was the predominant anatomical subtype. Infectious causes (35.7%) were most common, followed by autoimmune (21.4%) and autoinflammatory (11.2%) etiologies.sOHT was observed in 24 eyes (36.4%), while 16 eyes (16.3%) progressed to UG. A substantial proportion (43.9%) required anti-glaucoma medications: one class (11 cases), two (9), three (5), and four (15). Surgical intervention was necessary in refractory cases, including trabeculectomy (5 cases), glaucoma drainage device (GDD) implantation (8 cases), and transscleral cyclophotocoagulation (TSCPC) (3 cases).

Conclusion

Uveitic glaucoma remains a formidable challenge, with a high incidence of steroid-induced IOP elevation and a significant proportion requiring medical and surgical intervention. Early detection, vigilant IOP monitoring, and tailored treatment strategies are crucial to preserving vision. Further studies are warranted to refine management approaches and improve long-term outcomes for this sight-threatening complication.

ABSTRACT ID: 358

FACTORS ASSOCIATED WITH ANNUAL EYE EXAMINATIONS AMONG KNOWN DIABETICS IN MALAYSIA: A CROSS-SECTIONAL STUDY FROM THE NATIONAL HEALTH AND MORBIDITY SURVEY 2023

Yap Jun Fai[1], Wan Kim Sui[1], Halizah Mat Rifin[1], Tania Gayle Robert Lourdes[1], Mohd Ruhaizie Riyadzi[1], Muhammad Fadhli Mohd Yusoff[1]

[1]National Institutes of Health

Purpose

Diabetic retinopathy (DR) is largely preventable through early detection and timely intervention. However, despite the availability of diabetic eye screening services at primary healthcare facilities in Malaysia, adherence to annual eye examinations among adults with diabetes mellitus (DM) remains suboptimal. This study aims to identify the factors associated with adherence to these annual screenings.

Methods

Data from the latest National Health and Morbidity Survey (conducted from July to September 2023) were analyzed, involving community-dwelling adults aged 18 years old and above with self-reported DM. Eligible participants were interviewed face-to-face using a validated questionnaire. Multivariable logistic regression with complex sampling design was performed to identify factors associated with adherence to annual eye examinations.

Results

Among 1,554 respondents with known DM in Malaysia, 25.6% adhered to the recommended annual eye examinations. Higher odds of adherence were associated with referral for DR [adjusted odds ratio (aOR) = 4.63, 95% confidence interval (CI): 3.27, 6.55], insulin use (aOR = 1.93, 95% CI: 1.37, 2.72), secondary education (aOR = 1.71, 95% CI: 1.03, 2.85), and DM duration of more than 10 years (aOR = 1.48, 95% CI: 1.02, 2.16). Lower odds of adherence were observed among Chinese (aOR = 0.50, 95% CI: 0.29, 0.87) ethnicity, Indian (aOR = 0.47, 95% CI: 0.29, 0.78) ethnicity, and those with monthly incomes above RM10,000 (aOR = 0.45, 95% CI: 0.21, 0.95).

Conclusion

Only one-quarter of adults with DM in Malaysia comply with annual diabetic eye screenings. Ethnic and income disparities underscore the need for targeted interventions to improve adherence and reduce the risk of DR-related vision loss.

Miscellaneous

ABSTRACT ID: 46

PREVALENCE AND FACTORS ASSOCIATED WITH SELF-REPORTED DIFFICULTY IN SEEING AMONG OLDER PERSONS IN MALAYSIA: A CROSS-SECTIONAL STUDY FROM THE NATIONAL HEALTH AND MORBIDITY SURVEY 2023

Yap Jun Fai[1], Hamizatul Akmal Abd Hamid[1], Halizah Mat Rifin[1], Kishwen Kanna Yoga Ratnam[1], Mohd Ruhaizie Riyadzi[1], Filza Noor Asari[1], Norzawati Yoep[1], Chan Yee Mang[1], Hazwa Harith[1]

[1]Institute for Public Health

Purpose

Vision difficulty increases with age and, if left untreated, can progress to visual disability. However, nationally representative studies on vision difficulty among older persons are limited. This study aimed to determine the prevalence and factors associated with self-reported difficulty seeing among older persons in Malaysia.

Methods

Cross-sectional data from community-dwelling adults aged 60 and older in Malaysia, obtained from the National Health and Morbidity Survey 2023, were analyzed using the Statistical Package for the Social Sciences. Self-reported difficulty in seeing (despite wearing spectacles or contact lenses) was assessed using the validated Washington Group Short Set on Functioning via face-to-face interviews. Multivariable logistic regression with complex sampling design was performed to identify factors associated with self-reported vision difficulty.

Results

Among 2,979 older persons in Malaysia, 24.9% reported experiencing vision difficulty, while 1.6% reported having a visual disability. Minority ethnic groups comprising Bumiputra and others had higher odds [Adjusted odds ratio (aOR) = 2.93, 95% confidence interval (CI): 2.00, 4.29] of reporting difficulty seeing compared to Malays. Similarly, rural residents (aOR = 1.67, 95% CI: 1.10, 2.55) and individuals with diabetes mellitus (aOR = 1.40, 95% CI: 1.05, 1.87) were more likely to report difficulty seeing. Conversely, individuals with secondary education had lower odds (aOR = 0.66, 95% CI: 0.48, 0.91) of reporting difficulty seeing compared to those with no formal education.

Conclusion

Vision difficulties among older persons in Malaysia were associated with minority ethnicity, rural residence, diabetes mellitus, and education level. Public health policies should focus on these factors to reduce the burden of vision difficulties in this vulnerable population.

ABSTRACT ID: 193

FACTORS INFLUENCING MYOPIA AMONG SCHOOL-AGED CHILDREN: AN ANALYSIS OF DEMOGRAPHIC AND GEOGRAPHICAL ASSOCIATIONS IN THE UPPER INTERIOR DIVISION OF SABAH

Awatif Binti Mohamad Mohsin[1], Mohd Fariz Bin Mohd Ali[1], Nur Hayati Binti Mohamed Shabery[1], Norina Binti Abdul Gafor[2]

[1]Hospital Keningau; 2Hospital Duchess Of Kent

Purpose

To analyse demographic and geographical factors influencing myopia incident among school-aged children in the Upper Interior Division of Sabah.

Methods

This is a 5 years retrospective analysis used optometric records from Hospital Keningau for children referred by Unit Kesihatan Sekolah (UKS) from Keningau, Tambunan, Tenom, and Nabawan. Myopia was defined as spherical equivalent (SE) of less than -0.50 D, with severity categorized as low (-0.50 to -2.75 D), moderate (-3.00 to -4.75 D), and high (≥ -5.00 D).

Results

Among the 1,066 children, 606 (56.8%) were myopic. Significant gender association was observed, with 53.6% of males and 59.8% of females being myopic (p=0.041). The upper primary school children (73.7%) had higher myopia incident compared to lower primary school children (46.1%,p<0.001). Regarding racial distribution, Dusun (61.2%p=0.016) had the highest rate, followed by, Murut (49.5%) and Others (55.8%). Geographically, no significant differences were observed between sub-urban (58.2%) and rural (54.3%) locations (p=0.228). In terms of severity, there is no statistically significant difference in high myopia between males and females. However, high myopia was more significant in older age groups (p<0.001).

Conclusion

This study emphasizes that demographic factors significantly influence myopia and severity among children in this region. These findings highlight the need for early screening and interventions, such as increasing outdoor activities in school, to mitigate the rising burden of myopia.

ABSTRACT ID: 322

VISION HEALTH PROGRAM "GOOD EYE, GOOD VISION FOR EVERYONE" IN DETECTING REFRACTIVE ERROR AMONG SCHOOL CHILDREN IN KUDAT, SABAH

Siti Hafizawati Binti Jusoh[1], Nur Syafirah Zalaiqah Ruslan[1], Nur Syuhaidah Mahfuzah Saidil[1], Halimatul Gustia Binti Marasal[1], Sylves Bin Patrick[1], Chua Shee Wen[1], Shuaibah Binti Ab Ghani[2]

[1]University Malaysia Sabah; [2]University Of Malaya

Purpose

To report the outcomes of the Vision Health Program in detecting refractive error among school children in Kudat, Sabah

Methods

In phase I, selected teachers attended the theory and practical workshop regarding refractive error and vision screening. Their level of knowledge and skills in refractive error and vision screening before and after the workshop were assessed through a set of questionnaires. In phase II, teachers performed vision screening among students in their respective schools. Students who had failed the vision screening were referred to the University Malaysia Sabah (UMS) Ophthalmology team for refraction and glasses prescribed (phase III).

Results

A total number of 84 teachers from 48 schools were involved in the program. In phase I, prior to program, the knowledge of refractive error and the skills in vision screening among teachers was mainly moderate, 39 (46.4 %) and 33 (39.3%), respectively. After the program, the knowledge and the skills were improved to high level 53 (63.1 %) and 46 (54.8%), respectively.

A total more than thousands of students were screened by the teachers at their respective schools. 250 students with visual impairment were referred for refraction. 140 (56%) had refractive errors and required glasses, whereas 6 (2.4 %) had strabismus

Conclusion

The findings emphasize the importance of empowering teachers with knowledge and skills in vision screening to ensure early intervention of school children for better visual outcomes.

ABSTRACT ID: 352

COMPARISON OF RETINAL VESSEL CALIBER IN TYPE 2 DIABETES MELLITUS PATIENTS WITH AND WITHOUT CHRONIC KIDNEY: A STUDY FROM THE MALAYSIAN COHORT.

Inderpreet Kaur1, Noraidatulakma Abdullah2, Jemaima Che Hamzah2, Rahman Jamal2, Azwa Shawani Kamalul Ariffin2, Emanuele Trucco3

[1]Kementerian Kesihatan Malaysia; [2]Universiti Kebangsaan Malaysia (UKM); [3]University of Dundee,United Kingdom

Purpose

To compare retinal vessel caliber among Malaysians with Type 2 Diabetes Mellitus (T2DM) with and without chronic kidney disease (CKD) using retinal imaging.

Methods

A single-centered cross-sectional study with recruitment of 264 participants from the Malaysian Cohort was categorised into three groups: T2DM with CKD, T2DM without CKD and participants without T2DM and CKD. All participants underwent digital retina fundus imaging and images were analysed using the Vascular Assessment and Measurement Platform for Images of the Retina (VAMPIRE) software.

Results

Participants with T2DM and CKD have lower central retinal vein equivalent (CRVE), and central retinal artery equivalent (CRAE) compared to two other groups. Both T2DM groups with and without CKD have higher Zone C tortuosity of vein (TORTv) compared to those without T2DM and CKD [-9.75 (0.62) and -9.9 (0.7) vs. -10.0 (0.57) respectively; p= 0.024]. A lower fractal dimension was seen in T2DM participants with CKD (1.42 (0.04)) compared to without T2DM and CKD (1.44 (0.03); p= 0.033]. In the multinomial logistic regression, a unit increase in median Zone C TORT increased the odds for T2DM with CKD by 3.18 times [OR (95% CI): 3.18 (1.21, 8.32); p= 0.019] and a unit increase in CRAE decreased the odds of T2DM with CKD by 49.4% [OR (95% CI): 0.506 0.285,0.897); p= 0.020]

Conclusion

Lower CRAE and higher vein tortuosity in Zone C are associated with increased risk of T2DM with CKD. Retinal vessel analysis incorporation in routine screening is beneficial to facilitate early detection of CKD in diabetic populations.

ABSTRACT ID: 524

LIFESTYLE RELATED RISK FACTORS ASSOCIATED WITH PRIMARY OPEN ANGLE AMONG KADAZAN-DUSUN POPULATION IN SABAH, MALAYSIA.

Baskar A/L Panirsheeluam[1], Sheena Mary Alexander[1], Jemaima Che Hamzah[2], Cheng Teck Chee[2]

[1]Hospital Queen Elizabeth; [2]Hospital Canselor Tuanku Muhriz UKM

Purpose

To determine the lifestyle related risk factors associated with Primary Open Angle(POAG) among Kadazan-Dusun population in Sabah, Malaysia.

Methods

A cross-sectional comparative study was conducted involving individuals diagnosed with POAG and healthy controls from the Kadazan-Dusun ethnic group. Ocular risk factors assessed include intraocular pressure (IOP), refractive status, axial length, and family history of glaucoma. Dietary habits were measured with Food Frequency Questionnaire (FFQ). Smoking habits were measured with Global Adult Tobacco Survey (GATS), alcohol consumptions were measured with Alcohol Use Disorders Identification Test (AUDIT), and physical activity were measured with the General Practice Physical Activity Questionnaire (GPPAQ).

Results

In the univariate regression analysis, several factors showed potential associations with POAG. A family history of glaucoma was found to significantly increase the risk (OR = 2.05, p = 0.027). Intraocular pressure (OR = 2.50, p = 0.019) and best-corrected visual acuity (OR = 2.42, p = 0.045) were also significantly associated with POAG. Regarding dietary habits, more frequent consumption of salted fish was linked to an increased risk of POAG (OR = 2.27, p = 0.011), while less frequent consumption was associated with a reduced risk (OR = 0.77, p = 0.030). However, none of these factors remained significant in the multivariate analysis, suggesting they do not independently predict the risk of POAG in this population.

Conclusion

Family history of glaucoma, intraocular pressure, best-corrected visual acuity and dietary factors such as the frequency of salted fish consumption showed potential associations with primary open angle glaucoma in Kadazan-Dusun population.

ABSTRACT ID: 558

THE BURDEN OF REFRACTIVE ERRORS: PREVALENCE AND SOCIODEMOGRAPHIC DETERMINANTS AMONG SCHOOL CHILDREN IN SEREMBAN, NEGERI SEMBILAN

Siti Husna Binti Hussein[1], Maimunah Abdul Muna'aim[1], Azlina Mokhtar[1], Tengku Amatullah Madeehah T Mohd[1], Amirah Azzeri[1], Mohd Hafiz Jaafar[1]

[1]Universiti Sains Islam Malaysia

Purpose

To determine the prevalence of refractive errors among school children and their association with sociodemographic factors.

Methods

A cross-sectional study was conducted among school children aged 7-12 years in Seremban, Negeri Sembilan. Universal sampling included all children diagnosed with refractive errors during school-based vision screenings. These children then underwent visual acuity assessment and cycloplegic refraction to further determine the prevalence and type of refractive errors. Sociodemographic data, including household size, number of dependents, household income, and parental education level, were collected from the parents through structured questionnaires. Descriptive and inferential statistical analyses were performed to assess the relationship between refractive errors and these demographic determinants.

Results

Among the 312 children screened, 28 (9%) had refractive errors requiring corrective glasses, with myopia being the most common refractive error, followed by astigmatism. Uncorrected visual acuity ranged from 6/6 to 6/18. Children from larger households and those with a higher number of dependents were more likely to experience delayed access to corrective glasses due to financial constraints. Household income also significantly influenced the likelihood of obtaining spectacles.

Conclusion

Refractive errors among school children are a public health concern, with socioeconomic factors affecting access to vision care. This study highlights the role of household income and family size in determining access to corrective glasses. School-based vision screenings, parental awareness programs, and financial aid are essential to ensure early detection and improved access to vision correction for children from lower-income and larger households.

ABSTRACT ID: 576

THE EFFECTIVENESS OF MULTIDISCIPLINARY CVI THERAPY PROGRAM AT A PRIVATE HOSPITAL IN SHAH ALAM

Fatimah Az-Zahra binti Shukran Jamil[1], Duratul Ain binti Hussin[2]

[1]Ara Damansara Medical Centre; [2]Allied Health Sciences Division

Purpose

Cerebral Visual Impairment (CVI) is a leading cause of childhood visual impairment due to damage to the brain's visual pathways. Early intervention through specialized rehabilitation programs is critical for improving outcomes in children with CVI. This case study evaluates the effectiveness of a hospital-based, multidisciplinary therapy program at a private hospital in Shah Alam, involving optometrists, occupational therapists, physiotherapists, and speech therapists. The program provides individualized treatment plans designed to address each child's unique needs based on their CVI characteristics.

Methods

The CVI range scores and phases are used to guide intervention approaches required to improve levels of visual functioning. Effectiveness of the CVI therapy program was assessed through progress reports spanning from 2021 to 2024, focusing on each child’s progression across the CVI range scores and phases.

Results

Results

Conclusion

The study underscores the importance of personalized care and highlights the potential benefits of hospital-based rehabilitation programs for children with CVI.

ABSTRACT ID: 580

SCREEN TIME, VISUAL FATIGUE, AND BINOCULAR FUNCTION IN CHILDREN WITH DYSLEXIA

Suhaida binti Shahudi[1], Sabrina binti Subri[2]

[1]Hospital Kuala Lumpur; [2]Universiti Teknologi MARA (UiTM)

Purpose

Dyslexia is a reading difficulties disorder which has been linked with visual processing problems. Research has shown visual fatigue symptoms were more prevalent in this group. These symptoms are often linked to higher exposure to digital devices and binocular dysfunction, which was reported to be impaired in dyslexia. Since this has not been reported among dyslexic children in Malaysia, this study aimed to evaluate visual fatigue symptoms score and its association with screen time exposure in dyslexic children. Additionally, this study investigated which binocular vision (BV) parameters can predict visual fatigue in dyslexia.

Methods

This cross-sectional study involved 89 dyslexic children and 83 typically developing (TD) aged 13 to 17 years. Visual fatigue and screen time exposure were assessed using Malay-translated questionnaires. Seven BV parameters were assessed in dyslexic children.

Results

TD had higher screen time exposure compared to dyslexic children. Watching videos, online games, and social media engagement were common among dyslexic children while online classes and searching for information were popular among the TD group. Visual fatigue score was significantly higher in the TD group, which was significantly correlated with screen time duration. Most symptoms were highly reported in the TD group, with only tired eye symptom being comparable between groups. Near point convergence (NPC) was found to be a significant predictor for visual fatigue in dyslexic children.

Conclusion

Visual fatigue symptoms were higher in the TD group, aligned with higher screen time exposure, while NPC is a predictor of tired eye symptoms in dyslexia.

Neurophthalmology

ABSTRACT ID: 268

TRANSIENT OCULOMOTOR NERVE PALSY FOLLOWING SUBTENON ANAESTHESIA: A CASE SERIES

T. Thanam Tamil Chelvan[1], Cheng Teck Chee[1], Jemaima Che Hamzah[1]

[1]Universiti Kebangsaan Malaysia

Purpose

To report a case series of transient oculomotor nerve palsy following uneventful cataract surgeries with subtenon injection of lignocaine and ropivacaine.

Methods

Case series.

Results

Case 1: An 81 year-old Malay male developed right droopy eyelid and binocular vertical diplopia following an uneventful cataract surgery with subtenon anaesthesia. Examination revealed right partial ptosis with limited elevation, which resolved spontaneously the next day.

Case 2: A 65-year-old Chinese male experienced right droopy eyelid one hour after an uneventful right eye phacoemulsification with subtenon anaesthesia. He exhibited right eye complete ptosis and ophthalmoplegia in all directions sparing the lateral rectus action. The signs and symptoms resolved on the following day.

Case 3: A 60-year-old Malay female reported right droopy eyelid right after an uncomplicated phacoemulsification with subtenon anaesthesia. Examination showed right complete ptosis with restricted elevation on extraocular movement which resolved completely on the next day.

Conclusion

Although subtenon anaesthesia is generally safe and effective, careful administration is crucial to minimize the risks of oculomotor nerve palsy. Nevertheless, most cases are transient with spontaneous recovery within 24 hours, as the anaesthetic effect dissipates.

ABSTRACT ID: 410

THE PERSPECTIVE OF OPTIC NEURITIS AMONG NORTHERN REGION POPULATION OF MALAYSIA (HOSPITAL PULAU PINANG)

Dhaneswary Shanmugam[1], Ang EL[1], Radtthiga C[2]

[1]Hospital Pulau Pinang; [2]Hospital Bukit Mertajam

Purpose

Optic neuritis (ON) is an inflammatory optic neuropathy characterized by sudden vision loss, dyschromatopsia and positive relative afferent pupillary defect (RAPD). This study aims to evaluate the clinical profile of patients diagnosed with ON in Hospital Pulau Pinang (HPP).

Methods

A retrospective study was conducted from January 2020 to December 2024, to analyse the demography, clinical features, laboratory results and visual outcome of ON patients in HPP.

Results

24 patients were diagnosed with ON, with a higher female predilection (62.5%). The commonest age group affected ranged between 21-40 years. Majority were Malays (n=13), followed with Chinese (n=7), Indians (n=3), and 1 case from other ethnicity. Three-quarter (n=18) of the patients had unilateral involvement. Almost all (n=21) of the patients presented with blurred vision while the remainder complained of painful eye movement. Fundus examination revealed 18 cases of papillitis and 6 cases of retrobulbar optic neuritis. Laboratory tests and neuroimaging were unremarkable in 14 patients, while 2 were diagnosed with infective ON. 3 patients were diagnosed as multiples clerosis (MS,) 2 as neuromyelitis optica spectrum disorder (NMOSD), 2 with optic perineuritis and 1 due to underlying Systemic Lupus Erythematosus. Significant visual improvement was observed in majority of the patients following intravenous methylprednisolone treatment.

Conclusion

This study emphasizes the importance of excluding infections and autoimmune diseases in patients with optic neuritis (ON). Visual recovery is linked to factors such as initial visual acuity, timely treatment with intravenous methylprednisolone, and the different underlying causes of ON, highlighting the need for personalized treatment plans.

ABSTRACT ID: 583

GAMMA KNIFE RADIOSURGERY FOR OPHTHALMIC LESIONS: A RETROSPECTIVE REVIEW

Ramesh Kumar[1], Ereena Alfian[1], Saravana Kumar Rajanthran[1], Niki Ho Wai Wye[1], Mae-Lynn Catherine Bastion[1], Othmaliza Othman[1], Farizal Fadzil[1], Jegan Thanabalan[1], Marfuah Nik[1], Eezamuddee Fuad Ismail[1], Shahizon Azura Mohamed Mukari[1], Siti Khadijah Hamsan[1]

[1]Hospital Canselor Tuanku Muhriz, Universiti Kebangsaan Malaysia

Purpose

To explore the role of gamma knife radiosurgery (GKRS) in the management of ophthalmic lesions, including benign and malignant tumors of the orbit, focusing on its efficacy and outcomes.

Methods

This retrospective study examined patients with orbital lesions treated with GKRS at Hospital Canselor Tuanku Muhriz Universiti Kebangsaan Malaysia, from April 2022 to July 2024. Key indications include optic nerve meningiomas, uveal melanomas, sebaceous carcinomas, and metastatic lesions. Clinical and radiological outcomes were assessed to evaluate its efficacy and safety.

Results

Six patients were included in the study, who were predominantly female, with a median age of 46 years old (range: 44-71) at the time of GKRS. The median follow-up was 11 months. Prior to GKRS, the median volume of the ophthalmic lesions was 1.59 cm^3, with a median marginal dose of 17 Gy. All of the patients demonstrated improved visual acuity and/or visual field following the treatment. None of the patients developed any complications. Radiological assessment via magnetic resonance imaging revealed median volume reduction of 12%. Serial imaging did not detect any tumor recurrence. These results are comparable to other studies that illustrated favorable local lesion control up to 93%, particularly in relation to lower marginal dose between 10 and 20 Gy.

Conclusion

GKRS is a valuable minimally invasive option in the multidisciplinary management of ophthalmic lesions, particularly in attaining local lesion control and preserving visual acuity. Further studies with larger cohorts and long-term follow-up are required to support these conclusions.

Orbit & Oculoplastic

ABSTRACT ID: 22
REVOLUTIONISING CARBUNCLE TREATMENT- A GROUNDBREAKING NON-INVASIVE APPROACH TO PERIORBITAL CARBUNCLE- A CASE SERIES

Felicity Mishan Ng Yiwey[1], Edwin Pheng[1], Wong Ling Sieq[1]

[1]Hospital Sibu

Purpose

This paper describes an unorthodox approach in treating periorbital carbuncles, highlighting its advantages over conventional methods in achieving better cosmetic and functional outcomes, as well as shorter hospital stays.

Methods

A case series.

Results

This paper reports two cases of periorbital carbuncles in which the management began with empirical systemic antibiotics and glucose control, followed by frequent drainage of pus and thorough wound irrigation with an antibiotic solution at least three times daily. The wounds were dressed with ribbon gauze, which also served as a means for mechanical debridement. Both patients achieved full recovery within 4 to 6 weeks, with no significant cosmetic or functional complications.

Conclusion

In contrast to conventional surgical methods like saucerization or incision and drainage of carbuncles, our treatment regime achieves better preservation of tissue integrity. This approach results in excellent healing within 4–6 weeks, notably faster than conventional surgical recovery times. These cases highlight the importance of individualized, less invasive treatment strategies for managing complex infections in sensitive anatomical regions.

ABSTRACT ID: 127

DEMOGRAPHICS, ETIOLOGY AND VISUAL OUTCOME OF ORBITAL CELLULITIS: A NINE-YEAR REVIEW IN HOSPITAL SULTAN ISMAIL

Fairuz Hazirah Kamaruddin[1], Christina Ng Wei Khee[1], Tengku Ain Kamalden[2]

[1]Hospital Sultan Ismail; [2]Pusat Perubatan Universiti Malaya

Purpose

This study aimed to assess the demographic profile, etiology, and visual outcomes of patients diagnosed with orbital cellulitis in Hospital Sultan Ismail, Johor Bahru (HSIJB).

Methods

Medical records of all patients diagnosed with orbital cellulitis at the Eye Department, HSIJB, over a 9-year period(January 2016-December 2024) were reviewed. Data collected included demographic information, presenting and discharge visual acuity, clinical findings, imaging results, and treatment modalities.

Results

A total of 28 eyes from 26 patients were diagnosed with orbital cellulitis.The age distribution ranged from 3 to 77 years, with the majority aged 41-60 years old. There was no gender predominance.Nine cases were immunocompromised in which 4 patients had uncontrolled diabetes mellitus.The most common cause was paranasal sinusitis(9 cases), followed by idiopathic(7 cases), dacryocystitis(4 cases), and panophthalmitis(2 cases). Staphylococcus aureus was the most common pathogen isolated.Complications include periosteal abscess(n=3), brain abscess(n=2), cavernous sinus thrombosis(n=1) and focal brain oedema(n=1).All patients were admitted and referred for ENT assessment.CT scans of orbit and paranasal sinus were performed for all cases.Broad-spectrum intravenous antibiotics were administered to all patients.Fourteen cases required surgical intervention.At presentation, 10 eyes had a visual acuity of 6/60 or worse.Upon discharge, vision of 14 eyes improved to at least 6/12, whereas 9 eyes remained unchanged.Four cases worsened in which 2 cases diagnosed with panophthalmitis underwent evisceration, 1 eye become phthysical, and 1 patient with mucormycosis had succumbed to death.

Conclusion

The clinical profile in this study was in line with most published reports.This study highlights the importance of prompt diagnosis, multidisciplinary management, and urgent surgical intervention in optimizing visual outcomes for patients with orbital cellulitis.

Paediatric Ophthalmology & Strabismus

ABSTRACT ID: 238

Psychological Distress in Parents of Children diagnosed with Retinoblastoma: A cross-sectional study in a tertiary eye centre in Kuala Lumpur

Pee Xu Kent[1], Chan Li Yen[1], Jamalia Rahmat[1], Zayani Zohari[2]

[1]Hospital Kuala Lumpur; [2]Universiti Sains Malaysia

Purpose

To measure the levels of depression, anxiety, and stress among parents/guardians of children diagnosed with retinoblastoma and to identify possible factors associated with increased psychological distress.

Methods

A cross-sectional psychological assessment was conducted at a tertiary eye center in Kuala Lumpur among parents/guardians of children diagnosed with retinoblastoma. The three main domains of psychological distress (depression, anxiety, and stress) were assessed quantitatively using the Depression, Anxiety, and Stress Scale 21 (DASS-21) questionnaire. Descriptive and comparative analyses of the outcomes were performed.

Results

A total of 135 parents of 137 children diagnosed with retinoblastoma (78 unilateral, 59 bilateral) were included in the study. The mean age of parents/guardians was 36.4 years (±7.55). The mean DASS-21 scores for parents/guardians were 4.20±5.47 for depression, 5.07±5.41 for anxiety, and 6.93±6.04 for stress. Overall, the abnormal DASS-21 score among parents were: depression in 21 parents (15.56%), anxiety in 38 parents (28.15%), and stress in 18 parents (13.33%). There were no significant differences in psychological distress levels due to tumor characteristics (laterality, focality, and mutation). Similarly, no statistical significance was found for any of the other factors studied in relation to psychological distress levels.

Conclusion

While the management of retinoblastoma tends to focus on the child's treatment, the psychological impact on parents/guardians is often neglected. This study highlights the need for psychological support for parents/guardians of children diagnosed with retinoblastoma. After all, optimal treatment may be compromised if the parents/guardians do not have good mental health to support their psychosocial function.

ABSTRACT ID: 332

Visual outcome in vitrectomized eyes of retinopathy of prematurity children: A 2-year follow up in a tertiary referral centre

Adnin Farha binti Fatahul Rashid[1], Sangeetha Tharmathurai[1], Widad Yusof[2]

[1]Hospital Tunku Azizah; [2]*Hospital Selayang*

Purpose

This study aims to report the visual outcome and risk factors of premature babies with severe retinopathy of prematurity that underwent surgical intervention

Methods

A retrospective case review of 11 babies with severe retinopathy of prematurity (ROP) (Stage 4 and 5 ROP) that underwent surgical intervention in Hospital Tunku Azizah between Jan 2023 to Dec 2024 were reviewed. Data collected include demographic data, risk factors, birth weight and visual outcome.

Results

Eleven babies (16 eyes) underwent surgical intervention in a 2 year follow up. The mean gestation age was 26 weeks (⍰ 3.5SD). Majority of babies (72.7%) had extremely low birth weight (<1000g). The most common risk factors for prematurity include prolonged oxygen use (100%), sepsis (72.7%) and intraventricular hemorrhage (54.5%). The most common maternal risk factor include gestational diabetes mellitus (18.2%). Most babies that underwent vitrectomy had Stage 4A ROP (56.3%). Majority of babies were able to be managed with vitrectomy alone (72.7%). At 2 years follow up most had poor visual outcome with most babies (63.6%) having visual acuity of less than 6/60.

Conclusion

Poor visual outcome is seen in cases of severe ROP despite surgical intervention. However, the main goal of vitrectomy is to prevent further retinal detachments, even if significant vision cannot be restored. The importance of early detection and intervention to prevent progression of ROP is paramount.

ABSTRACT ID: 473

The Forgotten Consequence of a Restricted Diet.

Roslin Azni Binti Abdul Aziz[1], Nurliyana Binti Hanifudin[1], Madihah Binti Mohd Lokman[1], Aimi Shazwani Binti Mohammad Musa[1,2], Tengku Ain Fathlun Binti Tengku Kamalden[2]

[1]Hospital Shah Alam; [2]Universiti of Malaya

Purpose

To report a case of severe xerophthalmia in a child with autism and a highly restricted diet, highlighting the importance of dietary assessment in children with neurodevelopmental disorders.

Method

A 5-year-old boy with autism presented with intermittent bilateral upper eyelid swelling for four months, followed by progressive ptosis and conjunctival redness over three months. He exhibited a severe head tilt to compensate for the ptosis. Examination revealed bilateral ptosis with margin reflex distance 1 (MRD1) of -2, multiple chalazia on the left upper eyelid, extensive conjunctival keratinization, and corneal dryness with superficial punctate keratitis, resulting in mild corneal haze. The anterior segment and fundus examination were otherwise unremarkable.

Results

Given the child's history of consuming only rice porridge with occasional chicken since the age of two, vitamin A deficiency was suspected as the underlying cause. Other potential causes of conjunctival keratinization were considered but unlikely. The case was co-managed with the pediatric team, and vitamin A supplementation was initiated.

Conclusion

Xerophthalmia, though rare in developed and middle-income countries, remains a concern in children with restricted diets, particularly those with autism. This case underscores the need for routine dietary assessments in patients with neurodevelopmental disorders to prevent micronutrient deficiencies. Early recognition and intervention are crucial to prevent irreversible visual impairment.

ABSTRACT ID: 562

A Clinical Audit of Retinopathy of Prematurity Screening Programme in Hospital Bintulu, Sarawak, Malaysia

Mabel Unyang Wan[1], Kenneth Teow Kheng Leong[1]

[1]Hospital Bintulu

Purpose

Retinopathy of prematurity (ROP) is a leading preventable cause of blindness in infants born premature. Evidence shows that low birth weight and gestational age are the most predictive risks factors for the development of ROP. Screening is important to identify infants with ROP as early treatment can halt progression of disease and improve visual prognosis. This study was done to determine the effectiveness of ROP screening programme in Hospital Bintulu and adherence to current screening guidelines.

Methods

A retrospective cross-sectional clinical audit was performed based on patients' case records. A total of 119 infants were audited based on national screening guidelines over two periods, 9 months and 4 months respectively.

Results

Audit showed 80% of eligible infants were screened for ROP, similar to the findings from the re-audit period. A total of 19 infants were detected to have ROP; 3 required treatment with laser.

Conclusion

Most premature infants underwent ROP screening; however we did not achieve intended target of 100% screened. We hope by taking steps to increase awareness regarding ROP among healthcare providers and parents, this would improve ROP screening and detection in the future.

Surgical Retina

ABSTRACT ID: 76
EVALUATION OF ANXIETY AND DEPRESSION IN PATIENTS PRE AND POST RHEGMATOGENOUS RETINAL DETACHMENT SURGERY USING HOSPITAL ANXIETY AND DEPRESSION SCALE (HADS)

Norshamsiah binti Md Din[1], Nurul Ibtisam binti Mohammad[1,2], Noram binti Mat Saad[2], Shakiran Gunaseelan[2], Noormazita binti Misran@Mislan[2]

[1]Pusat Perubatan Universiti Kebangsaan Malaysia; [2]*Hospital Tuanku Jaafar*

Purpose

To evaluate anxiety and depression score and their associated factors in RRD patient's pre and post-surgery using English version and validated Malay version of HADS scale for anxiety and depression.

Methods

A prospective, questionnaire-based study to assess preoperative and three-month postoperative anxiety and depression level using the validated HADS.

Results

The study found a statistically significant reduction in anxiety levels from preoperative assessments (11.25% reporting mild to moderate anxiety and 1.25% with severe anxiety) to three months postoperatively (6.25% reporting mild to moderate anxiety), with a p-value of 0.002. However, there were no significant changes in depression scores over the same period. Among the factors examined, only a waiting time of 3 to 4 weeks was found to be statistically significant, being associated with higher postoperative depression scores compared to other factors. No other variables, including demographic factors, systemic or ocular comorbidities, or surgical factors, showed significant associations with anxiety or depression levels.

Conclusion

This study is the first to explore anxiety and depression among retinal detachment surgery patients in Malaysia, highlighting the effectiveness of surgical interventions in reducing anxiety. While the prevalence of anxiety and depression was relatively low, the findings suggest the need for incorporating psychosocial support into postoperative care. The results underscore the importance of addressing mental health in surgical settings to enhance patient outcomes and well-being. Future research should consider multi-center designs and longer follow-up periods to better understand the long-term psychological impacts of such surgeries.

ABSTRACT ID: 80

CONTINUATION OF THE PRELIMINARY STUDY: ONE-MONTH OUTCOME COMPARISON OF 23G ULTRAVIT™ AND 27G ULTRAVIT™ VITRECTOMY ON PATIENT COMFORT AND OCULAR SURFACE DISEASE

Giovani Faustine[1], Mae-Lynn Catherine Bastion[1], Ainal Adlin Naffi[1], Mushawiahti Mustapha[1]

[1]Pusat Perubatan Universiti Kebangsaan Malaysia

Purpose

To evaluates and compares patient comfort and ocular surface disease impact one month post-surgery between 23G and 27G Ultravit vitrectomy techniques.

Methods

A retrospective study. All 23G and 27G vitrectomy cases at HUKM from October 2021 to November 2023 were included. Primary outcomes at one-month follow-up included pain score, visual acuity (VA), intraocular pressure (IOP), tear break-up time (TBUT), tear meniscus height (TMH), and Ocular Surface Disease Index (OSDI).

Results

A total of 29 patients were included (23G: 20 cases, 27G: 9 cases). The pain scores in the 23G group were 4/10 (1 patient, 3.44%), 2/10 (1 patient, 3.44%), and 1/10 (2 patients, 6.89%), while one patient in the 27G group had a 1/10 score (3.44%) and the rest reported no pain. Mean TMH was 0.236µl (SD±0.14) in 23G and 0.284µl (SD±0.1) in 27G. Mean TBUT was 6.76s (SD±4.79) in 23G and 10.95s (SD±6.71) in 27G. Mean IOPs were 15mmHg (SD±2.61) in 23G and 15.22mmHg (SD±3.76) in 27G. OSDI scores were significantly higher in 27G (28.58±20.16) than in 23G (12.65±14.23, $p<0.05$). Other parameters showed no significant differences ($p>0.05$).

Conclusion

One-month post-operative follow up showed that the 27G group had a significantly higher OSDI score than the 23G group, while pain score, VA, TMH, TBUT, and IOP demonstrated comparable outcomes. Further studies with larger samples are needed to confirm these findings.

ABSTRACT ID: 251

CASE SERIES OF PNEUMATIC CRYORETINOPEXY FOR RHEGMATOGENOUS RETINAL DETACHMENT (RRD) AT HOSPITAL KUALA LUMPUR (HKL): A 2-YEAR RETROSPECTIVE REVIEW

Yuvithra Devi A/P Shanmugam[1], Jason Allan Cheah Seng Soon[1], Choo Swee Ying[1]

[1]Hospital Kuala Lumpur

Purpose

To report the indications, visual outcomes, and complications of pneumatic cryoretinopexy.

Methods

A Case Series

Results

A total of 9 eyes from 9 patients, consisting of 6 females and 3 males with an age range of 49 to 70, underwent pneumatic cryoretinopexy between 2023 and 2024 in HKL. Among the 9 patients, 4 patients (44.4%) had superior RRD, 3 patients (33.3%) had temporal RRD, 1 patient (11.1%) had inferior RRD, and 1 patient (11.1%) had nasal RRD. Of these, 5 patients (55.5%) had RRD with the macula off, and 4 patients (44.4%) had RRD with the macula on. Seven patients had retinal tear, while 2 patients had more than 1 tear. One patient had tears spanning more than 1 clock hour. Among the 9 eyes, 3 eyes (33.3%) were pseudophakic. Seven out of 9 patients (77.8%) successfully achieved retinal reattachment within 1 month with improved visual acuity. Meanwhile, 2 patients (22.2%) failed to achieve retinal reattachment post-pneumatic cryoretinopexy, which required follow-up vitrectomy surgery. Seven patients (77.8%) achieved unaided visual acuity better than 6/24, while 2 patients (22.2%) achieved visual acuity of 6/120 post-pneumatic cryoretinopexy. There were no incidents of raised intraocular pressure (IOP) or cataract development within 1 month of the postoperative period.

Conclusion

Pneumatic cryoretinopexy is an effective surgical option for selected patients with uncomplicated RRD. However, it is crucial to emphasize strict positioning post-pneumatic cryoretinopexy to ensure treatment effectiveness and prevent retinal redetachment.

ABSTRACT ID 277

CLINICAL FEATURES OF POLYPOIDAL CHOROIDAL VASCULOPATHY WITH BREAKTHROUGH VITREOUS HEMORRHAGE AND IT'S VISUAL OUTCOME AFTER VITRECTOMY

Tharishini a/p Chandra Segaran[1], Khairuddin Bin Othman[1]

[1]Hospital Sultanah Bahiyah

Purpose

To study the clinical features of Polypoidal Choroidal Vasculopathy (PCV) with breakthrough Vitreous Hemorrhage (VH) and it's visual outcome after pars plana vitrectomy (PPV). PCV can lead to significant visual impairment especially when VH complicates its management and prognosis.

Methods

A Retrospective Study. Records of patients with PCV-related VH who underwent PPV from January 2020 to December 2024. The main outcome measures were best corrected visual acuity (BCVA) and OCT findings post-surgery and within 1 year.

Results

A total of 34 eyes of 34 patients with VH were enrolled. The mean follow-up period was 6 months post-surgery. We found that the preoperative vision does not strongly predict postoperative vision outcomes ($P>0.05$) and that the peak prevalence occurs in the sixth and seventh decades. Among the eyes, 38.2% achieved final BCVA of ≥ 20/200 compared to 2.9% prior to PPV. The findings showed that there were improvements in both the BCVA and retinal structure, indicated by fluid resolution. However, demographic factors such as age, gender and laterality showed no significant correlation with post operative visual outcomes, suggesting that the clinical parameters might have a more substantial role.

Conclusion

The visual prognosis in eyes with PCV-related breakthrough VH is variable after vitrectomy with some eyes showing significant recovery over time. Early vitrectomy may be beneficial for visual recovery after PCV-related VH. Clinical factors including severity of PCV at presentation, duration of hemorrhage before intervention, and preoperative retinal status, were likely better predictors of visual recovery than age, gender, and side of presentation.

ePoster Abstracts

Cataract & Refractive

ABSTRACT ID: 65
VISUAL ACUITY OUTCOMES OF IRIS-CLAW INTRAOCULAR LENSES IMPLANTATION IN DIFFERENT APPROACH

Andhika Putra Laksmana[1], Rizal Fanany[1], Wisnu Sadasih[1], Riskha Pangestika[1]

[1]Diponegoro University

Purpose

To describe the visual acuity outcomes of iris-claw IOL (intraocular lenses) implantation in corneal incision and scleral tunnel approaches.

Methods

The data from medical records of 32 eyes from 31 patients underwent (prepupillary and retropupillary) iris-claw IOL implantation. The mean UCVA (uncorrected visual acuity) LogMAR (Logarithm of the Minimum Angle of Resolution), mean BCVA (best corrected visual acuity) LogMAR, mean IOP (intraocular pressure), postoperative residual astigmatism, and postoperative complications were collected and compared at preoperative, a day, a week, and a month postoperative.

Results

Age ranged from 31 to 86 years old, mean (63.59 ± 11.78) years old. The mean UCVA LogMAR in the group with scleral tunnel retropupillary at preoperative (0.97 ± 0.38) and one month postoperative (0.47 ± 0.15) was better than in other groups. The mean BCVA LogMAR and mean IOP in the group with scleral tunnel prepupillary one month postoperative (0.12 ± 0.13) and (12.06 ± 3.44 mmHg) were better than in other groups, respectively. The percentage of residual mild astigmatisms (< 1.00 D) between the two approaches was 50%. Compared to the scleral tunnel approach, the corneal approach had a higher percentage of residual moderate astigmatisms (1.00-2.00 D) (66.6%). Most postoperative complications were pupil ovalization (11), corneal edema (9), and IOP elevation (6).

Conclusion

The scleral tunnel iris-claw IOL approach provided better visual outcomes (mean UCVA and mean BCVA (LogMAR)) and lower mean IOP than the corneal incision approach. The results are influenced by good surgical skills, accurate biometry, refractive measurements, and other eye conditions.

ABSTRACT ID: 75
SPONTANEOUS RUPTURE OF ANTERIOR LENS CAPSULE IN HYPERMATURE SENILE CATARACT

Low Zhen Ning[1], Nurul Ain Masnon[1]

[1]Hospital Kuala Lumpur

Purpose

To report a case of spontaneous lens capsule rupture in hypermature senile cataract (HSMC)

Methods

Case report

Results

An 83-year-old woman who was a known case of diabetes, hypertension and dyslipidemia presented with right eye redness for 2 months and poor vision for 2 years. There was no eye pain. She denied having any eye trauma or wearing spectacles.

On examination, right eye (RE) was 6/9 and left eye (LE) hand movements. No relative afferent pupillary defect was noted. LE showed conjunctival injection, with a small nucleus dislocated into the anterior chamber causing lenticular-corneal touch, inferior corneal edema, and Descemet's folds. Multiple calcified spots were observed in posterior capsule remnant. There was mild anterior chamber activity. Otherwise there was no pseudoexfoliative material at the pupillary margins. Intraocular pressure was 10mmHg. Fundus was not visible due to corneal edema. B-scan ultrasonography revealed flat retina and clear vitreous cavity. RE examination unremarkable except for immature cataract. She was of normal stature and systemic evaluation did not reveal any abnormalities.

She underwent LE intracapsular cataract extraction, anterior chamber washout, anterior vitrectomy, and surgical peripheral iridectomy the next day and was left aphakia. No intraoperative complications were encountered. Post-operatively, her LE was healing well and corneal haziness had improved. Vision maintained at counting finger.

Conclusion

Spontaneous lens capsule rupture is a rare complication of HSMC. It can lead to dislocation of nucleus into anterior chamber. Patient's negligence and lack of awareness are the main reasons of delay in seeking medical attention.

ABSTRACT ID: 125

A DECADE REVIEW OF POOR VISUAL OUTCOME AND ITS CONTRIBUTING FACTORS FOLLOWING CATARACT SURGERY IN PATIENTS WITH PSEUDOEXFOLIATIVE SYNDROME IN KELANTAN

Nur Fadilah Azhani Bt Mohammad[1], Nur Amni HS[1], Ainul KM Saidy[1], Azma Azalina[1], Zamri N[1], Shatriah I[2], Ng KS[2], Hazirah MM[2]

[1]Hospital Raja Perempuan Zainab II; [2]Health Campus Universiti Sains Malaysia

Purpose

To investigate the poor visual outcome and its contributing factors post cataract surgery in patients with pseudoexfoliative syndrome.

Methods

This is a retrospective study among pseudoexfoliative syndrome patients who underwent cataract surgery with intraocular (IOL) implantation in a tertiary centre, Kelantan, Malaysia from 2015 to 2024. Data was retrieved from the web-based Malaysian Cataract Surgery Registry (CSR). Poor visual outcome was defined as those with best corrected visual acuity (BCVA) worse than 6/12 taken at 6 weeks onwards postoperatively. Factors affecting poor visual outcomes (age group, gender, systemic comorbidity, and presence of other complications intraoperatively) were analysed using logistic regression to produce adjusted odds ratio (OR) for variables of interest.

Results

Out of 74 patients with pseudoexfoliative syndrome whom underwent cataract surgery, 62 (83.7%) cases were qualified for analysis. The proportion of poor visual outcome was 23(37.7%). In the simple logistic regression, vitreous loss (OR= 4.243, p = 0.024) and type of surgery in which extracapsular cataract extraction (ECCE) (OR = 0.215, p = 0.017) and intracapsular cataract extraction (ICCE) (OR= 0.092, p = 0.009) were significantly associated with poor visual outcome. However, after adjusting the covariates, no variables was statistically significant.

Conclusion

Vitreous loss and type of surgery done was the contributing factors for poor visual outcome among cataract surgery in patients with pseudoexfoliative syndrome. Effective intraoperative management and the use of appropriate surgical techniques can enhance postoperative visual outcomes. Further research with a larger sample is needed to enhance the applicability of this study in the future.

ABSTRACT ID: 137

CAPSULAR TENSION RING REDUCE TORIC INTRAOCULAR LENS ROTATION IN HIGH MYOPIA

Aleza Omar[1], Safiyah Jameelah MY[1], Suriana Suaibun[1]

[1]Putrajaya Hospital

Purpose

Toric intraocular lenses (IOLs) effectively correct astigmatism in cataract surgery but face challenges in high myopic eyes due to anatomical differences like longer axial lengths and elastic zonules. We present a case where a capsular tension ring (CTR) was used to stabilize a toric IOL in high myopia.

Methods

Case report

Results

A 44 years old, Chinese, Lady with underlying infiltrating ductal carcinoma, Left eye multiple retinal hole which lasered well and both eye high myopia came in for bilateral eye cataract surgery. Pre operatively, refraction of right eye -16.00D cyl -1.00 vision 6/9, corneal astigmatism (CA) of -1.38, while left eye -15.00D cyl -2.00 vision 6/15, CA of -2.58. Axial length of right eye 29.51mm while left eye 28.74 mm. She undergone both eyes cataract surgery one week apart with Zeiss AT Torbi Toric IOL along with CTR implantation. Toric IOL is implanted at pre-designed degree, right eye at 76° while left eye at 78°. Vision is good six weeks postoperatively, refracted right eye -0.50D cyl -0.50 vision 6/6, left eye +0.50D cyl -1.25 vision 6/6. Toric marker IOL is noted at 86° on right eye and 84° on left eye in which both is within ten degree from intended axis.

Conclusion

Using CTR has been shown to reduce the likelihood of toric IOL rotation by improving lens stability within the capsular bag. By minimizing rotation of toric IOL, CTR use enhances refractive outcomes and improves visual acuity, highlighting its importance in achieving optimal results in challenging cases.

ABSTRACT ID: 194

RECURRENT CORNEAL EROSIONS POST SMALL INCISION LENTICULE EXTRACTION: A CASE REPORT

Indra Dewi Bathumalai[1], Muhd. Syafi Abd Bari[1], Khairidzan Mohd Kamal[1]

[1]International Islamic University Malaysia (IIUM)

Purpose

To describe a case of recurrent corneal erosions (RCE) post Small Incision Lenticule Extraction (SMILE) laser vision correction.

Methods

Case report.

Results

A 36 years old lady, with history of bilateral eye SMILE surgery in 2017, presented to our centre in late October last year. She presented with history of recurrent corneal erosions bilaterally since 2020. The episodes occurring more frequently over left eye (LE) compared to right eye (RE), with more than 4 episodes on LE and 2 episodes on RE.

She experienced unprovoked burning and gritty eye sensation upon waking up in the morning on every occasion. She visited multiple eye centre throughout the years and was treated with eye lubricants and ointments. She was also put on Bandage Contact Lens (BCL) once. Despite all efforts, she was still experiencing recurrent episodes of corneal erosions that was affecting her daily activities.

Upon our initial review, there was LE corneal erosion at the inferior paracentral cornea. We rendered LE epithelial debridement with basement membrane polishing with diamond burr. Post operatively she was put on BCL for 5 days and treated with topical dexamethasone and moxifloxacin. Subsequently, patient remained symptom free over the LE till date. The same treatment has been rendered to the RE recently.

Conclusion

When conservative treatment with BCL and lubricants for RCE involving the central cornea is inadequate, surgical options need to be explored. Epithelial debridement with basement membrane polishing have been shown to be effective in literature and as demonstrated in this case.

ABSTRACT ID: 218

SAFETY AND VISUAL OUTCOMES OF CATARACT SURGERY IN THE FIRST YEAR AT HOSPITAL SULTAN ZAINAL ABIDIN: A ONE-YEAR REVIEW

Muhammad Arif Ozir[1], Mohammad Hudzaifah Nordin[1], Syaratul Emma Hashim[1]

[1]Hospital Sultan Zainal Abidin

Purpose

To evaluate the safety and visual outcomes of cataract surgery in the first year of surgical services at Hospital Sultan Zainal Abidin (HoSZA) from December 2023 to December 2024.

Methods

A retrospective review of cataract surgeries performed by a single surgeon under senior consultant supervision was conducted. Data was extracted from the hospital's electronic medical record system.

Results

A total of 162 cataract surgeries were performed, with 96.3% using phacoemulsification and 3.7% extracapsular cataract extraction. The mean patient age was 68 years (range: 38–86). The majority (92.6%) were from Terengganu, and 98% had age-related cataracts. Preoperative visual acuity was 6/9–6/12 in 12%, 6/12–6/60 in 47%, and worse than 6/60 in 41%. Postoperatively, 84% achieved 6/9 or better, 13% had 6/12–6/36, and 3% remained worse than 6/60. Refractive outcomes showed 50% achieving emmetropia, 45.5% myopia, and 5.5% hyperopia. The complication rate was 4.3%, including capsular rupture (4 cases), zonular dehiscence (2 cases), and retinal detachment (1 case).

Conclusion

In its inaugural year, cataract surgery at HoSZA demonstrated excellent safety and efficacy, with 95.1% achieving a postoperative vision of 6/12 or better, aligning with international benchmarks (97.1%). These findings highlight the successful establishment of surgical services and reinforce the hospital's ability to provide high-quality ophthalmic care.

ABSTRACT ID: 273

1 YEAR OVERVIEW OF SMALL INCISION CATARACT SURGERY (SICS) PRACTICE IN HOSPITAL KUALA LIPIS

Nur Sakinah MM[1], Mumahhad Fadhli AH[1]

[1]Hospital Kuala Lipis

Purpose

To demonstrate the overview of SICS practice in Ophthalmology Department, Hospital Kuala Lipis.

Methods

Six SICS cases within a 1 year were collected and analysed from National Eye Database.

Results

SICS practice is still in early phase of recognition and practices among Ophthalmic surgery practitioners in Malaysia. We started to use this technique in certain indicated cases such as in a dense cataract or a dislocated lens. Four cases were converted to SICS due to various reasons while 2 dislocated lenses were carried out as planned. Out of 4 converted cases, 2 were converted due to profound zonular weakness while the rest due to fibrotic anterior capsules. Two dislocated lens cases underwent uneventful SIC to retrieve the pathologic lens. All eyes had at least HM of visual acuity preoperatively. Intraoperatively, 5 out of 5 require anterior vitrectomy, 4 ACIOL were implanted while the other 2 posterior capsule and sulcus intraocular lens respectively. 5 cases receive 2 to 4 sutures while the last patient no suture required..

Postoperatively from 1st week until 6th week post period, no incidence of wound leak nor post operative endopthalmitis were recorded. All 6 patients had recorded improvement of visual acuity from 6/24 up to 6/9 best corrected vision as early as 1 week post operative period. No worsening of residual cylinder power was recorded after 6 weeks.

Conclusion

Six SICS as above had shown a very promising outcome in term of post op Visual acuity and safety up to 6 weeks postoperatively.

ABSTRACT ID: 282
INTRAOCULAR LENS (IOL) OPACIFICATION FOLLOWING UNCOMPLICATED CATARACT SURGERY: A CASE REPORT

Ling Hwee Minn[1], Ng Zhi Yun[1], Chow Kit May[1]

[1]Hospital Sultan Haji Ahmad Shah

Purpose

To discuss a case of intraocular lens (IOL) opacification following an uncomplicated cataract surgery.

Methods

Case Report

Results

An 84-year-old man with hypertension and type 2 diabetes mellitus underwent an uncomplicated right eye cataract extraction with implantation of hydrophobic acrylic IOL in the capsular bag. During the one week post-operative review, ocular examination showed poor visual acuity of hand movement for right eye. Anterior segment examination noted diffuse opacification on anterior surface of IOL. There was no evidence of active inflammation in the anterior and posterior segments. He was asked to continue instilling dexamethasone sodium phosphate 0.1% and ciprofloxacin hydrochloride 0.3% eyedrops every two hourly and return in a week's time. During review, the IOL was much clearer, however there was still multiple gray-white deposits on anterior lens surface with rim of opacity at periphery. Anterior segment examination showed no evidence of inflammation. B-scan ultrasonography noted vitritis with loculation. He was then treated as acute post-operative endophthalmitis and was given serial intravitreal injection of vancomycin and ceftazidime. Intravitreal tapping sent for culture and sensitivity showed no growth. His progress throughout one week showed slight improvement, in terms of lesser granulomatous deposits on IOL surface with better visual acuity, however vitritis persisted. We then decided to proceed with IOL explantation, which he showed rapid improvement with resolution of vitritis in three days.

Conclusion

Acute post-operative endophthalmitis must be suspected in post-operative patients with inflammation greater than the usual postop course. Any IOL defect or safety compromise should be reported to the Medical Device Authority.

ABSTRACT ID: 331

A GLIMPSE THROUGH THE CAT'S EYE

Siti 'Aisyah binti Nik Mazlan[1], Siti Shahrulbariyah binti Samsuddin[1], Fatimah Halwani binti Ismail[1], Zamri bin Noordin[1]

[1]Hospital Raja Perempuan Zainab II, Kelantan

Purpose

To report a case of recurrent pupillary optic capture in sutured scleral-fixated IOL.

Methods

A case report

Results

A 59-year-old male with history of sutured SFIOL implantation in 2015. He underwent repositioning of intraocular lens twice for pupillary optic capture after 3 months postoperative. He presented to our clinic with complaint of left painful red eye with reduced vision of 3 days duration after a recent ocular blunt trauma. His uncorrected visual acuity was 6/60. Ocular examination showed hazy cornea with high intraocular pressure (36mmHg). There is presence of cells and vitreous in anterior chamber, peaked pupil at 11 and 5 o'clock with optic-iris capture. He was started with intraocular pressure lowering agents to control the IOP. We repositioned the optic into the posterior chamber by using viscoelastic, followed by creating surgical peripheral iridotomy. At one month post operative, patient achieved BCVA of 6/36.

Conclusion

Pupillary optic capture is a common postoperative complication following SFIOL, and recurrence has been reported in several cases. In our case, a standard surgical technique was used, with prevention of complications being considered. However, some studies have suggested surgical methods that show promising results in preventing recurrence.

ABSTRACT ID: 492

MANAGEMENT OF RECURRENT PUPILLARY OPTIC CAPTURE OF SCLERAL-FIXATED INTRAOCULAR LENS WITH SUTURELESS SURGICAL TECHNIQUE USING 7-0 POLYPROPYLENE FLANGED SUTURES

Choo-Hwee Siew[1], Michele Shi-Ying Tey[1], Mohamad Fathi Ismail[1], Hayati Abdul Aziz[1]

[1]Hospital Sultanah Aminah Johor Bahru

Purpose

To report a sutureless surgical technique for repositioning of a Yamane scleral-fixated intraocular lens (SFIOL) with recurrent pupillary optic capture.

Methods

A case report.

Results

A 40-year-old Chinese gentleman presented to us with right eye (RE) optic capture in June 2024. He had past history of RE cataract extraction in 2007. Subsequently he had pars planar vitrectomy for RE rhegmatogenous retinal detachment in 2017. In 2020 he had removal of RE subluxated IOL with SFIOL implantation. On presentation, his right pupil was eccentric with pupillary optic capture of the SFIOL. His intraocular pressure was normal with gonioscopy showed an open angle, and hyperpigmented trabecular meshwork. The RE optic disc showed glaucomatous changes. He initially underwent a optic capture release by pushing the optic posterior to the iris, nevertheless repeated recurrence of pupillary optic capture was noted at one week post-op. Subsequently optic capture release and repositioning of the SFIOL was done using two parallel 7/0 polypropylene flanged sutures. Following the surgery, no recurrence was observed and the SFIOL remained stable.

Conclusion

The sutureless surgical technique using two parallel 7–0 polypropylene flanged sutures is an effective technique in managing repeated optic capture of SFIOL.

ABSTRACT ID: 497

YAMANE TECHNIQUE SCLERAL-FIXATED INTRAOCULAR LENS (SFIOL): A SEREMBAN EXPERIENCE

Tan Chern Meng[1], Noram binti Mat Saad[1], Wan Mohd Hafidz[1], Norlelawati binti Abu[1]

[1]Hospital Tuanku Ja'afar Seremban

Purpose

To present the demographic data, surgical outcomes and complications of patients who underwent Yamane technique SFIOL at Hospital Tuanku Ja'afar Seremban.

Methods

A retrospective analysis from January 2021 to May 2023.

Results

41 eyes of 40 patients underwent Yamane technique SFIOL implantation. Main indication was posterior dislocation of IOL (n=15) followed by aphakia (n=8). Mean age was 62 years old predominantly male patient (73.2%). Racial distribution consists of Malay (66%), Chinese (22%), Indian (10%), Others (2%). 20 eyes (48.9%) had combined vitreo-retinal surgeries. Mean follow up duration was 10.2 months. Mean pre-operative visual acuity was 1.20 logMAR, while mean post-operative visual acuity was 0.60 logMAR. Total of 39 eyes (95.1%) had improved vision.

Contributory factors to poor post-operative visual acuity in 11 patients were diabetic macular oedema, pre-existing macular scar, epiretinal membrane, glaucoma, and exogenous endophthalmitis. 13 eyes (31.7%) had high intraocular pressure (IOP), with mean pre-operative IOP for these group of patients was 30.5mmHg, reduced to 15.5mmHg post-operatively. Causes of high IOP were trauma, pre-existing uncontrolled glaucoma, phacomorphic and phacolytic glaucoma.

The most common complication was IOL subluxation (n=5, 12.2%) of which 2 patients required IOL reposition, followed by vitreous haemorrhage (n=4, 9.8%) which was managed conservatively. 1 patient developed post-operative endophthalmitis and underwent pars plana vitrectomy and intravitreal antibiotics.

Conclusion

Yamane technique SFIOL emerges as a promising technique for IOL implantation in eyes with inadequate iris and capsular support, however, the learning curve is steep. A longer follow up is required to ascertain the long term functional and anatomical outcomes.

ABSTRACT ID: 514
MIMICKING CAPSULAR BAG DISTENSION SYNDROME: THE OPACIFIED IOL

Siva Sathi a/p Kanesan[1], Ummi Faradiana Abdul Rahim[1]

[1]Hospital Raja Permaisuri Bainun, Ipoh

Purpose

To report a case of opacification of intraocular lens (IOL)

Methods

A case report

Results

A 71 years old gentleman presented with left eye painless generalise blurring of vision for 9 months. He had history of uncomplicated phacoemulsification and intraocular lens implantation into the capsular bag (PCIOL) seven years prior. The best-corrected visual acuity (BCVA) using a Snellen chart was 6/9 right eye (OD) and hand movement in the left eye (OS). Slit-lamp biomicroscopy of the OD was unremarkable, upon examining the OS single piece lens in bag seen with cloudy fluid seen posterior to PCIOL and square edge haptic. Intraocular pressure 16mmHg and no fundus view. B scan shows no vitreous loculations seen and retina was flat. Patient underwent left eye PCIOL explantation/internal search and surgical peripheral iridotomy, revealed an opacified PCIOL intraoperatively. Posterior capsule appears intact and clear after IOL explantantion. No vitreous loss. IOL was sent for culture and sensitivity sampling. Patient underwent secondary IOL implant and after surgery, the patient's visual acuity improved to 6/18. IOL was sent for culture and sensitivity with negative result.

Conclusion

Opacification of IOL is a rare but significant complication that can compromise visual outcomes following cataract surgery. This condition is often associated with the type of material used in the IOL, such as hydrophilic acrylic, and can result from factors like aging, the presence of deposits, or manufacturing defects.

ABSTRACT ID: 568

Simple Modified Trendelenburg Position for Phacoemulsification in a Severely Kyphotic Patient

Lee Jia Ning[1], Woon TQ[2]

[1]Hospital Pakar Sultanah Fatimah; [2]*OasisEye Specialists, Muar*

Purpose

To describe an inventive technique of positioning a patient with severe kyphosis using a simple modified Trendelenburg technique for phacoemulsification

Methods

A case Report

Results

A 52-year-old severe kyphotic patient with history of right below knee amputation, was diagnosed with both eyes moderate non-proliferative diabetic retinopathy and both eyes immature cataract. His right eye vision was 6/18 and left eye 6/12. He was planned for both eyes phacoemulsification under local anesthesia. Patient has a limited neck extension, resulting in a chin-down position that made the conventional supine position for cataract surgery not feasible for him. Intraoperatively, due to limitation of the operative table, he was placed in a modified Trendelenburg position, where during his first eye phacoemulsification surgery, thick layers of cloths were placed below his head and neck, without left knee flexion. One week later during his second eye phacoemulsification surgery, another modified Trendelenburg technique was used where lesser layers of cloths were placed under his head and neck but this time with his left knee flexed at 90 degrees. Patient was comfortable during both surgeries with each surgery uneventful. Extended Depth of Focus (EDOF) lens was implanted in his both eyes. 6 weeks post-operatively, his best corrected vision for right eye 6/12 and left eye 6/6. Both eyes cornea was clear with quiet anterior chamber and stable intraocular lens. Right eye macula later revealed to have epiretinal membrane.

Conclusion

Simple operative equipment can attain a position that is feasible for awake cataract surgery in patients with gross neck anatomical changes to ensure patient’s comfort and optimal surgical outcomes.

ABSTRACT ID: 575

Comparison of Predictability Using Barrett Universal II and SRK/T Formulas in Normal Axial Length Senile Cataract Patient

Helga Sharon El Shemida[1], Rizal Fanany[1], Wisnu Sadasih[1], Riskha Pangestika[1]

[1]Diponegoro University / Kariadi General Hospital

Purpose

To compare the predictability of intraocular lens (IOL) power calculation using the Barrett Universal II and the SRK/T formulas in immature senile cataract with normal axial length.

Methods

We retrospectively reviewed the clinical charts of 35 eyes who had undergone phacoemulsification cataract surgery with intraocular lens implantation from January 2024 until December 2024 at Kariadi General Hospital. Preoperative biometric measurements were made using an IOL Master® 500 and 700. Intraocular lens power calculations were performed using the Barrett Universal II and the SRK/T formulas. RayOne Aspheric Monofocal IOL was used in all patients. We compared the uncorrected visual acuity (UCVA) before and after operation, best corrected visual acuity (BCVA) before and after operation, mean refractive spherical equivalent (MRSE) and mean absolute error (MAE) 1 month postoperatively using the two formulas in patient who in normal axial length (22.00-24.5mm) and corneal astigmatism less than 1.5D.

Results

Our study showed significant differences UCVA and BCVA between before and after operation ($p<0.05$). The mean refractive spherical equivalent with Barrett Universal II formula was smaller than SRK/T formula. There were no significant differences between the mean absolute error using the Barrett Universal II formula and SRK/T formula ($p=0.626$).

Conclusion

The Barrett Universal II formula provides a better predictability of IOL power calculation than the SRK/T formula in normal axial length immature senile cataract.

ABSTRACT ID: 582

Risk Factors and Visual Outcome of Cataract Surgery in Highly Myopic Patients at a Tertiary Hospital in Semarang

Edo Sun de Putra[1], Wisnu Sadasih[1]

[1]Diponegoro University Indonesia

Purpose

To describe the visual outcome of highly myopic eyes following cataract surgery and to identify associated risk factors for poor post-surgery vision.

Methods

We carried out a retrospective, non-comparative case study at the Department of Ophthalmology, Kariadi Hospital, Semarang, Indonesia. High myopia was defined as an axial length equal to or more than 26 mm. The primary outcomes included best corrected visual acuity (BCVA), visual improvement, and complications during the first 3 months after surgery.

Results

Eighty-three eyes were enrolled from January 2024 to December 2024. A total of 74 (89.2%) eyes had good visual improvement (≥ 3 line Snellen chart), 63 eyes (75.9%) had good postoperative vision (BCVA ≥ 6/18), and 9 eyes had poor postoperative vision (BCVA < 6/60). A total of 5 patients experienced complications, including posterior capsular opacification and retinal detachment, within 3 months of follow-up. Age of the patient, pre-existing posterior segment abnormalities, and having systemic diseases such as hypertension and diabetes were risk factors that influenced postoperative vision ($P<0.001$).

Conclusion

Most of highly myopic eyes achieved good visual improvement and good postoperative visual acuity after cataract surgery. Age of the patient, systemic diseases, and pre-existing posterior segment abnormalities were risk factors for postoperative visual outcome.

Cornea & Anterior Segment Disease

ABSTRACT ID: 32

CHRONIC CORNEA-CONJUNCTIVAL CYST AT PRE EXISTING PHACOEMULSIFICATION WOUND FOLLOWING EYE TRAUMA

Maimun Bashir[1], Shikin Shakri[1], Adlina Kadir[1], Amirah Hassan[1], Zalifa Zakiah[1], Shazwani Azmi[1]

[1]Hospital Cyberjaya

Purpose

To highlight a case of left eye conjunctival cyst following miscellaneous eye trauma.

Methods

Case report

Results

79 years old lady complained of left eye foreign body sensation for 2 months during regular follow up clinic. She had bilateral eye cataract operation done in 2020 that was uneventful. She had left eye ocular trauma,sustained left eye periorbital hematoma due to fall 1 year prior to presentation. Visual acquity of left eye was 6/15.Slit lamp examination showed a solitary raised,whitish cyst at 11 oclock at limbus measuring 5mm x 3.2mm with central leaking descemetocele. However, anterior chamber was formed with occasional cell and anterior synechae at growth area with iris atrophy underneath it. Fundus examination was unremarkable. Case was consulted with cornea team, a diagnosis of left eye chronic cornea-conjunctival cyst with leaking descemetocele from previous phacoemulsification wound was made and left eye gluing and bandage contact lens was done to control leaking along with topical gutt vigamox 4Hourly and gutt alphagen TDS left eye. Follow up at 1 week, conjunctiva cyst appearing flatter measuring 3.6mm x 4mm , glue was loose with positive seidel test centrally of descematocele. Regluing and BCL was performed, patient was advised for left eye patching under general anaesthesia for long term management however refuse for operation due to old age.

Conclusion

Conjunctival cyst is a rare late complication of phacoemulsification operation precipitated by trauma. Eye symptoms like foreign body sensation in previous ocular surgery should be presented early to prevent serious complication.

ABSTRACT ID: 54
LOOKS CAN DECEIVE: NOT ALL CONJUNCTIVAL BUMPS ARE CANCER

Lee Wan Qing[1], Sangeetha Tharmathurai[1], Norhafizah Hamzah[1]

[1]Hospital Tunku Azizah, Kuala Lumpur

Purpose

To report a rare case of benign conjunctival tumor mimicking malignancy.

Methods

Case report

Results

A 10-year-old boy has a long-standing history of multisystem Langerhans cell histiocytosis (LCH), diagnosed since 4 years old. His disease involved multiple organ systems, including the skin, nails, bilateral ears, hepatosplenomegaly, and bones. This multisystem organ involvement required systemic chemotherapy over several years. Despite treatment, he experienced three episodes of progressive disease. During the most recent episode, the patient developed a right eye conjunctival lesion associated with discomfort, and gradual enlargement over three weeks. On examination, the left eye conjunctival lesion was located at superonasal limbus measuring 6mm horizontal x 2.75mm vertically, appeared raised, irregular, dark-pigmented, multilayered, and was accompanied by feeder vessels. Due to strong suspicion of malignant appearance, he underwent excisional biopsy of the conjunctival lesion which was subsequently sent for histopathological examination (HPE). Surprisingly, the histopathological examination revealed a benign compound nevus with no evidence of malignancy. This finding was unexpected, as the lesion's clinical presentation raised concerns for malignancy, particularly in the context of recurrent LCH. The patient otherwise experienced resolution of symptoms following excision, and no recurrence was observed during follow-up.

Conclusion

This rare case demonstrates that not all raised conjunctival lesions with feeder vessels are malignant. Thus, histopathological examination (HPE) plays an important role in distinguishing benign from malignant conjunctival lesions.

ABSTRACT ID: 66

PRECISION MEETS VISION: ANTERIOR SEGMENT OPTICAL COHERENCE TOMOGRAPHY IN MANAGING INFECTIOUS KERATITIS

Noor Sarah Khor MAK[1], Norlina Ramli[1], Sujaya Singh[1]

[1]University Malaya

Purpose

To report a case series of infective keratitis evaluated using anterior segment optical coherence tomography (AS-OCT).

Methods

A retrospective analysis of three cases of infective keratitis.

Results

Case 1: An 80-year-old woman was treated for a bacterial corneal ulcer in the left eye secondary to corneal decompensation with ruptured bullae. Treatment, guided by clinical evaluation and history, led to improvement. AS-OCT scans during follow-up assessed treatment effectiveness.

Case 2: A 70-year-old man presented with infective keratitis in the right eye, complicated by elevated intraocular pressure due to a pupillary block. A hazy cornea obscured the fundus view, but AS-OCT identified a retro-corneal endothelial plaque with well-defined boundaries, suggesting non-fungal etiology. This finding, combined with clinical judgment, enabled effective management.

Case 3: A 67-year-old woman was treated for herpetic stromal keratitis in the right eye, complicated by suspected fungal infection. Challenges included a geographic corneal epithelial defect, soil exposure, and prolonged use of topical steroids. Despite negative corneal scraping cultures, AS-OCT revealed irregular and thickened endothelium without breach, aiding diagnosis and guiding treatment. A series of AS-OCT scans confirmed the effectiveness of the therapy.

Conclusion

AS-OCT provides clinicians with valuable diagnostic patterns in infective keratitis, serving as an additional tool to evaluate treatment effectiveness and confirm lesion healing, beyond what clinical assessment alone can achieve.

ABSTRACT ID: 73
NECROTIZING SCLERITIS POST-SCLEROTHERAPY FOR ORBITAL VENOUS MALFORMATION

Low Zhen Ning[1], Chin Yie Ping[1], Valarmathy Vaiyavari[1], Nurul Laila Binti Salim[1], Rohanah Binti Alias[1]

[1]Hospital Kuala Lumpur

Purpose

To report a case of right eye necrotizing scleritis post-sclerotherapy for orbital venous malformation

Methods

Case report

Results

A 38-year-old woman with a history of right eye (RE) slow-growing proptosis since childhood reported worsening symptoms over the past week. She had no pain nor noted any change in proptosis with Valsalva manoeuvre. Examination showed RE vision of 6/36, non-axial proptosis, limited extraocular movement over all gazes and inferior conjunctival injection with chemosis. Hertel exophthalmometry readings were 15 mm for RE and 13 mm for left eye (LE). Imaging revealed an extraconal lesion in the superomedial aspect of the right orbit, leading to a diagnosis of right orbital venous malformation. She underwent image-guided percutaneous sclerotherapy with 3 ml mixture of Sodium Tetradecyl and Lipidol. One week later, she developed RE pain, swelling, and tearing, with vision deteriorating to 3/60. Slit-lamp examination showed inferior conjunctiva and sclera melt, leading to a diagnosis of RE necrotizing scleritis. Culture revealed Staphylococcus aureus sensitive to chloramphenicol. She was treated with oral ibuprofen, oral doxycycline, and topical antibiotics (moxifloxacin and chloramphenicol). Her condition improved, with reduced chemosis and improved vision to 6/24.

Conclusion

Sclerotherapy is an effective treatment for orbital venous malformation. However it can lead to necrotizing scleritis, which is a rare but serious complication. Therefore, close monitoring following the procedure is essential to identify any potential complications and ensure timely intervention.

ABSTRACT ID: 89
DESCEMET'S MEMBRANE TEAR FOLLOWING FORCEPS-ASSISTED DELIVERY

Yeap Zhi Ling[1], Sujaya Singh[1], Maftuhim Binti Addenan[2], Che Mahiran Binti Che Daud[2], Siti Nor Roha Binti Daman Huri[2], Gan Sin Hui[2]

[1]Universiti Malaya; [2]Hospital Sungai Buloh, Selangor, Malaysia

Purpose

To report a case of late presentation forceps-induced Descemet membrane tears (FIDMT) as bullous keratopathy

Methods

Case report

Results

A 49-year-old Malay lady, previously no known medical illness, presented with left eye (OS) painless progressively worsening blurring of vision for 4 years. There was a history of left eye bacterial corneal ulcer 8 months prior to her first visit to Cornea transplant center. Further history revealed that she was born via forceps assisted delivery. Systemic review was unremarkable. OS visual acuity was counting finger at 2 feet's, with no relative afferent pupillary defect. OD visual acuity was 6/9. OS examination showed hazy cornea with 2 oblique line of Descemet folds involving visual axis, cornea oedema with bullae inferiorly and a central endothelial scar. Fundus examination view was hazy. OD Anterior segment and fundus examination were unremarkable. She was then treated as Left eye bullous keratopathy secondary to Descemet membrane detachment, underwent Left eye Descemet stripping endothelial keratoplasty. Intra-operatively revealed 2 Vertical oblique Descemet membrane detachment with folds, hazy cornea, minimal stromal scarring inferior to pupil and at inferonasal of the cornea. Post op one week, her OS visual acuity improved to 6/24 with attached graft.

Conclusion

Although the incidence is low, undiagnosed FIDMT may present late with complications such as astigmatism, amblyopia, bullous keratopathy, corneal ulcer and corneal decompensation. Newborns post forceps delivery should be examined carefully as early detection, prompt treatment, and ongoing monitoring of visual system development can help to prevent further vision impairment.

ABSTRACT ID: 135

FROM CONJUNCTIVITIS TO CATASTROPHE: A RAPIDLY PROGRESSIVE PSEUDOMONAS KERATITIS IN A COMPROMISED PSEUDOPHAKIC EYE

Noor Amy Farhana binti Mohammad Amin[1], Noor Amalina Bt Saidi[1], Faridah binti Mat Min[1]

[1]Hospital Sultanah NurZahirah

Purpose

To report a case of rapidly progressive corneal ulcer

Methods

A case report

Results

An 81-year-old male with diabetes mellitus, hypertension, and ischemic heart disease, known to have left eye pseudophakic bullous keratopathy and recurrent herpetic keratouveitis on acyclovir prophylaxis, presented with a one-day history of severe left-sided headache causing insomnia and a four-day history of left eye redness, discharge, and blurred vision. Initially managed as conjunctivitis with topical antibiotics, his condition unexpectedly worsened into a rapidly progressing corneal ulcer. Examination revealed a right eye visual acuity of 6/6 and left eye perception of light only, with lid swelling, purulent discharge, diffuse conjunctival injection, and near-total corneal opacity with an extensive epithelial defect. Intraocular pressure was elevated at 29 mmHg. The patient was admitted and treated with intensive topical antibiotics, anti-glaucoma medications, systemic acetazolamide, doxycycline, and vitamin C. Corneal scraping confirmed Pseudomonas aeruginosa, sensitive to ceftazidime. Despite aggressive treatment, the cornea developed an impending perforation with total infiltrate, melting, and descemetocele formation by day three. Intravenous ciprofloxacin was initiated, but worsening ocular pain and headache necessitated evisceration. Intraoperatively, the cornea showed full-thickness infiltration, though no vitreous pus was present. The patient recovered well postoperatively with one week of intravenous ceftazidime.

Conclusion

This case highlights the aggressive nature of Pseudomonas keratitis in high-risk patients and underscores the need for early recognition and prompt intervention to prevent irreversible vision loss.

ABSTRACT ID: 136

YEAST ON STAINING, BACTERIA IN CULTURE: MANAGING A CHALLENGING KERATITIS CASE

Noor Amy Farhana binti Mohammad Amin[1], Noor Amalina Bt Saidi[1], Faridah binti Mat Min[1]

[1]Hospital Sultanah NurZahirah

Purpose

To report a case of challenging corneal ulcer

Methods

A case report

Results

A 67-year old woman with diabetes mellitus, hypertension, hyperlipidemia, and bilateral neovascular glaucoma secondary to proliferative diabetic retinopathy (left eye absolute) presented with a three-day history of left eye redness and itchiness, without pain or history of trauma. Visual acuity was 6/60 in the right eye (NIPH) and NPL in all quadrants of the left eye. Anterior segment examination revealed mild lid swelling and a generalized hazy, edematous cornea with a 5 mm × 5 mm paracentral stromal infiltrate nasally and an endothelial plaque. The anterior chamber was deep with a 2 mm hypopyon and nasal corneal thinning. Given the clinical suspicion of fungal keratitis, early antifungal treatment was initiated based on gram stain findings, which showed the presence of yeast. She was started on intensive topical antifungals (fluconazole 0.25%, amphotericin B) and antibiotics (cefuroxime, gentamicin 1.4%), along with atropine TDS, oral fluconazole 200 mg OD, and doxycycline 100 mg BD. Despite one week of treatment, the corneal infiltrate and hypopyon remained static. Corneal scraping culture later grew Raoultella terrigena. Given the lack of clinical improvement, an anterior chamber washout with intracameral amphotericin B was performed. Six days post-procedure, there was significant improvement, with reduction in corneal infiltrate size, resolution of hypopyon streaking, and clearer iris details.

Conclusion

This case highlights the importance of early antifungal treatment in suspected fungal keratitis and the role of intracameral amphotericin B in refractory cases, even when culture results suggest bacterial infection.

ABSTRACT ID: 138

SILVER: A FRIEND OR A FOE

Chua Jian Yang[1], Tiong Lik Wei[2]

[1]Hospital Selayang; [2]*Hospital Sarawak*

Purpose

To highlight the effects of acute exposure to concentrated silver.

Methods

Case report

Results

A 46 years old lady with no known medical illness presented with bilateral eye redness and discomfort. She is a contact lens wearer with improper technique and hygiene. Prior to onset of symptoms, she had been using eye drop containing 99.99% pure silver bought from unlicensed online vendor. On examination, there was total corneal epithelial defect over right eye and subtotal corneal epithelial defect over left eye. Other examinations were normal. Bilateral eye irrigation was done and patient was start on topical antibiotics, anti-inflammatory and lubricants. Cessation of unlicensed eyedrops were advised. 1 week later, bilateral corneal epithelial defect resolved and patient made fully recovery.

Conclusion

Silver is a adjunct in the field of medicine but caution is advised to ensure safe usage.

ABSTRACT ID: 179

EFFICACY OF AZELASTINE AND OLOPATADINE IN ALLERGIC KERATOCONJUNCTIVITIS: A SYSTEMIC REVIEW APPROACH

Bellakusuma Nurdianningrum[1], Dina Novita[1], Amalia Budhi Hapsari[1]

[1]Diponegoro University / Dr. Kariadi General Hospital

Purpose

To compare the efficacy between azelastine and olopatadine for the treatment of allergic keratoconjunctivitis

Methods

A systematic literature search from 2014-2024 was performed using websites such as PubMed, Google Scholar, and Scopus under PRISMA guidelines. Five clinical trials met the inclusion criteria.

Results

Five studies involving 384 patients found that olopatadine and azelastine significantly reduced symptoms of allergic keratoconjunctivitis. Olopatadine was found to be better in reducing symptoms ($p<0.05$) in 4 studies, while one study showed azelastine was quicker and more effective. However, only one study assessed adverse effects and showed that azelastine had more side effects, such as burning and tingling sensations ($p=0.000$). The significance of the reduction of symptoms was not assessed statistically in one study.

Conclusion

Both olopatadine and azelastine could significantly reduce the symptoms of allergic keratoconjunctivitis; however, olopatadine showed more effective results and fewer side effects.

ABSTRACT ID: 188

SUCCESSFUL MANAGEMENT OF INFECTIOUS CRYSTALLINE KERATOPATHY WITH TOPICAL VANCOMYCIN

Md Zulfadli bin Mohd Razali[1,2], Mohd Naim bin Ashri[2], Julieana binti Muhammed[1], Muhammad Aizuddin bin Ahmad[2]

[1]Health Campus University Sains Malaysia; [2]*Hospital Sultanah Nur Zahirah*

Purpose

Successful management of infectious crystalline keratopathy with topical vancomycin.

Method

A case report.

Result

A 40 years old male with history of hypertension and hyperlipidemia presented with a two-day history of right eye discomfort and foreign body insertion. One year prior, he had been treated for a left eye corneal ulcer following foreign body insertion, which resolved with residual corneal scarring. On presentation, his visual acuity was 6/6 in both eyes, with no relative afferent pupillary defect. Slit lamp examination revealed a stromal opacity near the temporal limbus of the right eye, without infiltrate, and meibomitis. Subsequently, the right eye exhibited stroma infiltrate with surrounding edema, yet no satellite or dendritic lesions were observed; anterior chamber tap was deferred, and corneal scraping revealed no microbial growth, suggesting a bacterial-infectious etiology. The patient was managed as a case of worsening marginal keratitis with meibomitis, receiving topical steroid with a series of topical antibiotics including moxifloxacin, gentamicin, cefuroxime, and ceftazidime. After two months of minimal improvement, the patient was re-evaluated , and a diagnosis of infectious crystalline keratopathy (ICK) was made based on the appearance of white, branching, crystalline deposits within the cornea stroma in the right eye. Treatment was escalated to topical vancomycin, and demonstrated a remarkable response. Within two months of vancomycin therapy, the ICK showed significant contraction, with no further progression of stromal opacities.

Conclusion

This case underscores the importance of considering ICK in cases of refractory keratitis and the efficacy of targeted antimicrobial therapy, particularly topical vancomycin. Early suspicion, appropriate diagnostic workup, and timely intervention are critical in managing this cornea pathology.

ABSTRACT ID: 213

A CASE OF CORNEAL ULCER WITH UNDERLYING EPITHELIAL BASEMENT MEMBRANE DYSTROPHY

Amreth Kaur Dhalywal[1], Sangitha Maniam[1], Chandramalar T Santhirathelagan[1]

[1]Hospital Sungai Buloh

Purpose

Poor management of recurrent corneal erosion (RCE) syndrome with underlying epithelial basement membrane dystrophy (EBMD) could potentially lead to a catastrophic development of corneal ulcer. EBMD has an autosomal dominant genetic predisposition, which many are not aware of. It causes abnormalities in the epithelial basement membrane, leading to poor adhesion of corneal epithelium.

Methods

Case study

Results

A 34-year-old healthy Malay lady was referred from a private ophthalmology center for left eye corneal ulcer. Patient had a brief 3-day history of worsening left eye redness, pain and excessive tearing. She had also noticed formation of a whitish opacity over her eye causing blurring of vision. No recent history of trauma, foreign body entering the eye, contact lens or steroid use. Patient had visited the private ophthalmologist several times previously in the last 2 years for corneal abrasion in both eyes. Upon examination, reflex afferent pupillary reflex was negative. Vision over right eye 6/9, and left eye hand movement. Slit lamp examination of right eye revealed small, irregular, putty like grayish white opacities (dot patterns) over cornea with negative staining. Left eye examination revealed generalized corneal edema, well defined central corneal infiltrate with overlying epithelial defect, and hypopyon. Fundus examination over right eye was unremarkable, left eye had no view in view of central opacity, otherwise B-scan showed flat retina with no loculations.

Conclusion

Early recognition and proper management of EBMD helps to reduce recurrence of corneal erosion, thus reducing prevalence of corneal ulcer.

ABSTRACT ID: 242

A VENOMOUS GAZE: UNDERSTANDING SNAKE VENOM'S OPHTHALMIA

Manissha Rajan[1], Sobanah Rajakumar[1], Ooi Say Ting[1], Ng Sok Lin[1]

[1]Hospital Taiping

Purpose

Snake venom ophthalmia is a potentially devastating form of ocular injury caused by the splash of venom from a snake onto the surface of the eye, which can lead to serious ocular damage if not treated promptly.

Methods

Case report.

Results

Conclusion

Snake venom ophthalmia, is a potentially sight-threatening condition requiring immediate attention and treatment. Prompt irrigation of the eyes and appropriate pharmacologic management can significantly reduce the risk of long-term ocular complications.

ABSTRACT ID: 243

RARE CASE OF NECROTISING SCLERITIS WITH UNDERLYING SCLEROMALACIA PERFORANS IN A SEROPOSITIVE RHEUMATOID ARTHRITIS PATIENT

Timothy Liew Khai Wing[1], Tajunisah Belgum Iqbal[1], Nurul-Laila Salim[2], Rohanah Alias[2], Norlaila Talib[3]

[1]Universiti Malaya Medical Centre; [2]Hospital Kuala Lumpur; [3]Hospital Serdang

Purpose

To report a case of Necrotising Scleritis with underlying Scleromalacia Perforans in a Seropositive Rheumatoid Arthritis patient

Method

A case report

Result

A 69-year-old Malay woman presented with a painful, red right eye (RE), associated with watering and blurred vision for two weeks. Symptoms were gradual but progressively worsening. She had no prior similar episodes, fever, trauma, or eye surgery. There were no systemic autoimmune disease features, though she had knee pain for a year. Systemic examination was unremarkable. Ocular examination showed hand movement vision in both eyes due to dense cataracts, with intraocular pressures of 10mmHg. Slit-lamp examination of the RE revealed diffuse conjunctival injection with temporal scleral thinning measuring 8mm × 5mm, 3mm from the limbus. Anterior chamber had 3+ pigmented cells without hypopyon or fibrin. 360 degree posterior synechiae were present, and pupils were sluggish. The left eye had normal anterior segment except for generalized bluish sclera, indicating thinning. Fundus examination was obstructed by white cataracts. B-scan confirmed scleral thinning and a positive T-sign. A provisional diagnosis of necrotizing scleritis in the RE with bilateral scleromalacia perforans was made. She was admitted and started on intravenous ciprofloxacin and antibiotic eye drops. Infective markers were negative, but anti-CCP antibodies were positive. Despite clinical improvement with antimicrobial therapy, choroidal tissue prolapsed from scleral thinning. An amniotic graft membrane and temporal frost stitch were performed. Immunosuppressive therapy stabilised inflammation with prednisolone tapering and weekly methotrexate.

Conclusion

Scleromalacia Perforans is rare (4% of scleritis cases), mostly affecting elderly women with longstanding rheumatoid arthritis. Early diagnosis is vital to prevent complications.

ABSTRACT ID: 258

UNMASKING ACANTHAMOEBA KERATITIS: ROLE OF CONFOCAL MICROSCOPY AND MOXIFLOXACIN IN THE EARLY DIAGNOSIS AND MANAGEMENT OF ACANTHAMOEBA KERATITIS

Pan Ting Sun[1], Fariza Binti Fauzun[1], Fadzilah Hanim Binti Rahim[1], Adzura Salam[1], Ahmad Nurfahmi[1]

[1]IIUM International Islamic University Malaysia

Purpose

To highlight the utility of confocal microscopy in diagnosing Acanthamoeba keratitis (AK) in a 14-year-old boy with an ambiguous clinical presentation following adenoviral conjunctivitis.

Case report

A 14-year-old boy presented with a one-week history of ocular redness, pain, blurred vision, photophobia, and watery discharge in his left eye, following a recent episode of adenoviral conjunctivitis. Clinical examination revealed conjunctival hyperemia and the presence of a corneal ulcer with anterior stromal infiltration. There was no history of contact lens use, ocular trauma, or recent exposure to contaminated water. Given the unusual presentation, confocal microscopy was performed, revealing numerous double-walled cysts, consistent with Acanthamoeba keratitis. Treatment was initiated with topical chlorhexidine and moxifloxacin (due to the unavailability of Brolene).

Results

The corneal ulcer resolved completely after two weeks. Follow-up confocal microscopy conducted one month later confirmed the absence of cysts.

Conclusion

Confocal biomicroscopy is an essential diagnostic tool in the management of AK with ambiguous presentations. The combination of chlorhexidine and moxifloxacin is potentially effective in treatment.

ABSTRACT ID: 283

A CASE OF PERIPHERAL ULCERATIVE KERATITIS WITH SCLERITIS SECONDARY TO GRANULOMATOSIS WITH POLYANGIITIS

Sangitha Maniam[1], Amreth Dhalywal[1], Chandramalar T Santhirathelagan[1]

[1]Hospital Sungai Buloh

Purpose

Granulomatosis with polyangiitis (GPA) is a multisystem autoimmune disorder and a rare type of vasculitis affecting small to medium size vessels in multiple organs including the eyes. We report a rare case of GPA whereby a patient initially presented with ocular involvement.

Methods

Case Report

Results

A 52-year-old healthy Orang Asli male with no known medical illness presented with a history of worsening bilateral eye (BE) redness, tearing, irritation and reduced vision for 3 months. Ocular examination revealed, vision over right eye (RE) was counting fingers and left eye (LE) was light perception with absence of relative afferent pupillary defect. BE conjunctiva was injected and there was generalised 360 degrees peripheral corneal thinning and multiple corneal infiltrates. His autoimmune workup showed positive anti-neutrophil cytoplasmic IgG autoantibodies (ANCA) with elevated anti-proteinase 3 antibody (PR3). His full blood count, renal profile, urinalysis and chest radiography were normal. B-scan showed BE thickened sclera.

He was diagnosed with GPA associated with BE peripheral ulcerative keratitis (PUK) and scleritis. His significant corneal thinning required prophylactic cyanoacrylate gluing and bandage contact lens. He was initially treated with intravenous methylprednisolone and topical antibiotics. He is currently being managed with tapering oral steroids in addition with methotrexate maintenance therapy and is clinically stable.

Conclusion

GPA can result in serious life threatening complications, hence in patients with PUK and scleritis there must be a high index of suspicion with targeted laboratory and radiological workup to make an accurate diagnosis as prompt management is crucial in managing the disease.

ABSTRACT ID: 288
BLINDED BY THE SPARK: A CASE REPORT OF SEVERE OCULAR FIRECRACKERS INJURY

Beh Renping[1], Siew Hong Wai[1], Ooi Say Ting[1], Ng Sok Lin[1]

[1]Hospital Taiping

Purpose

To describe a devastating case of severe ocular surface firecrackers burn injury requiring prompt treatment

Methods

Case study

Results

An 18-year-old Indian male presented with alleged firecrackers explosion near his left eye. During the incident, he was a bystander and was unaware that fireworks had been lit beside him. Upon arrival, immediate left eye irrigation and removal of firecracker remnants were performed. Left eye visual acuity showed no-perception-to-light in all quadrants, with a positive relative afferent pupillary defect. He sustained second-degree burns over left eyelid, charred eyelashes, and a grade VI ocular surface burn according to Dua classification. The conjunctiva and entire cornea were burned, with an epidefect and 360-degree limbal ischemia. The cornea appeared generally hazy and edematous. A temporal conjunctival and partial-thickness scleral lacerations were noted. The intraocular pressure of left eye was 26mmHg. The anterior chamber, iris, and fundus were not visible. B-scan showed left eye vitreous haemorrhage. Right eye examinations were unremarkable. Imaging with a CT scan of the brain and orbit revealed left globe irregularity with vitreous haemorrhage. The left eye conjunctival and scleral lacerations were sutured. He was started on frequent topical steroids, antibiotics, and lubricants. Oral vitamin C and Doxycycline were initiated. Subsequently, he underwent two amniotic membrane transplant; however, his vision remained poor despite healing of the corneal epithelial defect.

Conclusion

This case describes a severe ocular surface burn caused by firecrackers, resulting in a poor visual outcome. Public education on the dangers of firecrackers and safety measures to protect the eyes is crucial in preventing blinding complications.

ABSTRACT ID: 290
A RARE CASE OF FUNGAL CORNEA ULCER CAUSED BY TRICHOPHYTON MENTAGROPHYTES

U - Nee Lam[1], Chandramalar T. Santhirathelagan[2], Siti Nor Roha Daman Huri[2]

[1]Hospital Kuala Lumpur; [2]Hospital Sungai Buloh

Purpose

To describe a rare case of Trichophyton Mentagrophytes corneal ulcer which was successfully treated with Intracameral, topical and systemic antifungal

Methods

Case Report

Results

A 41 year old gentleman in the agricultural industry presents with history of foreign body entering the left eye, complaints of acute blurring of vision with accompanying pain and redness. Initial visual acuity was 6/24 OS which rapidly deteriorated to hand movement within 2 weeks. There's no RAPD and the IOP was initially normal. A central partial thickness cornea laceration wound measuring 2.8 x 1mm with epithelial defect, infiltrate, endothelial plaque at 6 o'clock and a streak of hypopyon was seen. Fundus examination was normal. Topical antimicrobial was initiated, but the hypopyon level increased, cornea became hazier, descemetocele developed at the central cornea with corresponding cornea thinning and increase in IOP. Therefore topical and oral antifungal together with antiglaucoma was added to the regime, and 2 doses of intracameral Amphotericin B injections were administered, however there was minimal clinical improvement. Corneal scraping revealed Trichophyton mentagrophytes. G Amphotericin B was switched to G Natamycin and patient demonstrated marked improvement of cornea clarity, resolving infiltrate and hypopyon, achieving a final visual acuity 6/36 OS.

Conclusion

Trichophyton Mentagrophytes corneal ulcers require prompt identification and swift initiation of appropriate treatment. Lack of suspicion and delayed diagnosis herald the onset of complications which leads to permanent vision loss or worse enucleation. This is crucial in cases of Trichophyton Mentagrophyte corneal ulcers as majority of cases results in evisceration. This highlights the importance of tailoring treatment strategies in complex ocular infections.

ABSTRACT ID: 292

FROM CATS TO CONJUNCTIVA : SPOROTHRICOSIS - THE UNSEEN RISK IN HOSTEL LIVING

Adina Wati MS[1], Saidatun NMF[1], Suriana S[1], Siti Husna H[2]

[1]Putrajaya Hospital; [2]Universiti Sains Islam Malaysia

Purpose

Sporotrichosis is a subacute or chronic infection caused by dimorphic fungus Sporothrix spp., primarily affecting subcutaneous tissue, occasionally involving extracutaneous areas, including the eyes. Ocular sporotrichosis is rare. We report a case of ocular adnexa sporotrichosis in a young girl living in hostel, presenting with conjunctival granuloma.

Methods

Case report

Results

13-year-old Malay girl with no known medical illness presented with non-progressive and painless right upperlid swelling for 3 days duration. It associated with eye redness, mild discomfort and foreign body sensation. There was history of cat exposure in her hostel area, however no history of cat's scratch or direct contact with cats. Ocular examination revealed best corrected vision of 6/9 in the affected eye, with multiple palpebral conjunctival granuloma on both upper and lower lid, along with generalized mild conjunctiva redness. Systemic examination showed tender right preauricular lymph nodes. Histopathological biopsy of the lid granuloma revealed chronic granulomatous inflammation with granulation tissue and positive mycological culture of Sporothrix schenckii. She was treated with oral itraconazole 200mg once daily for six weeks. At one month follow up, her symptoms resolved, and anterior segment of the right eye showed flattened granuloma.

Conclusion

Ocular sporothricosis is a rare manifestation of Sporothrix fungus infection, primarily affecting the ocular adnexa, which can mimic various condition. In this case, the patient's residence in a hostel with potential exposure to stray cats highlights the role of environmental and living as risk factors. Histopathological examination with fungal culture remains essential for accurate diagnosis, while early antifungal treatment can lead to successful recovery and prevent complications.

ABSTRACT ID: 293
CORNEAL ULCER: WHERE DID IT WENT WRONG?

Lee Jia Ning[1], Alex Yee CS[1]

[1]Hospital Pakar Sultanah Fatimah

Purpose

To report a case of rare organisms corneal ulcer complicated with pan-ophthalmitis post penetrating keratoplasty (PK)

Method

Case Report

Results

A 52-year-old healthy man presented with left eye (LE) redness and pain after alleged foreign body entry upon cutting grass. He was initially given 'Neo-Deca' eyedrop by general practitioner. Post trauma day 4, during our first visit revealed that LE visual acuity was hand movement (HM). No reverse afferent pupillary reflex. There was a 10x10mm central corneal infiltrate with thinning area but no satellite lesion; and hypopyon measuring 3mm. No loculation seen on B-scan. Eyedrops Gentamicin 0.9%, Cefuroxime 5%, Fluconazole 0.2%, Amphotericin B 0.15% hourly, oral Fluconazole 200mg OD and Doxycycline 100mg BD were started. LE corneal scrapping showed Pseudomonas aeruginosa with no fungal growth initially. Eyedrop Natamycin was added in view of worsening condition with leaking descemetocele. Emergency PK was done on day 24. Despite given intensive antifungal and antibacterial, his corneal graft showed progressive melting post-op day 10, with re-accumulation of hypopyon. B-scan showed evidence of pan-ophthalmitis with loculation and scleral thickening. Intravitreal tapping and antifungal/antibiotic were given few times. In view of worsening vision (NPL) and condition, he agreed for evisceration. Intraoperatively thick yellowish vitreous seen, which subsequently revealed Aspergilus spp. and Psathyrella sp. growths.

Conclusion

Treatment for corneal ulcer with vegetative origin can be very challenging and some cases may end up with evisceration despite all salvaging methods were taken promptly. Steroid eyedrop usage initially can mask the identification of the causative fungal organism, and hence should be avoided.

ABSTRACT ID: 305

The Mysterious Corneal Nodules: A Case of Salzmann's Nodular Degeneration

Mohd Fadhil Bin Ismail[1], Nur Nazifah Norran[1], Nurul Ain Shahrudin[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

Salzmann's Nodular Degeneration is a rare condition that causes small, white bumps to form on the cornea. The bumps can be asymptomatic or cause blurring of vision and a foreign body sensation. We reported a case of Salzmann's Nodular Degeneration.

Methods

Case report

Results

A 68-year-old Chinese lady with underlying hyperlipidaemia presented with right eye painless blurring of vision for one year, along with a foreign body sensation. There was no documented eye pain or eye redness. She denied any history of ocular trauma.

On initial examination, her right eye visual acuity was 6/60, improving with pinhole to 6/15. Intraocular pressure was within normal limits. Slit-lamp examination revealed multiple well-circumscribed, raised, smooth surfaced paracentral whitish nodules on the corneal epithelium of the right eye. Fluorescein staining showed punctate epithelial erosions with no areas of epithelial defect. There were no signs of active inflammation.

The patient was prescribed preservative-free lubricating eye drops along with a steroid eye drop. Over the following month, her vision in the right eye improved, with visual acuity of 6/21 with pinhole 6/15, coinciding with flattening of the corneal nodules and an improvement in punctate epithelial erosions.

Conclusion

Early diagnosis and appropriate management of Salzmann's nodular degeneration are important for improving visual symptoms and to prevent disease progression.

ABSTRACT ID: 310

Sympathetic Ophthalmia Following Limbal Relaxation Incision in an Eye with History of Penetrating Trauma

Aiman Ifwat bin Samsolbari[1], Lam Chen Shen[1], Wan Haslina binti Wan Abdul Halim[1], Mazaya binti Mahmud[2]

[1]Hospital Canselor Tuanku Muhriz, Universiti Kebangsaan Malaysia; [2]Universiti Putra Malaysia

Purpose

To report a case of sympathetic ophthalmia following limbal relaxation incision in an eye with history of penetrating trauma.

Methods

Case report

Results

We report a case of symphathetic ophthalmia (SO) that developed following a limbal relaxation incision for corneal scar with high astigmatism post penetrating injury. A 13-year-old girl presented after three month of alleged left eye (LE) penetrating injury with fidget spinner. She sustained perforated cornea, iridodialysis and posterior dislocation of crystalline lens. Following primary cornea suturing, she underwent pars plana vitrectomy, lens removal and iris repair. This resulted with trauma induced corneal astigmatism of -8.0D. Thereafter, she was planned for staged cornea and lens refractive surgery. At 8 months post primary suturing, she underwent limbal relaxation incision (LRI) prior to elective secondary intraocular lens implantation. Upon outpatient review, she presented with bilateral anterior uveitis and increased choroidal thickness by optical coherence tomography (OCT) and subsequently diagnosed with SO after thorough investigation was done to rule out other causes. She responded well with oral prednisolone and topical steroid. No recurrence was seen.

Conclusion

This case highlights the importance of high clinical suspicion, early detection and OCT assisted diagnosis of SO in patient with history of penetrating eye injury with multiple surgeries.

ABSTRACT ID: 311

Subconjunctival 5-Fluorouracil (5FU) Injection as Adjunct for Post-Surgical Excision of Recurrent Pterygium: A Case Series

Aiman Ifwat bin Samsolbari[1], Lam Chen Shen[1], Wan Haslina binti Wan Abdul Halim[1], Mazaya binti Mahmud[2]

[1]Hospital Canselor Tuanku Muhriz, Universiti Kebangsaan Malaysia; [2]Universiti Putra Malaysia

Purpose

To report cases of recurrent pterygium treated with subconjunctival 5-FU injection post-pterygium excision.

Methods

Case series

Result

We report 3 cases of recurrent pterygium who underwent consecutives 5-fluorouracil (5-FU) subconjunctival injection post-pterygium excision.

Case 1: AHA, a 41-year-old (YO) female, underwent pterygium excision and conjunctival autograft (CAG) with Topocryl glue, which is widely used in cutaneous lesions rather than in pterygium surgery. Signs of recurrence were noted at 3 months post-operation and were subsequently treated with 3 subconjunctival 5-FU injections at monthly intervals.

Case 2: MA, 64-YO female, is a patient who had recurrence pterygium with symblepharon after multiple pterygium excision surgeries. She underwent pterygium excision, symblepharon release and amniotic membrane transplant (AMT). Signs of recurrence were noted at 3 months post-operation. She was then treated with total 6 injections of subconjunctival 5-FU alternate with intralesional Bevacizumab in monthly intervals.

Case 3: NM, a 62-YO female, underwent initial pterygium excision with bare sclera and later presented with signs of recurrence 2 months post-operatively. She received 3 injections of subconjunctival 5-FU at monthly intervals.

All patients showed no sign of worsening nor progression of recurrence pterygium up to 6 months after completing treatment, with no side effects from 5-FU.

Conclusion

This report highlights the efficacy and safety of 5-Fu injection as adjunct therapy to pterygium excision in recurrent pterygium.

ABSTRACT ID: 318
A CASE OF *BIPOLARIS* SPP. CORNEAL FUNGAL ULCER

Alene Liu Wan Yi[1], Lam CS[1,2], Wan Haslina WAH[1,2], Mazaya M[1,2,3]

[1]University Kebangsaan Malaysia; [2]Hospital Cancelor Tuanku Muhriz; [3]Universiti Putra Malaysia.

Purpose

To report a rare case of *Bipolaris* spp. corneal fungal ulcer complicated with intense inflammation and secondary high intraocular pressure

Methods

Case Report

Results

A healthy 24-year-old female presented with a 2-week history of left eye redness, tearing, photophobia, foreign body sensation, and blurred vision following alleged sand exposure while performing Umrah. She was diagnosed with viral conjunctivitis with nummular and filamentary keratitis, and started on steroid eyedrops by an ophthalmologist. Subsequently her vision deteriorated from 6/36 to hand movements (HM) within two weeks. Examination revealed a central corneal infiltration (4.0 mm vertical × 6.0 mm horizontal) with an epithelial defect and surrounding ground-glass opacity, without endothelial plaque or satellite lesions which conferred the diagnosis of infective keratitis. Corneal scraping identified *Bipolaris* spp., requiring morphological confirmation via molecular sequencing for sensitivity testing. Initial treatment included topical Amphotericin-B, Fluconazole, Cefuroxime, Gentamicin, and oral Ciprofloxacin. Still, the condition worsened with intense inflammation, fibrin formation, and secondary elevated intraocular pressure. Due to suboptimal response, systemic Fluconazole was initiated, and topical Fluconazole was switched to Voriconazole. Aggressive supportive therapy was initiated with intracameral injections of Voriconazole (1%), Amphotericin-B, and Gentamicin. Intrastromal injections of Voriconazole, Amphotericin-B, and Vigamox were also performed. Gradual improvement was observed, with contraction of the corneal infiltration and epithelial defect.

Conclusions

This case highlights the challenges in managing fungal keratitis caused by Bipolaris spp., emphasizing the importance of early molecular diagnosis and aggressive, multimodal antifungal therapy.

ABSTRACT ID: 330

Multifaceted Case Series of Peripheral Ulcerative Keratitis (PUK)

Khairun Nisa binti Mohd Zaidan[1], Wan Haslina Wan Abdul Halim[2], Mazaya Mahmud[2], Lam Chenshen[2], Ayesha Mohd Zain[2]

[1]Universiti Kebangsaan Malaysia; [2]Universiti Kebangsaan Malaysia

Purpose

To report PUK cases with various courses of disease and treatment responses.

Methods

Case series

Results

We described three PUK cases with different treatment responses. All patients are in the middle age group and had negative workup for autoimmune diseases.

Case-1: A 45-year-old lady with hyperthyroidism had left eye redness and pain for one year. Left vision was 6/24. She had peripheral corneal ulcer and stromal thinning inferiorly. She required oral immunomodulators as well as conjunctival resection. After four years, she was stable with vision of 6/12, maintained with low-dose oral steroid and an oral immunomodulator.

Case-2: A 44-year-old healthy gentleman complainned of left eye redness and pain after pterygium excision. Left vision was counting fingers. He had peripheral cornea ulcer with stromal thinning and melting. He required courses of high-dose steroids and oral immunomodulators with conjunctival resections and tectonic keratoplasty. Despite that, he had advanced progression requiring intravenous rituximab. After four years, he achieved disease stability, maintained with low-dose oral immunomodulators.

Case-3: A 48-year-old healthy lady presented with left eye redness and pain for two months. Left vision was hand movement. Her cornea was opaque with peripheral melting. She had multiple conjunctival resections and patch graft done, maintained with high dose of immunomodulators and oral prednisolone. Despite that, she was refractory to treatment and refused to be treated with biologic drugs. After two years, disease is still active with recurrent secondary infection.

Conclusion

It is a challenge to predict the treatment response of PUK. Co-management with rheumatologists for judicious use of immunosuppressive agents may yield favourable outcomes, tailored to individual response.

ABSTRACT ID: 337

Herpes Simplex Stromal Keratitis or 'Penawar' Eye Drops Causing Infectious Keratitis: A Diagnostic Dilemma in Atypical Presentation

Kevin Kwan Joo Ern[1], Julieana binti Muhammed[1]

[1]Hospital Pakar USM, Universiti Sains Malaysia

Purpose

To report a case of atypical herpetic stromal keratitis.

Methods

Case report

Results

We report a case of a 7-year-old boy with eczema and allergic rhinitis, who presented with right eye redness for one month associated with discharge and blurred vision. He was treated with 'Penawar' eye drops which was given by his mother's friend. Subsequently, the condition worsened, with whitish opacity over the right cornea observed.

Ocular exam of the right eye showed 6/45 visual acuity, no relative afferent pupillary defect, and reduced corneal sensation. Findings included injected conjunctiva, central stromal ring infiltrate and multiple subepithelial and anterior stromal infiltrate at peripheral cornea. Superficial vascularisation seen superiorly and nasally. The cornea had no epithelial defect, and the anterior chamber was deep and quiet with no hypopyon. The intraocular pressure and fundus were normal. The left eye was unremarkable.

The initial impressions were 'Penawar' eyedrops causing infectious keratitis or herpetic stromal keratitis. Conjunctival swab culture was negative, whereas the cultured eye drops revealed mixed growth. He was treated with oral acyclovir 400mg 5 times per day which was then tapered to 400mg twice a day and topical predforte every 2 hours and tapered accordingly over 3 months. The keratitis resolved with minimal scar and his visual acuity improved.

Conclusion

Atypical herpetic stromal keratitis is a great mimicker and may resemble infectious keratitis, especially with a history of using traditional medications.

ABSTRACT ID: 369

RECURRENT BAND KERATOPATHY IN PATIENTS WITH JUVENILE IDIOPATHIC ARTHRITIS: SUCCESFULLY TREATED WITH ETHYLENEDIAMINETETRAACETIC ACID CHELATION THERAPY

Hawwa Najiza[1], Julieana Muhammed[1]

[1]Universiti Sains Malaysia

Purpose

Band keratopathy (BK) is a corneal degenerative disorder characterised by calcium deposition in the superficial corneal layer due to various aetiologies. This report presents a case of recurrent BK successfully treated with ethylenediaminetetraacetic acid (EDTA) chelation therapy.

Method

Case report

Results

An 11-year-old female with underlying juvenile idiopathic arthritis had a history of right eye cataract surgery for uveitic cataract, left eye sensory amblyopia due to chronic uveitic cataract, and bilateral eyes BK (chelation done in 2019).

She presented with recurrent BK in both eyes with poor vision. The visual acuity (VA) was 6/45 in the right eye (OD) and perception of light in the left eye (OS). Slit-lamp examination (SLE) revealed bilateral eyes irregular BK at interpalpebral area from limbus to limbus. Other SLE findings of OD were deep and quiet anterior chamber and stable intraocular lens. SLE findings of OS were shallow anterior chamber, posterior synechiae of 360 degrees and cataractous lens. The intraocular pressure was normal and no fundus view bilaterally.

She underwent EDTA 2% chelation therapy, calcium deposits were polished using diamond burr. Postoperatively, a bandage contact lens (BCL) was applied due to a large epithelial defect. She was treated with tapering doses of topical PredForte 1% and preservative-free artificial tears. By post-operative day five, the BCL was removed, revealing complete epithelial healing, resolution of BK with subepithelial fibrosis. At 10 weeks postoperatively, VA improved to 6/12 OD and hand movements OS with resolution of BK and subepithelial fibrosis.

Conclusion

EDTA chelation therapy is a safe and effective treatment for BK.

ABSTRACT ID: 370

CORNEAL PERFORATION SECONDARY TO EXPOSURE KERATOPATHY IN A PEDIATRIC PATIENT WITH LAGOPHTHALMOS: A DISASTROUS COMPLICATION

Hawwa Najiza[1], Julieana Muhammed[1]

[1]Universiti Sains Malaysia

Purpose

Lagophthalmos, or incomplete eye closure, causes reduced corneal lubrication and epithelial breakdown leading to exposure keratopathy (EK) of varying severity. We present a case of bilateral EK with corneal perforations.

Method

Case report

Results

A 7-year-old male with history of posterior fossa ependymoma and hydrocephalus presented with one week history of eye redness and discharge. His mother reported incomplete eye closure for five years, previously treated with lubricants but with poor follow-up. Ocular examination of the right eye revealed bilateral lagophthalmos, thinning and perforation of inferior corneal area and uveal tissue prolapse whereas the left eye showed inferior thinning with a descemetocele.

An emergency corneal patch graft was performed for the right eye. Corneal gluing and bandage contact lens application were applied to the left eye. Bilateral temporary tarsorrhaphy was done for both eyes. Postoperatively, the patient received preservative-free artificial tears, and topical and systemic antibiotics.

Three weeks later, during active resuscitation for tumour-related complications, tarsorrhaphy was removed. The right eye corneal graft remained intact with no further thinning. However, the left eye glue was dislodged with a remaining area of stable thinning at inferior cornea. The patient ultimately succumbed to death due to his underlying tumour.

Conclusion

This case underscores the importance of early recognition and timely intervention in exposure keratopathy to preserve corneal integrity. Corneal patch grafting may be a valuable option in severe cases.

ABSTRACT ID: 386

Fibrinous Membrane Mimicking Anterior Crystalline Lens Dislocation Post Ocular Trauma

Sabrina Lizy Fernandez[1], Mohd Fariz Bin Mohd Ali[1]

[1]Hospital Keningau

Purpose

To report a case of fibrinous membrane in anterior chamber post-trauma resembling a crystalline lens.

Methods

Case report

Results

We reported a 31-year-old gentleman sustaining right eye open globe injury with scleral laceration, hyphaema and fibrin in anterior chamber. Preliminary slit lamp examination showed a scleral laceration wound with uveal tissue and vitreous prolapse. Cornea was hazy with diffuse hyphaema. Pupil and iris were fairly visible but the crystalline lens could not be appreciated the. The patient underwent emergency right eye examination under anaesthesia, scleral toilet and suturing, vitreous tapping and intravitreal antibiotic administration. Intraoperatively, a scleral laceration 9.5mm extending superonasally from limbus was noted. The cornea was not involved.

During slit lamp examination on post-operative Day 1, the cornea was hazy, the anterior chamber appeared deep with 4+ cells and the hyphaema level was 1mm. The iris and pupil were fairly visible. We noted a translucent, round structure in the anterior chamber but unable to appreciate the position of crystalline lens. B-scan and computed tomography (CT) scan of orbit showed the lens in its normal position.

To err on the side of caution, the patient proceeded with right eye anterior chamber washout and corneal toilet and suturing. Intraoperatively, the translucent, round structure was found to be a fibrinous membrane. The crystalline lens was in situ.

Conclusion

Ocular trauma can cause severe inflammation leading to dense fibrinous membrane formation. Imaging modalities like B-scan and CT scan are useful if the clinical findings are vague such as in this case. If in doubt, surgical exploration is advisable.

ABSTRACT ID: 392

Blinding Eye Drops

Tan Teik Wei[1], Tan Chek Kuan[1], Goh Hui Yin[1], Tan Chai Keong[1]

[1]Hospital Selayang

Purpose

To report a case series of corneal complications (thinning and perforation) after unmonitored use of neomycin, dexamethasone, and chloramphenicol (Neodeca).

Method

Case series

Results

Steroids can impede corneal wound healing, suppress immune function, and worsen infection. They can potentiate corneal melting and perforation if used without follow-up on corneal integrity.

Case 1: A 22-year-old Chinese male with left eye conjunctivitis had been using Neodeca for 3 weeks after being prescribed by a general practitioner. Upon presentation, vision was NPL. There was corneal perforation with iris tissue plugging and total corneal melting with pus discharge. Subsequently, the left eye was eviscerated.

Case 2: An 8-year-old Chinese girl with right eye pseudomembrane (PSM) conjunctivitis had been using Neodeca bought over-the-counter for 1 week. Upon presentation, right eye vision was PL and left eye was 6/15. The right conjunctiva was injected with PSM. There was 360° stromal melting with central corneal perforation and uveal tissue prolapse. She was referred to the corneal team, and corneal gluing was done.

Case 3: A 4-year-old Chinese girl (sibling of case 2) had been using the same bottle of Neodeca from her sister for both eye PSM conjunctivitis. Upon review, both conjunctiva were injected with pseudomembrane. In the right eye, there was a subtotal epithelial defect with inferior corneal thinning. There was no cornea perforation. She was treated with intensive topical gentamicin and cefuroxime. Subsequently, the cornea healed with scarring.

Conclusion

Ocular use of steroids should be cautious and under ophthalmologic supervision. Alternative treatments should be considered to avoid these complications.

ABSTRACT ID: 404

PRIMARY HERPETIC BLEPHAROKERATOCONJUNCTIVITS IN CHILDREN: A RARE CONDITION

Mohd Asroy Mat Daud[1], Julieana Muhammed[1], Azhany Yaakub[1]

[1]Universiti Sains Malaysia

Purpose

To report a case of primary herpetic blepharokeratoconjunctivitis in a child.

Methods

Case report

Results

A 7-year-old boy presented with left eye redness, discharge, and vesicular rashes around the periocular area and on the left side of his face for five days. He had no history of primary varicella infection, ocular trauma, insect bites or rashes elsewhere. Despite being prescribed oral antibiotics and steroids by private clinic, symptoms showed little improvement.

On examination, vesicular rashes were noted on the periorbital and periocular region, with some spreading to the right side, not following a dermatomal pattern and crossed the vertical midline. The visual acuity in the left eye was 6/24, with conjunctival injection, pseudomembrane, corneal epithelial defects, and diffuse punctate epithelial erosions. The anterior chamber was deep and quiet. The intraocular pressure and fundus examination were unremarkable. The examination of the right eye was normal.

The patient was treated with intravenous acyclovir 250 mg every 8 hours and intravenous augmentin 250 mg every 8 hours for one week, along with topical acyclovir 3% applied five times per day, topical moxifloxacin 0.5% every 4 hours and topical predforte 1% every 8 hours for the left eye. After a six-week follow-up, the patient showed signs of improvement, with the left eye vision improving to 6/9, resolution of vesicular rashes, and minimal punctate epithelial erosions.

Conclusion

Primary herpetic blepharokeratoconjunctivitis is rare. Early recognition and management lead to good visual recovery.

ABSTRACT ID: 406

HERPETIC STROMAL KERATITIS MIMICKING INTERSTITIAL KERATITIS: DIAGNOSTIC CHALLENGE

Mohd Asroy Mat Daud[1,2], Julieana Muhammed[1,2], Azhany Yaakub[1,2]

[1]Universiti Sains Malaysia; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To report a case of interstitial keratitis

Methods

Case report

Results

An 18-year-old Malay boy presented with a 3-day history of right eye redness, discharge, and mild blurring of vision. There was no history of ocular trauma, previous herpes infection, contact lens wear, or swimming in rivers.

Ocular examination of the right eye revealed a visual acuity of 6/24 and 6/9 in the left eye. Slit-lamp examination showed mildly swollen and erythematous eyelids, injected conjunctiva, and the presence of a triangular-shaped anterior stromal up to mid-stroma corneal infiltrate paracentrally with superficial and deep corneal vascularisation towards the infiltrate at 11 o'clock area. Absence of corneal epithelial defect. The intraocular pressure and fundus examination were normal.

Examination of the left eye and systemic examination was unremarkable. The diagnosis of interstitial keratitis (IK) was made. Systemic investigations to look for aetiology of infectious keratitis were all normal. In view of normal investigations results, the diagnosis of herpetic stromal keratitis was presumed and was treated with oral acyclovir 400 mg five times per day for 10 days and tapering to 400 mg twice a day, topical predforte 1% every 6 hours and tapering dose and prophylactic topical moxifloxacin 0.5% every 6 hours. The acyclovir and topical steroids were continued until 3 months.

He responded well to treatment with resolution of stromal keratitis with minimal scar and visual acuity improved to 6/6.

Conclusion

Herpetic stromal keratitis may mimic interstitial keratitis and poses diagnostic challenge.

ABSTRACT ID: 427

THE CLINICAL CHARACTERISTIC OF KERATOCONUS PATIENTS: A YEAR DESCRIPTIVE STUDY

Bellakusuma Nurdianningrum[1], Fatimah Dyah Nur Astuti[1]

[1]Diponegoro University, Kariadi Hospital

Purpose

Keratoconus is a progressive corneal disorder characterized by thinning and bulging of the cornea, leading to visual impairment. This study aims to describe the clinical characteristics of keratoconus patients in Dr. Kariadi Hospital, including the risk factors, examination results, and treatment.

Methods

A descriptive retrospective study was conducted in Dr. Kariadi General Hospital Semarang, Indonesia. The clinical data of patients with keratoconus were obtained from medical records from January to December 2024.

Results

The data were collected from 12 (24 eyes) patients' medical records. Keratoconus was more commonly found in men than women (56.25% vs. 43.75%). The mean age of patients with keratoconus was 22 (13-38). The most common risk factors of the patients are the habit of rubbing their eyes (67%), atopic/allergy history (0.17), family history of keratoconus or refraction error (0.08), and history of using contact lenses (0.08). Regarding the severity based on the Amsler-Krumeich Classification, 33% (4 patients) were classified as stage I, 42.5% (5 patients) were stage II, 0.08% (1 patient) were stage III, and 17% (2 patients) were stage IV. Throughout the period, 58% of patients were referred to do corneal crosslinking, 8% were treated using contact lenses, and 17% of patients chose spectacles as the treatment.

Conclusion

This study showed that keratoconus patients in Dr. Kariadi Hospital were predominantly men and of a young age. The most common risk factor is the habit of rubbing their eyes. Corneal cross-linking is the most common treatment choice to treat keratoconus.

ABSTRACT ID: 430

Acanthamoeba Keratitis and the Challenge of Late Recognition

Naveenahrani A/P Selvam@Ganesan[1], Nurul-Laila Salim[1], Rohanah binti Alias[1], Valarmathy Vaiyavari[2]

[1]Hospital Kuala Lumpur; [2]Hospital Sungai Buloh

Purpose

This case series highlights three patients initially diagnosed with viral keratitis, later confirmed as Acanthamoeba Keratitis (AK), underscoring the challenges in early detection and appropriate treatment.

Methods

Case Series

Results

Case 1: A 31-year-old woman presented with a painful red eye and decreased vision following trauma to the eye. An initial misdiagnosis as viral keratitis led to worsening symptoms despite one month of antiviral treatment. Subsequent evaluations suggested AK due to a central corneal ulcer, subepithelial infiltrates, and poor treatment response. The diagnosis was confirmed based on the positive response to chlorhexidine and fortified antibiotics, leading to healing with a corneal scar.

Case 2: A 22-year-old female contact lens user, with a history of persistent nummular keratitis, developed painful eye swelling and photophobia. Initially treated for viral keratitis, her symptoms worsened over four months. Persistent perineuritis and ring infiltrates led to the diagnosis of AK. Intensive antimicrobial therapy, including Chlorhexidine and Brolene, was initiated. The ulcer improved over two weeks and healed, leaving a vascularised corneal scar.

Case 3: A 24-year-old man, a contact lens user, presented with unilateral eye pain and deteriorating vision. Despite initial management for disciform keratitis over two months, the presence of perineuritis confirmed the diagnosis of AK. He subsequently developed severe AK with multiple limbal abscesses and scleritis. Intensive therapy with Chlorhexidine, Brolene and non-steroidal anti-inflammatory Drugs (NSAIDs) resulted in recovery with vascularised corneal scar.

Conclusion

Misdiagnosis of AK as viral keratitis is common, and delayed treatment can lead to increased complications and severe visual impairment. Contact lens use remains a major risk factor.

ABSTRACT ID: 454
A MOLE'S DARK SIDE: CONJUNCTIVAL MELANOMA IN A YOUNG EYE

Nur Athirah binti Adnan[1,2], Sharina Yusoff[3]

[1]Hospital Kuala Pilah; [2]Universiti Kebangsaan Malaysia; [3]Hospital Raja Perempuan Zainab II

Purpose

To highlights an atypical presentation of conjunctival melanoma (CM) in a young Asian female, contrasting with its usual demographic profile

Methods

Case report

Results

We report a case of a 34-year-old lady with no known comorbidities, presenting with a growing right eye (RE) mass over a 2-3 years duration. Clinical assessment found nasal hyperpigmented conjunctival mass in the RE with papilliform shape and feeder vessels, extending from 2-5 o'clock and encroaching the nasal cornea from 2 to 3 o'clock.

RE wide excision biopsy, cryotherapy and amniotic membrane patch graft were performed. Intraoperative findings revealed an elevated pigmented conjunctival mass from 1 to 5 o'clock, measuring about 2mm (horizontal) x 2.5 mm (vertical) at 1 to 3 o'clock towards the corneal limbus. A lobulated surface with gelatinous mass was observed at 3 to 4 o'clock, 2.0mm from limbus, measuring 4.5mm (horizontal) x 15mm (vertical), and 6.0mm (horizontal) at 4 to 5 o'clock.

The lesion was tagged with two different sutures – Silk 4-O (black) for the superior conjunctival mass and Vicryl (purple) for the medial part – and sent for histopathological examination (HPE).

HPE confirmed melanoma, positive for Melan-A antibody. Tumor markers were all negative. She underwent three cycles of topical Mitomycin C (Gutt MMC) 0.02%. On the latest review, the patient remained stable with good visual acuity (BE 6/6) and no signs of recurrence.

Conclusion

This case underscores the need for heightened clinical suspicion of CM in younger patients, even in populations where it is rare. Timely diagnosis and multidisciplinary management are essential for optimal outcomes.

ABSTRACT ID: 468

Herpes Simplex Keratouveitis in Child with Prader-Willi Syndrome: A Case Report

Syeikha Zulaikha Al-Zahra binti Zahari[1], Aasiah Ahmad Sharifuddin[1], Nur Aliah binti Hassan[1]

[1]Hospital Enche' Besar Hajjah Khalsom

Purpose

To report a case of bilateral eye chronic Herpes Simplex Keratouveitis(HSK) in a child with Prader-Willi Syndrome (PWS). To our knowledge, no previous reports of such an association exist.

Methods

Case report

Results

A 6-year-old girl with underlying PWS presented with bilateral eye blurring of vision for the past 1 year, associated with on-and-off bilateral eye redness and photophobia. There were no features of arthritis. Ocular assessment revealed a best corrected visual acuity (BCVA) of 4/60 in the right eye (OD) and 5/60 in the left eye (OS). There were features of white-eye chronic uveitis in both eyes (OU) with seclusio pupillae and intraocular pressure of 10 mmHg OU. OS also showed rubeosis iridis. OU had reduced corneal sensation with dendritic pattern staining and endothelitis, raising suspicion of Herpes Simplex Virus (HSV).

Both eyes had white cataract; therefore, a B-scan was performed, which identified old vitreous clumps in both eyes. Laboratory investigations showed increased acute phase reactants. However, autoimmune and other infectious causesd of uveitis were excluded. The keratouveitis responded well to oral and topical acyclovir, along with topical steroids. She is planned for lens aspiration cataract surgery and anti-vascular endothelial growth factor (VEGF) later on.

Conclusion

HSK in a child with PWS presents a unique clinical challenge due to the genetic disorder. PWS is associated with hypotonia, developmental delays, and potential immunodeficiency, increasing susceptibility to viral infections, including HSV.

Early diagnosis and treatment are crucial to prevent complications. However, managing HSK in PWS requires a multidisciplinary approach, considering factors like poor pain perception, treatment compliance, and metabolic issues.

Given the complex interplay between PWS and immune dysfunction, further research is needed to optimize treatment strategies.

ABSTRACT ID: 485

Xerophthalmia in a Child with Autism: Navigating Diagnostic and Therapeutic Challenges in Pediatric Ocular Surface Disease

Lim Jian Fu[1], Ng Pey Yih[1], Krishnalatha A/P Buandasan[1]

[1]Hospital Sultanah Nora Ismail

Purpose

To report a case of an 11-year-old autistic boy with bilateral xerophthalmia, complicated by a perforated corneal ulcer in the left eye secondary to corneal thinning. This case highlights the rapid progression of corneal xerosis in xerophthalmia, along with the diagnostic and management challenges in patients with neurodevelopmental disorders.

Methods

Case report

Results

An 11-year-old autistic boy was brought by his mother, who reported that he had been constantly rubbing both eyes and had refused to open his left eye for the past week. Due to examination challenges, an Examination Under Anesthesia (EUA) was performed. Ophthalmic evaluation revealed bilateral conjunctival and corneal xerosis, with a large Bitot's spot in the right eye. The left eye exhibited significant corneal thinning, superimposed with infection. Despite immediate corneal gluing and treatment, the thinned area perforated the following day. The patient subsequently underwent tectonic penetrating keratoplasty, amniotic membrane transplantation, and tarsorrhaphy.

Conclusion

Xerophthalmia is a rare and preventable spectrum of disease in Malaysian children, affecting the retina and ocular surface caused by Vitamin A deficiency (VAD). Children with neurodevelopmental disorders (NDDs) are especially vulnerable to nutrient-related diseases, compounded by diagnostic and management challenges due to communication barriers, atypical symptoms, and feeding difficulties, all of which increase the risk of VAD. Multidisciplinary care is essential for optimal outcomes. Public health measures like food fortification and supplementation programs are vital for prevention, especially in vulnerable populations.

ABSTRACT ID: 495

RIGHT EYE SCLERAL THINNING IN WEGENER GRANULOMATOSIS WITH POLYANGIITIS: A CASE REPORT

Ibrahim Nasir[1], Khairidzan Mohd Kamal[1]

[1]International Islamic University Malaysia

Purpose

To report a case of right eye scleral thinning associated with Wegener Granulomatosis with Polyangiitis (GPA), its clinical presentation, surgical management, and outcome.

Methods

Case report.

Results

A 67-year-old female with a known history of granulomatosis with polyangiitis (GPA) presented with progressive thinning of the sclera in the right eye. Slit-lamp examination revealed significant scleral thinning measuring 22 mm circumferentially at the corneoscleral junction, extending from 9 to 3 o'clock, with a maximal diameter of 7 mm. There were no signs of active inflammation or impending perforation. Given the extent of scleral thinning and the risk of further complications, the patient underwent a right eye conjunctival patch graft under general anaesthesia. The surgical procedure was uneventful, and postoperative recovery was favourable, with adequate graft integration and no signs of recurrence or infection. The patient was continued on systemic immunosuppressive therapy to manage the underlying GPA.

Conclusion

Scleral thinning is a rare but serious ocular manifestation of granulomatosis with polyangiitis, requiring prompt recognition and intervention to prevent perforation. Conjunctival patch grafting is a viable surgical option in cases where significant thinning poses a risk. Long-term follow-up and systemic immunosuppressive management are crucial to prevent recurrence and maintain ocular integrity.

ABSTRACT ID: 505

OVERCOMING CHEMICAL CATASTROPHE: A CASE OF BILATERAL EYES GRADE III (ROPPER HALL) CHEMICAL INJURY WITH GOOD VISUAL OUTCOME

Rifhan Aliah Mhd Nasir[1], Siti Amra Abd Rahman[1], Akmal Haliza Zamli[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

Severe ocular chemical injuries often result in poor visual prognosis. We report a case of bilateral eyes chemical injury Ropper Hall grade III, who eventually achieved good visual outcome with timely management and good compliance.

Methods

Case report.

Results

A 29-year-old Malay gentleman had workplace injury involving alkaline chemical splash into both eyes. Immediate irrigation was done both on site and at emergency department. Initial ocular pH measured was 14, which improved to 7 post irrigation. Presenting visual acuity was 6/24 in bilateral eyes which then worsened to counting finger (CF) three days post trauma. He had bilateral grade III chemical injury complicated with sterile hypopyon and limbal stem cell deficiency. Topical steroids, antibiotics and lubricants as well as oral doxycycline and vitamin C were started, and he proceeded with bilateral eyes amniotic membrane transplantation (AMT) to hasten the corneal epithelialization. He also developed left eye cicatricial entropion and trichiasis four months post trauma in which he underwent left eye posterior lamellar tarsal rotation and electrolysis. Finally, he underwent diamond burr polishing for pseudopterygium after 12 months post trauma. Despite all the complications, he managed to obtain best corrected visual acuity of 6/9 OU with minimal scarring over bilateral inferior cornea.

Conclusion

Grade III ocular chemical injury can lead to various complications. Current technological advancements such as AMT and diamond burr polishing are helpful in diminishing complications hence obtaining better visual outcomes.

ABSTRACT ID: 506

A CASE OF CONGENITAL PRIMARY IRIS CYSTS

Adnin Farha Fatahul Rashid[1], Sangeetha Tharmathurai[1], Norhafizah Hamzah[1]

[1]Hospital Tunku Azizah

Purpose

We report a rare case of congenital primary iris cyst.

Methods

Case report.

Results

A 2-month-old boy with presented with complaint of left eye corneal opacity and haziness. On examination, right eye was normal. The left eye cornea was hazy with presence of iris cysts that occupies more than half of the anterior chamber and obstructing the pupil. There was fine vascularization over the surface of the iris cysts. There was no cataract or lens subluxation seen. Limited temporal fundus view revealed flat retina with Bergmeister papilla at the optic disc. Ultrasound bio-microscopy revealed multiple fluid filled hyperechoic sac occupying at least 70% of the cornea with involvement of the corneal endothelium. Intraocular pressure for both eyes were normal.

Conclusion

Primary iris cysts are congenital and may occur sporadically. Commonly, iris cysts are stable and are managed conservatively. However, some develop secondary complications such as glaucoma, cataract, corneal oedema or lens subluxation, Risk of amblyopia should also be explained if involves visual axis.

ABSTRACT ID: 509

COMPARISON OF SUTURE, FIBRIN GLUE AND AUTOLOGOUS BLOOD TECHNIQUE FOR CONJUNCTIVAL AUTOGRAFT FIXATION IN PTERYGIUM EXCISION

Ibrahim Nasir[1], Khairidzan Mohd Kamal[1], Woon Tian Qing[2]

[1]International Islamic University Malaysia; [2]Hospital Pakar Sultanah Fatimah Muar

Purpose

The most effective treatment of pterygium is surgical excision and covering the bare sclera with conjunctival autograft. Various methods are used for grafting such as suture, fibrin glue or autologous blood. The objective of this study was to compare surgical outcomes of these three methods. Duration of these study are pterygium excision done in our hospital from January 2023 until February 2024.

Methods

A retrospective study consisting of 74 eyes with primary pterygium underwent pterygium surgery and conjunctival autologous graft was undertaken. The methods were divided into suture (33 eyes), fibrin glue (23 eyes) and autologous blood (18 eyes). The study includes the mean operative time and postoperative one week review to see if the graft is intact.

Results

The mean operative time for suture were 57.70 min, for fibrin glue were 26.57 min and autologous blood was 50.44 min. For graft intact postoperatively one-week results, suture scored 100%, fibrin glue 70% and autologous blood scored 89%.

Conclusion

The operating time is the least in fibrin glue, followed by autologous blood and suture. Suture conjunctival autograft showed the best result while fibrin glue and autologous blood is comparable. Autologous blood method is recommended in view of shorten operation time and great autologous graft intact rate. It is also cheap and easily available.

ABSTRACT ID: 538

OCULAR TRAUMA AND ANTERIOR STAPHYLOMA: A CASE OF DELAYED DIAGNOSIS LEADING TO ENUCLEATION

Syarul Haziq Mohd Shah[1], Nor Fadhilah Mohamad[1], Stephanie Evelyn Fong Mui Ha[2], Mohamad Israk Mohamad Isa[2], Chua Shee Wen[3]

[1]Universiti Malaya; [2]Hospital Wanita dan Kanak-Kanak Sabah; [3]Universiti Malaysia Sabah

Purpose

To report a rare case of anterior staphyloma in an 8-year-old boy and highlight the clinical and management considerations.

Methods

Case report.

Results

An 8-year-old boy was referred to our clinic with a progressively enlarging swelling in his left eye (LE) over four years. He had a history of sand entering his eye during childhood, followed by vigorous eye rubbing, but did not seek medical attention at that time. On presentation, visual acuity was 6/9 in the right eye, while the LE had no light perception. Examination revealed an opaque, pedunculated mass measuring 6x6 cm on the LE, with a vascularised and keratinised surface appearing to protrude from the anterior segment of the globe. An orbital computed tomography scan revealed elongation and anterior protrusion of the LE globe. Following a thorough assessment, enucleation of the LE was performed.

Conclusion

Anterior staphyloma is a rare ocular condition requiring careful clinical evaluation to determine the most appropriate management strategy. This case emphasises the importance of early intervention and increased awareness of such conditions in paediatric populations to prevent severe visual impairment.

ABSTRACT ID: 540

AN UNEXPECTED FINDING OF KERATOGLOBUS IN DOWN SYNDROME: A RARE CASE REPORT

Syarul Haziq Mohd Shah[1], Nor Fadhilah Mohamad[1], Chua Shee Wen[2], Mohamad Israk Mohamad Isa[3]

[1]Universiti Malaya; [2]Universiti Malaysia Sabah; [3]Hospital Wanita dan Kanak-Kanak Sabah

Purpose

To present a case of unexpected bilateral keratoglobus in a 12-year-old male patient with Down syndrome.

Methods

Case report.

Results

We describe a case of a 12-year-old male with Down syndrome who was consulted to our centre for evaluation of buphthalmos, initially suspected to be infantile glaucoma. He had a history of missed ophthalmologic follow-ups for bilateral astigmatism since the age of seven. Over the past three years, his mother had observed a progressive bulging of both eyes and recurrent tearing. A comprehensive ophthalmic examination under anaesthesia was performed. Examination findings revealed diffuse, globular-shaped corneas with deep anterior chambers bilaterally and diffuse corneal thinning, consistent with a diagnosis of keratoglobus. Additionally, bilateral horizontal lower corneal scarring was noted. Intraocular pressure was within normal limits in both eyes. No clinical features suggestive of connective tissue disorders were present.

Conclusion

Keratoglobus is a rare and often underrecognized form of corneal ectasia, characterised by diffuse corneal thinning and globular protrusion. Early detection and awareness of this condition are essential for guiding appropriate management and mitigating potential complications, particularly in the paediatric population.

ABSTRACT ID: 545

SHATTERED VISION: TRAUMATIC OCULAR LACERATIONS FROM WINDSHIELD SPLINTERS

Tharishini Chandra Segaran[1], Noor Khairul Rasid[1]

[1]Hospital Sultanah Bahiyah

Purpose

To report a case of a corneoscleral and lid laceration involving lid margin sustained as a direct result of broken windshield in a pregnant lady at 20 weeks' gestation.

Methods

Case report.

Results

A patient who sustained a severe ocular injury in a low-speed motor vehicle accident presented with counting finger vision over the left eye and a substantial laceration from the right eyebrow extending across the glabella to the left eye. She had a full thickness corneal laceration with iris prolapse and hyphaemia. There was also an upper eyelid laceration involving lid margin and a scleral laceration with a punctured wound. There were no neurological deficits or posterior segment injuries. Computed tomography (CT) orbit showed reduced left globe and lens with comminuted fracture of superomedial wall. Hyperdensity structures in the wound were suggestive of foreign bodies. Once both maternal and foetal safety were ensured, the left eye underwent examination under anaesthesia, primary repair of a complex corneoscleral and lid laceration with intravitreal vancomycin/ceftazidime. One week postoperatively, visual acuity in the left eye remained at hand motion, shallow anterior chamber with blood clots. There was iridodialysis from 3 to 10 o'clock and lens showed traumatic cataract.

Conclusion

Prompt evaluation and intervention is crucial in corneoscleral lacerations. The globe must be sealed to ensure it is watertight, with the original anatomy restored to closely approximate its original function. Eye injuries from windshield splinters can be reduced with high-impact laminated glass windshields, which should be a consideration when purchasing cars.

ABSTRACT ID: 565

SUCCESSFUL COMBINED TREATMENT OF HIGH MYOPIA WITH KERATOCONUS: CROSSLINKING, CORNEAL INTRASTROMAL RING SEGMENTS AND VISIAN TORIC ICL IMPLANTATION

Ainur Rahman Anuar[1], Fatimah Az-Zahra Shukran Jamil[1], Tharanni K Manimaran[1], Siti Aishah Ismail[1]

[1]Ara Damansara Medical Centre

Purpose

Keratoconus is a progressive corneal disorder that often leads to significant visual impairment. Management of advanced keratoconus requires a multi-faceted approach, particularly in cases where conventional methods fail.

Methods

This case report is the first to describe the successful use of a combined treatment regimen for a patient with high myopia and keratoconus, starting with corneal crosslinking, followed by Corneal Allogenic Intrastromal Ring Segments (CAIRS), and concluding with the implantation of a Toric Implantable Collamer Lens (TICL).

Results

A 33-year-old male patient presented to the clinic with progressive keratoconus on his left eye. His left eye pre-operative refraction was -11.00/-6.00x175 with best corrected visual acuity (BCVA) of 6/38. Initially, corneal crosslinking was performed to halt the progression of the disease. Following stabilization, CAIRS surgery was performed to further improve the corneal shape and reduce the patient's visual disturbances. Post-CAIRS, the patient's left eye refraction improved to +1.25/-3.50x170 with a BCVA of 6/7.5. Subsequently, a Visian Toric Implantable Collamer Lens (TICL) was implanted to correct the remaining refractive error. Post-operative results demonstrated a significant improvement in visual acuity, achieving 6/6 with a manifest refraction of plano.

Conclusion

This multi-step approach provided substantial functional visual improvement and demonstrated the efficacy of combining corneal crosslinking, CAIRS, and TICL implantation for the management of keratoconus.

Glaucoma

ABSTRACT ID: 192

PROSTAGLANDIN ANALOGUES FOR GLAUCOMA: WEIGHING THE EFFICACY AND SAFETY IN INTRAOCULAR PRESSURE REDUCTION – A SYSTEMATIC REVIEW (ALL CAPITAL)

Aulia Kezia Mulyazhara[1], Aulia Zinedinita Rahmasari[1], Yulia Primitasari Soetomo[1]

[1]Universitas Airlangga

Purpose

Glaucoma is a leading cause of blindness, with intraocular pressure (IOP) as the primary modifiable risk factor. Primary open-angle glaucoma (POAG) is the most prevalent type. Prostaglandin analogues (PGAs) reduce IOP by enhancing aqueous outflow. This review examines the efficacy and safety of latanoprost 0.005%, travoprost 0.004%, and bimatoprost 0.01% in POAG treatment.

Methods

A systematic review following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) in 3 databases was performed for studies published between 2015 and 2025. Studies were selected based on the population, intervention, comparison, outcome, study (PICOS) framework, including randomized controlled trials on POAG patients (age >18) comparing latanoprost 0.005%, travoprost 0.04%, and bimatoprost 0.01% over 12 weeks. Reviews, non-randomized studies, case reports, and incomplete data were excluded. Extracted data focused on IOP reduction and adverse events.

Results

Out of 2010 studies identified, 7 met the inclusion citeria. Latanoprost 0.005%, travoprost 0.04%, and bimatoprost 0.01% effectively reduced IOP over 12 weeks, with bimatoprost showing the highest percentage reduction. Conjunctival hyperemia was the most common side effect, while other minor ocular effects were well tolerated. No severe adverse events were reported.

Conclusion

Bimatoprost's dual mechanism makes it the most potent prostaglandin analogue but increases side effects like hyperemia and eyelash growth, impacting adherence. Choosing between bimatoprost, latanoprost, and travoprost should consider patient needs and glaucoma severity.

ABSTRACT ID: 199
‘RING OF STEEL’ BLEB LOCALIZATION POST-TRABECULECTOMY: A CASE REPORT

Fatin Atiqah Ibrahim[1], Fatimah SS[1], Mohd Aziz Husni[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

Successful trabeculectomy is characterized by a well-formed bleb with minimal fibrosis, ensuring effective drainage and stable intraocular pressure (IOP) control. A "ring of steel" refers to fibrous scar tissue formation around the base of the bleb, which obstructs posterior aqueous humor drainage, leading to surgical failure and elevated IOP. Needling procedure

with 5-fluorouracil (5-FU) is often employed to break down this fibrous tissue and restore bleb functionality.

Methods

Case report

Results

A 65-year-old gentleman with underlying hypertension and diabetes mellitus was on our follow-up for bilateral treated proliferative diabetic retinopathy. After a complicated left cataract surgery, he developed neovascular glaucoma. Despite maximum anti-glaucoma medications and additional laser pan-retinal photocoagulation, the IOP fluctuated between 20-40 mmHg. Consequently, the patient underwent trabeculectomy in December 2024, followed by two subconjunctival injections of 5 mg 5-FU. By the third week, an elevated, well-demarcated, avascular bleb over the scleral flap was observed, with IOP ranging between 8-12 mmHg. In January 2025, the patient underwent bleb needling with an intraoperative subconjunctival injection of 5-FU. One week after the procedure, the bleb became shallow, posteriorly diffuse, and moderately vascularized, with an IOP of 10 mmHg without any anti-glaucoma medication.

Conclusion

The "ring of steel" is a scar formed after trabeculectomy that impedes posterior subconjunctival aqueous humor drainage, leading to elevated IOP. Timely intervention, such as bleb needling with 5-FU, is crucial to restore posterior drainage and prevent the need for more invasive procedures. Early detection and management of fibrotic changes are essential for trabeculectomy success.

ABSTRACT ID: 223

A CASE SERIES OF JOAG PATIENTS THAT UNDERWENT GONIOSCOPY-ASSISTED TRANSLUMINAL TRABECULOTOMY WITH GOOD SURGICAL OUTCOME

Khoo Ming Yu[1], Nurull Bahiyah Suliman[1], Norshamsiah Md Din[2], Niki Ho[2]

[1]Hospital Tengku Ampuan Rahmah; [2]Hospital Canselor Tuanku Muhriz UKM

Purpose

To highlight case series of Gonioscopy-Assisted Transluminal Trabeculotomy (GATT) with good surgical outcome.

Methods

A Case series.

Results

Four eyes from three young patients (ages 14–38) with Juvenile-Onset Open-Angle Glaucoma (JOAG) underwent GATT. Their preoperative intraocular pressure (IOP) ranged from 18 to 52 mmHg while on maximum glaucoma medication, including oral acetazolamide. One eye had a prior failed trabeculectomy. Fundus examination showed pale, cupped optic discs, and gonioscopy confirmed open angles in all eyes. Three eyes underwent GATT under general anaesthesia. Postoperatively, three eyes developed transient hyphema, and one experienced a temporary IOP spike. Medications were discontinued in three eyes, while one required two antiglaucoma drops due to steroid supplement use. Postoperative IOP ranged from 10 to 12 mmHg.

Conclusion

GATT is a safe and effective minimally invasive surgical technique. It is useful to reduce IOP and medication burden in glaucoma patients, particularly those with JOAG. GATT is commonly used to treat primary congenital glaucoma (PCG), which is associated with CYP1B1 gene mutation, which leads to abnormalities in the trabecular meshwork and an impaired drainage system. This procedure enhances aqueous outflow in affected eyes. In this case series, we highlight the outcomes of GATT in young-onset JOAG patients. As JOAG genetically associated with CYP1B1 mutation, goniotomy might have a role as one of surgical treatment modalities A significant IOP reduction was seen in all eyes post operatively. Hence, GATT may serve as a safer, less invasive blebless procedure which provides an alternative and potentially delaying the need for definitive filtering glaucoma surgery in JOAG patients.

ABSTRACT ID: 244

SUCCESSFUL TRABECULECTOMY IN A VITRECTOMISED EYE

Haireen Kamaruddin[1], Zabri Kamarudin[1], Preshaantini Ponnaiah[1,2], Wan Haslina Wan Abdul Halim[2]

[1]Hospital Selayang; [2]Hospital Canselor Tuanku Muhriz, Universiti Kebangsaan Malaysia

Purpose

To report a case of successful trabeculectomy for secondary glaucoma in a vitrectomised eye.

Method

Case report

Results

A 44 year old, male presented with right eye(OD) worsening vision one month after Pars Plana Vitrectomy(PPV)/Endolaser/Silicone oil(SO) for retinal re-detachment. The patient had injected conjunctiva, hazy cornea and deep anterior chamber(AC) with no SO in AC. Intraocular pressure(IOP) was 46mmHg. Oral and topical IOP lowering agents were commenced. Subsequently, patient underwent Phacoemulsification/Intraocular lens implantation and removal of silicone oil. He also underwent Aurolab aqueous drainage implantation and subsequently a Transscleral Cyclophotocoagulation due to uncontrolled IOP. However his OD IOP remained high. Thus we proceeded with OD augmented trabeculectomy with mitomycin C(MMC) 0.03% and 5 doses of subconjunctival 5-fluorouracil post operatively. Patient was also started on intensive topical steroids and tapered off. During early post operative review, some SO globules were seen visible in the trabeculectomy bleb which dissappeared over time. Thereafter IOP normalised without IOP lowering agents. 3years post surgery, visual acuity is 6/12 with IOP of 15mmHg and bleb is functioning well. Fundoscopy showed fully cupped, pale optic disc with flat retina.

Conclusion

Trabeculectomy in a vitrectomised eye is often not favourable for treatment as it is related to high failure rate. This is contributed by residual SO as it is impossible to remove in total. SO globule under conjunctiva may increase risk of trabeculectomy failure. However, intensive post operative 5-fluorouracil injection may increase the survival rate of trabeculectomy.

ABSTRACT ID: 246

UNMASKING ALLERGIC CONTACT DERMATITIS INDUCED BY ANTIGLAUCOMA MEDICATIONS: A CASE OF PERSISTENT EYELID SWELLING

Muhammad Fauzan Redzuan[1], Aisyah Amirah Mohd Zahari[1], Khairul Husnaini Mohd Khalid[1]

[1]Hospital Tuanku Ampuan Najihah

Purpose

Antiglaucoma agents are the mainstay treatment for controlling intraocular pressure in glaucoma patients. Herein, we describe a case of allergic contact dermatitis (ACD) induced by these antiglaucoma agents.

Methods

A 77-year-old woman with a history of neovascular glaucoma (NVG) secondary to ischemic central retinal vein occlusion (CRVO) developed periorbital swelling, initially suspected to be of infective origin. However, her condition did not improve despite appropriate antibiotic treatment, prompting further investigation and leading to the diagnosis of ACD, likely triggered by her antiglaucoma medications.

Results

A skin biopsy confirmed ACD. The patient was treated with Mometasone and Hydrocortisone creams, and her glaucoma medications were tapered. Her symptoms subsequently improved, and her intraocular pressure remained stable.

Conclusion

ACD should be suspected in patients on antiglaucoma agents who present with persistent eyelid swelling, erythema, and pruritus that do not respond to antibiotics.

ABSTRACT ID: 316

THE GREAT GLAUCOMA IMPLANT SHOWDOWN: A 2024 COMPARATIVE STUDY OF OUTCOMES AT HOSPITAL SELAYANG

Beatrice Chua Yoong Ni[1], U Kern Rei, Shalini Rajamany[1], Tan Chai Keong[1], Haireen Kamaruddin[1]

[1]Hospital Selayang

Purpose

To evaluate the efficacy of different glaucoma implants in managing refractory glaucoma at Hospital Selayang in 2024.

Method

Retrospective review of medical records of all patients who underwent glaucoma drainage device (GDD) implantation at our institution in 2024. 21 eyes of 19 patients were recruited. Glaucoma outcomes were evaluated based on intraocular pressure (IOP) and anti-glaucoma medications (AGs) need at last review, complications, and need for further intervention.

Results

The median follow-up duration 3 (3-6) months. The median preoperative IOP was 24 (18.5 -33) mmHg with 4 (3-4) topical AGs with 7 (33%) patient requiring systemic AGs. In this study, Aurolab Aqueous Drainage Implant (AADI) displayed the best overall profile with the highest rate of complete success in glaucoma control (final IOP≤18 mmHg without AGs) at 77.8%. It also showed good IOP and AGs reduction of 45.83% and 100% respectively. It also had one of lowest complications rate (55.6%) and need for further intervention (66.7%), second only to Ahmed Glaucoma Valve (AGV) in that regard. Ahmed Clear Path (ACP) reported a comparable success rate (66.7%) and IOP reduction (45.10%) to AADI. However, it had the highest rate of complication (83.3%) and need for further intervention (83.3%). Only AADI and ACP showed no deterioration from preoperative visual acuity.

Conclusions

AADI showed the best overall effectivity and safety profile in the management of glaucoma. However, due to the limited sample size of this study, future longitudinal study with equal sample size for each GDD is warranted to verify its' significance.

ABSTRACT ID: 443

MANAGEMENT OF REFRACTORY INTRAOCULAR PRESSURE FOLLOWING BLUNT OCULAR TRAUMA

Haireen Bt Kamaruddin[1], Oui Pei Chia[1,2], Wan Haslina Wan Abdul Halim[2]

[1]Hospital Selayang; [2]University Kebangsaan Malaysia

Purpose

We report a case of a 20-year-old Indian male with severe ocular trauma and complicated clinical course, emphasizing surgical interventions and an intraocular pressure (IOP) control strategies.

Methods

Case report

Results

A 20-year-old male presented with a history of blunt trauma to the right eye (RE) after being struck by a stone. Initial management included RE anterior lens washout, plain lens aspiration, and anterior vitrectomy. Postoperative findings included choroidal rupture, inferior vitreous hemorrhage (VH), and commotio retinae were noted. Despite maximum topical and oral anti-glaucoma therapy, the patient developed persistently elevated IOP (48mmHg) secondary to angle recession. Transscleral cyclophotocoagulation (TSCPC) was performed for IOP control. Subsequently, the patient underwent multiple surgeries, including pars plana vitrectomy (PPV) with silicone oil (SO) tamponade for total rhegmatogenous retinal detachment (RRD) secondary to retinal dialysis. Four months later, retinal redetachment necessitated revision procedures, including removal of silicone oil (ROO), retinectomy, endolaser (EL), and SO 5500 centistokes tamponade. Due to uncontrolled IOP, ROO was performed and an Suggest to author to change to Aurolab Aqueous Drainage Implant (AADI) was implanted. Six months following AADI implantation, the IOP remained within normal range, and the patient did not require any antiglaucoma treatment.

Conclusion

This case highlights the complexity of managing refractory IOP following severe ocular trauma. The incidence of elevated IOP within six months of closed globe injury is approximately 3.4%. It highlights the necessity for a multimodal surgical approach and the potential role of glaucoma drainage devices in achieving long-term IOP control when conventional therapies fail.

ABSTRACT ID: 474

COMBINED GONIOSCOPY-ASSISTED TRANSLUMINAL TRABECULOTOMY AND PHACOEMULSIFICATION IN LOWERING INTRAOCULAR PRESSURE IN PRIMARY OPEN ANGLE GLAUCOMA PATIENTS

Safinaz Mohd Khialdin[1], Nur Shahirah Amir Hamzah[1], Yeong Sze Yuen[1,2], Ridhwah Sapingi[2], Nurull Bahya Suliman[2]

[1]Hospital Canselor Tuanku Muhriz, Universiti Kebangsaan Malaysia; [2]Hospital Tengku Ampuan Rahimah, Klang

Purpose

Gonioscopy-assisted transluminal trabeculotomy (GATT) is a type of glaucoma surgery to reduce intraocular pressure (IOP). It is less invasive with shorter recovery time compared to other forms of glaucoma surgery. This case series will evaluate the effectiveness of combined GATT with phacoemulsification in lowering IOP in patients with primary open angle glaucoma (POAG) with cataract.

Methods

Case Series

Results

Two patients with POAG have undergone phacoemulsification and intraocular lens (IOL) implant combined with GATT operation in Klang Hospital. Their pre and post-operative IOP control were evaluated. The mean IOP pre-operatively for both patients was 36mmHg and both were on four topical anti-glaucoma medications. Both patients had an uneventful phacoemulsification with a successful posterior chamber IOL implant and completed 360 degree goniotomy. Post operatively, both patients achieved mean IOP reduction of 27mmHg after one month with 87.5% reduced anti-glaucoma eyedrops for optimal IOP control. There was also no significant drop in visual acuity post-operatively. One of the patients developed grade 1 hyphema post-operation but resolved within a week. There were no other vision threatening complications in these patients.

Conclusion

GATT combined with phacoemulsification is a safe choice of surgical option with effective reduction of IOP and number of medications. It is an alternative microinvasive glaucoma surgery (MIGS) procedure, which is relatively cheaper with minimal risk of side effects. Besides, more invasive glaucoma surgery can also be delayed for more advanced progression of glaucoma in the future if needed. This study shows promising results but longer follow up with larger sample size is required.

ABSTRACT ID: 475

SURGICAL OUTCOMES OF A NON-VALVED GLAUCOMA DRAINAGE DEVICE COMPARED WITH AHMED GLAUCOMA VALVE IN MALAYSIA

Siow Suyi[1], Roslinah Muji[1]

[1]Hospital Kuala Lumpur

Purpose

Aurolab aqueous drainage implant (AADI), a prototype based on the Baerveldt Glaucoma Device, has been introduced to Malaysia around 2018. The study aims to examine the efficacy and safety of AADI against Ahmed Glaucoma Valve (AGV)in the management of refractory glaucoma at one year.

Methods

Retrospective analysis of glaucoma patients who either underwent AADI or AGV from January 2021 to December 2022 in Hospital Kuala Lumpur and Hospital Selayang. Primary outcomes measures were success rates (intraocular pressure; IOP >18 and 6mmHg) and numbers of post operative antiglaucoma medications (AGM). Secondary outcome measures include early and late post operative complications.

Results

Thirty one patients underwent AADI while 23 patients underwent AGV implantation. AADI patients was observed to have a significantly lower IOP at 3 and 6-months ($p<0.001$ and $p<0.003$). At 12 months, overall success was 90.3% in AADI and 65.2% in AGV group respectively ($p=0.093$). AADI group had significantly lower number of AGM at 12-months post operation ($p=0.028$). There were no significant differences in early and late post operative complications.

Conclusion

AADI is shown to have higher overall success rates while requiring lesser number of AGM as compared to AGV. They also have similar safety profile.

ABSTRACT ID: 542
SMALL EYE, HIGH PRESSURE !

Wong Cheun-Seng[1], Tan Chai Keong[1], Haireen Kamaruddin[1]

[1]Hospital Selayang

Purpose

To report a case of glaucoma secondary to microphthalmos.

Methods

Case report

Results

A 22-year-old man with no underlying illness was referred for left eye glaucoma after experiencing headaches for three weeks. He had high myopia since childhood but no known glaucoma risk factors. His visual acuity was 6/19 in both eyes, with significant hyperopia. Intraocular pressure (IOP) was 10 mmHg (right eye) and 26 mmHg (left eye). Corneal diameter was 10.5 mm bilaterally. Gonioscopy showed an open angle in the right eye but closed angles in all quadrants of the left eye. Fundus examination revealed a small, crowded optic disc (right) and a deep cup with a cup-disc ratio of 1.0 (left).

The patient was started on topical anti-glaucoma medications and scheduled for left eye lens aspiration with intraocular lens (IOL) implantation. Despite an uneventful surgery, his left eye IOP remained elevated at 22 mmHg five weeks post-op, with persistent angle closure. Left eye visual field testing showed superior scotoma. A glaucoma implant was planned for better IOP control.

Conclusion

Microphthalmos and microcornea increase the risk of glaucoma, necessitating early cataract surgery, proper IOL selection, and ongoing IOP monitoring to prevent vision loss.

ABSTRACT ID: 547

NAVIGATING COMPLEX OCULAR HISTORY: POLYPROPYLENE-GUIDED AB INTERNO AC TUBE PLACEMENT OF A NON-VALVED IMPLANT IN AN EYE POST-KERATOPLASTY AND SCLERAL SUTURED ANIRIDIA INTRAOCULAR LENS IMPLANTATION WITH REFRACTORY SECONDARY ANGLE-CLOSURE GLAUCOMA

Hazrain Mohamed Roslan[1], Ru Jian Jonathan Teoh[1], Nurul Bahya Binti Suliman[1]

[1]Hospital Tengku Ampuan Rahimah

Purpose

Glaucoma drainage device implantation can be complex and challenging, particularly in eyes with multiple surgical histories. We report a case describing a polypropylene-guided ab interno technique for anterior chamber tube placement of a non-valved implant in an eye post-penetrating keratoplasty and scleral sutured aniridic intraocular lens (Morcher®) implantation.

Methods

Case report

Results

A 74-year-old man with refractory angle-closure glaucoma secondary to a perforating injury presented with uncontrolled intraocular pressure (IOP) of the right eye. He underwent penetrating keratoplasty two months before presentation and had a trans-scleral sutured posterior chamber black diaphram intraocular lens (Morcher®) implantation three years ago. On presentation, the best corrected visual acuity (BCVA) in his right eye was 6/18 and the IOP was 44 mmHg on maximum tolerated medical therapy. Slit lamp examination of his right eye demonstrated a full-thickness central corneal graft with intact interrupted sutures, aniridia, and pseudophakia. Dilated fundoscopic examination demonstrated a pink optic disc with a cup-to-disc ratio of 0.8. A 24-2 Humphrey visual field test revealed a tunnel vision defect with a mean deviation of -17.39dB. The Aurolab aqueous drainage implant (AADI) was successfully implanted using a scleral traction suture and a polypropylene-guided ab interno technique for anterior chamber tube placement. No intraoperative complications were observed.

Conclusion

This case illustrated that the ab interno method for anterior chamber tube placement of the AADI is a precise technique of tube insertion. It may serve as a safe alternative to existing ab externo approach, particularly in eyes with complex surgical histories.

Medical Retina & Ocular Inflammation

ABSTRACT ID: 5
STROKE IN THE EYE, A TELLTALE SIGN OF SOMETHING SINISTER

Amutha A/p Anbazagan[1], Prema Chendran[2]

[1]Hospital Tuanku Ja'afar; [2]Hospital sultan idris shah

Purpose

To report a case of branch retinal artery occlusion (BRAO) secondary to a cardiac event, in a relatively young healthy female.

Methods

Case report

Results

A 33 year old female with no known comorbidities presented with sudden painless blurring of vision on her left eye involving superonasal visual field loss. She sought treatment upon developing palpitations, chest tightness, shortness of breath and intermittent fever 2 days after the ocular symptoms. Visual acuity on the left eye was counting finger. Relative afferent pupillary defect was negative. Anterior segment findings were unremarkable. Fundus examination revealed left inferior BRAO with a visible calcific emboli. Echocardiogram showed an oscillating mass on the aortic valve. Blood markers indicated leukocytosis with raised inflammatory markers. An initial diagnosis of left BRAO secondary to possible infective endocarditis was made. In view of delayed presentation, vision remained the same despite ocular massage and antiglaucoma initiation. Patient was started on intravenous antibiotics and subsequently underwent cardiac surgery. Intraoperatively there was a large calcified vegetation on the aortic valve and noted to be bicuspid in nature. Postoperatively, patient's visual field remained the same and no further vascular event had occurred

Conclusion

This case report highlights the link between infective endocarditis and BRAO. Congenital heart disease accounts for 15% of infective endocarditis cases, most common example being bicuspid aortic valve. Hence urgent medical attention and thorough investigations are crucial in the event of a retinal artery occlusion to deter a possible cardiac adverse event.

ABSTRACT ID: 21
RED WRECKING TUMOUR ! : A CASE OF CHOROIDAL HAEMANGIOMA

Nur Syarafina Abdul Malek[1], Nazima Shadaht Ali[1], Cheng Teck Chee[2], Hanizasurana Hashim[1], Norshamsiah Md Din[2]

[1]Hospital Selayang; [2]Hospital Canselor Tuanku Muhriz UKM

Purpose

To report a rare case of choroidal haemangioma in a healthy elderly gentleman

Methods

Case Report

Results

A 70-year-old Chinese man with no known medical illness presented with gradual central blurring of vision in the right eye (OD) for over one year. On examination, best-corrected visual acuity (VA) was 6/45 in the right eye and 6/12 in the left eye. Bilateral anterior segment examinations were unremarkable. Fundus examination of the right eye revealed an orange-red elevated lesion at the posterior pole, measuring 4 disc diameters horizontally and 3 disc diameters vertically. No drusen or pigmentation were seen in the lesion, and no similar findings were present in the left eye.

Optical Coherence Tomography (OCT) of the right eye showed choroidal elevation with subretinal fluid overlying the lesion. B-scan ultrasonography revealed a fusiform, biconvex choroidal mass, while A-scan demonstrated high internal reflectivity. Fundus Fluorescein Angiography (FFA) revealed early hyperfluorescence with late-phase dye staining. Indocyanine Green Angiography (ICGA) demonstrated early hypercyanescence.

These findings were consistent with a diagnosis of choroidal hemangioma. Observation was chosen as the initial management. OCT at two weeks showed reduced subretinal fluid, though VA remained unchanged. The patient was managed conservatively, with photodynamic therapy considered for future deterioration.

Conclusion

Choroidal hemangioma can mimic choroidal melanoma and choroidal metastasis, particularly in elderly patients. With the aid of ancillary testing and appropriate timely intervention, progressive visual impairment can be prevented.

ABSTRACT ID: 27
MIMICRY IN THE RETINA

Barathan a/l Ananthan[1], Madihah Mohd Lokman[1], Roslin Azni Abdul Aziz[1]

[1]Hospital Shah Alam

Purpose

To present a case of bilateral proliferative diabetic retinopathy with macular edema demonstrating clinical features that closely resemble cytomegalovirus (CMV)

retinitis

Methods

Case report

Results

This case is of a 60-year-old Chinese man with diabetes mellitus and hypertension who presented with a 1-month history of painless, progressive blurring of vision in both eyes. Prior to referral, he was treated for CMV retinitis and received intravitreal and intravenous ganciclovir injections. His blood serology results showed a positive CMV IgG and negative IgM.

On the initial examination, visual acuity was counting fingers in both eyes. Fundus examination revealed extensive hard exudates with dot blot and flame shaped hemorrhages, and presence of new vessels at the disc and elsewhere. Optical coherence tomography confirmed presence of intraretinal and subretinal fluid centrally with exudates in the outer retinal layer.

A diagnosis of bilateral eyes active proliferative diabetic retinopathy (PDR) with diabetic macular edema (DME) was made. The patient then underwent laser pan-retinal photocoagulation treatment and was given intravitreal ranibizumab injections.

On follow up, visual acuity of right eye remained at counting fingers and left eye improved to 6/36. Both eyes showed quiescent PDR with resolving DME.

Conclusion

This case illustrates how exudative PDR with macular edema can closely mimic the clinical appearance of CMV retinitis. A thorough ocular examination and evaluation of comorbidities, combined with appropriate laboratory tests, imaging and clinical judgment, is crucial to ensure an accurate diagnosis and to guide timely and targeted treatment.

ABSTRACT ID: 28
IS PET SCAN THE RIGHT SURVEILLANCE TOOL FOR THE HEAD AND NECK TUMOURS?

Barathan a/l Ananthan[1], Rajasudha Sawri Rajan[1], Roslin Azni Abdul Aziz[1]

[1]Hospital Shah Alam

Purpose

To present a rare case of Left eye compressive optic neuropathy that was incidentally noted leading to the diagnosis of metastases to the maxillary, ethmoid and sphenoid sinuses from a neuroendocrine tumor despite recent negative surveilance.

Methods

Case report

Results

This is the case report of a 29-year-old Malay man with Type 2 Diabetes mellitus, fatty liver disease, thrombocytosis and metastatic neuroendocrine tumour of unknown origin. He is a known case of Right eye old branch retinal arterial occlusion initially presenting with right eye superior visual field defect in 2023. A year later, patient was found to have left eye optic disc swelling with tortuous peripapillary vessels. Patient had no visual symptoms in the left eye. Fundus fluorescein angiography revealed late leakage from the optic disc with delay in superotemporal vessels filling. Recent PET scan and CT scan of the brain did not reveal masses. Despite normal imaging, an MRI of brain and orbit was requested anyway due to unexplained fundus findings. Magnetic resonance imaging revealed hyperintensities in the region of the left greater sphenoid wings, maxillary sinus and ethmoid sinus highly suggestive of metastasis. Patient is under oncology clinic follow up for his primary neuroendocrine tumour and is on monthly Lanreotide injections. Patient was referred to Institut Kanser Negara for further management in view of new sites of metastases identified.

Conclusion

Masses at the paranasal sinuses can cause compressive optic disc swelling although few cases have been reported. Prompt imaging modalities such as magnetic resonance imaging is crucial in determining the extent of metastasis for further management and prognosis.

ABSTRACT ID: 36

MASKED MENACE ! : POST-TSCPC INFLAMMATION MASQUERADING AS ENDOPHTHALMITIS

Nur Syarafina Binti Abdul Malek[1], Tan CK[2], Cheng Teck Chee[2], Norshamsiah Md Din[2]

[1]Hospital Selayang; [2]University Kebangsaan Malaysia

Purpose

To report a case of severe transscleral cyclophotocoagulation (TSCPC)-induce inflammation mimicking endophthalmitis

Methods

Case Report

Results

A 31-year-old Malay male with no prior medical history underwent a successful right eye combined scleral buckle and pars plana vitrectomy with silicone oil (SO) tamponade for inferior rhegmatogenous retinal detachment, followed by SO removal. Postoperatively, his best-corrected visual acuity (BCVA) was 6/12, and intraocular pressure (IOP) was 14 mmHg.

Several months later, he developed secondary glaucoma in the right eye, presenting with a painful red eye and SO in the anterior chamber (AC). His IOP remained at 40 mmHg despite maximum medical therapy. His left eye was blind from chronic retinal detachment. He underwent cataract surgery, AC washout, and 360° TSCPC using settings of 1000 shots, 2000 mW, and 2000 ms.

Two weeks later, he presented with redness, reduced vision (counting fingers), conjunctival injection, keratic precipitates, AC inflammation with cell 2+, emulsified SO in the AC, suture infiltrates, and an IOP of 12 mmHg. Fundus examination showed severe vitritis and blurred optic disc margins. B-scan ultrasonography revealed dense vitritis and loculation.

Initially diagnosed with presumed exogenous endophthalmitis, he was treated with intravitreal vancomycin, ceftazidime, systemic ciprofloxacin, and topical moxifloxacin, prednisolone acetate 1%, and atropine 1%. Negative vitreous cultures, persistent hypotony, and static inflammation led to a revised diagnosis of severe TSCPC-induced inflammation with ciliary body shutdown.

A six-week course of systemic and topical steroids restored his BCVA to 6/12 and stabilized IOP.

Conclusion

This case highlights the need to differentiate post-TSCPC inflammation from infective endophthalmitis for timely and effective management.

ABSTRACT ID: 57
THE EYE IN PERIL: A CASE OF LEFT SUBPERIOSTEAL ABSCESS WITH ORBITAL CELLULITIS

Nabila Binti Sheikh Ismail[1], Safiyah JMY[1], Suriana S[1]

[1]Putrajaya Hospital

Purpose

Reporting a case of orbital cellulitis complicated by subperiosteal abscess in a young patient and emphasize the importance of timely management.

Methods

Case report

Results

A 15-year-old Malay male with a history of allergic rhinitis presented with a 3-day history of painless, progressive swelling in the left eye, preceded by a week-long frontal headache radiating to the left eye and nasal congestion. Visual acuity was 6/9 on presentation, with left eye proptosis and mechanical ptosis. Optic nerve function was intact, and extraocular movement was limited except laterally. The left eyelid was swollen and erythematous, extending to the upper cheek with mild conjunctival injection. Fundus examination and intraocular pressure were normal. Contrast-enhanced Computed Tomography (CECT) showed a ring-enhancing collection in the medial left extraconal region. The patient received broad-spectrum antibiotics and underwent functional endoscopic sinus surgery with septoplasty, orbital decompression, and pus drainage. Symptoms improved significantly and resolved completely with vision 6/6.

Conclusion

Subperiosteal abscess complicating orbital cellulitis is a serious condition that requires prompt diagnosis and treatment to avoid long-term complications, including vision loss and systemic infection.

ABSTRACT ID: 63
KEEPING AN EYE ON SYPHILIS

Chee Rean Lim[1], Nor Azita Ahmad Tarmidzi[1], Annuar Zaki Azmi[1]

[1]Hospital Kuala Lumpur

Purpose

To review the various clinical manifestations and visual outcomes of ocular syphilis.

Methods

A retrospective, non-contiguous case series which highlight three patients diagnosed and treated with ocular syphilis in Hospital Kuala Lumpur

Results

Among the 3 patients reviewed, two patients presented with panuveitis while one had intermediate uveitis. Only one had unilateral eye involvement. All patients initially presented with decreased visual acuity (VA). One patient had a previous diagnosis of human immunodeficiency virus (HIV) while the other two patients had concurrent HIV at presentation. VDRL test and TPHA test were reactive in all patients. All patients were being treated with intravenous (IV) penicillin and two patients also required laser therapy as they had occlusive vasculitis. All patients reported improved visual acuity after their course of treatment.

Conclusion

Re-emergence of syphilis and varied manifestations make it necessary to keep it as a differential diagnosis for most uveitis entities. With prompt diagnosis and treatment after onset of symptoms, the prognosis of ocular syphilis may be quite favorable.

ABSTRACT ID: 64

ACUTE SYPHILITIC POSTERIOR PLACOID CHORIORETINITIS IN AN IMMUNOCOMPETENT INDIVIDUAL: A CASE REPORT

Saritrasaraswathy Thilagaraj[1], Mimiwati Zahari[1], Roslin Azni[2]

[1]UMMC; [2]Hospital Shah Alam

Purpose

We would like to present a case of Acute Syphilitic Posterior Placoid Chorioretinitis which is rarely reported but pathognomic for ocular syphilis.

Methods

Case report

Results

A young immunocompetent gentleman with a history of high risk behaviour presented with an inconspicuous placoid subretinal lesion surrounding the left posterior pole and a few choroiditis spots over the inferior right macula. Left fundus autofluorescence showed parafoveal hyperautofluorescence over the placoid area. Spectral Domain Optical Coherence Tomography (SD-OCT) of both macula showed choroidal thickening and hyperreflective irregularities over outer retina except intact external limiting membrane and ellipsoid layer over the right eye. Fundus fluorescein angiography showed generalized small vessel vasculitis. He was positive for Syphilis with a significant titre of 1:256. He was then treated with intravenous antibiotic for two weeks and responded well with resolution of the abnormal fundus findings and recovery of outer retinal layers.

Conclusion

Acute Syphilitic Posterior Placoid Chorioretinitis can also occur in immunocompetent patients, and prompt recognition and timely treatment lead to a good prognosis.

ABSTRACT ID: 67

FROM PLEASURE TO MISERY : A CASE OF ACUTE SYPHILITIC POSTERIOR PLACOID CHORIORETINITIS

Davidson Anak Intan[1], Nur Afzan Binti Mohd Jaffar[2]

[1]Hospital Sri Aman; [2]Hospital Umum Sarawak

Purpose

To present a case report on a patient with acute syphilitic posterior placoid chorioretinitis (ASPPC)

Methods

Case report

Results

A 20-year-old male college student presented with a one-week history of painless blurring of vision in his right eye. He also had a brief history of engaging in sexual activity with male partners. His visual acuity was 6/12 in the right eye and 6/6 in the left eye. Dilated fundus examination of the right eye revealed multiple whitish placoid chorioretinal lesions over the macula. Optical coherence tomography (OCT) of the macula showed a disrupted ellipsoid zone with hyperreflective elevated lesions in the retinal pigment epithelium (RPE). Laboratory tests confirmed the presence of Treponema Pallidum IgG, and the rapid plasma reagin (RPR) test showed a titre of 1:64. He was started on intravenous penicillin G at a dosage of 4,000,000 units every 4 hours for total of two weeks. After completing the treatment, his vision improved to 6/6 and made a full recovery.

Conclusion

Syphilis should be considered in all patients with intraocular inflammation. ASPCC is a pathognomonic manifestation of ocular syphilis; timely identification and management of this disease is crucial in preventing permanent blindness and systemic complications.

ABSTRACT ID: 87
IRIS METASTASIS FROM DOUBLE PRIMARY MALIGNANCIES

Liew Yee Shan[1], Koh Koon Ling[1]

[1]Hospital Raja Permaisuri Bainun

Purpose

To report a case of right eye iris metastasis in a patient with double primary malignancies and its challenges in managing ocular complications.

Methods

A case report

Results

A 62-year-old gentleman with history of treated Diffuse large B cell lymphoma (DLBCL) around 13 years ago, has underlying stable Large cell neuroendocrine carcinoma (LCNEC) under surveillance, presented with right painful red eye associated with photophobia and blurred vision for a month. Right eye symptoms started a few days after receiving prophylactic cranial radiotherapy. Right eye vision was 6/18 (pinhole 6/12) while left eye vision was 6/9. Anterior segment of right eye showed anterior chamber inflammatory reaction cells 1+, multiple fluffy whitish iris nodules, iris vascularization and iris mass arising from inferior periphery. Fundus examination of right eye and all examinations of left eye were unremarkable. Computed tomography of Brain, thorax, abdomen and pelvis (CT B-TAP) showed worsening lung lesions and brain metastasis. Patient was co-managed with Oncology team. Considering the advanced stage of the primary disease, patient did not agree for further chemotherapy. Ocular management prioritized intraocular pressure (IOP) and symptomatic control, including topical anti-glaucoma, cycloplegics, steroids and oral acetazolamide. Throughout 4 months of follow-up, patient's condition was initially improving and responding to treatment. Unfortunately, he later developed right eye hyphaema and vision dropped to light perception. Patient opted for conservative management despite complications had developed.

Conclusion

Metastatic iris tumour is a rare ocular metastasis with challenges in IOP and symptomatic control. Despite poor systemic prognosis, timely detection and treatment may improve survival.

ABSTRACT ID: 102
THE BETRAYAL

Chin Yie Ping[1], Low Zhen Ning[1], Rathinamsvannie Selvam[1], Nor Azita Ahmad Tarmidzi[1], Hamisah Ishak[1], Choo Swee Ying[1], Amelia Lim[1]

[1]Hospital Kuala Lumpur

Purpose

To report a cluster of Burkholderia cepacia endophthalmitis cases following intravitreal injections

Methods

Case series of 3 patients

Results

Over three weeks, three patients at a single facility developed exogenous endophthalmitis caused by Burkholderia cepacia following intravitreal anti-VEGF injections. Two patients presented as early as day two post-procedure. Clinical findings included conjunctival injection, hypopyon, and vitreous loculations on B-scan ultrasonography. Prompt management was initiated, including vitreous tap with intravitreal antibiotics, as well as topical and systemic antibiotics, with early pars plana vitrectomy performed. Vitreous cultures confirmed Burkholderia cepacia in all cases, which was sensitive to Bactrim and Meropenem.

Despite these interventions, outcomes were poor: one patient developed phthisis bulbi, another experienced complete vision loss, and one was left with poor vision, limited to counting fingers. The outbreak prompted further investigation, and with a multidisciplinary approach, we identified the source of infection as contaminated local anesthetic eye drops. This highlights the critical importance of maintaining a high index of suspicion based on organism yield and recognizing clusters of cases involving the same infective agent within a short timeframe.

Conclusion

Burkholderia cepacia represents a significant opportunistic pathogen in nosocomial infections, with outbreaks frequently linked to contaminated medical products. Clinicians should remain vigilant for atypical organisms in cases of post-procedural endophthalmitis, and investigations into potential sources of contamination are critical. Immediate cessation of suspect products and thorough investigation are important to prevent further outbreaks.

ABSTRACT ID: 104
THE QUIET INTRUDER: BILATERAL RETINAL CAPILLARY HEMANGIOMA IN A HEALTHY YOUNG ADULT

Premalatha A/P Marthay[1], Zulfadli Mohd Zawawi [1], Noranida Abd Manan[1]

[1]Hospiral Raja Perempuan Zainab Ii

Purpose

To report a rare case of asymptomatic bilateral retinal capillary hemangioma in a young adult.

Methods

Case report.

Results

A 23-year-old male student nurse who had no prior medical history was referred to our clinic after bilateral abnormal findings were accidentally discovered on fundus photographs while practicing with a fundus camera at his primary health care clinic. Otherwise, he had no visual complaints. The visual acuity in the right eye was 6/9 and the left eye was 6/6. There was no relative afferent pupillary defect and the anterior segment was unremarkable bilaterally. The right eye fundus revealed a raised, rounded, orange-red retinal lesion, measuring half a disc diameter, overlapping the optic disc superonasally. Tortuous inferotemporal arcade vessels leading to another orange-red retinal lesion measuring one disc diameter in the inferotemporal periphery with feeder vessels. Exudates were noted in the nasal retina. The left eye fundus showed a similar retinal lesion overlapping the superior optic disc with a feeder vessel superotemporally leading to another lesion in the superotemporal periphery. Optical Coherence Tomography (OCT) showed intraretinal fluid involving the fovea in the right eye only. Diagnostic investigations were negative for von Hipple-Lindau (VHL) disease. Bilateral focal laser to the feeder artery and intravitreal ranibizumab for the right eye were administered after fundus fluorescein angiography (FFA), and the lesions appeared stable at the last clinic visit.

Conclusion

Retinal capillary hemangioma (RCH) is a benign vascular tumor of the retina that can occur sporadically or in association with VHL disease. Early diagnosis and treatment are crucial for both visual and systemic prognosis.

ABSTRACT ID: 109

ACUTE RETINAL NECROSIS AS A MANIFESTATION OF CYTOMEGALOVIRUS RETINITIS IN A PATIENT WITH ASCITES

Yeohan Yoong Gar Gean [1], Nurul Ashikin binti Abdullah[1], Siti Zaitihani binti Hamdan[1], Nazima Binti Shadaht Ali[1], Hanizasurana H [1], Penny LPW[2]

[1]Hospital Selayang; [2]Universiti Malaya Eye Research Centre

Purpose

To report a case of cytomegalovirus (CMV) retinitis manifesting as acute retinal necrosis (ARN) in a patient with ascites.

Methods

Case report

Results

A 73-years-old lady with underlying congestive heart failure presented with right eye painless blurring vision for 2 weeks. Right eye vision was counting fingers and left eye 6/18. Right relative afferent pupillary defect was positive. Right cornea had diffuse stellate-shaped keratic precipitates, anterior chamber cells 2+ with anterior vitreous cells 2+. Right fundus was hazy with vitritis 4+ and confluent, circumferential and coalescing patches of retinitis all 4 quadrants up to zone 1. No retinal hemorrhages seen. Left eye was normal. Right eye anterior chamber tap was performed and aqueous sent for viral polymerase chain reaction. Patient was treated for ARN secondary to Varicella-Zoster Virus (VZV) with Intravenous acyclovir 10mg\kg TDS. Patient was co-managed with medical team for symptomatic pleural effusion and ascites. Her aqueous sample was positive for CMV thus intravitreal Ganciclovir 2mg/0.1ml twice weekly was initiated. Patient was referred to infectious disease team to workout for possible causes of CMV infection.

Conclusion

Acute retinal necrosis is a clinical diagnosis requiring prompt and accurate diagnosis, as it can be caused by various viruses. In this case, initial suspicion of ARN secondary to VZV was revised after aqueous sample analysis revealed CMV infection. This underscores the importance of performing aqueous humor viral analysis in ARN cases to guide appropriate antiviral therapy. The most common causes for ARN in immunocompetent individuals are HSV or VZV. In contrast, ARN caused by CMV are commonly associate with immunocompromised individuals.

ABSTRACT ID: 111

A 3-YEAR RETROSPECTIVE STUDY ON SCLERITIS AT MEDICAL-RETINA REFERRAL CENTRES IN NEGERI SEMBILAN AND HOSPITAL CANSELOR TUANKU MUHRIZ.

Sai Priyalatha Mariapan [1], Mae-Lynn Catherine Bastion [1], Wan Mohd Hafidz bin Wan Abdul Rahman[2], Sangeeta Kuganasan [2]

[1]Hospital Canselor Tuanku Muhriz UKM; [2]Hospital Tuanku Ja'afar Seremban

Purpose

To determine the demographic profile, common presentations, aetiology, course of disease, management, and visual outcomes of scleritis in adults at Medical Retina centres in Negeri Sembilan and Hospital Canselor Tuanku Muhriz over the past 3 years.

Methods

Retrospective study

Results

The majority (68.1%) had unilateral involvement, with 68.1% being female and the peak age between 31-40 years. Red eye and pain were the most common symptoms (36.1%). Diffuse anterior scleritis was the most prevalent subtype seen in 42 patients (65.7%). Ocular complications occurred in 22.2%, including cataract (13.9%), raised intraocular pressure without glaucoma (9.7%), glaucoma (5.6%), and corneal involvement (2.8%). Among infectious causes, tuberculosis (63.6%) was the most common, while rheumatoid arthritis (8.3%) was the most frequent autoimmune cause. Treatment included oral non-steroidal anti-inflammatory drugs (83.3%), topical steroids (81.9%), oral steroids (18.1%), and second-line immunosuppressive agents (8.3%). 9.7% received anti-tuberculosis therapy. Median BCVA on presentation for the different types of scleritis was 0.18, while final median BCVA at 1-year post-treatment, was 0.00 for diffuse and nodular anterior scleritis, 0.18 for posterior and necrotizing anterior scleritis without inflammation. 83.3% recovered well with treatment, while recurrence occurred in 23.6%.

Conclusion

This study found that the majority of cases were unilateral, with diffuse anterior scleritis being the most common subtype. Female patients comprised a larger proportion. Bilateral involvement emerged as a significant risk factor for recurrence, with a good overall visual prognosis.

ABSTRACT ID: 112
CILIORETINAL ARTERY OCCLUSION IN A PATIENT WITH ANTIPHOSPHOLIPID SYNDROME

Penny Lott Pooi Wah[1], Yeohan Yoong Gar Gean[1,2], Nuratiqah Binti Zainal Abidin[2], Stella Sinnappan[2]
[1]Universiti Malaya Eye Research Centre; [2]Hospital Selayang

Purpose

To report a case of cilioretinal artery occlusion

Methods

Case report

Results

A 35-year-old lady with Systemic Lupus Erythematosus and Antiphospholipid Syndrome presented with sudden, painless right eye blurring of vision for one day. She also reported cyanosis, numbness, and pain in her right hand for one week. Ocular assessment showed right eye vision at 1/60 and left eye at 6/12, with a relative afferent pupillary defect, reduced red desaturation and light sensitivity over right eye. Confrontation examination revealed inferior temporal visual field defect in the right eye. Fundus examination revealed localized retinal whitening over fovea and superior nasal macula without cherry-red spots, emboli, or hemorrhages. Her left eye was normal. She was diagnosed with right cilioretinal artery occlusion. Prompt ocular massage and intravascular acetazolamide (500 mg) were initiated. Her computed tomography angiogram revealed thrombosis of her right brachiocephalic, common carotid, and internal carotid artery. She was co-managed with rheumatology and vascular teams and started on subcutaneous enoxaparin (60 mg twice daily), oral warfarin (3 mg), cardiprin (100 mg), and prednisolone (30 mg). Following treatment, her right eye vision improved to 6/9.

Conclusion

Central retinal occlusion (CRAO) is an ophthalmic emergency that requires prompt recognition and intervention. The cilioretinal artery, a branch of the short posterior ciliary artery, present in 15-20% of the population, supplies blood to the central macula, allowing CRAO patients with this artery to retain vision. In contrast, cilioretinal artery occlusion, a rare variant, typically leads to poor vision despite most of the retina being well-perfused.

ABSTRACT ID: 118

VISUAL ACUITY AND ANATOMIC IMPROVEMENTS AT WEEK 24 MAINTAINED THROUGH WEEK 72 WITH FARICIMAB TREAT-AND-EXTEND DOSING FOR MACULAR EDEMA DUE TO RETINAL VEIN OCCLUSION IN THE PHASE 3 BALATON AND COMINO STUDIES: RESULTS AND PATIENT CASE PROFILES

Rubamalar Gunatheesan[1], Christiana Dinah[2], Pablo Arrisi[3], Anne-Cecile Retiere[3], Ying Liu [4], Liliana P. Paris[4]

[1]The Tun Hussein Onn National Eye Hospital; [2]London North West University Healthcare, NHS Trust, London, UK; [3]Roche Products Ltd., Welwyn Garden City, UK; [4]Genentech, Inc., South San Francisco, CA, USA

Purpose

Faricimab, a dual angiopoietin-2/vascular endothelial growth factor-A (Ang-2/VEGF-A) inhibitor and the first bispecific antibody for intraocular use, demonstrated efficacy and safety for treating macular edema due to retinal vein occlusion (RVO) in the phase 3 BALATON (NCT04740905)/COMINO (NCT04740931) randomized controlled clinical trials. Here the 72-week results and real-world patient case(s) are presented.

Methods

Patients in BALATON (N=553) and COMINO (N=729) trials received 6 monthly faricimab 6.0 mg or aflibercept 2.0 mg from day 1–week 20. The primary endpoint was change in best-corrected visual acuity (BCVA) from baseline at week 24. From weeks 24–72, patients received faricimab following a modified treat-and-extend regimen based on central subfield thickness (CST) and BCVA.

Results

The results showed that BCVA gains and CST reduction at week 24 were maintained through week 72. Mean (95% confidence interval) BCVA and CST changes from baseline with faricimab, averaged over weeks 64, 68, and 72, were +18.1 (16.9, 19.4) letters and −310.9 (−315.6, −306.3) µm, and +16.9 (15.2, 18.6) letters, and −465.9 (−472.5, −459.3) µm in BALATON and COMINO trials, respectively. At week 68, 64.1% and 45.5% of patients in BALATON and COMINO trials, respectively, were on ≥Q12W faricimab dosing. Faricimab was well tolerated with no new safety signals.

Conclusion

The 72-week results from BALATON and COMINO trials demonstrated that dual Ang-2/VEGF-A inhibition with faricimab offers long-term disease control in patients with RVO, and faricimab was well tolerated with no change in safety profile.

ABSTRACT ID: 119

"BEYOND THE OBVIOUS: A DIAGNOSTIC CONUNDRUM OF CHOROIDAL OSTEOMA AND THE IMPERATIVE OF EARLY RECOGNITION"

Wong Joon Leek[1], Muhammad Aizuddin bin Ahmad[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

Reporting an uncommon case of choroidal osteoma presenting as blurring of vision with floaters in the eye

Methods

A case report

Results

A 20-year-old Indonesian female with no prior medical history presented to primary care with acute-onset left eye blurred vision and floaters, prompting referral for suspected retinal detachment. Initial evaluation revealed left eye visual acuity of 6/12 (correcting to 6/6 with pinhole) and normal anterior segments bilaterally. However, fundus examination unveiled a striking orange-red peripapillary lesion with subretinal exudates and pigment clumping in the left eye, contrasting sharply with an unremarkable right eye. Multimodal imaging, including optical coherence tomography (OCT) and fundus photography, confirmed the unexpected diagnosis of choroidal osteoma—a rare, benign ossifying tumor marked by cancellous bone deposition in the choroid. OCT delineated a hyperpigmented peripapillary lesion, retinal atrophy, and peripheral calcifications, hallmarks of this enigmatic entity.

Conclusion

This case underscores the diagnostic challenges posed by choroidal osteoma, which often masquerades as other subretinal pathologies due to its variable presentation. The patient's atypical symptoms and subtle fundoscopic clues demanded a high index of clinical suspicion to pivot from the initial presumption of retinal detachment. Choroidal osteoma, though rare, necessitates inclusion in the differential diagnosis of young patients with unexplained visual disturbances, particularly when imaging reveals calcified subretinal lesions. Early recognition is paramount, enabling timely surveillance for complications such as choroidal neovascularization or tumor growth, which threaten long-term visual outcomes. This presentation emphasizes the synergy of meticulous clinical evaluation and advanced imaging in unraveling rare ocular diagnoses which aids ophthalmologists in optimizing management strategies and mitigate vision loss

ABSTRACT ID: 121
A CHILD WITH LIPAEMIA RETINALIS: A CASE REPORT

Mohammad Syafiq Bin Yusop[1], Wan Hazabbah Wan Hitam[1], Nazima Shadaht Ali[2]

[1]Universiti Sains Malaysia; [2]Hospital Selayang

Purpose

To report a case of Lipaemia Retinalis in a paediatric patient.

Methods

Case Report

Results

We report a case of Lipaemia Retinalis in a 12-year-old girl with underlying systemic lupus erythematosus, detected during a routine eye assessment. The patient was asymptomatic, with a visual acuity of 6/6 in both eyes. Fundoscopic examination revealed generalized pinkish-white arterioles and venules, with no signs of vascular occlusion. The optic disc and macula appeared unremarkable. Optical Coherence Tomography (OCT) shows hyper-reflectivity of the retinal vessel segments. The diagnosis was confirmed through a serum lipid profile, which showed a total triglyceride level of 23,700 mg/dL. Following the initiation of lipid-lowering therapy, retinal vessel appearance improved as triglyceride levels decreased to 11,300 mg/dL at a subsequent visit after 3 months.

Conclusion

This case highlights the significance of ocular findings as an indicator of underlying metabolic disorders. Early detection and prompt treatment can reduce the risk of systemic complications, such as pancreatitis and cardiovascular disease.

ABSTRACT ID: 123

EALES' DISEASE REVISITED: A TRIAD OF CASES HIGHLIGHTING ITS SPECTRUM OF PRESENTATION

Lim Kit Wing[1], Khor Hui Gim[1]

[1]Miri Hospital

Purpose

Eales' disease is an idiopathic, inflammatory vaso-occlusive retinal disease that predominantly affects young males. It progresses through three overlapping stages: venous inflammation, capillary ischaemia, and retinal neovascularisation, leading to recurrent vitreous haemorrhages and visual loss. We describe three cases of Eales' disease with varied clinical manifestations and treatment responses.

Methods

A case series.

Results

Case 1: A 24-year-old man presented with an acute onset of unilateral blurred vision. His presenting visual acuity (VA) was 6/200. Fundus examination revealed vitreous and preretinal haemorrhage. Fundus fluorescein angiography (FFA) showed peripheral vessels leakages and neovascularisation. The Mantoux test was positive. Laser photocoagulation and antitubercular therapy (ATT) were initiated. His final VA improved to 6/9 post-treatment.

Case 2: An 18-year-old man, a known case of smear-positive tuberculosis undergoing an intensive phase of ATT, presented with transient episodes of unilateral reduced vision. His VA was 6/12. There were Roth spots and periphlebitis in the fundus. FFA confirmed periphlebitis with no capillary fallout areas. He was prescribed a nine-month course of ATT. His post-treatment VA improved to 6/7.5.

Case 3: A 31-year-old man presented with a unilateral central scotoma. VA was 6/18. The fundus showed a premacular haemorrhage. FFA revealed peripheral retinal periphlebitis with neovascularisation. QuantiFERON-TB Gold was negative. Laser photocoagulation was done and he was started on tapering dose of oral prednisolone 1mg/kg. The final VA remained as 6/18 despite the resolution of the haemorrhage.

Conclusion

This case series highlights the heterogeneity of Eales' disease and the importance of early diagnosis and immediate tailored treatment to preserve vision.

ABSTRACT ID: 124

BLINDED BY THE LIGHTS: A CASE REPORT ON PHOTIC RETINOPATHY WITH CHOROIDAL NEOVASCULARISATION SECONDARY TO LASER-ARC WELDING

Kert H'ng[1], Norlina Mohd Ramli[1], Benjamin Ching How Lim[2], Radtthiga Chelvaraj[2], Ee Ling Ang[2]

[1]Universiti Malaya; [2]Hospital Pulau Pinang

Purpose

To report a case of bilateral eyes photic retinopathy with its complications and management

Methods

Case report

Results

A 22-year-old welder presented with acute painless bilateral eyes central scotoma following alleged prolonged laser-arc welding exposure for six months. On presentation, his best corrected visual acuity (BCVA) was 6/9 bilaterally, normal anterior segment findings with no relative afferent pupillary defect. Fundus examination revealed an orange-reddish hue over the right fovea and yellowish hue on the left fovea. Optical Coherence Tomography (OCT) exhibited bilateral foveal focal photoreceptor layer and retinal pigment epithelium disruption. His visual acuity deteriorated tremendously just a fortnight later to right eye (OD) 2/60 and left eye (OS) 6/24. Repeated OCT portrayed choroidal neovascularization alongside macular edema on OD; foveal contour disruption with fibrosis on OS. A diagnosis of bilateral eyes photic maculopathy complicated with right eye choroidal neovascularization was made. Despite both eyes were started on topical Nepafenac TDS, OS subsequently developed subfoveal hemorrhage over macula within a month. Two doses of intravitreal Ranibizumab were loaded bilaterally. Follow-up review a month post injection showed favourable improvement of BCVA to OD 6/9 and OS 6/12 with small paracentral scotoma. OCT showed bilateral foveal focal loss of ellipsoid/interdigitation zone with resolution of macular edema.

Conclusion

Prolonged exposure to laser-arc welding poses significant risk to photic retinopathy. Younger workers are highly vulnerable considering their clearer ocular media. This case highlighted the effectiveness of anti-vascular endothelial growth factor (anti-VEGF) in managing choroidal neovascularization secondary to photic retinopathy and underscores the importance of protective eyewear and early intervention to minimize visual impairment.

ABSTRACT ID: 129

ASSESSMENT OF THE CLINICAL EFFECTS OF ANTI-ANG-2 WITH FARICIMAB BASED ON KEY OUTCOMES FROM THE YOSEMITE/RHINE TRIALS AND REAL-WORLD FARETINA/FARWIDE STUDIES IN PATIENTS WITH DIABETIC MACULAR EDEMA (DME)

Barkeh Hanim Binti Jumaat[1], Niranjan Manoharan[2], Judy E. Kim[3], Kara Gibson[4], Francis Abreu[5], David Tabano[5]

[1]International Specialist Eye Centre; [2]University of Colorado School of Medicine, Aurora, CO, USA; [3]University of Texas Southwestern Medical Center, Dallas, TX, USA; [4]Roche Products Ltd., Welwyn Garden City, UK; [5]Genentech, Inc., South San Francisco, CA, USA

Purpose

Summarise key findings from phase 3 YOSEMITE/RHINE trials and real-world FARETINA/FARWIDE studies of faricimab in DME patients.

Methods

Patients in YOSEMITE/RHINE (NCT03622580/ NCT03622593; n=1,891) received faricimab 6mg every 8 weeks (Q8W) or treat-and-extend; or aflibercept 2mg Q8W after loading doses. Efficacy and safety were assessed through week 100. FARETINA and FARWIDE, two retrospective studies utilizing 2022-2023 data from IRIS Registry (US), and Medisoft EHR (UK), respectively, assessed patients receiving faricimab for ≥12 months.

Results

In YOSEMITE/RHINE, robust vision gains comparable with aflibercept, and greater central subfield thickness (CST) reductions with faricimab vs aflibercept (FvA) were achieved. At year 2, ~80% of faricimab-treated patients achieved ≥Q12W dosing. First CST <280µm or absence of intraretinal fluid were achieved faster with fewer injections with FvA. After 16-week head-to-head dosing, more patients achieved macular leakage resolution with FvA. Hyperreflective foci volume reductions were greater at week 48, and epiretinal membrane formation risk lower at 2 years, with FvA. In Tx naive eyes from FARETINA (n=1,139) and FARWIDE (n=101), mean (SD) faricimab injection frequencies during months 1–6 vs 7–12 were 3.5 (1.6) vs 1.7 (1.7) and 4.5 (0.9) vs 1.8 (1.3), respectively. Visual acuity mean (SD) change from baseline at month 12 was +3.8 (11.6) and +5.3 (1.2) letters, respectively. Mean (SD) CST improvement in FARETINA (n=96 eyes) at 12 months was –62.0 [0.8]µm.

Conclusion

Findings from YOSEMITE/RHINE trials demonstrated robust disease control and extended durability with faricimab. Retinal biomarkers showed improvements in a larger proportion of eyes with FvA. Faricimab was well tolerated in real-world.

ABSTRACT ID: 134

A VISION ON THE BRINK: SAVING SIGHT FROM THE CLUTCHES OF NEUROSYPHILIS

Noor Izzati Akhmal Binti Zulkefli[1], Nazima Shadaht Ali[1], Ayesha Binti Md Zain[2]

[1]Hospital Selayang; [2]Hospital Universiti Kebangsaaan Malaysia

Purpose

Acute Syphilitic Posterior Placoid Chorioretinitis (ASPPC) is a vision-threatening but underrecognized manifestation of neurosyphilis. It is particularly concerning in immunocompromised individuals, where timely diagnosis and treatment are critical to prevent irreversible blindness. This case series highlights two striking cases of ASPPC in immunocompromised men, emphasizing the importance of early recognition and intervention.

Methods

Two male patients, aged 51 and 29, with a history of high-risk behavior (men who have sex with men), presented with acute bilateral vision loss. Both eyes showed anterior segment inflammation with extensive placoid lesion on fundus examination, consistent with ASPPC. Laboratory investigations revealed markedly elevated VDRL titers (1:128 and >1:512) and severely decreased CD4 counts (102 and 91), suggesting profound immunosuppression. Both patients were treated with intravenous crystalline penicillin (2.4 million units every 4 hours for 14 days).

Results

As the inflammation cleared, both patients had a significant improvement in vision, affirming the life-changing power of early detection and treatment.

Conclusion

This case series underscores the need for increased vigilance and prompt management of ASPPC, especially in immunocompromised or high-risk patients. Delay in diagnosis will lead to irreversible blindness, whereas prompt treatment offers a chance for full recovery of vision. In the fight against blindness from syphilis, knowledge is sight, and sight is life.

ABSTRACT ID: 142
HYDROXYCHLOROQUINE RETINOPATHY: A CASE OF PERICENTRAL INVOLVEMENT

Tan Li Faung[1], Khalilah Zahari[2], Annuar Zaki Bin Azmi[2], Nor Azita Binti Ahmad Tarmidzi[2]

[1]Hospital Kuala Lumpur; [2]Universiti Kebangsaan Malaysia

Purpose

To outline a case of pericentral hydroxychloroquine (HCQ) retinopathy which was diagnosed based on visual field testing and optical coherence tomography of the macula.

Methods

Case report

Results

A 29-year-old female presented for an annual routine eye examination with no complaints of blurred vision or metamorphopsia. She has a history of HCQ use for the management of systemic lupus erythematosus. She had been taking 200 mg daily (5.6 mg/kg) of HCQ for nine years, with no history of kidney dysfunction.

While her initial eye exam was normal, she was lost to follow-up for two years due to the COVID-19 pandemic. Upon return, her visual acuity remained 20/20 in both eyes. The anterior segment examination was unremarkable. There was no obvious presence of bull's-eye maculopathy, and the peripheral retina appeared unremarkable.

However, optical coherence tomography imaging revealed subtle thinning of the outer nuclear layer and disruption of the ellipsoid zone in both eyes.

Fundus autofluorescence showed bilateral increased hyperfluorescence inferotemporally.

Humphrey visual field testing (central 24-2) demonstrated a superonasal scotoma, which correlated with the inferotemporal macular findings.

Her rheumatologist was notified of these findings, and HCQ was discontinued immediately.

Conclusion

This case highlights the importance of appropriate HCQ dosing and early detection of toxicity to minimize visual consequences. HCQ dosage remains the most critical risk factor, and pericentral involvement is more commonly seen in Asian populations.

ABSTRACT ID: 148

POST OPERATIVE ACHROMOBACTER XYLOSOXIDANS ASSOCIATED ENDOPHTHALMITIS IN A SILICON OIL-FILLED VITRECTOMIZED EYE

Lim Zhi Yiu Hiang Weang[1], Siti Zaitihani Hamdan[1], Azhan Bin Azman[1], Hanizasurana Hashim[1]

[1]Hospital Selayang

Purpose

We report the clinical features, predisposing factors, and treatment challenges of this rare cause of post-operative endophthalmitis.

Methods

Case report

Results

73-year-old man with poorly controlled diabetes underwent complicated cataract surgery with posterior capsule rent and vitreous loss, sulcus intraocular lens (IOL) was implanted.

Ten days postoperatively, he had persistent anterior chamber (AC) inflammation (3–4+ cells) and best-corrected visual acuity (BCVA) of 6/60 despite intensive topical steroids and antibiotics. Due to questionable compliance, he was admitted for intensive therapy. After one day, hypopyon and dense vitritis on B-scan confirmed endophthalmitis. He underwent AC washout, pars plana vitrectomy (PPV), intravitreal vancomycin and ceftazidime (Fortum), and silicone oil (SO) tamponade.

The initial vitreous sample showed no growth, but one month later, persistent AC cells and hypopyon prompted another AC tap, which grew Achromobacter xylosoxidans and mold. The organism was sensitive to ceftazidime and piperacillin/tazobactam but resistant to cefepime. He underwent AC washout, SO removal, and IOL explantation with intravitreal antibiotics. Intraoperatively, SO appeared turbid, and cultures from SO and the lens capsule confirmed Achromobacter xylosoxidans.

He was treated with oral ciprofloxacin and fluconazole, topical Fortum, and intravitreal Fortum and amphotericin B. Two weeks postoperatively, the eye remained stable, with a BCVA of 6/36

Conclusion

The optimal treatment strategy for A. xylosoxidans endophthalmitis after cataract surgery remains controversial. Due to the high rate of recurrence, current treatment typically involves pars plana vitrectomy, capsulectomy, IOL removal, and intravitreal antibiotic injection to achieve a favorable visual outcome.

ABSTRACT ID: 149
CLAWED VISION: INFECTIVE PANUVEITIS SECONDARY TO CAT SCRATCH DISEASE

Benjamin Lim Ching How[1], Radtthiga Chelvaraj[1], Ang Ee Ling[1]

[1]Hospital Pulau Pinang

Purpose

To report a case of acute panuveitis secondary to Bartonella henselae infection, emphasizing the diagnostic challenges and management strategies.

Methods

Case report.

Results

A 50-year-old woman presented with left eye (LE) pain, redness, and blurred vision for three days. Examination revealed negative relative afferent pupillary defect with hand movement vision (LE). Conjunctiva was injected with dense fibrin plaque obscuring the pupil, 360-degree posterior synechiae (PS) and a cataractous lens. B-scan was unremarkable. The right eye (RE) showed broken PS and optic disc swelling.

The patient was Initially treated as LE severe non-granulommatous anterior uveitis and started on topical steroid eye drop. Positive Bartonella henselae serology (IgM positive, IgG titer 1:128) confirmed the diagnosis and a 6-weeks course of oral Azithromycin was initiated. Marked improvement on the anterior segment enabled LE fundus visualisation that showed optic disc swelling with macula star suggestive of neuroretinitis. Hence, her diagnosis was revised to left infective panuveitis. Topical steroid drop was continued and non steroidal anti-inflammatory eyedrop was initiated, leading to further improvement in vision and resolution of inflammation. At follow-up, her LE vision improved to 6/18, with resolved anterior chamber activity and reduced macular star with optic disc swelling. Computed tomography(CT) of the orbit and brain were unremarkable. Repeated serology post treatment showed reduced titer.

Conclusion

This case highlights Bartonella henselae as an uncommon cause of panuveitis, underscoring the importance of timely diagnosis and management.

ABSTRACT ID: 151

A CASE OF BILATERAL CENTRAL RETINAL VEIN OCCLUSION AS PRESENTING FEATURES OF LYMPHOPLASMACYTIC LYMPHOMA

Law Jin Xing[1], Nurul Ain Binti Shahrudin[1]

[1]Ophthalmology Hospital Tengku Ampuan Afzan

Purpose

To report a case of bilateral central retinal vein occlusion in a 45-year-old male with underlying lymphoplasmacytic lymphoma (LPL), highlighting the clinical and investigative challenges in diagnosing this condition.

Methods

A 45-year-old Malay male with no significant medical history presented with painless bilateral ocular vision (BOV) loss for 3 months. He was referred from the medical department to ophthalmology due to retinal hemorrhages. His ocular examination included visual acuity testing, intraocular pressure measurement, and a fundus examination. Diagnostic investigations included optical coherence tomography (OCT), full blood count (FBC), coagulation profile, erythrocyte sedimentation rate (ESR), and bone marrow aspiration.

Results

Ophthalmological examination revealed bilateral central retinal occlusion, characterized by extensive intraretinal hemorrhages, optic disc swelling, and macular edema. OCT showed significant retinal thickness with intraretinal and subretinal fluid. Laboratory tests indicated normochromic normocytic anemia, thrombocytopenia, prolonged prothrombin time, and low complement levels. Bone marrow aspiration revealed 31.2% abnormal lymphoid cells, including lymphoplasmacytoid cells, leading to a diagnosis of lymphoplasmacytic lymphoma.

Conclusion

This case demonstrates the importance of a thorough diagnostic approach in patients presenting with retinal hemorrhages and unexplained BOV, as these may indicate underlying systemic malignancies such as lymphoplasmacytic lymphoma. Early recognition of systemic involvement can significantly impact treatment and prognosis.

ABSTRACT ID: 160

SHOCK WAVE-INDUCED MACULOPATHY WITH CENTRAL SCOTOMA FOLLOWING GAS CYLINDER EXPLOSION

Law Jin Xing[1], Nur Afiah Binti Kamaluddin[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

To report the clinical findings and diagnostic workup of a case of shock wave-induced maculopathy in a patient exposed to a gas cylinder explosion at close range.

Methods

A 46-year-old male with no prior medical or ocular history presented with reduced vision and a central scotoma in the left eye following a workplace explosion. A detailed ocular examination, Bjerrum chart visual field testing, and optical coherence tomography (OCT) were performed.

Results

Examination revealed visual acuity of 6/6 in the right eye and 3/60 in the left eye, with Bjerrum chart testing revealing a central scotoma. Fundus examination showed a dull macular reflex in the left eye, while the optic discs and retinal findings in both eyes were normal. OCT of the left macula demonstrated corrugated retinal pigment epithelium (RPE) without breaks or fluid. The right macula appeared normal. These findings were consistent with shock wave-induced maculopathy.

Conclusion

Shock wave-induced maculopathy is a rare ocular condition that may result in significant vision loss despite a lack of overt structural damage. Early detection using OCT and visual field testing is crucial for diagnosis. This case highlights the importance of awareness and protective measures in occupational settings to prevent blast-related ocular injuries.

ABSTRACT ID: 178
WINGS OF TROUBLE: A RARE CASE OF INSECT-INDUCED OPHTHALMIA NODOSA

Chan SY[1], Ng QX[1]

[1]Hospital Queen Elizabeth

Purpose

To report a rare case of ophthalmia nodosa caused by a retained insect wing, highlighting its clinical presentation, diagnostic challenges, and management approach.

Methods

A case report.

Results

A 63-year-old male with underlying hypertension, presented with the complaint of foreign body sensation, redness and blurred vision over the right eye for the past two days. There was history of foreign body entered his eye while opening door one week ago. During initial presentation, he was treated for corneal abrasion and initiated on topical antibiotics. However, symptoms were not improving, and visual acuity had deteriorated from 6/20 to 6/120 during his subsequent follow-up. Anterior segment evaluation of the right eye revealed a corneal foreign body, suspected to be an insect wing, embedded up to the anterior stromal layer. Surrounding findings included endothelial striae and non-granulomatous anterior uveitis with 3+ cells. Notably, there were no signs of ocular infection, such as infiltrates or hypopyon. Fundus examination of the eye was unremarkable. The Insect wing was removed under slit lamp magnification using 26G needle. The epithelial defect post foreign body removal was treated with topical and ointment antibiotics. One week later, the patient was asymptomatic with visual acuity 6/10 in the affected eye.

Conclusion

This case highlights ophthalmia nodosa as a rare but important differential diagnosis in ocular inflammation caused by retained insect fragments. Prompt removal of the foreign body, coupled with appropriate medical management, can lead to successful recovery and prevent complications.

ABSTRACT ID: 185

A MULTISYSTEMIC CHALLENGE: ANTERIOR UVEITIS AS THE INITIAL PRESENTATION OF GRANULOMATOSIS WITH POLYANGIITIS

Nur Amalina Akmal Shafie[1], Faridah Mat Amin[1], Noor Amalina Saidi[1], Khairiyah Ridyan@Riduan[1], Nik Nur Hakimah Nik Mohd Ali[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To report a case of Granulomatosis with polyangiitis (GPA) that often presents with diverse organ involvement, making early diagnosis challenging.

Methods

Case report.

Results

A 69 –year-old male with underlying diabetes mellitus and hyperlipidaemia who presented with a one-week history of left eye redness and discomfort. There was no history of blurry vision or trauma. His right eye had poor vision for one year, with examination revealing a white cataract. Ocular assessment showed anterior chamber inflammation in the left eye, while posterior segment evaluation was unremarkable. He was treated as left acute anterior uveitis with topical corticosteroids. Further systemic evaluation revealed chronic skin blisters, oral ulcers and a persistent cough. He previously investigated for pulmonary tuberculosis, which was negative. Additionally, he had progressive hoarseness and was diagnosed with vocal cord palsy. Nasoendocopic examination revealed a multilobulated mass in the left nasal cavity, which was biopsied and identified as sinonasal inflammatory polyps. Laboratory test showed anaemia (Hb 8.6g/dl), elevated inflammatory markers, and negative autoimmune serology. Despite this, the constellation of symptoms suggested GPA with ocular, pulmonary, skin, peripheral nerve, and nasal involvement. He was initiated on systemic corticosteroids with clinical improvement.

Conclusion

This case highlights the importance of considering GPA in patients with anterior uveitis and systemic symptoms, more than half of GPA cases involve ocular manifestations, necessitating a multidisciplinary approach. Early ophthalmologic recognition and timely systemic treatment are crucial to prevent morbidity. This report emphasizes the role of ophthalmologists in the early detection of life-threatening systemic vasculitis.

ABSTRACT ID: 187

PROMPT RECOGNITION AND TREATMENT OF BILATERAL RETINAL DETACHMENT IN A PREECLAMPSIA PATIENT

Muhammad Aizuddin Ahmad[1], Noor Amy Farhana Mohammad Amin[1], Md Zulfadli Mohd Razali[1,2], Julieana Muhammed[2]

[1]Hospital Sultanah Nur Zahirah; [2]Health Campus University Sains Malaysia

Purpose

Prompt recognition and treatment of bilateral retinal detachment in a preeclampsia patient.

Methods

A case report.

Results

A 26 year old female, myopia with no history of hypertension, presented at the 30th week pregnancy with symptoms of preeclampsia, including oedema in lower limbs and was treated with labetalol (100 mg every 8 hours), and methyldopa (750 mg every 8 hours). By 31 weeks, she was referred for severe preeclampsia, with blood pressure of 184/114 mmHg and proteinuria (3.77 g over 24hours). Laboratory tests shown thrombocytopenia and elevated liver enzymes. A caesarean section was performed, resulting in the delivery of a healthy baby. Five days postpartum, the patient reported blurred vision in her right eye, only detecting hand movements. Her best-corrected visual acuity (BCVA) was 6/9 in the left eye, with no relative afferent pupillary defect noted. Fundus examination of the right eye revealed exudative retinal detachment involving the macula, with signs of hypertensive choroidopathy in both eyes. Optical coherence tomography (OCT) revealed bilateral eyes exudative detachment, subretinal and intraretinal fluid accumulation. The patient was treated with intravenous methylprednisolone for three days, followed by a two-week course of oral prednisolone in view of slow visual recovery, while blood pressure was managed with labetalol (200 mg every 8 hours). After three weeks postpartum, the patient's right eye vision improved to 6/7.5, with successful reattachment of the retina.

Conclusion

With prompt recognition and timely treatment, significant visual recovery is not only possible but achievable and this highlights the necessity for vigilant monitoring of patients with preeclampsia.

ABSTRACT ID: 190

FROM MYSTERY TO RECOVERY: CURIOUS CASES OF ENDOPHTHALMITIS

Norma Asmira Mohd Nor[1], Derrick Chuah Jun Quan[1], Wan Norliza Wan Muda[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

Endophthalmitis is a sight-threatening condition. We report two cases of endophthalmitis with varying ocular presentation in extreme age.

Methods

Retrospective case report.

Results

Case 1: 4-year-old Orang Asli healthy boy experienced left eye (OS) redness for three days after having injury with a pencil. OS vision was 6/36. Examination under anaesthesia revealed no obvious entry wound or foreign body with anterior chamber (AC) cells 4+, single nidus of inflammatory cells at 4 o'clock and hypopyon. Fundus showed vitritis, multifocal retinitis and early macula star. B-scan showed vitritis. However, imaging study reported no intraocular foreign body and septic workup were all negative. Dental assessment revealed early childhood caries. He underwent vitreous tapping with intravitreal antibiotic, and vitreous culture grew Streptococcus Viridans. Successful treatment with systemic and topical antibiotics led to final vision of 6/6. Case 2: 81-year-old Malay lady with comorbidities and history of uncomplicated OS cataract surgery 1-year prior, experienced throbbing OS pain for three weeks. OS vision was 3/60 with ciliary injection, presence of old keratic precipitate, AC cells 2+, but no hypopyon seen. B-scan showed vitritis and loculation. Unfortunately, vitreous, blood and urine culture were negative. Systemic and intravitreal antibiotic commenced immediately, followed by trans-pars plana vitrectomy and intraocular lens explantation. Intracameral Recombinant Tissue Plasminogen Activator was instituted for severe post-operative inflammation. She achieved complete resolution of infection with best-corrected visual acuity of 6/45 (aphakic).

Conclusion

We described two different spectrums of endophthalmitis cases, emphasizing importance of prompt diagnosis and treatment for a better visual outcome.

ABSTRACT ID: 196

OCULAR BARTONELLOSIS MIMICKING VASCULAR RETINOPATHY IN A POST-ANGIOPLASTY MYOCARDIAL INFARCTION PATIENT: A CASE REPORT

Aleza O[1], Siti Aishah S[1], Suriana S[1], Ayesha MZ[2], Siti Husna H[3]

[1]Hospital Putrajaya; [2]Hospital Canselor Tunku Muhriz; [3]Universiti Sains Islam Malaysia

Purpose

Ocular Bartonellosis (OB), caused by Bartonella henselae, is clinically diagnosed with serological support. It presents as neuroretinitis or retinal vasculitis, often resembling vascular events. We report OB case in patient with recent myocardial infarction, highlighting the diagnostic challenges and vascular complications.

Methods

Case report.

Results

33-year-old man with hypertension, hyperlipidaemia, and recent admission for myocardial infarction requiring angioplasty presented one day post-discharge with sudden blurred vision six days in right eye and one day in left eye. He had a pet cat but denied scratches. Ocular examination showed right relative afferent pupillary defect (RAPD), reduced optic nerve function, and vision of 2/60 (right eye) and 6/18 (left eye). Fundus findings revealed right optic disc (OD) swelling, mottled macula, Roth spots, tortuous vessels, and vitreous haemorrhage, while left eye had inferior blurred OD margin and mottled macula. Optical Coherence Tomography (OCT) showed subretinal fluid, central foveal thickness (CFT) of 961µm (right) and 350µm (left). Fluorescein angiography was incomplete due to anaphylaxis. Within a week, bilateral neuroretinitis with a macular star developed, with resolving Roth spots and vitreous haemorrhage in right eye. Serology for Bartonella IgM confirmed OB. Treatment with doxycycline and prednisolone improved vision to 6/24 (right), 6/6 (left) with resolving OD swelling and residual hard exudates. OCT showed resolved subretinal fluid with CFT of 208µm (right) and 271µm (left).

Conclusion

This case highlights unique overlap between infectious retinopathy and vascular pathology, stressing high clinical suspicion of OB after cardiovascular events. Early recognition and treatment could prevent permanent vision loss.

ABSTRACT ID: 197

UNILATERAL CHORIORETINAL COLOBOMA WITH OCULAR HYPERTENSION IN A 24-YEAR-OLD WOMAN: A RARE CASE REPORT

Muhammad Azhar[1], Andhika Guna Dharma[1], Satya Hutama Pragnanda[1], Denti Puspasari[1]

[1]Diponegoro University

Purpose

To present a rare case of a 24-year-old-woman with chorioretinal coloboma of the right eye, accompanied by ocular hypertension (OHT) on both eyes. Highlighting the clinical presentation, the treatment given and the final outcome after administration.

Methods

This is a retrospective case report of complex chorioretinal coloboma accompanied by OHT.

Results

We present the case of a 24-year-old woman who consulted for her blurred vision on the right eye since child with visual acuity was 6/30, while the left eye visual acuity remained 6/6. The intraocular pressure (IOP) in both eyes increased to 24.0 mmHg in the right eye and 22.3 mmHg in the left eye. Anterior segment examination with gonioscopy confirmed no closed angle and peripheral anterior synechiae (PAS). Fundus examination showed chorioretinal folds in the infero-nasal retinal periphery, with a full thickness scleral defect on the right eye. Glaucomatous optic neuropathy was not present on both eyes. Visual field examination was performed, and a supero-temporal visual field defect was found in the right eye. Prophylactic demarcation laser treatment alongside with timolol maleate 0.5% to decrease the IOP was used on the patient to avoid future issues. Regular ophthalmological monitoring is necessary to detect any complication associated with coloboma.

Conclusion

We describe diagnosis and management of chorioretinal coloboma case with OHT. The malformation in this structure may also affect the development of the anterior segment, including the trabecular meshwork and Schlemm's canal, that can lead to impaired aqueous humour drainage contributing to OHT.

ABSTRACT ID: 198

AN UNUSUAL PRESENTATION OF BILATERAL OCULAR TUBERCULOSIS IN A PAEDIATRIC PATIENT WITH A REMOTE HISTORY OF TB EXPOSURE

Nur Azureen Mohd Ali[1], Farhana Ibrahim[1], Anis Baidura Azal[1], Julieana Muhamed[2]

[1]Hospital Tuanku Ja'afar Seremban; [2]Health Campus University Sains Malaysia

Purpose

To report a case of subclinical presentation of bilateral ocular tuberculosis in a paediatric patient

Methods

Case report.

Results

A 13-year-old female with no known comorbid presented with left eye (LE) redness, gradual in onset, generalized vision reduction in both eyes over the past 10 days. She had a history of tuberculosis (TB) contact with her grandfather over 10 years ago, who had completed TB treatment. Vision in right eye (RE) was 6/9 and left eye (LE) was 6/12, with no relative afferent pupillary defect. Anterior segment examination of the LE showed conjunctival hyperaemia, multiple fine keratic precipitates inferiorly, anterior chamber inflammation, posterior synechiae at 12 and 5 o'clock, and iris pigment on the lens. The RE was unremarkable. Fundus examination revealed bilateral optic disc hyperaemia with RE superotemporal vasculitis and LE well-defined hypopigmented scar inferior to the optic disc, with no retinitis and choroiditis seen. Optical coherence tomography (OCT) demonstrated subclinical vitritis in both eyes, with no cystoid macular oedema. Fundus fluorescein angiography (FFA) revealed a hot optic disc with choroiditis in the LE, while the RE FFA was normal. The patient was diagnosed with bilateral ocular TB after a positive TB QuantiFERON test. She was treated with topical steroids in BE and anti-TB therapy, followed by oral steroids one week after starting the anti-TB treatment.

Conclusion

Considering ocular tuberculosis in paediatric patients with unexplained vision changes, particularly those with a history of TB exposure, is crucial for early diagnosis and effective treatment to prevent vision loss.

ABSTRACT ID: 211

HELP I CAN'T SEE MY BABY! WHEN PRE-ECLAMPSIA STRIKES THE EYES: EXUDATIVE RETINAL DETACHMENT IN HEMOLYSIS, ELEVATED LIVER ENZYMES, AND LOW PLATELET COUNT (HELLP) SYNDROME

Nurul Yasirah Mohd Yunus[1], Sangeetha S[1]

[1]Hospital Sungai Buloh

Purpose

To report a case of exudative retinal detachment a rare complication of haemolysis, elevated liver enzymes, and low platelet count (HELLP) syndrome.

Methods

Case report.

Results

We report a case of 32 years old Malay female, at G2P1 at 33 weeks 4 days admitted to obstetrics and gynaecology ward for uncontrolled hypertension and pre-eclampsia as noted blood pressure ranged was 161-162/97-105 mmHg and urine albumin 2+. Done emergency Lower Segment Caesarean Section (LSCS) for severe pre-eclampsia complicated with abruptio placenta and primary post-partum haemorrhage (PPH). She complained both eyes blurring of vision for 1 day prior to emergency LSCS. Upon review, visual acuity right eye was 6/60, left counting finger. Both eye anterior segment was unremarkable with normal intraocular pressure. Fundus at both eyes showed exudative retinal detachment at macula (left eye more bullous compared to right). We are monitoring both eye fundus noted exudative retinal detachment resolved within 1 week with mottled macula. Optical coherence tomography (OCT) macula at 1 week showed resolved bullous retinal detachment with minimal serous retinal fluid, central macular thickness right eye was 290µm and left 324µm. Repeated vision after 4 weeks noted visual acuity at right eye 6/9 and left eye 6/12 (pin hole 6/9) with OCT macula showed improving serous retinal fluid, central macular thickness right eye was 241µm and left 242µm.

Conclusion

Serous retinal detachment should always be considered in the absence of hypertensive retinal changes within the differential diagnosis of sudden loss of vision in cases complicated with HELLP syndrome.

ABSTRACT ID: 214

RETINAL FIREWORKS: A FIERY DISPLAY OF OCULAR TOXOPLASMOSIS

Nur Amni Hajar Suhaimi[1], Ainul Kauthar Mohamad Saidy[1], Siti Aisyah N Mazlan[1], Nur Fadilah A Mohammad[1], Azma Azalina A Alwi[1]

[1]Hospital Raja Perempuan Zainab II

Purpose

To report a case of atypical presentation of clinical toxoplasmosis.

Methods

A case report.

Results

A 33-year-old immunocompetent cat lover lady presented with blurred right vision and metamorphopsia for 1 week, associated with fever. She recently tended sick, unvaccinated cats. On examination, right eye relative afferent pupillary defect (RAPD) was positive with visual acuity of Counting Finger. Fundus examination demonstrated clear vitreous, swollen and hyperaemic disc with splinter haemorrhages. Posterior pole showed presence of macular star and choroiditis with focal retinitis at superior arcade. Optical Coherence Tomography (OCT) unveiled accumulation of subfoveal fluid. Work up for Toxoplasma and Bartonella serology turned out non-reactive. Based on her clinical findings, she was treated with a 6-week course of Bactrim and oral prednisolone. At 2 weeks follow up, there was tremendous vision improvement to 6/24 and reduction of the subfoveal fluid.

Conclusion

Cases with neuroretinitis with choroiditis should trigger high suspicion of Toxoplasma infection. Toxoplasma neuroretinitis has a favourable visual outcome. Although rare, it should be a part of differential diagnosis in neuroretinitis.

ABSTRACT ID: 215

A VIVID GLIMPSE INTO THE SWOLLEN DISCS: UNVEILING THE MANIFESTATIONS OF HEMANGIOBLASTOMA

Ainul Kauthar Mohamad Saidy[1], Nur Amni H Suhaimi[1], Nur Fadilah A Mohammad[1], Tengku Norina T Jaffar[1]

[1]Hospital Raja Perempuan Zainab II

Purpose

To report a case of hemangioblastoma with bilateral compressive optic neuropathy related to Von Hippel Lindau Syndrome.

Methods

A case report.

Results

A 19-year-old presented with worsening right eye vision of 1 month duration that is associated with pounding headache over right occipital region. On examination, right eye relative afferent pupillary defect (RAPD) was positive with visual acuity of Counting Fingers, while 6/36 for left eye. Dilated examination demonstrated both eyes papilloedema with peripapillary exudates, extensive flame shaped haemorrhages surrounding optic discs and macula oedema. Neurological examination revealed positive cerebellar signs. Imaging of the brain and orbit with contrast showed left cerebellar extra axial lesion with obstructive hydrocephalus and tonsillar herniation. A ventricular-peritoneal (VP) shunt was placed as immediate treatment and subsequent tumour debulking was performed 6 months later. Histopathology examination confirmed the presence of hemangioblastoma. Post operatively, vision improved up to 6/12. A year follow-up showed deterioration of vision to perception of light due to enlarging residual brain lesion and herniation. Patient underwent multiple subsequent VP shunt and radiotherapy.

Conclusion

Hemangioblastoma of the central nervous system is seen in approximately 72% of VHL patients. Presentation of bilateral papilloedema should raise a high index of suspicion of this disease. Recurrence of disease may occur even after aggressive early surgical intervention. Hence, close life-long follow up is crucial.

ABSTRACT ID: 225

A RARE ENCOUNTER WITH A CASE OF PRIMARY VITREORETINAL LYMPHOMA (PVRL)

Khoo Ming Yu[1], Mohammad Fahim Mohd Jais[1], Nurull Bahya Suliman[1], Norshamsiah Md Din[2], Niki Ho[2]

[1]Hospital Tengku Ampuan Rahmah; [2]Hospital Canselor Tuanku Muhriz UKM

Purpose

To present a case of Primary Vitreoretinal Lymphoma

Methods

A case report and discussion.

Results

A 54-year-old Malay woman with newly diagnosed diabetes mellitus presented with progressive, painless bilateral blurring of vision for three months. Her visual acuity was Counting Fingers in both eyes. Ophthalmic examination revealed vitritis, subretinal exudates, multiple yellowish subretinal deposits, and macular subretinal deposits in the right eye (RE), while the left eye (LE) had dense vitritis, obscuring further details. B-scan showed choroidal effusion. Fluorescein angiography and indocyanine green angiography of the RE revealed punctate areas of hyperfluorescence corresponding to subretinal deposits. Vitreous biopsy of both eyes confirmed B-cell lymphoma via flow cytometry, although cytology was inconclusive. MRI of the brain showed no central nervous system (CNS) involvement. The patient was started on intravitreal methotrexate in BE, resulting in regression of subretinal exudates. She is currently co-managed with the haematology team.

Conclusion

Primary Vitreoretinal Lymphoma (PVRL) is a rare and aggressive subset of primary CNS lymphoma (PCNSL) with a high mortality rate (9–81% within 12–35 months). It often mimics chronic uveitis and requires a high index of suspicion, particularly in bilateral cases. More than half of affected patients develop CNS involvement. Early recognition is critical, and vitreous biopsy with flow cytometry remains the gold standard for definitive diagnosis to prevent CNS spread and improve outcomes.

ABSTRACT ID: 240
A RARE CASE OF ACUTE IDIOPATHIC MACULOPATHY

Lim Su Chern[1], Ashvini Devi Paramesvaran[1], Daphne Teh[1], Roslin Azni[1], Mae-Lynn Catherine Bastion[2], Ayesha Mohd Zain[2]

[1]Hospital Shah Alam; [2]Universiti Kebangsaan Malaysia; [3]Hospital Canselor Tuanku Muhriz (HCTM) UKM

Purpose

To report a rare case of Acute Idiopathic Maculopathy (AIM).

Methods

Case report.

Results

A 13-year-old boy presented with a sudden, painless onset of blurred central vision in his right eye, associated with metamorphopsia. This was preceded by a low-grade fever and sore throat one day earlier. Otherwise, he was well, with no prior ocular history. On presentation, visual acuity was 6/60 in the right eye and 6/9 in the left. The anterior segment was normal, with no signs of inflammation. Fundus examination revealed a dull macula with a small yellowish lesion surrounded by dot haemorrhages. There was no vitritis, retinitis, vasculitis, or choroiditis. The left eye was normal. Optical Coherence Tomography (OCT) of the right macula showed subfoveal subretinal fluid (SRF) with hyperreflective material within. Central subfoveal thickness was elevated at 718µm. Hyperreflective dots were seen in the vitreous. Fundus fluorescein angiography revealed a hyperfluorescent ring over the macula. Blood investigations and infective screening were unremarkable. Five days later, vision improved to 6/40 (ph 6/30), and the SRF completely resolved, leaving subretinal exudates. At six weeks, visual acuity improved to 6/20 and further to 6/6 at six months. OCT showed no residual fluid, reduced subretinal deposits, and a well-defined retinal pigment epithelium and ellipsoid zone. The patient was scheduled for follow-up.

Conclusion

Acute Idiopathic Maculopathy (AIM) is a self-limiting condition resolving over days to weeks. The prognosis is favourable, with most patients achieving full visual recovery. Though the exact cause is unclear, AIM is postulated to have a viral infectious origin, often following a flu-like illness.

ABSTRACT ID: 250
BILATERAL EALES DISEASE: A DIAGNOSIS OF EXCLUSION

Maizatul Akmal Mohamad Nazri[1], Patricia Ann John[1]

[1]Hospital Segamat

Purpose

Eales disease is a rare idiopathic occlusive vasculitis affecting the mid-peripheral retina, characterized by retinal venous inflammation (periphlebitis), vascular occlusion and retinal neovascularization, leading to recurrent vitreous haemorrhage and its complications.

Methods

A case report.

Results

A 39-year-old male with newly diagnosed hypertension presented with three months of bilateral vision blurring and floaters. His initial best-corrected visual acuity (BCVA) was 1/60 in the right eye (RE) and 6/24 in the left eye (LE), with normal anterior segment and intraocular pressure. Fundus examination revealed vitreous haemorrhage, multi-layered retinal haemorrhages, and fibrovascular proliferation with traction in the RE. Fluorescein angiography showed a peripheral avascular zone with leakage. The patient was treated with bilateral laser photocoagulation and underwent pars plana vitrectomy in the right eye. After treatment, BCVA improved to 6/12 in the LE, while the RE remained stable.

Conclusion

Bilateral Eales disease is a diagnosis of exclusion. Early identification through detailed clinical assessment and advanced imaging, such as fluorescein angiography, is crucial for timely intervention, preventing severe complications and preserving vision.

ABSTRACT ID: 259
RAPID PROGRESSION OF MASQUERADE SYNDROME OF BILATERAL EYE IN STAGE IV BREAST CARCINOMA

Pan Ting Sun[1], Adilah Zulkifly[1], Nadhirah Ahmad Fauzi[1], Ahmad Nurfahmi[1], Adzura Salam[1]

[1]IIUM International Islamic University Malaysia

Purpose

To report a case of rapid progression of masquerade syndrome secondary to metastases of stage IV breast carcinoma.

Methods

Case report.

Results

A 58-year-old woman diagnosed with stage IV invasive breast carcinoma with liver and lung metastases. She presented with complaints of progressive blurring of vision in the bilateral eye and photophobia for a month. Her best corrected vision was 6/60 in the right eye and 6/9 in the left eye. RAPD and IOP were normal. Both eye anterior segment examinations were unremarkable. Fundus examination revealed subretinal masses in both eyes: a 7-disc-diameter lesion in the superotemporal quadrant of the right eye and a 2-disc-diameter lesion in the left eye sparing both optic discs. Ocular ultrasound and optical coherence tomography confirmed bilateral choroidal metastases. The patient is comanaged with surgical and oncology team. Within a month, while awaiting chemotherapy, she presented with complaints of worsening of vision. Her vision was profoundly reduced with the presence of RAPD in the right eye. Fundus examination showed lesion enlargement, subretinal haemorrhage, and optic disc involvement and exudative retinal detachment inferiorly in the right eye. Enlargement of the lesion in the left eye was also seen.

Conclusion

Masquerade syndrome secondary to metastases of stage IV breast carcinoma shows rapid progression. Chemotherapy, which is a definitive treatment, should be given in a timely manner. Multidisciplinary collaboration and communication are essential for a good outcome.

ABSTRACT ID: 265
OCULAR TUBERCULOSIS: THE GREAT MIMICKER

Nur Diyana Khairul Anuar[1], Lee Hsin Yi[1]

[1]Hospital Miri

Purpose

To report a case of ocular tuberculosis with presence of large iris nodules mimicking an intraocular tumour.

Methods

Case report.

Results

We report a case of a 6-year-old boy who presented with mild blurring of vision and recurrent alternating eye redness over 3 months. Examination revealed multiple large iris nodules with engorged iris vessels in the left eye and bilateral seclusio pupillae, anterior chamber inflammation and keratic precipitates. Fundus examination showed bilateral swollen optic discs with cystoid macular oedema. These findings raised the suspicion of intraocular tumour; however, MRI results of the brain and orbit were not suggestive. A positive tuberculin skin test established the diagnosis of ocular tuberculosis (TB), and he was initiated on a course of anti-TB medication with subsequent systemic corticosteroids. Gradual clinical improvement was seen over the course of treatment. Best corrected visual acuity improved from 6/12 at presentation to 6/7.5 bilaterally.

Conclusion

Ocular TB is known as a great mimicker of various eye pathologies due to its widely variable clinical presentation. However, a high level of suspicion is vital to exclude other life-threatening conditions when encountering suspicious iris lesions.

ABSTRACT ID: 272
BILATERAL EYE OCULAR SYPHILIS - DIAGNOSTIC DILEMMA

Siti Nur Aliah Rosly[1], Shalini Rajamany[1], U Kern Rei[1], Nazima Shadaht Ali[1]

[1]Hospital Selayang

Purpose

To report a case of bilateral eye ocular syphilis.

Methods

Case Report.

Results

A 73-year-old male presented with left eye pain for 1 week associated with floaters and oral ulcers for 3 weeks. There were no constitutional symptoms and other uveitic history was unremarkable. Patient denies any high-risk behaviours. On examination, visual acuity (VA) of the right eye was 6/9 with anterior chamber (AC) cells of 1+. Fundus examination showed blurred disc margin nasally with drusen at the macula. Left eye VA was 6/12 with injected conjunctiva, generalised fine keratic precipitates and AC cells +1. Fundus examination showed vitritis 1+, 360 blurred disc margin, and drusen at the posterior pole. Systemic examination revealed oral candidiasis. Initial uveitic work-up was unremarkable. Fundus fluorescein angiography (FFA) showed bilateral hot discs, angiographic cystoid macular oedema (CMO) with foveal avascular zone slightly enlarged. Presumptive diagnosis of intermediate uveitis was made, and he was started on oral prednisolone and gutt maxidex. On subsequent follow up, patient's left eye VA dropped to CF1ft with reduced optic nerve function test. There was no space occupying lesion on CT brain. Due to a high index of suspicion, repeated VDRL in dilution was performed and the result came back as positive. Hence, the patient was started with IV C-Penicillin for 14 days.

Conclusion

When a patient with uveitis does not respond to initial treatment and exhibits worsening symptoms, it is crucial to revisit the possibility of syphilis. In this instance, the patient exhibited prozone phenomenon, where high levels of antibodies in the blood can interfere with serological tests.

ABSTRACT ID: 281

A RETROSPECTIVE ANALYSIS OF CLINICAL PROFILES AND THERAPEUTIC OUTCOMES IN CYTOMEGALOVIRUS RETINITIS: A SINGLE-CENTER STUDY IN TERENGGANU, MALAYSIA

Nurulhuda Hayati Mohd Sabri[1], Rosiah Muda[1], Muhammad Aizuddin Ahmad[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To characterize the clinical profiles, management outcomes, and prognostic indicators of Cytomegalovirus (CMV) retinitis in patients managed at a tertiary ophthalmology referral center in Terengganu, Malaysia.

Methods

A retrospective cross-sectional analysis was conducted on 21 patients diagnosed with CMV retinitis and treated between 2017 and 2024. Demographic data, clinical features, treatment regimens, and visual outcomes were evaluated.

Results

Twenty-nine eyes were included. All patients identified as ethnically Malay, with a male predominance (71.4%, n=15). The mean age at diagnosis was 39.5 years (range: 17–63). HIV coinfection was identified in 90.5% (n=19) of cases. Unilateral involvement occurred in 61.9% (n=13). The most common presenting symptom was blurred vision (66.7%, n=14). Disease recurrence was observed in 31.0% of eyes (n=9). At baseline, 20.7% of eyes (n=6) exhibited no visual impairment (LogMAR <0.30), while 31.0% (n=9) presented with blindness (LogMAR >1.30). Post-treatment, 24.1% (n=7) achieved no visual impairment, 17.2% (n=5) had mild impairment (LogMAR 0.30–0.50), 10.3% (n=3) moderate impairment (LogMAR 0.60–1.00), and 48.3% (n=14) remained blind. Visual acuity significantly improved in 17.2% (n=5), stabilized in 48.3% (n=14), and deteriorated in 34.5% (n=10) of eyes.

Conclusion

CMV retinitis persists as a vision-threatening complication in immunocompromised populations, particularly among HIV-positive individuals. Despite systemic and intravitreal therapies, progressive visual decline occurred in over one-third of cases, underscoring the need for early diagnosis and aggressive management. This study highlights the persistent morbidity associated with CMV retinitis in our cohort, emphasizing the importance of multidisciplinary care in mitigating ocular complications.

ABSTRACT ID: 286
VITREOUS TAP PROVEN CYTOMEGALOVIRUS RETINITIS AND CHALLENGES FACED

Tan Chern Meng[1], Nurul Shima Ismail[1]

[1]Hospital Tuanku Ja'afar Seremban

Purpose

To present an immunosuppressed patient with vitreous tap proven Cytomegalovirus (CMV) retinitis.

Methods

A case report.

Results

A 57-year-old male with red cell aplasia on Ciclosporin presented with bilateral eyes (BE) blurring of vision for 3 weeks. Visual acuity of BE was 6/9, no relative afferent pupillary defect. BE showed keratic precipitates with anterior chamber cells 1+ in the right eye and 2+ in the left eye. BE intraocular pressure were 14mmHg. The right eye showed vascular sheathing over superonasal and inferonasal arcades with retinal haemorrhages. The left eye showed granular appearance over superotemporal arcade and vascular sheathing over inferonasal arcades with retinal haemorrhages. BE no vitritis. Clinically, he was diagnosed with Zone 2 BE CMV Retinitis. His absolute neutrophil count was low (1.04) owing to Ciclosporin. Haematology team was consulted for initiation of subcutaneous Neupogen 300mg nocte twice per week while on induction of intravenous Ganciclovir. On Day 3 of intravenous Ganciclovir, right eye retinitis worsened to involve Zone 1. Vitreous tap was performed and sent for CMV Polymerase Chain Reaction (PCR) as per infectious disease team suggestion. The CMV PCR was positive (6134999 IU/mL). He was given 3 months of oral Valganciclovir 900mg OD as prophylaxis. Upon completion of intravenous and intravitreal Ganciclovir, the retinitis scarred up, vessels sclerosed.

Conclusion

Management of CMV retinitis was challenging in immunosuppressed patients as drug interactions with Ganciclovir caused worsening of bone marrow suppression. Vitreous tap was helpful in cases where diagnosis is uncertain and planning for duration of antivirals.

ABSTRACT ID: 291
THE ONE THAT ALMOST GOT AWAY: INTRAOCULAR TUBERCULOSIS, A GREAT MIMICKER

Rifhan Aliah Mhd Nasir[1], Wan Norliza Wan Muda[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

The myriads of intraocular tuberculosis (TB) manifestations can mimic other intraocular inflammation, making diagnosis challenging. Delays in its diagnosis can lead to permanent vision loss. This report highlights the dilemma in managing intraocular TB which may be encountered in our clinical practices.

Methods

Case report.

Results

A 19-year-old Bangladeshi lady presented with recurrent episodes of bilateral eyes (BE) blurring of vision for 5 years, treated as bilateral recurrent panuveitis previously. Her visual acuity (VA) at presentation was 6/9 OU with posterior synechiae and anterior chamber cells in her left eye (LE), bilateral multifocal old choroiditis scar and vitritis in the LE. Her chest X-ray was clear and initial test of TB QuantiFERON was negative. She was treated as BE presumed ocular sarcoidosis and started on oral Azathioprine and prednisolone. After 10 days of commencing Azathioprine, her right eye developed a new enlarging choroidal granuloma with exudative retinal detachment (ERD) and VA dropped to hand movement. Repeated TB QuantiFERON test and Mantoux test were positive. Her oral Azathioprine was discontinued, and she was started on anti TB regime with immunosuppressant dosage of oral prednisolone. Currently she is on intensive phase of anti TB drug with slow resolution of both granuloma and ERD. LE remains status quo.

Conclusion

As diagnosis of intraocular TB may be empiric, it is necessary to maintain high index of suspicion aided by a targeted review of systems and directed laboratory testing. This case report emphasizes the importance of revising approach and diagnosis at any points of doubts.

ABSTRACT ID: 295

SUDDEN BILATERAL VISION LOSS IN AN INDIVIDUAL WITH SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): UNRAVELLING OCULAR SYPHILIS IN SLE

Nur Farhana Kamardin[1], Noorlaila Baharuddin[1], Suriana Suaibun[1], Evelyn Tai Li Min[2]

[1]Hospital Putrajaya; [2]Universiti Sains Malaysia

Purpose

Highlights challenges in distinguishing syphilis in SLE. SLE is an autoimmune disorder, common cause of reduce vision in SLE patients are choroiditis, vasculitis, central retinal artery occlusion, optic neuritis and hydrochloroquine toxicity. Most common presentation in ocular syphilis are posterior uveitis and panuveitis. Syphilitic outer retinopathy can mimic above SLE presentation thus complicating diagnosis.

Methods

Case Report.

Results

53-year-old female with underlying SLE presented with a bilateral sudden onset central reduced in vision for 4 days. Vision was 1/60 in both eyes. Anterior segment examination was unremarkable. Fundus examination showed bilateral sectoral optic disc swelling with few intra-retinal haemorrhages. Disruption of outer retinal layer in both eyes observed in optical coherence tomography (OCT) and OCT of retinal nerve fibre layer showed increased thickness of optic nerve. Uveitis workout turns out positive for syphilis. Magnetic Resonance Imaging (MRI) showed mild enhancement of right optic nerve. She was co-managed with neuro-medical and rheumatology team with prompt initiation of intravenous Benzylpenicillin 4mu 4 hourly for two week and her vision improved to 6/24 in both eyes.

Conclusion

Ocular syphilis and SLE can present with similar retinal changes and vision loss. Early identification of syphilis is crucial for initiating appropriate antimicrobial therapy, while SLE-related ocular manifestations require immunosuppressive management. This case underscores the importance of a comprehensive diagnostic workup to avoid misdiagnosis and ensure optimal patient care.

ABSTRACT ID: 298
VALSALVA RETINOPATHY: A UNIQUE CASE WITH TWIN BLEEDS

Adina Wati Mohamad Shukor[1], Noor Sheereen AB[1], Suriana S[1]

[1]Putrajaya Hospital

Purpose

Valsalva retinopathy is a preretinal haemorrhage as a result of a sudden increase in intrathoracic or intraabdominal pressure. We report a unique case with two large sub-internal limiting membrane (ILM) haemorrhages, in which pars plana vitrectomy with ILM peel was performed, following which his vision markedly improved. Management recommendations are also evaluated and reported.

Methods

Case report

Results

A 40-year-old Malay gentleman with underlying hypertension, chronic kidney disease stage 3 and gouty arthritis, presented with right eye sudden onset painless decrease in vision associated with central scotoma for three days. He was suffering from prolonged cough for three weeks duration. There was no history of trauma, bleeding tendencies, diabetes or blood dyscrasias. On presentation, his right eye visual acuity was 3/60 with negative relative afferent pupillary defect. Fundus examination of the right eye showed presence of two large boat-shaped sub-ILM haemorrhages, in which one was premacular covering inferior half of the macula with presence of the classical double-ring sign and the other was located superonasally. After a period of observation for a month, the premacular bleed persisted, hence he underwent right eye pars plana vitrectomy, ILM peeling with air tamponade, following which his vision subsequently improved to 6/6 with complete resolution of retinal haemorrhages.

Conclusion

Valsalva retinopathy with two large sub-ILM bleed is a unique case which is rarely reported. In our case, pars plana vitrectomy with ILM peeling was the treatment of choice with excellent visual outcome. Alternative modalities of treatment such as Nd:YAG laser membranotomy may also be considered.

ABSTRACT ID: 299

A CASE OF SUPRACHOROIDAL HAEMORRHAGE IN A THERAPEUTIC WARFARIN-TREATED PATIENT: CLINICAL INSIGHTS

Siti Zaitihani Hamdan[1], Nurul Ashikin Abdullah[1], Nazima Shadaht Ali[1], Hanizasurana H[1], Yeohan Yoong Gar Gean[1 2], Penny Lott Pooi Wah[2]

[1]Hospital Selayang; [2]Universiti Malaya Eye Research Centre

Purpose

To report a case of suprachoroidal haemorrhage (SCH) in a therapeutic warfarin-treated patient.

Methods

Case report.

Results

A 77-year-old male patient with a history of chronic rheumatic heart disease and ischemic heart disease, currently on Tab Warfarin (2mg Monday-Friday; 2.5mg Saturday-Sunday) and came in with a sudden onset of pain in his left eye. He had active polypoidal choroidal vasculopathy (PCV) in both eyes, treated with intravitreal anti-VEGF injections. However, treatment was deferred due to recent heart attack. On examination, left eye vision was light perception, and the right eye vision was counting fingers. A positive relative afferent pupillary defect (RAPD) was noted over the left eye, with intraocular pressure (IOP) of 50 mmHg. Examination of the anterior chamber showed a hazy cornea, a shallow anterior chamber, and iris bombe with a pupillary block. Fundus examination showed kissing choroidal folds, and B-scan ultrasonography confirmed the presence of SCH. Blood investigations show his International Normalized Ratio (INR) 2.52 was within therapeutic range and platelet counts were normal. The patient was treated with oral acetazolamide (250 mg 6 hourly) and four topical IOP-lowering agents. His IOP managed to come down to 18 mmHg and pupillary block was resolved. Although suprachoroidal drainage surgery was offered, the patient chose to decline.

Conclusion

Spontaneous SCH is an uncommon occurrence, as SCH is generally linked to surgical interventions. In patient with ocular PCV, there may be an increased susceptibility to SCH, even when receiving a therapeutic dose of warfarin.

ABSTRACT ID: 303
THE CAT'S OUT OF THE BAG

Nurliyana Hanifudin[1], Jacqueline YL Ting[1], Rajasudha S Rajan[1], Roslin A Abdul Aziz[1]

[1]Hospital Shah Alam

Purpose

To report on Fundus Fluorescence Angiography (FFA) guided diagnosis of Bartonella neuroretinitis with concurrent non-arteritic anterior ischaemic optic neuropathy (NAION).

Methods

Case report.

Results

A 50-year-old Indonesian lady, with underlying uncontrolled hypertension presented with two weeks history of sudden onset of painless right eye blurring of vision with inferior and superior visual field defect. Ocular examination showed her best corrected visual acuity was counting fingers (CF) over the right eye and 6/9 over the left eye. There was presence of relative afferent pupillary defect (RAPD) with reduced optic nerve function. Fundus showed swollen pale optic disc with adjacent splinter haemorrhages, sclerosed vessels and macula star. Otherwise, the left eye findings were unremarkable. Systemic examination was normal. Blood investigations revealed Bartonella serology titre 1:128. Fundus Fluorescence Angiography (FFA) showed reduce perfusion of arteries with no optic disc leakage and there was no associated vasculitis.

She was treated with oral Doxycycline 100mg BD over 6 weeks. Unfortunately, her vision improved minimally with a course of oral Doxycycline, final visual acuity of 6/45 over right eye and residual optic nerve function defect.

Conclusion

Patient with NAION in infective posterior uveitis although classified as rare must not be overlooked especially in Bartonella neuroretinitis. Thus, clinician's skills equipped with available imaging modalities is crucial in differentiating between causes of pale optic disc swelling with concurrent macula star. Diagnosis is crucial in achieving prompt treatment of underlying comorbidities which in this case would have remained 'in the bag' otherwise.

ABSTRACT ID: 304

FADING VISION, HIDDEN CANCER: A CASE OF PRESUMED CANCER-ASSOCIATED RETINOPATHY.

Liew Kar Yan[1], Rafidah Salleh[1]

[1]Hospital Sultan Abdul Aziz Shah UPM

Purpose

We are reporting a case of Cancer-associated retinopathy (CAR) which is a rare paraneoplastic syndrome causing progressive vision loss caused by an autoimmune response on the retinal antigens.

Methods

Case report.

Results

A 49-year-old lady, nulliparous, with underlying DM and strong family history of cancer, presented with sequential sudden onset reduced vision for the past 2 months. Systemically, she has menorrhagia for 5 months. On examination there was RAPD over the right eye (RE). RE visual acuity was 6/18 (6/15), left eye (LE) 6/12 (6/12). On fundoscopy, BE CDR 0.3 pink, flat retina, macula dull, all arteries attenuated with some periarterial cuffing and sclerosed vessels seen with bilateral vitritis. LE OCT macula shows swollen optic disc and loss of peripheral outer retinal layers. RE shows severely atrophic retina with loss of all outer retinal layer with minimal foveal sparing. RE Bjerrum showed tunnel vision while LE, left temporal hemianopia with macular sparing. In the Fundus Fluorescein Angiography (FFA) there was small vessel vasculitis seen with multiple arterial occlusions. We referred her to a gynaecologist, who diagnosed a large cervical mass. HPE confirmed stage 4B neuroendocrine carcinoma of the cervix with right external iliac lymphadenopathy and possible metastatic lung nodules. Finally, we concluded it was likely autoimmune cancer retinopathy (CAR) and referred her to the National Cancer Institute (IKN) for further treatment.

Conclusion

This case highlights the importance of considering CAR in unexplained vision loss and the need for a thorough systemic evaluation.

ABSTRACT ID: 312
ANEMIA'S SILENT DANGER: CILIORETINAL ARTERY OCCLUSION

Mohd Farahi Syazani Ab Halim[1], Seow Sieng Teng[1], Juliana Jalaluddin[1]

[1]Hospital Melaka

Purpose

We report a case of cilioretinal artery occlusion in a patient with iron-deficiency anaemia.

Methods

Case report.

Results

A 46-year-old female with no known medical illness presented with sudden painless decrease of vision in her left eye for 1 week. She has a history of blood transfusion in 2023 for blood loss after surgical laparotomy. The best corrected visual acuity in the left eye is 6/30, with positive relative afferent pupillary defect. The anterior segment is normal. The left fundus showed a pale retina below the superior arcade with anaemic retinopathy, evidence of optic disc swelling, multilayered retinal haemorrhages, Roth spots, and tortuous and dilated vessels. Right eye examination is unremarkable. The optical coherence tomography revealed the presence of pigmented epithelial detachment. Humphrey visual field showed a central scotoma in her left eye. Fluorescein angiography revealed normal perfusion, with no capillary fallout and a masking effect of pre-retinal haemorrhage. A thorough evaluation for underlying aetiology revealed severe iron deficiency anaemia attributable to menstrual loss with haemoglobin 5.2g/dl. Her blood sugar, blood pressure, lipid profile, carotid doppler, echocardiogram, coagulation profile, infective screening, and immunological workup were unremarkable. She was treated with packed cell transfusion, in addition of oral and intravenous iron supplementation. At 3 months of follow-up, visual acuity in the left eye remained static despite retinal whitening and retinal haemorrhages resolved.

Conclusion

Cilioretinal artery occlusion is a very rare complication of iron deficiency anaemia. It can be a complication of anaemic retinopathy and can lead to severe visual loss without early treatment.

ABSTRACT ID: 328
FLAVOBACTERIUM LINDANITOLERANS AS A RARE CAUSE OF ENDOGENOUS ENDOPHTHALMITIS

Maggie Ng Boon Yee[1], Carynn Ng Mae Li[1]

[1]Hospital Ampang

Purpose

We report a case of endogenous endophthalmitis secondary to a rare causative pathogen, Flavobacterium lindanitolerans, which is an extremely rare human pathogen that have been linked to cases of pneumonia and meningitis as opportunistic infections.

Methods

Case report.

Results

A 42-year-old female with underlying type 2 Diabetes mellitus defaulted follow up and treatment presented with redness and floaters for 2 weeks. She denies pain and discharge with no history of trauma. She also complained of malaise and lethargy past 3months with no fever or respiratory or abdominal symptoms. Upon examination, visual acuity (VA) right eye (RE) was CF1FT with left eye (LE) 6/60 PH 6/18. RE was injected with keratic precipitates on corneal endothelium and anterior chamber reaction of 3+ with central fibrin and hypopyon level 1mm. There was anterior vitreous cells 3+ with dense vitritis and poor fundal view. LE examination showed no infection but noted to have proliferative diabetic retinopathy changes. Once diagnosis of RE endophthalmitis was established, we proceeded with vitreous tapping and intravitreal antibiotic (IVT) Vancomycin and Ceftazidime injection. Vitreous culture grew Flavobacterium lindanitolerans sensitive to Ciprofloxacin and Ceftazidime. Given the likely hood of endogenous endophthalmitis, septic workup was done and was negative except urine culture that grew E. coli sensitive to Ceftazidime. With inpatient strict control of diabetes, intravenous Ciprofloxacin with repeated IVT antibiotics, patient's condition improved drastically to VA RE of 6/18.

Conclusion

Endogenous endophthalmitis is usually seen in patients with diabetes mellitus, immunosuppression, and other systemic pathologies. Clinician must be vigilant in these cases to ensure prompt diagnosis and treatment, crucial for best visual outcome.

ABSTRACT ID: 338
MALARIA RETINOPATHY IN A CASE OF CEREBRAL MALARIA KNOWLESI

Tiong Lik Wei[1], Nazima Shadaht Ali[2]

[1]Sarawak General Hospital; [2]Hospital Selayang

Purpose

Plasmodium knowlesi, a zoonotic malaria species prevalent in Southeast Asia, presents a significant diagnostic challenge due to its rapid progression and potential for severe complications, including cerebral malaria (CM).

Methods

A case report.

Results

A 57-year-old male with P. knowlesi CM and bilateral retinal haemorrhages. While the patient demonstrated a favourable outcome following prompt treatment, the case underscores the potential for multi-organ involvement and rapid clinical deterioration. Importantly, the retinal findings differed from the classic malarial retinopathy typically observed in children with P. falciparum CM, characterized by retinal whitening and specific vascular changes. This discrepancy suggests potential variations in the pathophysiological mechanisms underlying CM across malaria species and age groups. The absence of the characteristic malarial retinopathy in this adult patient with P. knowlesi CM raises questions about the diagnostic utility of retinal examination in adults and the need for further research to clarify the pathogenesis of retinopathy in different malaria species and age groups.

Conclusion

This case emphasizes the importance of prompt diagnosis and appropriate treatment for P. knowlesi and the need for further investigation into the clinical presentation and pathophysiological mechanisms of this increasingly prevalent infection.

ABSTRACT ID: 340
BILATERAL CYTOMEGALOVIRUS RETINITIS (CMVR) IN A CHILD WITH ACUTE LYMPHOBLASTIC LEUKEMIA (ALL) ON MAINTENANCE CHEMOTHERAPY

Sim Tze Shen, Adeline Low[1], Shelina Oli Mohamed[2]

[1]Sarawak General Hospital; [2]Universiti Teknologi MARA

Purpose

To report a case of bilateral CMVR in a paediatric patient during maintenance chemotherapy for ALL.

Methods

Case report.

Results

A 6-year-old boy with underlying precursor B-cell ALL CNS 3 high-risk status, was treated according to standard Berlin-Frankfurt-Munich (BFM) 2009 protocol for paediatric ALL. At week 15 of maintenance chemotherapy, his mother noted he cannot appreciate near objects and his left eye deviated outward. Left relative afferent pupillary defect (RAPD) was positive. The best-corrected visual acuity (BCVA) of his right eye was 6/60 and his left eye was no light perception (NLP). Fundus examination of both eyes showed multiple large yellow-white chorioretinal lesions with areas of intraretinal haemorrhages with no vitritis. His left eye showed a pale disc. Intraocular pressure was normal. A Cytomegalovirus (CMV) serum polymerase chain reaction (PCR) test revealed a high viral load of 55630. An induction dose of intravenous Ganciclovir 5mg/kg 12-hourly was given with both eyes biweekly intravitreal Ganciclovir 2mg/0.1ml for three weeks under monitored sedation. This was followed by maintenance oral Ganciclovir and weekly intravitreal Ganciclovir. He subsequently developed preretinal haemorrhage in right eye due to occlusive vasculitis and secondary neovascularization. Thus, he received pan-retinal laser photocoagulation. Eventually, patient's right BCVA improved to 6/45 with a decreasing trend in his CMV viral load. Left eye remained NLP.

Conclusion

CMVR is a potential visual threat in immunocompromised patients. Physicians should do CMV screening for paediatric patients with ALL on maintenance chemotherapy as paediatric patients can barely complain of their visual symptoms, resulting in late presentation. Early diagnosis and prompt treatment is important to preserve vision and prevent future visual morbidity.

ABSTRACT ID: 344

NO CONNECTION, JUST COINCIDENCE: BILATERAL ACUTE RETINAL NECROSIS IN AN IMMUNOCOMPETENT PATIENT WITH A HISTORY OF OCULAR TB

Nur Athirah Adnan[1], Brindha Gulendran[1]

[1]Hospital Tuanku Ampuan Najihah

Purpose

To report a rare case of bilateral acute retinal necrosis secondary to Herpes Simplex (HSV) Type I in an immunocompetent patient with a coincidental history of treated right ocular TB.

Methods

Case Report.

Results

A 30-year-old immunocompetent man presented with left eye (LE) pan uveitis complaining of LE blurry vision for about 2 weeks duration. He had history of TB pleura with right multiloculated empyema with superimposed MRO Enterobacter septicaemia and treated right eye (RE) ocular TB with optic nerve involvement in 2020 and completed anti TB treatment for 8 months. He was initially treated as presumed recurrent ocular TB but clinical examination shown evidence of acute retinal necrosis. An anterior chamber paracentesis of the LE was performed, and the aqueous sample was positive for HSV Type I by polymerase chain reaction (PCR) and negative for Varicella Zoster Virus and Cytomegalovirus. The patient completed IV Acyclovir 10mg/kg TDS for 14days and discharge with oral T Acyclovir 800mg 5x/day for 4 months. His vision was improved which showed best corrected vision of right eye was 6/9 and 6/12 for the left eye.

Conclusion

This case highlights the occurrence of bilateral acute retinal necrosis in immunocompetent patient with a coincidental history of unilateral ocular tuberculosis. It underscores the importance of considering viral aetiologies in similar presentations, regardless of past TB history, to ensure timely and appropriate management.

ABSTRACT ID: 347
HIDDEN DANGER LIVING WITH FELIS CATUS- A CASE REPORT

Chiam Lee Yan[1], Zalilawati M[1], Norlaila Talib[1], Kamalden TA[2]
[1]Hospital Sultan Idris Shah Serdang; [2]Universiti Malaya Medical Centre

Purpose

We report a case of right eye neuroretinitis and left eye retinitis with good vision, which was eventually diagnosed as Cat-Scratch Disease (CSD) and discuss its management. CSD is caused by Bartonella henselae which is transmitted from feline to human via a scratch or bite that is contaminated with flea faeces. Patients typically presented with systemic symptoms such as fever and unilateral lymphadenopathy. About 5-10% of patients will develop ocular bartonellosis.

Methods

Case report.

Results

A 31-year-old Malaysian male, presented with acute frontal headache, nausea and vomiting for two days, without other neurological or ocular symptoms. Visual acuity on presentation was 6/6 in both eyes, which dropped to 6/9 in the right eye over the next 2 days. Relative afferent pupillary defect were negative and optic nerve function tests were normal in both eyes. Right eye optic disc was swollen with bilateral eyes retinitis spots upon presentation, with macular star seen the following week. Bjerrum tests showed enlarged blind spot in the right eye with subsequent centrocecal scotoma. Further history revealed that patient has cats at home. Bartonella immunoglobulin was later tested positive. Patient was treated with oral doxycycline and subsequently showed improvement of scotoma.

Conclusion

Patients with neuroretinitis without a decline in vision should raise a suspicion of CSD especially when other infective causes were excluded. Histopathological and serological tests are diagnostic. Visual field testing, fluorescein angiography and optical coherence tomography can aid in ophthalmic examination. CSD mostly is self-limiting, however oral doxycycline can be prescribed for systemic and ocular complications.

ABSTRACT ID: 354
GET A GRASP ON MULTIPLE EVANESCENT WHITE DOT SYNDROMES

Ariana Syamsidi[1], Mohd Fahdil Abdul Zaim[1], Muhammad Hazim Sharum[1], Wai Yong Zheng[1], Nurhayati Abdul Kadir[1], Chiang Wai Seng[1]

[1]Hospital Duchess of Kent

Purpose

To have a better understanding in managing Multiple Evanescent White Dot Syndromes (MEWDS).

Methods

Case Report.

Results

47 years old lady with known case of diabetes mellitus and hypertension presented with painless left eye (LE) blurring of vision (BOV) for the past 2 weeks. LE visual acuity (VA) is 6/18 with grade 2 relative afferent pupillary defect (RAPD). Anterior segment is unremarkable. Fundus examination showed hyperaemic, swollen optic disc, numerous small white greyish lesions at the level of the deep retina/choroid located at the posterior pole but sparing the fovea with granular changes within the fovea. Fundus auto fluorescence (FAF) showed multiple hyperautofluorescence spot at the posterior pole. Blood parameters and imaging were normal. Following 10 weeks, her signs and symptoms resolved without treatment with VA of 6/9.

Conclusion

MEWDS is an uncommon idiopathic self-limiting inflammation of the retina and choroid which has an excellent prognosis. Diagnosis can be difficult, as objective findings may be subtle. So, it is important to accurately diagnose and differentiate it from other retinal condition that can present similarly but required further workout and treatment.

ABSTRACT ID: 357
CYTOMEGALOVIRUS (CMV) RETINITIS IN A PATIENT RECEIVING LONG-TERM IMMUNOSUPPRESSIVE THERAPY

Renugkha N[1], Reena K[1], Murshidah HB[1]

[1]Hospital Sultan Idris Shah Serdang

Purpose

To report a case of CMV retinitis in a patient on long-term oral steroids and mycophenolate mofetil (MMF).

Methods

Case report.

Results

A 38-year-old gentleman who was being treated with mycophenolate mofetil (MMF) and long-term oral prednisolone for immune complex mediated glomerulonephritis, was under Ophthalmology follow-up for bilateral eye steroid-induced glaucoma and cataract. During his follow-up, he complained of 1-month duration of right eye floaters and glare with a recent history of varicella zoster virus (VZV) infection over his trunk and limbs, which was treated with oral acyclovir. Examination showed visual acuity of 6/9 (OD) and 6/6 (OS). Intraocular pressure was within normal range. The right eye showed anterior chamber (AC) inflammation. Fundus examination revealed the presence of haemorrhagic retinitis and vasculitis inferonasal to the optic disc with no vitritis. In view of the recent VZV infection, the patient was initially treated for Acute Retinal Necrosis (ARN) with intravenous acyclovir, however, his retinitis worsened. AC tap results returned positive for CMV-DNA. A diagnosis of CMV retinitis was made and he was treated with renal-adjusted dose of intravenous ganciclovir and intravitreal ganciclovir biweekly, with which the patient showed favourable scarring up of the retinitis. The Nephrology team diagnosed the patient with lipoprotein glomerulopathy as there was no evidence of immune complexes in his recent renal biopsy, and discontinued MMF and prednisone therapy.

Conclusion

CMV retinitis may be considered as a typical presentation in patients on long-term immunosuppressive therapy and require close monitoring and a multidisciplinary approach.

ABSTRACT ID: 361

"THE RETINAL TUG-OF-WAR": EALES DISEASE COMPLICATED BY TUBERCULOSIS AND TRACTIONAL RETINAL DETACHMENT

Bavithira Balasubramaniyam[1], Fazliana Ismail[1], Annuar Zaki Azmi[2], Nor Azita Ahmad Tarmidzi[2]

[1]University Malaya; [2]Hospital Kuala Lumpur

Purpose

Eales disease (ED) is a rare retinal vasculitis often associated with vision-threatening complications such as retinal neovascularization and tractional retinal detachment (TRD). Although tuberculosis (TB) is an uncommon association, it can mimic or exacerbate the course of retinal diseases like Eales disease. This case highlights the diagnostic challenges and therapeutic management of bilateral Eales disease complicated by TB and associated with tractional retinal detachment.

Methods

A case report.

Results

A 19-year-old man presented with blurred vision and floaters in left eye for two weeks. On examination, visual acuity in the left eye was hand movement and 20/20 in the right eye. There was a positive relative afferent pupillary defect (RAPD) on the left eye. Fundus examination of right eye showed peripheral retinal perivasculitis with neovascularization. Left eye fundus showed tractional retinal detachment from 11 to 7 o'clock, macula off with retinal perivasculitis. Fluorescein angiography (FA) demonstrated typical features of vasculitis and leakage from retinal detachment area. Serum QuantiFERON-TB Gold (QFT) was taken and positive for TB infection. The patient was started on anti-tuberculosis regimen, and targeted laser photocoagulation was performed on areas of retinal ischemia. Subsequently, he underwent left eye vitrectomy surgery. Postoperatively, left eye vision improved to 1.0 logMAR (Snellen equivalent: 20/200) with stable retinal findings bilaterally.

Conclusion

This case highlights the complex interplay between Eales disease and tuberculosis complicated with tractional retinal detachment, emphasizing the need for systemic evaluation in retinal vasculitis cases. An early multidisciplinary approach, combining anti-tuberculosis therapy, laser treatment, and vitreoretinal surgery, is essential to prevent further vision loss and improve long-term prognosis.

ABSTRACT ID: 362

"THE BULLOUS TWIST" OF CENTRAL SEROUS CHORIORETINOPATHY IN SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): A CASE SERIES WITH CLINICAL INSIGHTS AND MANAGEMENT STRATEGIES

Bavithira Balasubramaniyam[1], Fazliana Ismail[1], Annuar Zaki Azmi[2], Nor Azita Ahmad Tarmidzi[2]

[1]University Malaya; [2]Hospital Kuala Lumpur

Purpose

Bullous central serous chorioretinopathy (bCSCR) is a rare and severe variant of CSCR, characterized by large bullous retinal detachments caused by subretinal fluid accumulation. This case series aims to highlight the clinical presentation, diagnostic methods, and treatment strategies for bCSCR, particularly in patients with systemic lupus erythematosus (SLE) .

Methods

A retrospective case series was conducted on two male patients with bCSCR in Hospital Kuala Lumpur. Optical coherence tomography (OCT) and fluorescein angiography (FFA) were performed to assess retinal structure and choroidal leakage patterns. Clinical features, imaging findings, treatment interventions, and visual outcomes were analysed.

Results

Two male patients, who had underlying SLE on chronic steroid therapy, with one having a history of renal transplant. The primary symptom was progressive blurred vision. Examination revealed reduced visual acuity bilaterally with bullous retinal detachment. Fluorescein angiography revealed classic leakage patterns from choroidal vessels, and OCT showed extensive subretinal fluid. Both patients received FFA guided focal laser at the first visit. The following treatment included steroid cessation and observation in one patient, and PPV/SRF drainage in the second patient (post renal transplant, without steroid cessation). Follow-up was done for 1 year with a mean improvement in best-corrected visual acuity (BCVA) of 0.4 logMAR (Snellen equivalent: 20/50). During the subsequent follow-up, the OCT showed no recurrent bullous detachment. However disrupted photoreceptor layer was seen.

Conclusion

Bullous CSCR is a vision-threatening CSCR variant, often associated with chronic steroid use in SLE patients. This case series underscores the importance of early diagnosis, individualized treatment strategies, and long-term monitoring to optimize visual outcomes.

ABSTRACT ID: 368

RARE CASE OF LEFT EYE PURTSCHER RETINOPATHY FOLLOWING HISTORY OF RIGHT EYE ENDOGENOUS PANOPHTHALMITIS - A CASE REPORT

Azzahra Muhamad Asri[1], Tan KS[1], Norlaila Talib[1], Othmaliza Othman[2]

[1]Hospital Sultan Idris Shah; [2]Hospital Canselor Tuanku Muhriz

Purpose

To report a rare case of left eye Purtscher retinopathy following history of right endogenous panophthalmitis.

Methods

Case report.

Results

A 61-year-old gentleman with uncontrolled diabetes mellitus and hypertension presented with right eye redness and blurring of vision for 5 days preceded by left lower limb redness. No history of trauma. Systemic examination showed he had lower limb cellulitis with sepsis. His visual acuity right eye was light perception and left eye was 6/9. He was diagnosed with right eye Staphylococcus aureus endogenous panophthalmitis with choroidal abscess and he underwent enucleation. Intravenous cloxacillin was commended with intravenous ciprofloxacin and intravitreal antibiotics. His left eye showed no anterior chamber activity. Fundus examination showed multiple whitish superficial retina lesions at the posterior pole. However, he had no vitritis, retinitis or choroiditis. Case reviewed by medical retina team, initially he was treated as left eye endogenous endophthalmitis. However, vitreous tapping showed no organism, and the whitish lesions were increasing in size and amount despite being given multiple intravitreal antibiotics. Re-examination by medical retina team showed the multiple superficial retinal lesions were cotton wool spots. OCT macula showed hyperreflective foci over inner retina with no subretinal fluid/intraretinal fluid. FFA showed masking over cotton cool spots with no vasculitis or capillary fallout. Thus, the revised diagnosis was left eye Purtscher retinopathy secondary to underlying sepsis.

Conclusion

The history of Purtscher retinopathy should not be ignored in complex clinical contexts even when there is no history of trauma. Hence, all cases with cotton wool spots should be viewed with high suspicion of Purtscher retinopathy.

ABSTRACT ID: 372

ENDOGENOUS ENDOPHTHALMITIS AND WIDESPREAD MULTIORGAN INVOLVEMENT: THE HIDDEN DANGER OF KLEBSIELLA PNEUMONIA

Nur Sofia Hafifi Zulkifly[1,2], Muhd Syafi Abd Bari[1,2], Khairul Anwar Ibrahim[1,2], Aidila Jesmin Jabbari[1,2]

[1]Sultan Ahmad Shah Medical Centre; [2]International Islamic University of Malaysia

Purpose

To present a case of endogenous endophthalmitis caused by Klebsiella pneumonia with multiorgan involvement, emphasizing the importance of early detection and treatment.

Methods

Case Report.

Results

A 74-year-old gentleman with underlying diabetes mellitus, hypertension, and ischemic heart disease was admitted for septic shock secondary to Klebsiella pneumonia and Type 2 myocardial infarction. Four days later, developed worsening right eye blurry of vision. The patient had previous cataract surgery on both eyes three years ago, with good postoperative vision. On ocular examination, no relative afferent pupillary defect (RAPD). Visual acuity of right eye was light perception, while the left eye 6/6 vision. The right conjunctiva was injected, cornea oedematous with endothelial striations, no keratic precipitates, posterior synechiae, or iris nodules. Anterior chamber deep, cells 4+, no hypopyon with stable posterior chamber intraocular lens. Fundus was hazy due to vitritis. B-scan ultrasonography revealed loculation in vitreous. Left eye finding was unremarkable. Abdominal ultrasound revealed a liver abscess, which was subsequently drained percutaneously to remove the abscess collection. In view of patient's recent myocardial infarction, vitrectomy was not performed. Conservative management was considered, and after three intravitreal injections of vancomycin and fortum, the eye remained static

Conclusion

Endogenous endophthalmitis is a serious eye infection that occurs when bacteria from systemic infection spread to the eye. The patient's underlying conditions, including diabetes and heart disease, made him more vulnerable to infections. Conservative treatment was considered due to recent myocardial infarction. Treatment for the liver abscess also contributed to his stabilization. Although the vision did not improve, the eye remained stable, highlighting the importance of timely intervention.

ABSTRACT ID: 376

FROM RENAL TO RETINA: BILATERAL EYE EXUDATIVE RETINAL DETACHMENT IN YOUNG PATIENT WITH RENAL ANOMALY

Siti Eliza Darussalam[1], Brindha Gulendran[1], Khairul Husnaini Mohd Khalid[1]

[1]Hospital Kuala Pilah

Purpose

To report a case of bilateral exudative retinal detachment in malignant hypertension.

Methods

Case Report.

Results

A case of 21 years old Malay man with underlying end-stage renal failure secondary to obstructive uropathy due to posterior renal valve anomaly. He presented to our centre with both eye painless blurring of vision gradually worsening for the past 1 month associated with throbbing headache for past 2 weeks. Upon arrival his blood pressure was 214/130 with bilateral pedal oedema and bibasal lungs crepitations. Otherwise, he was alert and conscious. On eye assessment, both eye vision was hand movement with positive relative afferent pupillary reflex over right eye. Anterior segment was unremarkable with normal intra-ocular pressure. Fundoscopy revealed both eyes have swollen optic disc with sub-retinal exudates over macula and extensive exudative retinal detachment with total detachment over right eye. Patient was admitted for blood pressure optimisation and started on intravenous infusion glyceryl trinitrate. He was stabilised and subsequently patient claims vision improving and fundoscopy revealed reducing both eye exudative retinal detachment over the periphery however his vision remains unclear.

Conclusion

Exudative retinal detachment was due to blood retinal barrier disruption causing accumulation of fluid in subretinal spaces. There are many causes that can lead to this presentation but in this case, we are discussing regarding the vascular aetiology such as malignant hypertension. There must be immediate intervention to prevent secondary complication that can be vision threatening as it can lead to permanent damage to photoreceptors and the retinal epithelium.

ABSTRACT ID: 381

A RACE AGAINST TIME: MANAGING ENDOGENOUS ENDOPHTHALMITIS IN LEUKAEMIA WITH RAPID PROGRESSION

Fathin Maisarah Jamaludin[1], Nur Aimi Najiah Sukur[1], Noor Amalina Saidi[1], Maizan Yaakub[1], Rosiah Muda[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To report a case of endogenous endophthalmitis with mixed infection in high-risk refractory acute myeloid leukaemia.

Methods

Case report.

Results

A 14-year-old Malay girl with high-risk refractory acute myeloid leukaemia (AML) who completed the first cycle of chemotherapy, undergoing treatment for candidemia secondary to an infected catheter. She complained of a one-day history of right eye redness. Her visual acuity was 6/6 bilaterally. Anterior segment examination was normal, but the fundus revealed the presence of bilateral multifocal chorioretinitis with right eye vitritis. The diagnosis of bilateral candida endogenous endophthalmitis was made. She initially refused intravitreal injection and was started on two topical antifungals alongside intravenous anidulafungin. Unfortunately, two days later, right eye vision deteriorated to 6/60, with a new large subretinal abscess noted at the macula with increasing vitritis. However, the initial chorioretinal lesions in both eyes were improved. Blood culture was repeated as the patient had recurrent spiking fever and grew Staphylococcus epidermidis. She had two intravitreal antibiotics and antifungal injections and only consented to vitrectomy three weeks later due to worsening of the right eye condition. Meanwhile, the patient had multiple systemic therapy interruptions due to difficult intravenous access. There was no organism isolated from the vitreous samples. Postoperatively, her right eye infection slowly improved, and vision remained at hand movement, while the left eye maintained at 6/6.

Conclusion

Leukaemic patients predispose to mixed infections of endogenous endophthalmitis, and it can progress rapidly. Therefore, non-aggressive antimicrobial therapy and delayed intervention may lead to irreversible vision loss.

ABSTRACT ID: 382
BEWARE OF FIRECRACKERS, THE "SNEAK THIEF OF SIGHT"

Rubahshini Gunaseelan[1], Seow Sieng Teng[1], Nor Fadzillah Abd Jalil[1]

[1]Hospital Melaka

Purpose

We report a case with bilateral eyes injuries secondary to a firecrackers blast injury in a young patient.

Methods

Case report

Results

A young male with underlying eczema and learning disability presented to the emergency department after alleged firecracker blast injury to both eyes, sustained while igniting a firecracker that unexpectedly exploded to his face. On examination, visual acuity was light perception for both eyes with normal intraocular pressure. Both eyes sustained periorbital hematoma with singed eyelashes. The right eye showed a partial thickness corneal laceration wound with a subtotal epithelial defect, traumatic uveitis, iridodialysis, and a streak of blood and vitreous in the anterior chamber. The left eye sustained conjunctiva laceration, corneal subtotal epithelial defect, traumatic anterior uveitis, traumatic mydriasis, and a streak of hyphaemia. The bilateral fundus view was hazy. B-scan revealed bilateral eyes with dense vitreous haemorrhage with a flat retina. Subsequent right eye's optical coherence tomography revealed choroidal rupture. He underwent examination under anaesthesia, and conjunctival toileting and suturing. He was treated for indirect traumatic optic neuropathy with intravenous methylprednisolone and tapering oral prednisolone. Subsequently, his right eye developed secondary traumatic glaucoma with cataract. Hence, intracapsular cataract extraction with iridodialysis repair was done, and left aphakic. 6-month post trauma his best-corrected vision improved to right eye 1/60 and left eye was 6/30.

Conclusion

Firecrackers can lead to severe eye injuries. Public awareness about the safe handling of firecrackers and the potential severity of eye injuries caused by them can help lower the incidence of serious harm.

ABSTRACT ID: 407

BEYOND THE SKIN:RETINAL MANIFESTATIONS OF PHAKOMATOSIS IN STURGE-WEBER SYNDROME

Nur Sofia Hafifi Zulkifly[1 2], Khairul Anwar Ibrahim[1 2], Khairidzan Mohd Kamal[1 2]

[1] Sultan Ahmad Shah Medical Centre; [2] International Islamic University Malaysia

Purpose

To report a case of Sturge-Weber Syndrome with associated retinal lesions due to phakomatosis and to explore their implications for patient outcomes and treatment strategies

Methods

Case Report

Results

A 26-year-old woman with a history of Sturge-Weber Syndrome, diagnosed at age 18, presented with progressive vision loss in the right eye in September 2023.She denied experiencing floaters, flashes of light, or any history of trauma or eye surgery.On general examination, a port-wine stain was observed over the right forehead extending to the lower eyelid.Ocular examination revealed a right eye relative afferent pupillary defect (RAPD) grade 1.Visual acuity in the right eye was reduced to hand movements, while the left eye retained 6/6 vision.Intraocular pressure was measured at 12.7mmHg in the right eye and 15.8mmHg in the left eye using air-puff tonometry.A bluish-purple discoloration of the right conjunctiva was noted, with the cornea, anterior chamber, and lens remaining clear. Fundus examination of the right eye revealed extensive subretinal fibrosis involving the optic disc and posterior pole, without any subretinal fluid, hemorrhage, or feeder vessels.The left eye showed no significant findings.A CT scan of the brain and orbit was planned, however she defaulted on subsequent follow-up

Conclusion

Sturge-Weber Syndrome (SWS) is a rare disorder with significant ocular and neurological implications.Retinal lesions, such as subretinal fibrosis, are common in SWS and can cause visual disturbances, as seen in this patient.Timely detection and monitoring of retinal involvement are critical for managing vision loss.This case highlights the importance of early imaging and regular follow-up to prevent further complications in SWS, particularly when planning for pregnancy and delivery

ABSTRACT ID: 409

SHORT-TERM OUTCOMES OF INTRAVITREAL DEXAMETHASONE IMPLANT (OZURDEX®) FOR MACULAR EDEMA IN EARLY PRACTICE: A CASE SERIES

Sahel Akmal Che Mohd Hazidi[1], Abdul-Hadi Rosli[1], Aidila Jesmin Jabbari[1]

[1] International Islamic University Malaysia

Purpose

To evaluate the short-term outcomes of intravitreal dexamethasone implant (Ozurdex®) in patients with diabetic macular edema (DME) and pseudophakic cystoid macular edema (CMO), focusing on visual acuity (VA), intraocular pressure (IOP), and macular thickness (OCT) pre- and post-injection.

Methods

A retrospective case series of six patients who received Ozurdex for refractory DME (n=2) and pseudophakic CMO (n=4) was conducted. Two patients defaulted follow-up, leaving four cases with complete data. BCVA, IOP (Goldmann), and OCT macular thickness were recorded at baseline and 1 month post-injection

Results

Three out of four patients demonstrated improvement in visual acuity, with the most significant gains observed in pseudophakic CMO cases, where visual acuity improved from 6/60 to 6/18. OCT macular thickness showed a reduction in all cases, with a decrease from 609 µm to 271 µm in pseudophakic CMO and 402 µm to 340 µm in DME. No severe complications were reported.

Conclusion

Ozurdex® demonstrated short-term efficacy in reducing macular edema and improving VA in refractory DME and pseudophakic CMO, providing a steroid-based alternative where anti-VEGF therapy is insufficient. Larger studies with extended follow-up are needed to validate these findings.

ABSTRACT ID: 419
POST SURGICAL INDUCED SCLERITIS

Goh Yong Hui[1], Emily Ng MC[1]

[1] Hospital Selayang

Purpose

To report a rare case of surgical (phacoemulsification followed by ECCE) induced scleritis. Patient was successfully treated with systemic and topical immunosuppressant

Methods

Case report.

Results

A 71 year old lady with underlying diabetic mellitus and hypertension presented with Left eye pain and redness for the past 2 weeks. She had complicated phacoemulsification operation converted to ECCE with PCIOL in view of interoperation noted inferior zonulodialysis 5 week prior. Visual acquity reduce from 6/60 to CF1FT. Examination revealed conjunctivae chemosis, injected with dilated scleral vessels circumciliary, 4 cornea suture superiorly and clean, anterior chamber deep with occasional cells, ACIOL stable. IOP and fundus examination were unremarkable. B scan showed retina flat with significant scleral thickening of 2.18mm of left eye while right eye scleral thickness was 1.72mm. OCT macula unremarkable. Prior the result of relevant investigations to exclude other infectious causes, patient was started with oral corticosteroid with tapering dose, gutt pred forte 2hourly and empirical treatment gutt vigamox 2hourly. subsequently, a serial of relevant investigations result are available and normal to exclude infectious and autoimmune disease. Thus, patient was diagnosed post phacoemulsification followed by ECCE induced scleritis. She was continued with corticosteroid and the symptoms resolved after commencement of steroid.

Conclusion

Surgery-induced scleritis is a rare type IV hypersensitivity reaction or molecular mimicry triggered by previous surgical procedure. It is a clinical diagnosis based on history and clinical examination, though infectious causes, connective tissue and autoimmune disease must be ruled out by relevant laboratory testings. It can often be managed using immunosuppressants and achieve good remission.

ABSTRACT ID: 432

SHATTERED GLASS, SHATTERED VISION : OPEN GLOBE INJURY AND THE FIGHT AGAINST INFECTION

U Kern Rei[1], Goh Yong Hui[1], Inderpreet Kaur[1], Low Yi Huey[1], Logesvaran Murugan[1]

[1] Hospital Selayang

Purpose

We report a case of panophthalmitis post open globe injury from a motor vehicle accident(MVA).

Methods

Case report

Results

A 40-year-old man presented with right eye (RE) corneoscleral laceration wound, uveal prolapse with intraocular foreign body (IOFB) post MVA and shattering of windshield glass. Visual acuity (VA) was hand movement with positive reverse afferent pupillary defect. The RE extraocular movement (EOM) was normal. Computed tomography scan (CT) showed RE globe rupture with foreign body at anterior periorbital region. He underwent RE IOFB removal, corneascleral toilet and suturing, and intravitreal (IVT) Vancomycin and Ceftazidime. Immediate post operative B scan showed retinal detachment with suprachoroidal haemorrhage.

Patient was started on topical Vigamox and Predforte with intravenous (IV) Augmentin however on postoperative day 4 there was a sudden worsening of RE discharge, visual acuity reduced to light perception at 2 quadrants, lid swelling, proptosis, chemosis, and generalised restriction of EOM RE. B-scan showed retina detachment superiorly with scleral thickening, T sign, and vitreous hyperechogenicity. Clinical suspicion of RE panophthalmitis confirmed by a repeat CT scan. Conjunctiva swab and vitreous tapping was sent for culture and IVT Vancomycin with Ceftazidime were given. He was started on IV Ceftriaxone and Oral prednisolone 0.5mg/kg/day. Swab culture showed Burkholderia Seminalis and Staphylococcus Capitis. At one week post-treatment, RE lid swelling, redness, proptosis, and chemosis resolved with restoration of EOM.

Conclusion

The nature of open-globe injuries is unpredictable and carries poor visual prognosis. Clinicians must have a high suspicion of secondary infection in post-traumatic eye.

ABSTRACT ID: 434

VAPING – THE REAL EYE KILLER

Tham Yue Keen[1], Goh Yong Hui[1], Beatrice Chua Yoong Ni[1], Nurul Ashikin Abdullah[1]

[1]Hospital Selayang

Purpose

To report a case of Polypoidal Choroidal Vasculopathy (PCV) in young vaper

Methods

Case Report

Results

A 43-year-old healthy Sarawakian lady, who is an active chronic vaper, presented with a sudden onset of painless central blurred vision in her right eye, which worsened over a two-week period. She reported no history of recent ocular trauma, straining, or heavy lifting prior to the onset of symptoms.

On examination, visual acuity of the left eye was counting fingers and right eye is 6/9 with intact optic nerve function test. Right eye fundus large submacular haemorrhage obscuring the fovea with no evidence of drusen, orange nodule or any scar that suggestive of previous ocular trauma. The anterior segment of both eyes and left eye fundus were unremarkable. Optical coherence tomography (OCT) of the left macula showed a multilobulated Pigment Epithelial Detachment (PED) with subretinal haemorrhage consistent with typical findings on of Polypoidal Choroidal Vasculopathy (PCV). The patient was scheduled for an intravitreal anti-VEGF injection and responded well after 3 loading doses of intravitreal injections as evidenced by resolution of subretinal haemorrhage and flattening of the PED.

Conclusion

Polypoidal Choroidal Vasculopathy (PCV) in relatively young patient should be considered in a chronic smoker or vapor as it is one of the risk factors to develop it. To date, no research to investigate the potential link between e-cigarette use and PCV. Larger studies and evidence-based trials are essential to better understand this association.

ABSTRACT ID: 435
IRON DEFICIENCY ANAEMIA; A RARE CAUSE OF PURTSCHER-LIKE RETINOPATHY

Lim Jian Fu[1], Ng Hui Ruan[1], Krishnalatha Buandasan[1]

[1] Hospital Sultanah Nora Ismail

Purpose

This case report describes a 44-year-old woman who presented with Purtscher-like retinopathy (PLR) and incidentally diagnosed with severe iron deficiency anemia (IDA), emphasizing the importance of systemic evaluation in ocular pathologies.

Methods

The patient presented with complaints of both eye glaring for one week. Ophthalmic evaluation, including fundoscopy, revealed multiple flame shaped hemorrhages and peripapillary cotton-wool spots (CWS) consistent with PLR on both eyes. Routine laboratory tests identified severe IDA (hemoglobin: 7.6 g/dL). There was no history of trauma or long bone fracture. A thorough systemic workup excluded PLR-associated etiologies such as pancreatitis, coagulopathies, and connective tissue disorders. Management included oral iron supplementation, dietary modifications, and regular ophthalmic and medical follow-up.

Results

Over two months, the patient's hematologic parameters normalized, whilst patient's visual complaints resolved. Residual retinal changes began to resolve and there were no recurrence of symptoms.

Conclusion

This case highlights the critical role of systemic evaluation in patients PLR, as incidental findings such as IDA may coexist and exacerbate microvascular compromise. While the direct link between IDA and PLR remains unclear, interdisciplinary management ensured favourable outcomes.

ABSTRACT ID: 437

SEEING THE BEST IN BEST DISEASE: CLINICAL VARIABILITY AND PROGRESSION IN A CASE SERIES

Tan Chek Kuan[1], Tan Teik Wei[1], Hanizasurana Hashim[1], Nazima Shadaht Ali[1], Adeline Khaw Mae Li[1]

[1] Hospital Selayang

Purpose

To present a case series of Best disease, documenting its presentation and progression

Methods

Case series

Results

Best disease known as vitelliform macular dystrophy is a rare hereditary disease due to mutation in BEST 1 gene. It affects macula causing progressive central vision loss with characteristic egg-yolk appearance on macula and later progresses through different stages

Case 1: 31-years-old, Malay Male, came for eye screening because of family history of Best disease. His vision was 6/9 both eyes, asymptomatic. Fundus examination showed area of hypopigmentation near the macula. Optical coherence tomography (OCT) macula showed subretinal vitelliform lesion with subretinal-fluid. He was diagnosed with both eye Juvenile Best disease Vitteliiruptive stage (Stage 4).

Case 2: 54-years-old Malay female, complaint of both eye central loss of vision associated with metamorphosia for 6 months. Vision right-eye 6/36 left eye 6/24. Fundus examination noted right eye presence of egg yolk appearance of fovea and there was hyperpigmentation over the fovea over left eye. OCT macula shows both eye subretinal fluid. However, intravitreal injection was not offered because it has protective mechanism for the vision.

Case 3: 80-years-old Malay female, complaint of progressive worsening of both eyes vision for 10 years. Both eye visual acuity were 6/60. Fundus examination showed central well defined macula scar at macula area. OCT revealed chronic intrarretinal-fluid with macula hole and left eye fovea atrophy. She was diagnosed with both eye Best disease: atrophic stage (Stage 5).

Conclusion

Clinical presentation of Best disease is heterogeneous. Understanding of disease progression is important for early diagnosis and exploring treatment options.

ABSTRACT ID: 438

RIGHT EYE TRACTIONAL RETINA DETACHMENT SECONDARY TO OCULAR TOXOCARIASIS AND LEFT EYE OLD OCULAR TOXOPLASMOSIS

Siti Nur Baizury Hassan[1], Khairuddin Othman[1], Chai Huei Xian[1], Nor Falina Ahmad Tajuddin[1], Muhammad Farez Mukhriz Jefridin[1]

[1] Hospital Sultanah Bahiyah

Purpose

To report of an unusual case of right eye tractional retina detachment secondary to ocular toxocariasis and left eye old ocular toxoplasmosis

Methods

Case report

Results

A 30 years old male was a full term baby born, attended normal schooling however at 7 years old, he has poor vision and need to see near for reading, he was then referred to tertiary centre and was told to have both eye myopia with anisometropia in 2001

Patient was then use glasses and vision was corrected, however noted right eye worsening blurring of vision for the past six months

Upon examination,

Right eye refractions non cycloplegics (Counting finger 1 feet)

Left eye refractions -6.50 /-1.50 x170 (6/24)

Normal anterior segments with minimal posterior subcapsular cataract

Normal intraocular pressure of both eye

Upon dilatation of right eyes, noted right eye retinal detachment with proliferative vitreoretinopathy changes, abnormal vitreous traction at macula, no break or hole seen, subretinal scar temporal to macula, folded retina involving posterior pole.

Upon dilatation of left eyes noted tilted disc with atrophic macula, 3 large hyperpigmented punch out lesion at inferotemporal arcade, macula coloboma and macula scars

Toxocara serology has been sent and came back as IgG positive:0.367OD and toxoplasma gondii IgG came back as reactive

Conclusion

The above case highlights the importance of clinical suspicion of ocular toxocariasis and ocular toxoplasmosis despite in an adult patient with reduce vision as its first presentation. Prompt investigations, managements and the approach of surgical intervention can provide better clinical outcomes

ABSTRACT ID: 445

NAVIGATING CHALLENGES IN MANAGING CHOROIDAL HEMANGIOMA : A CASE SERIES

Mohd Amirul Fauzi bin Ibrahim[1], Siti Zaitihani Hamdan[1]

[1] Hospital Selayang

Purpose

To report a case series of choroidal hemangioma with varying response towards the treatment provided.

Methods

Case series

Results

Case 1

58 year old male, presented with right eye progressive blurring of vision for one month. The right eye visual acuity was 6/18 with normal anterior segment examination. Fundus examination revealed elevated diffuse hypopigmented lesion over the superotemporal subretina area.

Case 2

30 years old male, complaint of left eye reduced vision for one week. Left eye visual acuity was 6/36 with fundus examination demonstrated diffuse subretinal orange like lesion located superotemporal to optic disc.

Fundus fluorescein angiogram (FFA) of both patients demonstrated the same findings which is hyperfluorescence lesion increasing in intensity over time corresponding to the fundus finding. Optical coherence tomography (OCT) showed presence of subretinal fluid (SRF) over the macula. Both patients were started on photodynamic therapy (PDT), and intravitreal anti Vascular endothelial growth factor (VEGF) injection, in which each patient responded to varying degrees.

Conclusion

Management of choroidal hemangioma presents challenges including the decision to choose the optimal treatment modality based on size and location of the lesion, potential treatment complications, and variable response towards the treatment.

ABSTRACT ID: 446

VARICELLA ZOSTER VIRUS UVEITIS: A CHALLENGING MIMIC OF ENDOPHTHALMITIS IN CLINICAL PRACTICE

Thanusha Ganasalingam[1], Damia Faiqah binti Mohamad Shahbodin[1], Chew Chia Chee[1], Rohana binti Taharin[1]

[1] Hospital Bukit Mertajam

Purpose

To report a case of severe varicella zoster virus (VZV) associated uveitis mimicking endophthalmitis in an immunocompetent adult

Methods

Case report

Results

A 30-year-old male with generalized anxiety disorder and bipolar disorder presented with left eye(OS) redness and blurred vision for 4 days, following a rash on the left side of his face. He reported a history of possible ocular trauma from a foreign object while riding motorbike. Examination revealed crusted lesion on the left side of his forehead extending to the nose tip. OS visual acuity(VA) was light perception, with negative relative afferent pupillary defect(RAPD) and reduced corneal sensation. Anterior segment examination showed conjunctival hyperemia, corneal edema, keratic precipitates, and hypopyon. The anterior chamber was deeper than the right eye, with 4+ cells, and intraocular pressure(IOP) was 24 mmHg with no fundus view and B-scan revealed dense vitritis. Contrast-enhanced computed-tomography of the brain/orbit ruled out intraocular foreign bodies as penetrating injury was suspected.

A vitreous tap was performed and intravitreal antibiotics was administered. Viral polymerase chain reaction(PCR) revealed VZV with a load of 343,893 copies/mL. The diagnosis of VZV uveitis was made. Serology for syphilis and HIV was positive and patient was referred to medical team for appropriate management. The patient was started on topical steroids, intravenous acyclovir, and oral prednisolone. Follow-up showed improvement with resolution of anterior chamber reaction, resolving vitritis, and peripheral retinitis. Best corrected VA improved to 6/24. Unfortunately, the patient defaulted subsequent follow-up.

Conclusion

VZV-associated uveitis can present with a broad and sometimes unusually severe clinical spectrum, in this case mimicking endophthalmitis.

ABSTRACT ID: 455

SIX-MONTH REAL-WORLD OUTCOME OF INTRAVITREAL FARICIMAB IN PREVIOUSLY TREATED NEOVASCULAR AGE-RELATED MACULAR DEGENERATION

Tanusha Dorairaja[1], Rajasudha Sawri Rajan[1], Daphne Teh Ai Lin[1], Roslin Azni Abdul Aziz[1]

[1] Hospital Shah Alam

Purpose

Faricimab, a bispecific antibody targeting VEGF-A and angiopoietin-2, has demonstrated significant potential in the treatment of neovascular age-related macular degeneration (nAMD). This study aims to evaluate the six-month outcomes of Faricimab in nAMD patients who were switched from prior treatments and were unsuccessful in maintaining treatment intervals beyond eight weeks with other anti-VEGF agents.

Methods

This single-center, prospective, observational study was conducted from January 2024 to December 2024. Patients switched to Faricimab for nAMD were assessed for best-corrected visual acuity (BCVA), central subfield thickness (CST), polyp regression, and treatment intervals at baseline and at the six-month follow-up.

Results

A total of 32 patients (32 eyes) were included in the study. At the six-month assessment, 59.4% (n=19/32) of patients showed improvement/stability in BCVA, with a mean CST reduction of 24.0 µm. At baseline, 20 patients (62.5%) exhibited polyps on indocyanine green angiography (ICGA), and polyp regression was observed in 35% (n=7) at six months. Regarding treatment intervals, 68.7% (n=22/32) of patients were able to extend their intervals from previous treatments at six months, with 65.6% (n=21/32) successfully transitioning to intervals exceeding eight weeks. Importantly, no adverse events associated with the use of Faricimab were reported during the study.

Conclusions

In our cohort of switched patients, Faricimab demonstrated stability in visual acuity, significant improvement in CST, and the ability to extend injection intervals. Further long-term follow-up is necessary to assess the potential for continued extension of treatment intervals while maintaining efficacy and safety.

ABSTRACT ID: 458

A 3-YEAR RETROSPECTIVE STUDY ON SCLERITIS AT MEDICAL RETINA REFERRAL CENTRES IN NEGERI SEMBILAN AND HOSPITAL CANSELOR TUANKU MUHRIZ

Sai Priyalatha Mariapan[1], Mae-Lynn Catherine Bastion[1], Wan Mohd Hafidz bin Wan Abdul Rahman[2], Sangeeta Kuganasan[2]

[1] Hospital Canselor Tuanku Muhriz UKM; [2] Hospital Tuanku Ja'afar Seremban

Purpose

To determine the demographic profile, common presentations, etiology, course of disease, management, and visual outcomes of scleritis in adults at Medical Retina centres in Negeri Sembilan and Hospital Canselor Tuanku Muhriz in the last 3 years.

Methods

Medical records for 95 eyes of 72 patients diagnosed with scleritis were retrospectively reviewed.

Results

68.1% patients had unilateral involvement and 68.1% were females, with a peak age between 31 to 40 years old. 36.1% presented with red eye and pain as the most common symptoms. Diffuse anterior scleritis in 42 patients (65.7%) is the most common type of scleritis. Ocular complications were detected in 22.2% of patients, including cataract (13.9%), raised intraocular pressure without glaucoma (9.7%), glaucoma (5.6%) and corneal involvement (2.8%). Among 11 patients with infectious cause, tuberculosis was the most common infection (63.6%) while rheumatoid arthritis was the commonest autoimmune cause (8.3%) associated with scleritis. 83.3% of patients were treated with oral non-steroidal anti-inflammatory drugs and 81.9% with topical steroids, while 8.3% required second-line immunosuppressive agents. 9.7% received anti-tuberculosis therapy. Median BCVA on presentation for the different types of scleritis was 0.18, while final BCVA at 1-year post-treatment, the median was 0.00 for diffuse and nodular anterior scleritis, 0.18 for posterior and necrotizing anterior scleritis without inflammation. 83.3% recovered well with treatment, while recurrence occurred in 23.6%.

Conclusion

This study found that the majority of cases were unilateral, with diffuse anterior scleritis being the most common subtype. Female patients comprised a larger proportion. Bilateral involvement emerged as a significant risk factor for recurrence, with a good overall visual prognosis.

ABSTRACT ID: 466

A CASE REPORT OF CONCURRENT OCULAR SYPHILIS AND CYTOMEGALOVIRUS RETINITIS IN HIV POSITIVE PATIENT

Sia Chye Chee[1], Nurul Farah Huda binti Shahrudin[1], Muhammad Ariff bin Shaharuddin[1]

[1] Hospital Sultan Haji Ahmad Shah

Purpose

To discuss a case of concurrent ocular syphilis and CMV retinitis in a newly diagnosed HIV positive patient.

Methods

Case report.

Results

A 63 years old Malay gentleman with a known case of diabetes mellitus, hypertension and seronegative rheumatoid arthritis presented with sudden onset of right eye (RE) pain, associated with blurring of vision. Ocular examination showed RE visual acuity was hand movement(HM) with good vision of 6/9 over the left eye. RE revealed features of panuveitis which clinically suggestive of syphilitic uveitis and cytomegalovirus (CMV) retinitis. Serologic testing confirmed the presence of positive HIV and active syphilis infection. The patient was subsequently treated as RE ocular syphilis with cytomegalovirus retinitis in a newly diagnosed HIV positive. He was started on systemic penicillin for neurosyphilis and ganciclovir for CMV retinitis, concurrently. Upon completion of treatment, his vision improves from HM to 6/36, with pinhole 6/18. Apart from the targeted eye therapy given, he was also initiated on antiretroviral therapy for his recently discovered HIV.

Conclusion

Ocular syphilis and CMV retinitis are both opportunistic infections that can occur in patients with advanced, particularly those with newly diagnosed HIV. While each condition is well-documented individually, concurrent presentation is rare and poses a significant diagnostic and therapeutic challenge.This case highlights the importance of considering multiple opportunistic infections in HIV-infected individuals with ocular manifestations.

ABSTRACT ID: 471

NODULAR ANTERIOR SCLERITIS ASSOCIATED WITH LATENT TUBERCULOSIS

Nur Diyana Syahirah binti Abdul Halim[1], Muhammad Adib bin Redzuan[2], Nurliyana Ain Abdul Ghani[3]

[1] UiTM Kampus Puncak Alam; [2] Hospital Al-Sultan Abdullah, Universiti Teknologi MARA; [3] Universiti Teknologi MARA

Purpose

Nodular non-necrotizing anterior scleritis is a painful inflammatory condition affecting the sclera, often linked to autoimmune disorders or occurring without a known cause. In uncommon instances, it can be associated to systemic infections like tuberculosis.

Methods

Case report.

Results

This report presents a case of a 42-year-old woman, with no prior medical conditions, who developed painful, unilateral nodular non-necrotizing anterior scleritis. A thorough evaluation ruled out other possible causes, and she was diagnosed with latent tuberculosis based on a positive QuantiFERON-TB test, despite a negative tuberculin skin test. She showed significant improvement with antitubercular treatment.

Conclusion

Although tuberculosis is an uncommon cause of scleritis, diagnosing inflammation secondary to extraocular tuberculosis, especially in latent cases, can be challenging. A strong suspicion is essential for prompt treatment. A positive QuantiFERON-TB test, even with a negative tuberculin skin test, helps confirm the diagnosis. Additionally, a favorable response to antitubercular therapy without relapse further validates the diagnosis.

ABSTRACT ID: 484
DUAL VASCULAR INSULT: A THREAT TO VISION

Thiruvarasu A/L Gunasekaran[1], Tajunisah Iqbal[1], Jasvinjeet Kaur[2], Fatimah SS[2]
[1]Universiti Malaya; [2]Hospital Tengku Ampuan Afzan

Purpose

To report a case of combined ocular ischemic syndrome (OIS) with cilioretinal artery occlusion (CLRAO).

Methods

Case report

Results

A 66-year-old diabetic male presented with four days history of sudden painful visual loss over his left eye (LE). Visual acuities were 6/9 in the right eye (RE) and CF in the LE. There was afferent pupillary defect in the LE. Slit-lamp examination of LE showed injected conjunctiva and a shallow anterior chamber with cells. Pupil was round and reactive with rubeosis around pupillary margin. The RE anterior segment was unremarkable. Both eyes (BE) were pseudophakic and the intraocular pressure (IOP) was 30 and 34mmHg, respectively. On gonioscopy, BE angle was open, but there was presence of new vessels at the angle in LE. Fundus examination of LE revealed a fully cupped disc and areas of retinal infarction in the region of occluded cilioretinal artery. Blot hemorhages were found at mid peripheral region, compatible with diagnosis of OIS. RE fundus showed pink disc with cup-to-disc ratio 0.7 and features of moderate diabetic retinopathy. Optical coherence tomography of LE revealed hyper-reflectivity of inner retinal layers corresponding to retinal infarction. Systemic examination revealed carotid bruit on both sides. Systemic work-up disclosed a poorly controlled diabetic status. The patient was treated promptly for retinal occlusion but without visual recovery. He was started on topical IOP lowering agents and panretinal photocoagulation session for LE.

Conclusion

Being a rare entity, this case highlights the co-occurrence of CLRAO with OIS and underscores the importance of identifying a common underlying cause.

ABSTRACT ID: 487

BREAKING THE THRESHOLD: CMV RETINITIS IN HIGH CD4 COUNTS WITH UNCONTROLLED DIABETES.

Nor Sahaila Binti Nor Hassan[1], Mohamad Muslim Bin Jamian[1], Shahrul Bariah Binti Mohd Ghazali[1]

[1]Hospital Pakar Sultanah Fatimah

Purpose

To highlight incidence of CMV retinitis despite high CD4 counts.

Methods

A case report.

Results

Cytomegalovirus (CMV) retinitis is uncommon in HIV patients with CD4 counts >200 cells/μL. We report a 47-year-old man underlying uncontrolled Diabetes and recently diagnosed HIV with CD4 of 360 cells/μL presenting with right eye blurred vision for 2 weeks. At presentation, right eye vision was light perception with positive RAPD. Anterior segment of right eye showed anterior uveitis with keratic precipitates. Fundus examination of right eye demonstrated vitritis, retinitis, retinal hemorrhages and vasculitis. Left eye showed diabetic retinopathy with retinitis changes. Both eyes vitreous tap sending for CMV PCR were positive confirming active cmv retinitis. The positive serum CMV PCR further confirm CMV infection. The patient was initiated on intravenous ganciclovir (5 mg/kg/day) and intravitreal ganciclovir, resulting in resolution of lesions from ophthalmoscopy. Risk factors for this include uncontrolled DM on top of his HIV status.

Conclusion

This case illustrates that CMV retinitis may occur despite higher CD4 counts especially if patient has other disease that cause immunosuppresion for instance Diabetes. Clinicians should maintain suspicion for atypical opportunistic infections even in immunologically competent HIV patients, emphasizing the role of CMV PCR in diagnosis and guiding therapy. Vigilant monitoring and prompt antiviral intervention are critical to prevent vision loss.

ABSTRACT ID: 507

MISDIAGNOSED BEHCET'S DISEASE: WHAT CAN WE DO?

Yap Jin Yi[1], Sheena Mary Alexander[2], Law Xing Yu[2]

[1] Universiti Malaysia Sabah; [2] Queen Elizabeth Hospital

Purpose

To report a case of recurrent panuveitis in a patient eventually diagnosed with Behcet's Disease.

Methods

Case Report.

Results

A 48-year-old woman with a history of gouty arthritis presented in February 2024 with left eye redness, pain, and blurred vision. Examination revealed anterior uveitis, retinitis, and vasculitis. Investigations, including blood tests, inflammatory markers, tuberculosis work-up, and autoimmune panels, were normal except for a 0 mm Mantoux test. She was treated with high-dose corticosteroids, and her panuveitis improved. Over the next year, she experienced multiple recurrences of left eye panuveitis, each resolved with corticosteroids. However, recurrent posterior uveitis led to tractional retinal detachment. Concurrently, she developed recurrent lower limb and perineal ulcers.

In February 2025, she was admitted for severe left eye panuveitis with mobile hypopyon and obstructed fundus view due to uveitis-related cataract and posterior synechiae. A B-scan showed tractional retinal detachment with subretinal exudates but no vitritis. The right eye exhibited mild anterior uveitis, retinitis, and vasculitis. A pathergy test was positive, and HLA-B51 testing was pending. She was diagnosed with Behcet's disease and treated with high-dose corticosteroids, resulting in improvement of her bilateral panuveitis.

Conclusion

This case highlights the importance of thorough history-taking and clinical examination in diagnosing Behcet's disease. Despite its rarity, early recognition and prompt treatment are crucial to prevent complications and improve outcomes.

ABSTRACT ID: 508

DOME-SHAPED MACULOPATHY WITH SEROUS RETINAL DETACHMENT: A CASE SERIES

Nadhirah Kharudin[1], Fatimah Nabilah Al-Fadhli Kamaruddin[1], Tanusha Dorairaja[1], Rajasudha Sawri Rajan[1], Roslin Azni Abdul Aziz[1]

[1]Department of Ophthalmology

Purpose

Dome-shaped maculopathy (DSM) is characterized by an anterior convex protrusion of the macula towards the vitreous cavity, as demonstrated by optical coherence tomography (OCT). Visual impairment associated with DSM may result from various changes, including retinal pigment epithelial (RPE) alterations, subfoveal serous retinal detachment, retinoschisis, and myopic choroidal neovascularization. This report presents three cases exhibiting DSM accompanied by serous retinal detachment.

Methods

We conducted a retrospective case series analysis involving three patients diagnosed with DSM. Each patient was monitored for a minimum of six months, during which their responses to anti-VEGF treatment were meticulously documented.

Results

Baseline best-corrected visual acuity (BCVA) varied between 6/10 and 6/45. OCT imaging confirmed the presence of a dome-shaped macula with serous neurosensory retinal detachment, which was particularly prominent in two patients during horizontal scans. Fluorescein angiography revealed mild, diffuse hyperfluorescence attributed to RPE changes, but no signs of leakage were noted. All patients underwent anti-VEGF therapy, with follow-up periods extending from six months to four years; however, both BCVA and OCT findings demonstrated no significant change over time.

Conclusion

Dome-shaped maculopathy is a rare condition that may mimic other maculopathies causing serous retinal detachment. A radial OCT scanning protocol is recommended in suspected cases, especially in myopic patients presenting with subretinal fluid. In this series, all patients exhibited refractoriness to anti-VEGF treatment, suggesting that careful observation could be a valid management strategy. Further studies are warranted to evaluate long-term outcomes and optimize treatment approaches for DSM.

ABSTRACT ID: 510
BILATERAL CENTRAL SEROUS CHORIORETINOPATHY MASQUERADING AS VOGT-KOYANAGI-HARADA DISEASE

Chong Kar Yong[1], Lim Shim Ni[1], Michele Tey Shi Ying[1], Hayati Abdul Aziz[1]

[1]Hospital Sultanah Aminah

Purpose

To report a case of bilateral central serous chorioretinopathy (CSCR) mimicking Vogt-Koyanagi-Harada (VKH).

Methods

A case report.

Results

A 40-year-old Chinese lady with hypertension presented with right eye blurred vision for 3 months. Two months later, she developed left eye metamorphopsia with subsequent superior visual field defect. The patient had not taken any steroids or hormonal drugs but had been applying traditional “bao fu ling” cream for eczema for six months. She experienced work stress. There were no systemic symptoms of VKH. Slit lamp examination did not showed any inflammatory cells or other signs of uveitis in the anterior or posterior segments. Fundus examination and optical coherence tomography (OCT) revealed normal optic discs and presence of subretinal fluids (SRF) without septae at the fovea region with adjacent pigmented epithelial detachments (PED) in both eyes. Left eye also had serous retinal detachment (RD) inferotemporal to the fovea. Right fundus fluorescein angiography (FFA) showed pooling at parafoveal region without any leakage points, while left eye showed leakage points and a focus of smoke-stack appearance inferotemporal to fovea. The patient was diagnosed with bilateral CSCR and left eye was treated with argon laser. One month later, there was near resolution of SRF with flattening of PED over right eye, while the left eye showed flattening of PED and reduction in SRF with near resolution of serous RD.

Conclusion

Bilateral CSCR is uncommon and can mimic VKH in the acute stage of the disease. FFA, OCT imaging and clinical symptoms, are helpful in distinguishing between the two.

ABSTRACT ID: 511

A RARE CASE OF OCULAR TOXOPLASMOSIS WITH MENINGIOMA, SUSPICIOUS OF FOSTER KENNEDY SYNDROME: A DIAGNOSTIC DILEMMA

Teng Nien Shoon[1], Nurul Farah Huda Binti Shahrudin[1]

[1]Hospital Sultan Haji Ahmad Shah

Purpose

To study a rare case of ocular toxoplasmosis with meningioma, mimicking Foster Kennedy Syndrome

Methods

Case report.

Results

A 59-year-old lady with underlying diabetes mellitus and hypertension presented with sudden onset of left eye (LE) blurring vision for 1 week. Otherwise, no other significant history and patient was generally well. Upon examination, her LE visual acuity was 3/60 with pinhole 6/60, and right eye (RE) 6/18 with pinhole 6/9. Optic nerve function test for LE was significantly reduced with positive relative afferent pupillary defect and 70% reduction of light and red saturation. Both anterior segment examinations were normal. Fundus examination revealed a swollen optic disc (OD) in her LE and a normal OD in RE. Both eyes retina was flat with mild diabetic retinopathy. Visual field testing showed central scotoma in her LE. Brain imaging identified the presence of right frontal extra-axial lesion represent meningioma with mild mass effect to the adjacent brain parenchyma. Meanwhile, her serological testing confirmed the presence of toxoplasma infection. She was started on oral Azithromycin 500mg OD for 6 weeks. Neurosurgical team consultation confirmed the diagnosis of meningioma and was managed conservatively with yearly imaging schedule. Her LE vision improved to 6/24 post therapy.

Conclusion

Ocular toxoplasmosis is a common cause of posterior uveitis, while meningiomas are typically slow-growing intracranial tumors. The coexistence of these two conditions is exceedingly rare and poses a significant diagnostic challenge, especially presenting with features suspicious of Foster Kennedy Syndrome. This case highlights the importance of a multidisciplinary and comprehensive approach in evaluating visual disturbances with optic nerve involvement.

ABSTRACT ID: 512

RARE PRESENTATION OF VOGT- KOYONAGI- HARADA IN A PAEDIATRIC PATIENT- A CASE REPORT

Jonathan Goh Sheng Wei[1], Rajasudha Sawri Rajan[1], Roslin Azni Binti Abdul Aziz[1], Yeap Zhi Ling[2]

[1] Hospital Shah Alam; [2] UM Eye Research Centre (UMERC)

Purpose

Vogt–Koyanagi–Harada (VKH) disease is a T-cell-mediated autoimmune disorder characterized by bilateral granulomatous panuveitis with various systemic manifestations.

Methods

Case report

Results

A 7-year-old girl with no known medical history presented with bilateral eye redness and blurred vision for one week.

Initial examination revealed a visual acuity of 6/36 in both OD and OS. Ocular examination revealed bilateral panuveitis characterized by severe anterior chamber inflammation demonstrated by granulomatous keratic precipitates, anterior chamber cells, patchy posterior synechiae, optic disc swelling, and exudates at the macula. The patient was initially treated for bilateral neuroretinitis and was started on topical and oral steroids as well as oral antibiotics.

After two weeks of treatment, her vision improved to 6/9 bilaterally, with corresponding improvement in anterior chamber inflammation. However, optic disc swelling and a macular star remained with multifocal choroiditis. Physical examination revealed new onset poliosis of the upper eyelashes and vitiligo on the trunk, forearms, and right forehead, which had not been observed previously. Fundus fluorescein angiography demonstrated hot discs with peripheral small vessel vasculitis and multifocal choroiditis. Both Bartonella and Toxoplasma antibodies yielded negative results, and MRI findings were unremarkable.

Given the new clinical findings, the diagnosis was revised to VKH disease. Her management was adjusted: antibiotics were discontinued, and a pediatric rheumatologist was consulted for the initiation of subcutaneous methotrexate. Oral steroids were tapered accordingly.

After two weeks of the revised treatment regimen, vision is 6/15 bilaterally, ocular inflammation resolved, appearance of sunset glow, with improving integumentary manifestations.

Conclusion

Early detection and prompt management are the key to maintaining good visual acuity.

ABSTRACT ID: 515

A RARE CASE OF CHOROIDAL NEOVASCULARIZATION SECONDARY TO OCULAR TUBERCULOSIS: DIAGNOSTIC AND THERAPEUTIC CHALLENGE

Aimaan bin Zain al-Aabideen[1], Rosiah binti Muda[1]

[1] Hospital Sultanah Nur Zahirah

Purpose

Choroidal neovascularization (CNV) is a rare but sight-threatening complication of ocular tuberculosis. This case highlights the clinical presentation, diagnostic challenges, and management of CNV secondary to ocular tuberculosis.

Methods

Case report.

Results

A 30-year-old Malay gentleman with pulmonary tuberculosis on two months of anti-tubercular therapy (Tablet Akurit) presented with a one-month history of painless, progressive central vision loss in the right eye. Examination revealed a visual acuity of 6/6 in both eyes, normal optic nerve function, and unremarkable anterior segment. Initial fundus examination of the right eye showed subretinal choroidal granuloma with surrounding subretinal fluid. At 5 months of follow-up, left eye was also notable for subretinal choroidal granuloma scarring at infero-temporal which did not progress. Subsequently, right eye fundus examination showed chorioretinal lesion temporal to the macula with surrounding haemorrhage, macular edema, and intraretinal fluid on optical coherence tomography (OCT). Fluorescein angiography (FA) demonstrated hyperfluorescence with leakage, consistent with CNV. He received two intravitreal ranibizumab injections, leading to initial improvement. However, after a nine-month follow-up default, he returned with significant right eye visual decline (6/60) and worsening macular hemorrhage. Fundus examination revealed multiple choroidal scars with recurrent CNV. Resumption of intravitreal anti-VEGF therapy resulted in substantial visual recovery.

Conclusion

This case underscores the potential for CNV as a late complication of ocular tuberculosis, emphasizing the importance of early diagnosis and continued follow-up. Delayed treatment can lead to severe visual impairment, highlighting the role of multimodal imaging and timely intervention with anti-VEGF therapy.

ABSTRACT ID: 516

CHOROIDAL OSTEOMA COMPLICATED BY CHOROIDAL NEOVASCULARISATION: A CLINICAL CASE REPORT

Fazliana Ismail[1], Yushalini A/P Manyam[1 2], Roslin Azni[2]

[1]Universiti Malaya Eye Research Centre (UMERC); [2] Hospital Shah Alam

Purpose

We report a case of choroidal osteoma complicated by secondary choroidal neovascularisation.

Methods

Case report.

Results

A 37-years-old Malay man with no known medical illness presented with left eye progressively worsening central scotoma over 1 year. Otherwise, no other significant ocular or systemic symptoms. On examination, visual acuity was 6/9 on the right eye and counting finger on the left eye with positive relative afferent pupillary reflex. Fundoscopy examination showed a well-defined geographical demarcated heterogenous choroidal lesion about 1.5-disc diameter at peripapillary area nasal to optic disc, with macula oedema on the left eye. The anterior segment of both eyes and fundoscopy of right eye were unremarkable. B scan ultrasonography revealed hyperechoic lesion temporal to optic nerve, with a double ray sign, while optical coherence tomography(OCT) macula showed choroidal elevation adjacent to subretinal fluid and intraretinal fluid. Fluorescein angiography (FFA) confirmed leakage consistent with choroidal neovascularisation.

The patient received intravitreal therapy consisting of two injections of ranibizumab followed by one injection of aflibercept at 6-week intervals. Despite treatment, vision remained static, with no significant improvement in retinal fluid. The patient was subsequently managed conservatively with regular monitoring.

Conclusion

Choroidal osteoma is a benign ossifying tumor characterized by bone replacing the choroid, occasionally complicated by choroidal neovascularisation. Key predictive factors for CNV include irregular tumor surface and subretinal hemorrhage. Anti-VEGF therapy remains the standard approach for managing CNV, although response may be limited, emphasizing the need for individualized management and close monitoring.

ABSTRACT ID: 517

UNMASKING A HIDDEN THREAT: CHOROIDAL MELANOMA MIMICKING TRAUMA SEQUELAE

Fazliana Ismail[1], Yushalini A/P Manyam[1 2], Roslin Azni[2]

[1] Universiti Malaya Eye Research Centre (UMERC); [2] Hospital Shah Alam

Purpose

To report a rare case of choroidal melanoma in a young Asian patient, initially misdiagnosed as a post-traumatic ocular complication.

Methods

Case report.

Results

A 33-year-old Chinese male with a history of motor vehicle accident 13 years prior, but no documented ocular injury, presented with progressive blurred vision in the right eye for 1 year. His visual acuity was 6/12 at that time, and he was diagnosed with choroidal rupture with scarring, receiving conservative treatment. Over time, his vision worsened, and he was treated with anti-VEGF injections for presumed choroidal neovascularization. However, a suspicious, progressively enlarging pigmented choroidal mass raised concerns.

On referral, his visual acuity had deteriorated to counting fingers. Examination revealed a large (5-disc diameter) pigmented choroidal mass near the optic disc. B-scan ultrasonography showed a dome-shaped mass with collar-stud appearance (7.2 mm), medium internal reflectivity, focal hyperechogenicity, and orbital shadowing. Fluorescein angiography (FFA) demonstrated double circulation, absent on indocyanine green angiography (ICG). MRI orbit confirmed an 8×8×9 mm mushroom-shaped soft tissue mass, hyperintense on T1, hypointense on T2, with gadolinium enhancement.

Due to its atypical presentation, choroidal biopsy done and confirmed melanoma, leading to enucleation. The patient remains under regular surveillance for metastasis, with no evidence of systemic spread to date.

Conclusion

Choroidal melanoma is rare in young Asian populations and may present atypically, mimicking post-traumatic changes. Awareness of its variable presentation is crucial to prevent delayed diagnosis and treatment.

ABSTRACT ID: 520

ATYPICAL BILATERAL OCULAR TOXOPLASMOSIS IN A HIGH-GRADE B CELL LYMPHOMA PATIENT

Tengku Ain Kamalden[1], Aimi Shazwani Mohammad Musa[1 2], Nadhirah Kharudin[2], Tanusha Dorairaja[2], Rajasudha Sawri Rajan[2]

[1] UM Eye Research Centre (UMERC); [2] Hospital Shah Alam

Purpose

To report a case of atypical ocular toxoplasmosis in an immunocompromised patient, emphasising that atypical presentations, characterised by large, multiple, or bilateral lesions, may delay diagnosis and treatment.

Methods

Case Report

Results

This case report details a 49-year-old woman with high-grade B cell lymphoma who had recently completed six cycles of chemotherapy. She presented with blurred vision in both eyes, worse in the right eye, along with floaters lasting one week. Visual acuity was counting fingers in the right eye and 6/24 in the left, with elevated intraocular pressure in the left eye. Examination revealed fine keratic precipitates, anterior chamber inflammation, and a large macular retinitis lesion in the right eye, accompanied by a nasal chorioretinal scar, however it was not adjacent to current active lesions. Additionally, a three-disc-sized retinitis lesion with periarteritis was seen at superotemporal quadrant in the left eye and a chorioretinal scar at inferonasal area. Vitritis was observed at 2+ in both eyes.

Initial treatment for cytomegalovirus retinitis with intravitreal Ganciclovir yielded poor results. Subsequent tests revealed negative viral PCR for Herpesviruses and positive Toxoplasma IgG leading to a revised diagnosis of atypical ocular toxoplasmosis. The patient received Bactrim (960 mg BD), intravitreal Clindamycin, and oral prednisolone. She showed significant improvement both on vision and clinically.

Conclusion

Atypical ocular toxoplasmosis can significantly delay diagnosis in immunocompromised individuals. Clinicians should maintain a high index of suspicion and conduct relevant tests to rule out this vision-threatening condition, particularly among susceptible populations.

ABSTRACT ID: 529
GONIOSCOPY, ALWAYS FORGOTTEN BUT ALWAYS IMPORTANT

Sarah Saihani[1], Nurull Bahya Suliman[1]

[1] Hospital Tengku Ampuan Rahimah

Purpose

To report a rare case of prolonged post-operative inflammation secondary to retained nuclear matter at angle.

Methods

Case report.

Results

A 73 year old Indian gentleman, with underlying Diabetes Mellitus, hypertension and history of cerebrovascular accident with left hemiparesis.

Patient underwent uneventful, uncomplicated left eye phacoemulsification/PCIOL under local anesthesia on the 28th of November 2022. His vision improved from 6/12 PH 6/9 to BCVA of 6/6 postoperatively. He had prolonged postoperative inflammation with steroid induced ocular hypertension. His IOP returned to baseline without antiglaucoma upon discontinuation of topical steroid.

Patient was well and presented in 2024, 2 years after cataract surgery complaining of sudden left eye redness, pain and floaters for 1 day. There were signs of anterior chamber inflammation and patchy iris atrophy but visual acuity was stable at 6/9.

He was investigated and treated as acute anterior uveitis. Gonioscopy examination revealed retained nuclear matter at angle.

He underwent left eye retained nuclear matter removal at angle with gonioscopy lens assisted. Postoperatively uneventful and topical steroid was discontinued.

Conclusion

This case highlights the importance of thorough ocular examination especially gonioscopy in patients with prolonged postoperative inflammation.

ABSTRACT ID: 532

SYPHILITIC UVEITIS WITH ALOPECIA

Mohd Fahdil bin Abdul Zaim[1], Chiang Wai Seng[2], Nurhayati Abdul Kadir[2], Wai Yong Zheng[2], Muhammad Hazim Sharum[2], Ariana Syamsidi[2]

[1] Ministry of Health Malaysia; [2] Department of Ophthalmology, Hospital Duchess of Kent, Malaysia

Purpose

Syphilis is a sexually transmitted disease caused by Treponema pallidum. It is especially more prevalent in men who have sex with men (MSM). In the United States of America, about 0.6% of syphilis cases, presented with symptoms consistent with ocular syphilis. In one of the studies done in Malaysia, the most common presentation of ocular syphilis were blurred vision (61%), eye redness (16%), floaters (13%), and incidental findings (10%).

Methods

Case report.

Results

54 years old, single gentleman with underlying diabetes mellitus and hypertension, presented with left eye redness and blurring of vision for 1 week. Patient also complained of patchy hair loss for the past 1 month. Patient denied high-risk behaviours.

On initial examination, visual acuity for left eye was counting fingers and we observed injected conjunctiva with mark inflammation at anterior chamber of left eye and iris pigments were seen on the lens. Fundus examination showed well defined pink optic disc with cup-disc ratio of 0.3. There was an area of yellowish white chorioretinitis patch at superonasal part of the fundus. Multiple dot and blot haemorrhages also seen. On systemic examination, multiple patchy hair loss observed. Other systems examination was unremarkable.

Serum rapid plasma reagin titre (RPR) was 1:64 and Treponema pallidum particle agglutination (TPPA) was positive. Patient refused for lumbar puncture. Contrast-enhanced Computed Tomography (CECT) brain was normal.

He was treated with intravenous penicillin G for two weeks and his vision improved after the treatment.

Conclusion

Ocular syphilis is a serious manifestation of syphilis. A good prognosis depends on early diagnosis and prompt treatment.

ABSTRACT ID: 536

FARICIMAB SWITCHING FOR POLYPOIDAL CHOROIDAL VASCULOPATHY WITH REAL-WORLD OUTCOMES IN REFRACTORY CASES – THE FAR-PEARL STUDY REPORT

Wong Hon Seng[1], Kenneth Fong[1], Manoharan Shunmugam[1], Wilson Wong[1], Ling Kiet Phang[1], Shir-Ning Fon[1]

[1]OasisEye Specialists

Purpose

To present real-world outcomes of switching to faricimab in eyes with polypoidal

choroidal vasculopathy (PCV) refractory to previous anti-VEGF treatments.

Methods

This retrospective study included PCV eyes switched to faricimab for recurrent PCV (>180 days from prior anti-VEGF), suboptimal extension (60-180 days), or recalcitrant PCV (<60 days). Patients were followed monthly, with PRN reinjections for persistent subretinal fluid (SRF), intraretinal fluid (IRF), or pigment epithelial detachment (PED) at the fovea, or a 1-line vision drop. The primary outcome was time to injection-free status (no injection for 3 months), analyzed via survival analysis.

Results

We included 49 eyes with PCV (mean age 66.1 ± 9.5 years; 59% women). Of these, 29% had recurrent PCV, 37% suboptimal extension, and 34% recalcitrant disease. Patients had a median of 8 prior aflibercept injections and received a median of 3 faricimab injections (IQR=2-4, range=1-8) over 344 days (IQR=198-446). The interval between the first two faricimabs averaged 64 ± 43 days, longer in recurrent (86 ± 55 days) vs. recalcitrant PCV (43 ± 26 days, p=0.008). By day 90, 49% were injection-free, increasing to 73% by day 210.

PED resolved in 53% after the first dose, and in those needing repeat injections, the interval peaked after the fourth dose with normalized CFT and no SRF, IRF, or PED.

Conclusion

The differential response to faricimab in PCV depends on disease type, with recurrent cases requiring fewer injections and recalcitrant cases needing more intensive initial treatment, but even recalcitrant eyes can achieve extended intervals after initial doses.

ABSTRACT ID: 543

ATYPICAL BILATERAL ENDOGENOUS ENDOPHTHALMITIS IN AN IMMUNOCOMPROMISED PATIENT WITH LEPTOSPIROSIS: A CASE REPORT

Fazliana Ismail[1], Chong Xin Yee[1 2], Siti Zaitihani binti Hamdan[2], Nazima binti Shadaht Ali[2]

[1] UM Eye Research Centre (UMERC),; [2] Hospital Selayang

Purpose

To report a rare case of bilateral endogenous endophthalmitis secondary to leptospirosis in an immunocompromised patient with undiagnosed Human Immunodeficiency Virus(HIV).

Methods

Case report

Results

A 23-year-old previously healthy Malay male presented with recurrent episodes of bilateral eye redness and blurred vision for the past 3 months. He denied high-risk behaviour but reported recent water park exposure.

On examination, visual acuity was 6/18 over both eyes. Anterior segment examination showed both eyes had granulomatous mutton-fat keratic precipitates(inferior cornea), posterior synechiae(3 and 9 o'clock), and anterior chamber cells. Fundoscopy revealed multiple pinpoint retinitis, vitreous ball condensation (temporal and inferior retina), and vitritis, with no obvious choroiditis. Fluorescein angiography showed Ferning sign with generalized peripheral small vessel vasculitis.

Blood investigations were positive for Leptospira IgM and HIV, indicating undiagnosed immunosuppression as a predisposing factor for severe leptospiral infection. He was diagnosed with bilateral endogenous endophthalmitis secondary to leptospirosis in an immunocompromised state and co-managed with the infectious disease team. Bilateral intravitreal tapping and antibiotic therapy were performed, followed by systemic and topical antibiotics. Oral steroids were introduced one week later and gradually tapered. After 6 months, his vision improved to 6/9 on both eyes and patient is satisfied with the outcome.

Conclusion

Leptospirosis can spread hematogenously and cause severe ocular manifestations, particularly in immunocompromised individuals. In endemic areas, a history of water exposure and immune status evaluation should raise suspicion of ocular leptospirosis, even in atypical presentations such as endogenous endophthalmitis. Early recognition and treatment are crucial for optimal outcomes.

ABSTRACT ID: 550
A DIAGNOSTIC PUZZLE: UNEXPLAINED MONOCULAR VISION LOSS IN A HEALTHY TEENAGER

Norhidayah binti Ahmad Zaidon[1], Farhana binti Ibrahim[1], Anis Baidura binti Azal[1], Evelyn Tai Li Min[2]

[1] Hospital Tuanku Ja'afar Seremban; [2] Universiti Sains Malaysia

Purpose

To report a case of monocular vision loss of with significant abnormal fundus findings, emphasizing the diagnostic challenges and the importance of further investigation.

Methods

Case report.

Results

A 16-year-old previously healthy Malay girl presented with blurred vision in her left eye. She first noticed the vision issue about a month ago, after rubbing her other eye, though the exact duration of her symptoms remains uncertain. She denied eye redness, pain and associated joint pain and hair loss. She also denied ocular trauma or chronic headaches.

On examination, her left eye vision was limited to hand movements, while her right eye vision was 6/6. A relative afferent pupillary defect (RAPD) was present in the left eye. Extraocular movements were full bilaterally, and the anterior segment examination was unremarkable with normal intraocular pressure.

Fundus examination of the left eye revealed a pale optic disc, a mottled macula, generalized sclerosed retinal vessels, and vascular sheathing, while the right eye fundus appeared normal. Fundus fluorescein angiography (FFA) demonstrated capillary fallout in all quadrants, sparing the nasal region, with multiple hyperfluorescent areas temporally, suggesting choroiditis. Comprehensive autoimmune and infectious workups were negative.

The cause remains unknown, and further investigation is ongoing. The patient has been referred to Medical Retina for evaluation, with ocular tuberculosis among other possible causes.

Conclusion

This case highlights the diagnostic challenge of monocular vision loss in a healthy adolescent with retinal ischemia and choroiditis, underscoring the need for further investigation and close follow-up to preserve vision.

ABSTRACT ID: 553

RETINAL PIGMENT EPITHELIUM TEAR AS A COMPLICATION OF TREATED VOGT-KOYANAGI-HARADA DISEASE

Kert H'ng[1], Norlina Mohd Ramli[1], Muhammad Khairuddin Mohd Azman[2], Ai Lin Daphne Teh[3], Rajasudha Sawri Rajan[3], Roslin Azni Abdul Aziz[3]

[1] UM Eye Research Centre (UMERC); [2] Universiti Kebangsaan Malaysia; [3] Hospital Shah Alam

Purpose

To report on two cases of retinal pigment epithelium (RPE) tears following treatment for Vogt-Koyanagi-Harada (VKH) disease at a Medical Retina Referral Centre.

Methods

Case series.

Results

The first case involved a 35-year-old Bajau woman who presented with bilateral blurring of vision and reduced hearing over two months. Her visual acuity (VA) was counting fingers bilaterally upon presentation. Follow-up examinations revealed bilateral panuveitis with multifocal subretinal fluid, dense subretinal exudates, inferior exudative retinal detachment and subretinal bands. Intravenous methylprednisolone was initiated, followed by tapering oral prednisolone. A week later, her right eye (OD) manifested two large, parallel, superior and inferior RPE tears, while left eye (OS) developed inferior RPE tear. Optical coherence tomography showed rolled-up edges of the ripped RPE involving the fovea of OD. Second-line treatment was commenced. Unfortunately, patient defaulted subsequent follow-ups.

The second case was a 50-year-old Chinese woman who was referred for second-line treatment of VKH. She experienced blurring of vision and reduced hearing for a fortnight. VA was counting fingers in OD; 6/36 in OS. An early sunset glow appearance was observed bilaterally. She was treated with intravenous methylprednisolone, followed by tapering of oral prednisolone. After two weeks, her VA improved to 6/20 in OD; 6/12 in OS. However, her OD exhibited multifocal subretinal fluid, inferior exudative retinal detachment, subretinal fibrosis, and a large, localized RPE tear temporal to the fovea.

Conclusion

RPE tears in VKH are rare. Both cases featured large RPE tears after high-dose steroid therapy. The combined effect of disease severity and treatment result in unforeseen complication.

ABSTRACT ID: 557

LOST IN THE FOG: A CASE OF SERONEGATIVE TOXOPLASMIC NEURORETINITIS

Suhaila binti Ibrahim[1], Siti Aisyah binti Mazlan[2], Noranida binti Abd Manan[2], Azma Azalina binti Ahmad Alwi[2], Shatriah binti Ismail[3]

[1] Universiti Sains Malaysia; [2] Hospital Raja Perempuan Zainab II; [3] Universiti Sains Malaysia

Purpose

Toxoplasmic neuroretinitis is a rare but significant cause of vision loss, characterized by optic disc swelling, a macular star, and retinal inflammation. Diagnosis can be challenging, especially in seronegative cases, necessitating a clinical approach. To report a case of seronegative toxoplasmic neuroretinitis, emphasizing the importance of multimodal imaging and early treatment in guiding diagnosis and management.

Methods

Case report.

Results

A 33-year-old female presented with blurred vision, floaters, and metamorphopsia in her right eye (RE) for one week, following a recent fever and exposure to sick cats. Examination revealed a relative afferent pupillary defect (RAPD) with a visual acuity of 6/60. The anterior segment was unremarkable, but fundoscopy showed optic disc swelling, splinter hemorrhages, a macular star, juxtapapillary choroiditis, and arcade retinitis. Optical coherence tomography confirmed macular edema with subretinal fluid. Despite negative Toxoplasma gondii IgG and IgM serology, clinical findings strongly suggested toxoplasmic neuroretinitis. Other infectious causes (Bartonella, syphilis, tuberculosis) were considered but less likely. She was treated with trimethoprim-sulfamethoxazole and oral prednisolone. At one-month follow-up, her RE vision improved to 6/12, with reduced floaters, resolving retinal edema, and optic disc swelling.

Conclusion

Seronegative toxoplasmic neuroretinitis remains a diagnostic challenge, requiring clinical suspicion and imaging for confirmation. This case emphasizes the importance of timely recognition and early treatment to optimize visual outcomes.

ABSTRACT ID: 559
INTRAOCULAR DIFFUSE LARGE B-CELL LYMPHOMA: INSIGHTS FROM A CLINICAL CASE

Sulochana Mohan[1], Brindha Gulendran[1], Khairul Husnaini Mohd Khalid[1]

[1] Hospital Tuanku Ampuan Najihah

Purpose

To report a patient with intraocular diffuse large B-cell lymphoma, who was successfully treated with IVT Methotrexate.

Methods

Case report.

Results

68 years old gentlemen, with hypertension and refractory diffuse large B-cell lymphoma stage 4B presented with right eye progressive blurring of vision for 3 months. On examination, the right eye visual acuity was hand movement, conjunctiva normal, cornea had fine keratic precipitates. Biomicroscopy shown anterior chamber cells 1 +, normal iris, and mild cataractous lens. On fundoscopy, vitritis 2+ with choroidal lesions at the inferotemporal region, sized 3-4 disc diameter with hemorrhage overlying it. Multiple punctate yellowish lesions seen over inferior half of the retina. Otherwise, retina flat, optic disc pink with cup to disc ratio of 0.3 but hazy view of the macula due to vitritis. On systemic examination, there was right cervical lymphadenopathy. Bscan showed hyperechoic homogenous choroidal mass sized 2.2mm. CECT orbit shown no orbital mass. Right eye choroidal biopsy shown atypical cells, suspicious of malignancy. Intravitreal injections of methotrexate (MTX) (400 µg/0.1 ml in the right eye) were performed twice weekly for 2 weeks, once weekly for the following month and once every two weeks for the next month. Patient showed a remarkable regression of the lesion after completing the treatment and vision improved to 6/9.

Conclusion

Although intraocular lymphoma is a rare disease, its clinical manifestations resemble symptoms and signals of common eye disorders. Biopsy of the lesion should be considered in these patients for diagnosis. Methotrexate intravitreal injection might extend the survival time and preserve visual acuity for patients with choroidal lymphoma.

ABSTRACT ID: 560

ARC WELDER'S MACULOPATHY : A DIM SIGHT FROM A BRIGHT LIGHT

Qamarul Izzat Amir bin Mazlan[1], Mohd. Ihsan bin Jamaludin[1], Suriana binti Suaibun[1]

[1] Putrajaya Hospital

Purpose

Arc welder's maculopathy (AWM) is a clinically diagnosed photochemical injury of retinal cells resulted by intense light radiated during arc welding. This case report highlights the significant nature of this occupational hazard which is preventable, though often irreversible, yet controllable with early diagnosis.

Methods

A 73-year-old former heavy-duty welder with metabolic syndrome experienced routine-disrupting metamorphopsia and vision loss. A detailed history was obtained, followed by a comprehensive examination, including visual acuity (VA) testing and slit-lamp examination. Optical coherence tomography (OCT) was used for diagnostic confirmation and disease progression monitoring upon initial presentation in which the pathology was conservatively managed.

Results

Upon the ocular evaluation, the diagnosis of bilateral maculopathy was established. Bilateral eyes (BE) pinhole VA was 6/9 while fundus examination revealed macula scarring with OCT displaying subfoveal hyperreflectivity with outer photoreceptor layer disruption. The patient's comorbidities were ruled out as the cause, confirming chronic photic insult as the key factor. Following 3 years of regular monitoring, patient's quality of life has been maintained since the presentation with only minimal disease progression as BE pinhole VA declining to 6/12 and left eye OCT changes became pronounced.

Conclusion

AWM is an infrequently encountered hazard of a common line of work in Malaysia. This case accentuates the withdrawal effect of photic insult towards the photochemical injury progression control and the crucial role of eye protection as a primary preventive measure. Healthcare practitioners are urged to obtain a thorough occupational history for an individualised consultation in minimising any potential harm to patients' sight.

ABSTRACT ID: 571

MULTIFOCAL CENTRAL SEROUS CHORIORETINOPATHY ASSOCIATED WITH LUPUS

Ummu Salamah Binti Ismail[1], Gowri Supramaniam[1], Anis Baidura[1], Ummu Salamah Ismail[12], Azhany Yaakub[2]

[1]Hospital Tuanku Jaafar Seremban; [2]Universiti Sains Malaysia

Purpose

To report a case of multifocal central serous chorioretinopathy (CSCR) in a young patient with newly diagnosed Systemic Lupus Erythematosus (SLE).

Methods

Case report

Results

A 16-year-old girl presented with a week history of painless, progressively worsening vision in both eyes. Two weeks earlier, she was diagnosed with seronegative SLE and started on oral prednisolone (0.6 mg/kg). She returned to the emergency department with an acute hypertensive crisis and overload symptoms, possibly caused by exogenous Cushing syndrome from the steroids. She reported that her ocular symptoms began after starting the oral steroids. Ocular evaluation revealed visual acuity (VA) of 6/24 in the right eye and 6/18 in the left; while the anterior segments were normal, fundus examination showed multiple ischaemic choroidopathy with multifocal area of exudatives retinal detachment in both eyes. Optical Coherence Tomography confirmed multiple areas of subretinal fluid (SRF) without bacillary detachment, and fundus fluorescence angiography displayed a "smoke stack appearance" pattern. The diagnosis of bilateral multifocal central serous chorioretinopathy (CSCR) with hypertensive choroidopathy was made. Following appropriate blood pressure control, tapering of oral prednisolone and initiation of second line immunosuppressive (Azathioprine), her SRF significantly reduced, and her VA improved to 6/9 in both eyes.

Conclusion

This patient presents with multiple risk factors for developing CSCR, including SLE and its treatment with oral steroids. Systemic vasculitis and the potential for systemic hypertension associated with SLE are thought to contribute to choroidal vascular pathogenesis, leading to CSCR. Additionally, glucocorticoid use is recognized as an independent risk factor for CSCR and is considered a relative contraindication for its treatment.

ABSTRACT ID: 578

DUAL MANIFESTATION : MULTIFOCAL CENTRAL SEROUS CHORIORETINOPATHY AND HYPERTENSIVE CHOROIDOPATHY ASSOCIATED WITH LUPUS

Anis Baidura Azal[1], Gowri Supramaniam[1], Ummu Salamah Binti Ismail[1 2], Azhany Yaakub[2]

[1] Hospital Tuanku Ja'afar Seremban; [2] Universiti Sains Malaysia

Purpose

To report a case of multifocal central serous chorioretinopathy (CSCR) and hypertensive choroidopathy in a young patient with newly diagnosed Systemic Lupus Erythematosus (SLE).

Method

Case report.

Results

A 16-year-old girl presented with a week history of painless, progressively worsening vision in both eyes. Two weeks earlier, she was diagnosed with seronegative SLE and started on oral prednisolone (0.6 mg/kg). She returned to the emergency department with an acute hypertensive crisis and overload symptoms, possibly caused by exogenous Cushing syndrome from the steroids. She reported that her ocular symptoms began after starting the oral steroids. Ocular evaluation revealed visual acuity (VA) of 6/24 in the right eye and 6/18 in the left; while the anterior segments were normal, fundus examination showed multiple ischaemic choroidopathy with multifocal area of exudative retinal detachment in bilaterally. Optical Coherence Tomography confirmed multiple subretinal fluid (SRF) areas without bacillary detachment, and fundus fluorescence angiography displayed a "smoke stack appearance" pattern. The diagnosis of bilateral multifocal central serous chorioretinopathy (CSCR) with hypertensive choroidopathy was made. Following appropriate blood pressure control, tapering of oral prednisolone and initiation of second-line immunosuppressive (Azathioprine), her SRF significantly reduced, and her VA improved to 6/9 in both eyes.

Conclusion

This patient presents with multiple risk factors for developing CSCR, including SLE and its treatment with oral steroids. Systemic vasculitis and the potential for systemic hypertension associated with SLE are thought to contribute to choroidal vascular pathogenesis, leading to CSCR. Additionally, glucocorticoid use is recognized as an independent risk factor for CSCR and is considered a relative contraindication for its treatment.

ABSTRACT ID: 581

UNVEILING THE HIDDEN: A CASE OF CHOROIDAL AND INTRACONAL TUBERCULOMA

Tan Li Faung[1], Lathalakhmi Thangavelu[1]

[1]Department of Ophthalmology

Purpose

We present a case of bilateral choroidal and intraconal tuberculoma.

Methods

Case report.

Results

A 38-year-old male from Myanmar presented with a one-month history of blurred vision in the left eye (LE) associated with central scotoma. He experienced constitutional symptoms, including fever, cough, and night sweats.

Upon examination, visual acuity in the right eye was 6/9, while in the LE, it was limited to counting fingers. Anterior segment examination was unremarkable. Fundoscopic examination of the right eye revealed multiple, well-defined yellowish choroidal tubercles, ranging from approximately half-to-one disc diameter in size. A single large choroidal tubercle was seen over the left macula. Optic disc appeared normal in both eyes.

Optical coherence tomography of the LE demonstrated serous detachment involving the macula. Enhanced depth imaging-optical coherence tomography showed hyporeflective lesions in the choroid.

Infective screening tests revealed the patient to be positive for human immunodeficiency virus, hepatitis B and C, and tuberculosis (TB). Computed tomography scan of the head incidentally identified a solid enhancing lesion in the right intraconal space, suggestive of a tuberculoma.

The diagnosis of choroidal tuberculoma was made. The patient was co-managed with the infectious disease team for disseminated tuberculosis. A regimen of anti-tubercular therapy and highly active antiretroviral therapy was initiated.

At his follow-up visit three weeks later, the patient showed improvement, with visual acuity improving to 6/36 and reduction in subretinal fluid in the left eye.

Conclusion

Choroidal tuberculoma is a rare presentation of ocular TB that can be a diagnostic challenge. It can be a part of systemic disseminated tuberculosis, especially in patients with immunocompromised conditions.

Miscellaneous

ABSTRACT ID: 140
LUCK IS MY SUPERPOWER

Chua Jian Yang[1], Nuratiqah Zainal Abidin[1]

[1]Hospital Selayang

Purpose

To highlight 2 cases of penetrating lid injuries sparing globe, both coincidentally presenting on the same day.

Methods

Case report

Results

47 years old man fell face first onto a tree branch at his orchard. He sustained a right penetrating eyelid laceration with embedded wooden foreign body (FB) at right upper eyelid. Globe remained intact after imaging confirmation. FB removal and lid toilet and suturing (T&S) was done. Patient made a full recovery.

44 years old Man was involved in motor vehicle accident and crashed into a roadside tree. He sustained significant left eyelids traumatic laceration with possible skin loss and embedded wooden FB at left upper eyelid. Fortunately, globe remained intact after imaging confirmation. Lid reconstruction with Tenzel Semicircular Rotational Flap was done with the help of plastic surgery team. Patient made a full recovery.

Both cases were reviewed at the emergency department on the same night.

Despite having penetrating eyelid injuries, both patients were extremely lucky to get away without any globe injuries.

Conclusion

Penetrating lid injury requires thorough examination to rule out other accompanying injuries such as globe injury. Prompt and appropriate treatment is crucial to ensure swift recovery and reduce complications.

ABSTRACT ID: 152

GLOBAL AND REGIONAL TRENDS IN MYOPIA PREVALENCE: A FOCUS ON ASIA

Wan Nor Akma Wan Zain[1], Ungku Noor Aqilla Ungku Hassan[1], Waheeda Azwa Hussein[2], Azhany Yaakub[2], Wan Nur Amirah Ibrahim[3], Siti Hajar Abdul Razak[4]

[1]Ministry of Health; [2]HUSM Kubang Kerian; [3]UITM Puncak Alam; [4]Private Sector

Purpose

This scoping review explores available evidence of trends in myopia prevalence and risk factors in children, with a particular emphasis on Asia, where the burden of myopia is the highest.

Methods

The literature search was conducted from PubMed, ScienceDirect, and Cochrane to find articles published in English between 2015 and February 2024 with the usage of AI applications such as Elicit to extract data from the articles. The data were extracted regarding publication date, geographical location, study setting, intervention mechanism, and outcome of the studies.

Results

Following the first phase of screening and duplication removal, 143 articles were identified out of 306 academic journals and 48 other relevant articles found related to this topic. Upon the second screening phase, 113 articles remained after full text article reviews and analysis. Analysis of data were grouped thematically as follows: prevalence of myopia and (1) pre-covid era; (2) covid confinement; (3) post-covid era; (4) interventions and (5) populations.

Conclusion

Myopia prevalence is increasing, needing immediate public health initiatives to combat the epidemic. Future studies should concentrate on longitudinal studies to better understand progression patterns and the effects of lifestyle changes on myopia control. Diagnostic criteria and data gathering methods must be standardised in order to conduct more reliable epidemiological assessments and establish policies.

ABSTRACT ID: 182

PRELIMINARY SURVEY ON PATIENT SATISFACTION IN UMMC OPHTHALMOLOGY SERVICES: AN INSIGHT

Nurul Ilham Binti Hussain[1], Norlina Ramli[1]

[1] Universiti Malaya Eye Research Center (UMERC), Universiti Malaya Medical Centre (UMMC)

Purpose

To assess patient satisfaction levels and explore their association with time spent in the clinic and other factors among patients attending the ophthalmology clinic at UMMC, which provide valuable insights for improving service quality and patient care.

Methods

A cross-sectional audit was conducted at the ophthalmology clinic in UMMC from September 23, 2023, to October 24, 2023. A universal sampling method was used to recruit patients and data were collected using a validated, self-administered Patient Satisfaction Questionnaire (PSQ-18), which measures satisfaction across seven domains: general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctors, and accessibility/convenience. Statistical analysis, including correlation and regression tests, was performed to determine associations between satisfaction levels and factors such as waiting time and time spent with doctors.

Results

A total of 30 respondents participated in the survey, majority reported high satisfaction levels across various aspects of care: overall services (90%), time spent with doctors (90%), interpersonal manner (90%), communication (89%), financial aspects (87%), technical quality (87%), and accessibility/convenience (85%). Statistical analysis revealed a significant positive association between patient satisfaction and the time spent with doctors ($p<0.05$). However, no significant correlation was found between satisfaction and waiting time ($p>0.05$).

Conclusion

This highlights a high level of patient satisfaction across multiple care dimensions, particularly regarding doctor-patient interactions. This underscores the importance of effective and unhurried consultations. This survey helps UMMC optimise clinic operations to enhance patient experience. The PSQ-18 proved to be a valuable tool for evaluating service quality and identifying key areas for improvement.

ABSTRACT ID: 252

AN AUDIT ON CANCELLATION RATE OF CATARACT SURGERY UNDER LOCAL ANAESTHESIA IN HOSPITAL SULTANAH BAHIYAH AND HOSPITAL JITRA.

Loh Chih Chung[1], Chai Huei Xian[1], Nur Muhammad Ammar Bin Mohd Razak[1], Siti Nur Baizury Binti Hassan[1]

[1] Hospital Sultanah Bahiyah

Purpose

The cancellation of the cataract surgery causes inconvenience and distress to patients, resource wastage and financial losses for both healthcare facilities as well as patients. Our audit focuses on determining the percentage of cataract surgery cancellations listed under local anaesthesia. We identify the reasons of cancellations and shortfalls in order to reduce the case cancellation.

Methods

A retrospective audit was conducted from January 2024 to July 2024.

Results

Majority of the cancellation reasons were skin problem (n=24, 27.91%), followed by upper respiratory tract infection (n=14, 16.28%), uncontrolled hypertension (n=12, 13.95%), fail to admit (n=9, 10.47%), fail to purchase the intraocular lens (n=7, 8.14%). Pre-intervention audit data of cataract cancellations in January 2024 & February 2024 were 11.74% & 15.4% respectively (Mean: 13.57%). We introduced the standard guideline for pre-operative (pre-op)assessment in the pre-op clinic and a pre-op calling system for our doctors and staff in eye clinic to tackle the issues and various reasons resulting cataract cancellations from March 2024 till May 2024. Post-intervention results showed that there was significant reduction of cataract cancellation of 8.55% & 7.95% in June 2024 and July 2024 respectively (Mean: 8.25%).There was at least a 39% reduction in cataract cancellation after the implementation of pre-op assessment guidelines and pre-op calling system in this audit research.

Conclusion

A simple phone call to patients prior to cataract surgery and a meticulous pre-op assessment can achieve a cataract cancellation rate of less than 10% and minimize the impacts as a result of cataract cancellation.

ABSTRACT ID: 267
A CASE OF ADULT GONORRHEA CONJUNCTIVITIS

Nurhafizah Binti Zainon[1], Nur Shamira Shamsudin[2], Siti Amra Abd Rahman[2]

[1] Hospital Tengku Ampuan Afzan; [2] Hospital Tengku Ampuan Afzan

Purpose

Adult gonococcal conjunctivitis (AGC) is a relatively rare disease caused by Neisseria Gonorrhea (NG). It is Gram-negative diplococcus, transmitted sexually from an infected individual. It is a major public health issue making treatment more difficult thus increases the risk of complications. We represent a case of ocular infection due to NG.

Methods

Case report.

Results

A 25 years old man with no known medical illness presented with left eye discomfort for 5 days followed by redness, yellowish eye discharge and blurry of vision for 3 days.

Visual acuity of right eye 6/6, left eye 6/24, pin hole 6/12. Ocular examination revealed copious mucopurulent yellowish discharge over left eye associated with lid swelling, generalized injected chemosis conjunctiva. Meanwhile the anterior chamber was quiet and posterior segment was unremarkable. Further history, he had penile discharge 6 month prior to ocular presentation with history of unprotected sexual partners. Left eye conjunctiva swab reported as NG isolation with presence of numerous pus cell. He was admitted and treated with intravenous ceftriaxone and oral azithromycin as well as Gentamicin and Ceftazidime eye drops. Patient was co-managed with Infectious Disease team. His ocular condition improved upon discharge.

Conclusion

AGC should not be overlooked, as it is sight threatening with progression to cornea perforation. It is common in young, sexually active males. Its incidence is expected to rise with increasing rates of gonorrhoea internationally.

The control of NG relies heavily on early diagnosis, appropriate treatment, public health education, preventive measure and regular screening. Continued research into development of a vaccine remains critical to long term control.

ABSTRACT ID: 269

EYE IS POPPING OUT!

Chia Tze Mein[1], Kenneth Teow Kheng Leong[1]

[1] Hospital Bintulu

Purpose

To report a case of subperiosteal abscess with Staphylococcus aureus bacteremia.

Methods

Case Report.

Results

Background

Subperiosteal abscess is common sequel of orbital cellulitis and sinusitis which can lead to intracranial abscess, cavernous sinus thrombosis and death. In children under the age of 10 years, paranasal sinusitis most often involves the ethmoid sinus which spreads through the thin lamina papyracea of the medial orbital wall into the orbit. Staphylococcus organism produces toxin help to promote virulence leading to rapid tissue destruction in the orbit.

Case Report

A one-month-old healthy term baby girl, presented with spontaneous left periorbital swelling and fever for 2 days. She was diagnosed with left preseptal cellulitis and admitted for IV Augmentin. On day 3, she developed left eye proptosis and chemosis. An urgent CECT brain, orbit, PNS revealed left orbital subperiosteal abscess with intraconal, intrasinonasal, intraoral, and intramuscular extension. Antibiotic was escalated to intravenous(IV) Ceftriaxone and an emergency endoscopic orbital decompression was done by the ENT team. Blood culture grew Staph aureus (sensitive to Oxacillin, gentamicin, resistant to Penicillin), and the antibiotic was switched to IV Cloxacillin and Gentamicin. Day 3 post op, proptosis recurred and patient was transferred to Sarawak General Hospital for a repeat emergency endoscopic endonasal orbital decompression. Sample of pus and fat culture yielded similar organism. Her condition improved and was discharged after completing antibiotics for 14 days.

Conclusion

Multidisciplinary approach, timely diagnosis and early surgical interventions are crucial for the management of sight and life-threatening disease like subperiosteal abscess.

ABSTRACT ID: 313

AUDIT ON WAITING TIME OF INPATIENTS' REFERRAL AT EYE CLINIC HOSPITAL BUKIT MERTAJAM

Nagasorhubini Muralitharan[1], Chew Rui Ping[1], Rohana Taharin[1]

[1] Hospital Bukit Mertajam

Purpose

Overcrowding is a common phenomenon seen in ophthalmology clinic. To audit the waiting time and we aim to identify the factors causing long waiting hours, to shorten the waiting time and to reduce the length of stay of inpatients in eye clinic Hospital Bukit Mertajam (HBM).

Methods

We collected pre-remedial data of all inpatients' referrals from 27th May to 31st May 2024. The time of arrival was captured using the queue management system (QMS) and each patient was given a timing chip in which timing at each station was manually filled. The data were entered into Microscoft Excel for analysis.

Results

Pre-remedial audit data revealed the average time to medical officer consultation was 36 minutes and to specialist consultation was 23 minutes. We employed priority lane for visual acuity examination, respective personnel to direct the accompanying staff and inpatients to specific station for further consultation. Pairing of Medical Officers (MO) with specialist in consultation room was implemented.

Reduction in the mean total length of stay was shown in the post-remedial data, from 117 minutes to 76 minutes. There was 67 % shorter in time spent from arrival to vision acuity (VA), and 69 % reduction of time from arrival to MO consultation. Our intervention has also reduced the time spent waiting for specialist consultation, from 23 minutes to 4 minutes.

Conclusion

Prioritisation of inpatient care in ophthalmology clinic should be implemented for the benefits of the ill inpatients and to ease the job of accompanying staffs, as well as to allow better utilisation of ambulance service.

ABSTRACT ID: 323

EMPOWERING TEACHERS IN DETECTING REFRACTIVE ERROR IN A REMOTE ISLAND IN SABAH

Nur Syafirah Zalaiqah Ruslan[1], Siti Hafizawati Jusoh[1], Halimatul Gustia Marasal[2], Chua Shee Wen[2], Shuaibah Ab Ghani[3]

[1] Hospital Pakar Universiti Malaysia Sabah; [2] Universiti Malaysia Sabah; [3] Universiti Malaya

Purpose

To assess the performance of school teachers as primary vision screeners in detecting refractive error in Pulau Banggi, Sabah

Methods

We conducted a vision health program for school teachers from Pulau Banggi. In the first phase, teachers who attended the program were given education and training in vision screening particularly in visual acuity assessment and squint screening. In the second phase, the teachers conducted vision screening with the provided screening kit at their respective schools and referred students who failed the screening to the ophthalmology team. In the later stage, the ophthalmology team reassessed the students' visual acuity and performed refraction to those identified with refractive error. Spectacles were prescribed and students who need further assessment were referred to the district hospital.

Results

16 teachers from 14 schools in Pulau Banggi joined the vision health program. 91 students failed the vision screening and have been referred to the ophthalmology team. 49 (53.85%) students came for reassessment and refraction were done by certified optometrists. 38 (77.55%) students were identified to have refractive error and glasses were prescribed. 3 (6.12%) students had strabismus and were referred to the district hospital for further management. The school teachers successfully provided up to 80% of accurate referrals.

Conclusion

Teachers can be effective vision screeners with proper training. This strategy is valuable to the less fortunate community in secluded island in terms of logistic and economic. Trained teachers can also help in reducing the workload of the eye care practitioner in detecting refractive error.

ABSTRACT ID: 343

ASSESMENT OF REFERRALS ON DIABETIC RETINOPATHY BY PRIMARY CARE TO TERTIARY CENTRE IN PERLIS

Noor Madihah Engah[1], Siti Nur Zaleha Zulkeffly[1], Nabilah Fitri Shamsuddin[1], Zulhisham Mohmad[1], Noramazlan Ramli[1]

[1] Hospital Tuanku Fauziah

Purpose

The purpose of this study is to assess compliance of Diabetic Retinopathy (DR) appointment given by ophthalmology clinic with Clinical Practice Guideline (CPG), to determine the accuracy of referral diagnosis from primary care and to identify the presenting diagnosis of DR.

Methods

A retrospective cross-sectional study was conducted in a tertiary centre in Perlis which involves all DR referrals by primary care to our centre from January to December 2023. Data were collected from medical records and analyzed.

Results

There were 136 patients referred by primary care to our centre for DR in 2023. Of these, 55% referrals were given appointments according to CPG. Total accuracy of diagnosis referrals from primary care was only 43%. Most cases referred by primary care were referred as moderate NPDR with maculopathy (47%). Diagnosis on first assessment includes no diabetic retinopathy (19%), moderate non proliferative DR (NPDR) with maculopathy (20%), severe NPDR (14%), proliferative DR (10%), advance diabetic eye disease (ADED) (2.2%), and maculopathy (32%) whereas presenting diagnosis that did not require referral was 51.5%. Mean HbA1c was 9.4%.

Conclusion

Slightly more than half of all DR appointments given complied with current CPG. Less than half of the DR referral diagnosis was accurate. About half of the referred DR cases by primary care were not indicated for referral. Further education needed to improve the compliance to CPG and accuracy of diagnosis.

ABSTRACT ID: 348

YAG MEMBRANOTOMY AS NON-INVASIVE TREATMENT FOR CHRONIC POST-OP FIBRINOUS PUPILLARY MEMBRANE

Farah Rasyiqah Mahamud[1], Ting Xiao Wei[1], Shakurthi Raj Partheeban[1]

[1] Hospital Tawau

Purpose

To describe a case of successful Yag membranotomy as a uncommon treatment in chronic post-operative dense fibrinous pupillary membrane.

Methods

Case report.

Results

Our patient is a 51 years old female. She has underlying Diabetes Mellitus, Hypertension, Hyperlipidemia and Schizophrenia, with history of Bilateral Severe Idiopathic Anterior Uveitis. She underwent uneventful bilateral synechiolysis, phacoemulsification with posterior chamber intraocular lens implantation 18 months ago. Immediate post op vision was good, but inflammation was severe which was managed with topical and systemic corticosteroids. However, she defaulted follow up and presented to the eye clinic 18 months post op with poor vision bilaterally.

On examination, both eyes exhibited counting fingers level of visual acuity. Both eyes showed thick opacified fibrinous membranes obscuring the whole pupil. There was presence of peripheral anterior synechiae and old keratic precipitates. Otherwise, anterior chamber was of moderate depth with no cells. Intraocular pressure (IOP) for both eyes was 10mmHg. B-scan shows posterior vitreous detachment.

The patient was started on topical dexamethasone for both eyes. Nd:YAG membranotomy was performed over a few visits with moderate power settings due to the thick membranes. Post laser, IOP remained normal. visual acuity improved to 1/60 bilaterally and the patient reported improvement in vision symptomatically.

Conclusion

Nd:YAG membranotomy is a safe and effective treatment option in managing fibrinous pupillary membranes secondary to chronic inflammation post operatively with minimal complications.

ABSTRACT ID: 408

RIGHT EYE RETROBULBAR HAEMORRHAGE POST PTERIONAL CRANIOTOMY

Salman bin Morhalim[1], Fadzilah Hanim Rahim[2], Zulhilmi Abdul Razak[2], Aidila Jesmin Jabbari[2]

[1]Sultan Ahmad Shah Medical Centre @ IIUM; [2]International Islamic University Malaysia

Purpose

To report a rare case of right eye retrobulbar haemorrhage following pterional craniotomy.

Methods

A case report.

Results

A 56-year-old woman with hypertension developed progressive right eye pain, redness, and swelling postoperatively immediately after undergoing right pterional craniotomy with aneurysm clipping. She initially presented with a ruptured right middle cerebral artery (MCA) aneurysm with subarachnoid haemorrhage. Her right eye vision was 6/15 pinhole, while the left eye was 6/7.5 pinhole. The right eye was firm on digital palpation, and extraocular movements were restricted (-2 in all directions). Optic nerve function was impaired, with 15% red colour desaturation and 50% light desaturation. Examination revealed right eyelid swelling, partial ptosis, conjunctival haemorrhage, and chemosis, with a clear cornea and no discharge. Fundus findings showed preretinal haemorrhage at the optic disc and minimal vitreous haemorrhage, with an otherwise normal retina and macula.

A CT brain scan on post-op day 3 showed increased right eye proptosis (0.5 cm), a bone defect in the right orbital roof, and hyperdensity extending to the right lacrimal gland and lateral rectus, confirming a diagnosis of retrobulbar haemorrhage. She was managed conservatively with intraocular pressure-lowering agents (Simbrinza BD, Duotrav ON). After three days, chemosis and lid swelling improved, along with optic nerve function.

Conclusion

Postoperative eye redness and swelling may mimic subconjunctival haemorrhage. A high suspicion for retrobulbar haemorrhage is crucial in post-neurosurgery patients, as it is an ophthalmic emergency.

ABSTRACT ID: 513

FIBRINOUS MEMBRANE MIMICKING ANTERIOR CRYSTALLINE LENS DISLOCATION POST OCULAR TRAUMA

Sabrina Lizy Fernandez[1], Mohd Fariz Bin Mohd Ali[1]

[1]Hospital Keningau

Purpose

To report a case of fibrinous membrane in the anterior chamber post-trauma resembling a crystalline lens.

Methods

Case report.

Results

We reported a 31-year-old gentleman sustaining right eye open globe injury with scleral laceration, hyphaema, and fibrinous membrane in the anterior chamber mimicking anterior crystalline lens dislocation. Preliminary slit lamp examination showed a scleral laceration wound with uveal tissue and vitreous prolapse. The cornea was hazy with diffuse hyphaema. Pupil and iris were fairly visible but unable to appreciate the crystalline lens. The patient underwent emergency right eye examination under anaesthesia, scleral toilet and suturing, vitreous tapping, and intravitreal antibiotic administration. Intraoperatively, a scleral laceration 9.5 mm extending superonasally from the limbus was noted; the cornea was not involved. During slit lamp examination on post-operative Day 1, the cornea was slightly clearer, anterior chamber appeared deep with cells 4+ and hyphaema level was 1 mm. Iris and pupil were fairly visible. We noted a translucent round structure in the anterior chamber but were unable to appreciate the position of the crystalline lens. B-scan and computed tomography (CT) scan of the orbit showed the lens in normal position. Subsequently, right eye anterior chamber washout and corneal toilet and suturing were performed. Intraoperatively, the translucent round structure was found to be a fibrinous membrane. The crystalline lens was in situ.

Conclusion

Ocular trauma can cause severe inflammation leading to dense fibrinous membrane formation. Imaging modalities like B-scan and CT scan are useful if the clinical findings are vague, such as in this case. If in doubt, surgical exploration is advisable.

ABSTRACT ID: 551

GONOCOCCAL CONJUNCTIVITIS AS A PRESENTING FEATURE OF RETROVIRAL DISEASE IN AN ADULT

Tamayanthi A/P Sellaodayan[1], Logeswari Krishna[2], Khairul Husnaini binti Mohd Khalid[2]

[1] Hospital Tampin, Negeri Sembilan; [2] Hospital Tuanku Ampuan Najihah

Purpose

To report a case of Gonococcal Conjunctivitis.

Methods

A case report.

Results

A 27-year-old man with no known medical illness presented from a private ophthalmologist with right eye redness and thick yellowish discharge for 4 days. There was no improvement seen despite being given topical antibiotics by the clinic. On examination, vision was 6/12, pinhole 6/9 in the right eye, and 6/6 in the left eye. There was copious mucopurulent discharge with erythematous eyelid over the right eye. No discharge was seen over the left eye. Posterior segment of both eyes was unremarkable. On further history, the patient is single and had a history of unprotected sexual intercourse with two men recently. He was initially started on tablet Azithromycin 500 mg OD, Gutt Fortum 5%, and Gutt Gentamicin 0.9% 2-hourly over the right eye. The eye swab culture and sensitivity was positive for *Neisseria gonorrhoeae*. Infective screening came back positive for Human Immunodeficiency Virus with a high viral load. Notification for contact tracing was done, and the patient was referred to the Infectious Disease clinic. He received a single dose of intramuscular Ceftriaxone 500 mg and a tablet of Azithromycin 1 gram immediately. He was then started on antiretroviral drugs. Subsequently, conjunctivitis resolved completely.

Conclusion

Gonococcal conjunctivitis is rare among adults these days. A detailed history is mandatory in unusual cases of conjunctivitis to be able to diagnose and treat this condition early to prevent further complications.

ABSTRACT ID: 574

FINANCIAL BARRIERS TO VISION CARE AMONG SCHOOL CHILDREN FROM LOW-INCOME FAMILIES IN SEREMBAN, NEGERI SEMBILAN

Maimunah binti Abdul Muna'aim[1], Siti Husna Husein[2], Azlina Mokhtar[2], Mohd Hafiz Jaafar[2], Amirah Azzeri[2], Tengku A Madeehah T M[2]

[1] Universiti Sains Islam Malaysia, Seremban
[2] Universiti Sains Islam Malaysia (USIM)

Purpose

This study aims to evaluate the financial burden of vision impairment among school children in Malaysia, particularly those from low-income (B40) households. It focuses on the cost of vision care, including spectacle affordability, transportation expenses, and the overall financial strain on families.

Methods

A cross-sectional study was conducted among school children aged 7–12 years from low-income (B40) communities. Demographic data and out-of-pocket expenditure questionnaires were collected. Vision screenings were conducted to identify children with refractive errors, and families were surveyed to assess their ability to afford corrective lenses. The financial impact of medical visits and spectacle affordability was analysed using descriptive and inferential statistics.

Results

A total of 28 children were identified with refractive errors from a sample of 312 students. Among the surveyed households, 42% relied on a single income earner, and 12% reported lost wages due to medical visits. Out-of-pocket healthcare expenses ranged from RM1 to RM50 per visit, with transportation costs adding to the financial burden. From the vision care assessment, 60% of children needed spectacles, but many families found them difficult to afford. Parents from lower-income groups often opted for basic lenses or delayed purchasing spectacles. Financial constraints, coupled with high dependency ratios, further limited access to essential vision care, resulting in uncorrected refractive errors among children.

Conclusion

The financial burden of vision care presents a significant challenge for low-income families, often resulting in delayed correction of refractive errors and potential long-term impacts on children's education. Enhancing school vision programs, increasing financial aid, and making spectacles more affordable can help ease these challenges and improve children's learning experiences.

ABSTRACT ID: 580

SCREEN TIME, VISUAL FATIGUE, AND BINOCULAR FUNCTION IN CHILDREN WITH DYSLEXIA

Suhaida binti Shahudi[1], Sabrina binti Subri[2]

[1]Hospital Kuala Lumpur; [2]Universiti Teknologi MARA (UiTM)

Purpose

Dyslexia is a reading difficulties disorder which has been linked with visual processing problems. Research has shown visual fatigue symptoms were more prevalent in this group. These symptoms are often linked to higher exposure to digital devices and binocular dysfunction, which was reported to be impaired in dyslexia. Since this has not been reported among dyslexic children in Malaysia, this study aimed to evaluate visual fatigue symptoms score and its association with screen time exposure in dyslexic children. Additionally, this study investigated which binocular vision (BV) parameters can predict visual fatigue in dyslexia.

Methods

This cross-sectional study involved 89 dyslexic children and 83 typically developing (TD) aged 13 to 17 years. Visual fatigue and screen time exposure were assessed using Malay-translated questionnaires. Seven BV parameters were assessed in dyslexic children.

Results

TD had higher screen time exposure compared to dyslexic children. Watching videos, online games, and social media engagement were common among dyslexic children while online classes and searching for information were popular among the TD group. Visual fatigue score was significantly higher in the TD group, which was significantly correlated with screen time duration. Most symptoms were highly reported in the TD group, with only tired eye symptom being comparable between groups. Near point convergence (NPC) was found to be a significant predictor for visual fatigue in dyslexic children.

Conclusion

Visual fatigue symptoms were higher in the TD group, aligned with higher screen time exposure, while NPC is a predictor of tired eye symptoms in dyslexia.

ABSTRACT ID: 584

A CLINICIAN'S TECHNICAL GUIDE TO GAMMA KNIFE RADIOSURGERY FOR OPHTHALMIC LESIONS

Ramesh Kumar[1], Ereena Alfian[1], Niki Ho Wai Wye[1], Mae-Lynn Catherine Bastion[1], Othmaliza Othman[1], Farizal Fadzil[1], Jegan Thanabalan[1], Siti Khadijah Hamsan[1], Shahizon Azura Mohamed[1], Marfuah Nik Eezamuddeen[1], Fuad Ismail[1]

[1]Hospital Canselor Tuanku Muhriz University Kebangsaan Malaysia

Purpose

Gamma Knife Radiosurgery (GKRS) is a minimally invasive technique for treating ophthalmic lesions, offering precision that minimizes damage to surrounding tissues. This paper describes a single-center experience using GKRS for ophthalmic lesions, focusing on the technical aspects.

Methods

The protocol involved pre-treatment imaging, eye fixation, stereotactic frame placement, and treatment planning. Ophthalmologists performed peribulbar regional sub-tenon anesthesia (0.5% bupivacaine and 2% lignocaine), globe immobilization (via suturing of recti muscles and applying retinal band), and temporary tarsorrhaphy in the operating theatre to secure the affected eye in position. The stereotactic frame was placed under local anesthesia and angled to center the lesion. A plastic cover filled with tissue-equivalent gel was then placed. Fat-suppressed magnetic resonance imaging (MRI) and Gamma Plan software (Version 11.1) were used for planning. Treatment focused on dose optimization, beam configuration, and protecting critical structures such as the optic nerve and retina. A dose of 15-25Gy with a 50% isodose was applied. Post-treatment follow-up imaging was done every 3-6 months to monitor outcomes and complications.

Results

The experience demonstrated that GKRS effectively controlled the ophthalmic lesions while preserving visual function. Accurate targeting and meticulous planning minimized complications, such as optic neuropathy and radiation retinopathy.

Conclusion

GKRS is a safe and minimally invasive alternative to traditional surgery for the management of ophthalmic lesions. With proper planning, optimized dosimetry, and diligent follow-up, favorable clinical outcomes can be achieved with minimal risks. This paper provides practical insights for clinicians seeking to adopt GKRS techniques in treating ophthalmic lesions.

Neurophthalmology

ABSTRACT ID: 4
HORNER SYNDROME AFTER CHEMOPORT INSERTION IN A 1-YEAR-OLD CHILD

Chong Yong Yuin[1], Wan Mohd Aiman Wan Abdul Rahman[1]

[1]Hospital Wanita dan Kanak-Kanak Sabah

Purpose

Chemoport insertion is estimated to be performed in millions of patients per year. It is most often inserted into the internal jugular vein and during this procedure, it may come into contact with the sympathetic chain. This is a case report of a 1-year-old child who developed Horner syndrome after chemoport insertion.

Methods

Case report.

Results

One day after chemoport insertion, right-sided partial ptosis and anisocoria were noted, with the right pupil measuring 2 mm and the left pupil measuring 4 mm, both otherwise reactive. There was no anhidrosis, and no other focal neurological deficits were observed.

Conclusion

Horner syndrome remains a relatively rare, yet definite, complication following chemoport insertion via a central venous catheter through the internal jugular vein.

ABSTRACT ID: 10

DECODING MOG OPTIC NEURITIS: THE ENIGMA OF MYELIN OLIGODENDROCYTE GLYCOPROTEIN (MOG)

Christina Chieng Ying Hui[1], Lim Thiam Hou[1]

[1]Hospital Sibu

Purpose

To report a case of myelin oligodendrocyte glycoprotein associated optic neuritis (MOG-ON) with a favorable response to intravenous corticosteroid treatment in a paediatric patient.

Method

Case report.

Results

A previously healthy 10-year-old girl presented with a 3-day history of painless bilateral vision loss. Visual acuity was hand movements, with a relative afferent pupillary defect (RAPD) and reduced optic nerve function in the left eye (LE). There was no limitation in extraocular movement or gaze-evoked pain. Fundus examination showed bilateral optic disc swelling and temporal pallor, though anterior segments were unremarkable. Magnetic resonance imaging (MRI) of the brain and orbit was consistent with optic neuritis, showing bilateral, longitudinally extensive, swollen, and enhancing optic nerves. No abnormal white matter lesions were seen. Investigations, including lumbar puncture and autoimmune screening, were unremarkable except for the presence of myelin oligodendrocyte glycoprotein (MOG) antibodies, which confirmed MOG-associated optic neuritis (MOG-ON). She was treated with a 5-day course of intravenous methylprednisolone (30 mg/kg/day), resulting in partial visual improvement (RE: 6/24, LE: 2/60). She was discharged on tapering oral prednisolone. Follow-up showed further visual recovery (RE: 6/9, LE: 6/15), with resolution of optic disc swelling but persistent temporal pallor and a positive RAPD in the LE.

Conclusion

MOG-ON is a rare but serious condition that can lead to permanent visual impairment, particularly in the pediatric population. Accurate diagnosis through thorough examination and MRI is essential to rule out other causes. While treatment can improve symptoms and visual acuity, the risk of recurrence underscores the need for ongoing monitoring and timely intervention to ensure optimal long-term outcomes.

ABSTRACT ID: 17

BILATERAL OPTIC DISC SWELLING AND SIXTH NERVE PALSY IN A TEENAGER WITH ATYPICAL MENINGITIS: A CASE REPORT

Karimmah Wahit[1], Wan Hazabbah Wan Hitam[1], Shatriah Ismail[1]

[1]Universiti Sains Malaysia

Purpose

To report a case of bilateral sixth nerve palsy with papilledema in a teenager, emphasizing multidisciplinary evaluation and treatment outcomes.

Methods

Case report.

Results

A 16-year-old female presented with a two-week history of generalized throbbing headaches, associated with nausea, neck stiffness, and a low-grade fever lasting for four days. One week before admission, she developed binocular horizontal diplopia without vision loss or eye pain. Her systemic history was unremarkable, with no significant family history. Examination revealed normal visual acuity (6/6 bilaterally) and intact optic nerve function, but restricted lateral gaze bilaterally. Fundoscopy showed bilateral optic disc swelling with blurred margins, venous dilatation, and peripapillary hemorrhages. Infective workup (including tuberculosis screening), cerebrospinal fluid (CSF) analysis, and contrast-enhanced CT scan were all unremarkable. She was started on empirical intravenous Rocephin and Azithromycin for suspected atypical meningitis. Over the course of treatment, her headache and fever gradually resolved. Diplopia improved, with partial recovery of lateral gaze function by the third week. Repeat fundoscopy showed reduction in optic disc swelling, and CSF opening pressure remained within normal limits on follow-up lumbar puncture. She was discharged with close neurological and ophthalmological follow-up, showing continued improvement over subsequent weeks.

Conclusion

The presence of bilateral sixth nerve palsy and papilledema in the context of meningitis is uncommon, making this an atypical presentation. Timely evaluation and empirical treatment were crucial in managing the condition and achieving a favorable outcome.

ABSTRACT ID: 18
BRUNS NYSTAGMUS AS A CLINICAL CLUE FOR LARGE CEREBELLOPONTINE ANGLE TUMOR: A CASE REPORT

Karimmah Wahit[1], Wan Hazabbah Wan Hitam[1], Shatriah Ismail[1]

[1]Universiti Sains Malaysia

Purpose

To report a case of Bruns nystagmus associated with a large cerebellopontine angle (CPA) tumor.

Methods

Case report.

Results

A 28-year-old female presented with a two-year history of intermittent headaches, exacerbated during pregnancy, accompanied by imbalance. In January 2023, she developed blurred vision in the left eye, which progressively worsened. She also experienced left-sided hearing loss, which began in May 2023. There were no other cranial nerve deficits or systemic symptoms.

On examination, visual acuity of right eye was 6/6 and left eye 6/12 , no RAPD, full extraocular movements and unremarkable anterior segment findings in bilateral eyes and normal intraocular pressure. Fundus examination over right eye revealed grade III papilledema and grade IV papilledema over left eye.

Magnetic Resonance Imaging (MRI) of the brain revealed a large left cerebellopontine angle tumor, compressing the cerebellum and brainstem, causing obstructive hydrocephalus. The lesion was consistent with a vestibular schwannoma (acoustic neuroma). There was significant mass effect, leading to displacement of surrounding neurovascular structures.

Multidisciplinary management included neurosurgical intervention, with tumor resection, and ophthalmologic monitoring to address the progressive papilledema and preserve visual function.

Conclusion

This case highlights the diagnostic value of Bruns nystagmus as a clinical clue for CPA tumors. Early detection through detailed ocular examination and neuroimaging is vital for timely intervention, which can significantly improve neurological and visual outcomes in patients with vestibular schwannomas.

ABSTRACT ID: 23
RECURRENT ATYPICAL BILATERAL OPTIC NEURITIS IN A 43-YEAR-OLD MALE: A DIAGNOSTIC CHALLENGE

Karimmah Wahit[1], Wan Hazabbah Wan Hitam[1], Shatriah Ismail[1]

[1]Universiti Sains Malaysia

Purpose

To report a case of recurrent bilateral optic neuritis, emphasizing the need for thorough evaluation and early immunosuppressive therapy to prevent long-term visual sequelae.

Methods

Case report.

Results

A 43-year-old male presented with painless blurring of vision in the left eye for three weeks, progressing to severe central vision loss. Three months earlier, he experienced a similar episode, initially diagnosed as bilateral atypical optic neuritis with macular edema. At that time, visual acuity (VA) was severely reduced in both eyes, with bilateral marked optic disc swelling. Treatment with high-dose intravenous methylprednisolone followed by oral corticosteroids resulted in partial improvement. During the current episode, despite being on oral prednisolone, his VA deteriorated to 6/60 in the right eye and 6/120 in the left eye, with diminished brightness and red saturation perception in the left eye. Pupil examination revealed sluggish responses with no obvious afferent pupillary defect. Fundus examination showed gross optic disc swelling bilaterally, without vitritis, vasculitis, or retinal involvement. MRI confirmed enhancement of the intraorbital optic nerves, consistent with optic neuritis. Despite a negative workup for aquaporin-4 and MOG antibodies, the patient's steroid-responsive course suggests an inflammatory etiology. He was started on azathioprine for long-term immunosuppression, with careful corticosteroid tapering.

Conclusion

This case underscores the importance of early diagnosis and treatment to mitigate recurrence and preserve vision.

ABSTRACT ID: 24

BILATERAL RETINOCHOROIDITIS IN A 21-YEAR-OLD WOMAN WITH HODGKIN LYMPHOMA AND STEROID-RESISTANT NEPHROTIC SYNDROME: A CASE OF MASQUERADE SYNDROME

Karimmah Wahit[1], Shatriah Ismail[1]

[1]Universiti Sains Malaysia

Purpose

To report a case of masquerade syndrome in systemic malignancy.

Methods

Case report.

Results

A 21-year-old Malay woman with Hodgkin lymphoma and steroid-resistant nephrotic syndrome due to focal segmental glomerulosclerosis (FSGS) presented with respiratory distress and sepsis. Her condition was complicated by respiratory failure attributed to fluid overload, hospital-acquired pneumonia, and central line-associated bloodstream infection. Acute seizures prompted neuroimaging, which revealed a ring-enhancing lesion in the left frontal lobe, suggestive of cerebritis. Ocular examination, despite her lack of visual complaints, revealed 6/9 visual acuity bilaterally, normal anterior segments, and full extraocular movements. Fundus examination identified a small yellowish lesion nasal to the optic disc in the right eye. In the left eye, a large superotemporal retinal mass with hemorrhage involving the macula, along with a small yellowish lesion near the optic disc, was observed. These findings raised suspicion for intraocular lymphoma masquerading as inflammation.

Conclusion

Masquerade syndromes, such as intraocular lymphoma, should be considered in immunocompromised patients with atypical ocular findings. Early recognition through comprehensive evaluation, including vitreous biopsy and imaging, is essential for timely diagnosis and treatment. This case highlights the importance of integrating ophthalmologic findings in systemic disease management to improve patient outcomes.

ABSTRACT ID: 25
LEFT ACUTE COMPRESSIVE OPTIC NEUROPATHY SECONDARY TO SPHENOID WING MENINGIOMA: A CASE REPORT

Karimmah Wahit[1], Wan Hazabbah Wan Hitam[1], Shatriah Ismail[1]

[1]Universiti Sains Malaysia

Purpose

To report a case of compressive optic neuropathy secondary to shepnoid wing meningioma.

Methods

Case report

Results

A 21 year old female, with history of hyperthyroidism, presented with sudden blurring of vision in her left eye, headache, and eye pain. CT imaging identified a left sphenoid wing meningioma displacing the lateral rectus, superior rectus, and optic nerve medially, with left eye proptosis. Her visual acuity was 6/6 in the right eye and 6/36 in the left, improving to 6/12 with pinhole. Examination showed a relative afferent pupillary defect in the left eye, reduced light brightness, and impaired color vision. Extraocular movements were restricted in left eye abduction, and Hertel exophthalmometry indicated left eye proptosis (LE 19 mm, RE 15 mm). Optic disc swelling was present in the left eye, without anterior segment abnormalities. The patient reported subjective improvement in vision during follow-up and was conservatively managed with close monitoring of optic nerve function, with further intervention contingent on her clinical progress.

Conclusion

Sphenoid wing meningiomas can compress the optic nerve, causing neuropathy with symptoms like reduced visual acuity, relative afferent pupillary defect, and optic disc swelling. Multidisciplinary management involving ophthalmology, neurosurgery, and radiology is essential for optimal outcomes. Early recognition and timely intervention remain crucial in preventing permanent vision loss in cases of tumour-induced optic neuropathy.

ABSTRACT ID: 26

MY HEAD IS HURTING AND MY LID IS DROOPING: A CASE OF POST-GANGLIONIC HORNER SYNDROME SECONDARY TO CLUSTER HEADACHE

Karimmah Wahit[1], Shatriah Ismail[1], Sunjay Parmar[2], Axel Petzold[2]

[1]Universiti Sains Malaysia; [2]Moorfields Eye Hospital, London

Purpose

To describe a case of post-ganglionic Horner syndrome associated with cluster headache and its diagnostic challenges.

Methods

Case report.

Results

A 40-year-old male with a history of migraine presented with new-onset, severe, right orbital headaches recurring nightly for 3–4 hours. These were accompanied by autonomic symptoms, including miosis, ptosis, and facial swelling. Persistent right ptosis was noted even between headache episodes. His systemic history included smoking and no illicit drug use. Examination revealed mild anisocoria with pupil dilation lag and Horner reversal confirmed with 0.1–0.2% phenylephrine. Fundoscopic findings were unremarkable. MRI imaging showed a tiny solitary right temporal parenchymal microhemorrhage and right maxillary sinus involvement, with no other significant pathology to explain the symptoms. The clinical presentation was consistent with cluster headaches, likely complicated by post-ganglionic Horner syndrome. He was treated with escalating doses of verapamil, monitored with serial ECGs, and educated on avoiding triggers.

Conclusion

This case highlights the importance of recognizing post-ganglionic Horner syndrome as a potential complication of cluster headaches. A systematic diagnostic approach, including neuroimaging, is critical to rule out secondary causes and ensure timely intervention. Further, careful monitoring during verapamil titration is essential for safety. This report underscores the need for a multidisciplinary approach in managing complex headache syndromes.

ABSTRACT ID: 30
DECODING NON-PTOTIC OCULAR MYASTHENIA GRAVIS: INSIGHTS FROM BILATERAL ADDUCTION DEFICIT

Alice Chiew Pei Jen[1], Lim Thiam Hou[1]

[1]Hospital Sibu, Sarawak

Purpose

We report a seronegative ocular myasthenia gravis (OMG) presented to us with an atypical presentation, notably without ptosis.

Methods

Case report.

Results

A 30-year-old woman with newly diagnosed hyperthyroidism was referred for active thyroid-associated orbitopathy evaluation. She presented with diplopia for five days, which had progressively worsened. She denied symptoms such as ptosis, dysphagia, dyspnoea, generalized muscle weakness, recent trauma, or fever. Her vision was unaffected, with a visual acuity of 20/20 in both eyes. Clinical examination revealed restricted adduction in both eyes (left eye: -2; right eye: -1/2). Anterior and posterior segment evaluations were normal. The Cogan lid twitch sign was absent, and the fatiguability test yielded negative results. Given the unusual presentation, further investigations were conducted. Brain MRI was performed to rule out central pathology, and blood tests for acetylcholine receptor antibodies (AchR-Ab) and muscle-specific kinase (MuSK) antibody titres were obtained, all of which returned negative. Single-fibre electromyogram (EMG) revealed evidence of a postsynaptic neuromuscular junction disorder, supporting the diagnosis of ocular myasthenia gravis. The patient was initiated on pyridostigmine, leading to a resolution of her symptoms. She is now symptom-free, and her extraocular movement deficits have improved.

Conclusion

Heightened clinical suspicion is essential for diagnosing non-ptotic ocular myasthenia gravis due to its atypical presentation. Single-fibre EMG remains an indispensable tool for seronegative cases.

ABSTRACT ID: 45

TERSON SYNDROME: A RARE OCULAR MANIFESTATION FOLLOWING ENDOSCOPIC TRANSCRANIAL BIOPSY

Noorhayati M Nadzir[1], Safiyah Jameelah Mohd Yusof[2], Suriana Suaibun[2]

[1]Institut Kanser Negara; [2]Hospital Putrajaya

Purpose

To report a case of Terson Syndrome following an endoscopic transcranial biopsy.

Methods

Case report.

Results

A 20-year-old Malay gentleman with known suprasellar mass and a possible synchronous germ cell tumour, complicated by cranial diabetes insipidus and panhypopituitarism underwent an endoscopic transcranial biopsy. Post-procedure, he complained of painless, poor vision on both eyes. On examination, his vision was 6/60 in the right eye and counting fingers in the left eye. Anterior segment examination was unremarkable; however, fundus examination revealed bilateral multi-level retinal bleeding surrounding the optic discs and along the vessels. Additionally in the left eye, there was a large subhyaloid hemorrhage covering the entire macula and extending inferonasally. He was treated conservatively, and his final vision in both eyes has improved to 6/9 during follow-up appointment.

Conclusion

Terson Syndrome following an endoscopic transcranial biopsy is plausible, with spontaneous resolution resulting in a favourable visual outcome, emphasizing the potential outcome of this procedure.

ABSTRACT ID: 78

THE ROOT OF THE DROOP: A CASE SERIES OF OCULOMOTOR NERVE PALSY

Fatin Diyanah Mazlan[1], Nurhafizah Abdullah[1], Zairah Zainal Abidin[1]

[1]Hospital Ampang

Purpose

To report a case series of oculomotor nerve palsy.

Methods

Case report.

Results

Case 1: A 57-year-old Malay female with premorbid hypertension presented with acute left eye ptosis and diplopia. Her left vision was 6/24. She had complete ptosis with pupillary involvement and total restriction of eye movements in all directions except abduction. Contrasted brain imaging revealed saccular aneurysm (2.3 x 2.5 x 2.9 mm) at supraclinoid segment of left internal carotid artery for which aneurysmal clipping procedure was performed.

Case 2: A 61-year-old Malay female with history of breast cyst presented with acute right eye complete ptosis and diplopia. Her right vision was 6/18. She had right complete ptosis with pupillary involvement and total extraocular movement limitations in all directions, sparing abduction. Brain angiography revealed multiple intra-axial lesions with adjacent mass effect, extra-axial lesions and lytic skull erosion highly suggestive of intracranial metastases. Breast lump biopsy showed invasive breast carcinoma. She was co-managed with the oncology team for radiotherapy.

Case 3: A 54-year-old Chinese male with uncontrolled diabetes mellitus, hypertension, and dyslipidemia presented with acute right eye ptosis and diplopia. His right vision was 6/24. He had pupil-sparing right complete ptosis and limited right extraocular muscles movement sparing abduction. Contrasted brain imaging revealed multifocal infarcts without evidence of focal enhancing brain or orbital lesion. He was referred to the medical team for further management.

Conclusion

This case series highlights the diverse etiologies oculomotor nerve palsy presentation. A systemic diagnostic approach is crucial in identifying the underlying cause and guiding clinicians for appropriate management.

ABSTRACT ID: 82

TRANSIENT ACUTE VISUAL LOSS SECONDARY TO WERNICKE'S ENCEPHALOPATHY IN PREGNANCY

Law Ngee Ling[1], Ayesha Mohd Zain[1], Siti Nur Amira Abu Kassim[2], Juliana Jalaluddin[2]

[1]Universiti Kebangsaan Malaysia; [2]Hospital Melaka

Purpose

To report a rare instance of transient acute visual loss linked to Wernicke's encephalopathy during pregnancy.

Methods

Case report.

Results

A 41-year-old woman, gravida 2 para 1, at 16 weeks and 3 days of gestation, experienced a sudden onset of generalized, painless vision drops over two weeks. Her medical history includes hospitalization a month earlier for severe hyperemesis gravidarum, accompanied by reduced appetite and significant weight loss of 15 kg over two months. On examination, she appeared cachexic with a delayed response during the history-taking process, though her vital signs were stable. Her visual acuity was hand movement and counting fingers for right and left eye respectively, without relative afferent pupillary defect. Ocular motility was intact, but horizontal nystagmus was noted. Otherwise other ocular findings were normal. A plain CT scan of the brain showed normal findings. However, blood parameters revealed anemia, hyponatremia, and low serum cobalamin. Wenicke's encephalopathy secondary to poor oral intake and hyperemesis gravidarum was considered. This case was co-managed with obstetrician and physician with commencement of intravenous dextrose 5% and thiamine 500 mg three times daily. Her vision improved markedly within hours, returned to normal within 24 hours.

Conclusion

This case highlights the importance of considering Wernicke's encephalopathy as a differential diagnosis for acute visual loss in pregnant lady with severe hyperemesis gravidarum. Prompt recognition and treatment can lead to rapid and complete recovery.

ABSTRACT ID: 97

BEYOND DIPLOPIA: UNVEILING AN INTERNAL CAROTID ARTERY ANEURYSM IN A CASE OF ISOLATED TROCHLEAR NERVE PALSY.

Muhammad Khairul Adha Fuaad[1], Adzleen Mohmood[1], Muhammad Mohd Isa[1], Amirah M Razali[1]

[1]Universiti Putra Malaysia, Selangor

Purpose

To report a case of isolated trochlear nerve palsy secondary to an internal carotid artery aneurysm.

Methods

Case Report

Results

A 62-year-old woman with underlying vertigo, presented with an 8-month history of vertical diplopia, which reduced upon left head tilt. This was also associated with intermittent headaches. On examination, visual acuity was 6/6 bilaterally. Relative afferent pupillary defect was negative. Hirschberg was central. There was right eye hypertropia on cover testing. Parks-Bielschowsky three-step test revealed right eye hypertropia, greater in left gaze and right head tilt. Anterior and posterior segment examination was normal. Hess chart showed underaction of the right superior oblique muscle. Magnetic resonance angiography identified a giant aneurysm in the cavernous segment of the right internal carotid artery (ICA). A final diagnosis of right trochlear nerve palsy secondary to a right ICA aneurysm was made. The patient underwent successful embolization of the right ICA aneurysm with coils and flow diverter. She had a good recovery with full resolution of her diplopia, four months after the procedure.

Conclusion

This case highlights the importance of thorough evaluation in isolated trochlear nerve palsy. ICA aneurysms, though rare, should be considered in persistent cases, as early intervention can prevent complications and lead to excellent outcomes.

ABSTRACT ID: 110
MOGAD-ASSOCIATED OPTIC NEURITIS

Jimmy Ling Nguong Shen[1], Syed Ahmed D Alsagoff[1]

[1]Hospital Sarikei

Purpose

To report a case of optic neuritis associated with Myelin Oligodendrocyte Glycoprotein Antibody Disease (MOGAD), highlighting the importance of early and accurate differentiation to prevent irreversible neurological damage.

Methods

Case report.

Results

A 32-year-old man who presented with fever, headache, and dizziness for three days, was initially treated as viral meningitis with intravenous acyclovir. Computed tomography (CECT) of the brain and lumbar puncture were unremarkable. On the 12th day of treatment, he developed right-sided blurred vision, prompting ophthalmic referral. Examination revealed a right visual acuity of 2/60 and left visual acuity of 6/9. The relative afferent pupillary defect was positive in the right eye, with grade 3 optic disc swelling. Cerebrospinal fluid (CSF) analysis, including culture, aquaporin-4, and oligoclonal bands, was negative. Serum myelin oligodendrocyte glycoprotein (MOG) antibody testing was positive. MRI of the brain and orbit showed right optic nerve thickening with abnormal T2/FLAIR signal intensity and enhancement, without other focal brain abnormalities. The patient was treated with intravenous methylprednisolone, leading to an improvement in visual acuity to 6/21 after five days. He was discharged with a six-week steroid taper.

Conclusion

MOG antibody-associated optic neuritis (MOG-ON) is a distinct demyelinating disorder and a key presentation of MOGAD. Although rare, a high index of suspicion is necessary to ensure timely diagnosis and treatment, preventing irreversible vision loss.

ABSTRACT ID: 117

SILENT THREAT: ATYPICAL PRESENTATION OF NON-ARTERITIC ISCHEMIC OPTIC NEUROPATHY

Fathin Maisarah binti Jamaludin[1], Noor Amalina binti Saidi[1], Mohd Alif bin W Mohd[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

This case report highlights the atypical presentation of non-arteritic anterior ischaemic optic neuropathy (NAION).

Methods

Case report.

Results

A 47-year-old gentleman with underlying hyperlipidemia and a previous history of ischemic heart disease. He presented with a three-day history of sudden onset right eye painless blurring of vision described as a central scotoma, without any associated symptoms. Comprehensive examination revealed a best-corrected visual acuity of 6/6 in both eyes, with no relative afferent pupillary defect, normal light and red saturation, and normal color vision. Anterior segment examination and intraocular pressure were unremarkable. Fundus examination showed a swollen right optic disc with blurred margins. Humphrey visual field testing revealed a right inferior altitudinal field defect. The left eye examination and posterior segment finding were unremarkable except for a small and crowded disc with a cup-to-disc ratio of 0.1. Extensive investigations to rule out infectious, inflammatory, and other systemic causes were unremarkable. Based on the clinical findings, the patient was diagnosed with NAION in the right eye. Management included co-management with a physician to optimize cardiovascular risk factors and close monitoring for potential involvement of the left eye.

Conclusion

This case underscores that NAION can present with normal visual acuity and optic nerve function, making it crucial to differentiate it from other causes of optic neuropathy. Early recognition, exclusion of other pathologies, and prompt management of systemic risk factors are vital in preserving vision and preventing contralateral eye involvement.

ABSTRACT ID: 144

A RARE CASE OF BINASAL HEMIANOPIA IN A PATIENT WITH PITUITARY MACROADENOMA: A DIAGNOSTIC AND THERAPEUTIC CHALLENGE

Wong Joon Leek[1], Lim See Theng[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To report an unusual visual field defect presentation in a patient with pituitary macroadenoma and its therapeutic challenges faced

Methods

A case report

Case Presentation

A 52-year-old, Malay man who is a chronic smoker with underlying type 2 diabetes mellitus, hypertension, macroprolactinoma, hypogonadotropic hypogonadism and previous history of stroke presented to ophthalmology clinic with complain of intermittent eye pain when looking at extreme gaze. He also complained of some degree of visual field defect however patient was unable to ascertain which part. On Humphrey visual field testing, patient was found to have binasal hemianopia. A thorough neurological examination revealed left sided upper and lower limb reduced power with no clonus and negative Babinski corresponding to his left sided residual weakness secondary to previous stroke. Upon neuroimaging via MRI of the brain demonstrated a pituitary macroadenoma (1.1 cm x 1.4 cm x 1.3 cm). Despite the tumor's proximity to the optic chiasm, the imaging did not reveal classic compression indicative of bitemporal hemianopia, prompting further investigation into the possible mechanisms of this unusual visual field defect.

Conclusion

This case highlights the importance of considering rare visual field defects, such as binasal hemianopia, in patients with pituitary macroadenomas. Early recognition of atypical visual presentations, in conjunction with neuroimaging, is critical for accurate diagnosis and management. This case also emphasizes the need for further research to understand the mechanisms behind unusual visual disturbances in pituitary tumors.

ABSTRACT ID: 157
THROUGH THE EYES OF PREGNANCY: UNRAVELING OPTIC PERINEURITIS

Oh Zhaogy[1], Loh Chih Chung[1], Lee Chia Ying[1], Chuah Gim Seah[1]

[1]Hospital Sultanah Bahiyah

Purpose

Optic perineuritis (OPN) is an orbital inflammatory disease causing inflammation of the optic nerve sheath, which can result in eye pain and visual disturbances. This report discusses a rare case of OPN initially misdiagnosed as optic neuritis in a pregnant woman.

Methods

Case report.

Results

A 22-year-old pregnant woman at 31 weeks of gestation, with dilutional anemia, presented with acute left eye vision loss and pain upon movement for 4 days. Visual acuity was 2/60, with positive RAPD, reduced optic nerve function, and failed to read the Ishihara chart. Fundus examination revealed optic disc swelling (Frisen grade 5) and a flame-shaped hemorrhage near the papillo-macular bundle, but no macular star. The retina appeared flat with normal vessels. Infective and autoimmune tests were negative. MRI showed tram-track and doughnut signs, suggesting optic perineuritis. After 3 days of intravenous methylprednisolone, a macular star developed, prompting an extension of treatment to 5 days. One month later, her vision improved to 6/60 with pinhole 6/36, and optic nerve function showed signs of recovery.

Conclusion

Early diagnosis and timely treatment of optic perineuritis lead to favorable visual outcomes. Delayed treatment can result in complete vision loss. The prognosis is worse when there is a delay between vision loss and steroid treatment initiation.

ABSTRACT ID: 163
ACUTE PROFOUND VISION LOSS AS A PRESENTATION OF INFILTRATIVE OPTIC NEUROPATHY

Sharmini Tamilselvan[1], Adzleen Mohmood[1], Shankari Sothirachagan[1], Rafidah M Salleh[1], Amirah M Razali[1]

[1]Universiti Putra Malaysia

Purpose

To report a case of right infiltrative optic neuropathy secondary to metastatic lung adenocarcinoma.

Methods

Case report.

Results

A 67-year-old lady with underlying hypertension and metastatic lung adenocarcinoma on Alfatinib, presented with a 1-week history of sudden onset, right eye blurring of vision, more so inferiorly which further deteriorated involving the whole visual field. Visual acuity was perception to light in the right eye and 6/7.5 in the left eye. There was a positive relative afferent pupillary defect over the right eye, with reduced light brightness, red saturation and colour vision. Anterior segment examination revealed dry eye disease and mildly cataractous lens. Fundus examination was normal with no evidence of optic disc swelling. Other neurological examination was normal. Magnetic resonance imaging of the brain and orbit revealed enhancement of the right optic nerve in keeping with a right retrobulbar optic neuritis. Blood investigations including erythrocyte sedimentation rate, C-reactive protein, rapid plasma reagin, human immunodeficiency virus (HIV) and hepatitis were all normal. Paraneoplastic antigen autoimmune profile, aquaporin-4 receptor antibody and myelin oligodendrocyte glycoprotein antibody were also negative. The patient was given pulse intravenous methylprednisolone 1g daily for 5 days which was then converted to oral prednisolone 1 mg/kg. She had initial improvement in vision to 6/60, but unfortunately dropped again to perception to light after two weeks on treatment.

Conclusion

Infiltrative optic neuropathy usually leads to profound visual loss with poor visual outcome. Co-management with the oncologist is key in ensuring a holistic approach for the management of these patients.

ABSTRACT ID: 171
WHEN THE EYES FREEZE: THE MILLER FISHER SYNDROME MASQUERADE

Lekkha Yuvaraj[1], Inderpreet Kaur[1], Jamuna Lachumanan[1], Deivanai Subbiah[1]

[1]Hospital Selayang

Purpose

To report a case of Miller Fisher Syndrome (MFS) post cerebrovascular accident (CVA) presenting with total ophthalmoplegia with absence of ataxia and areflexia.

Methods

Case report.

Results

A 68-year-old Chinese gentleman with underlying hypertension and chronic obstructive pulmonary disease presented with left sided body weakness. CT scan showed bilateral fronto-parietal multifocal lacunar infarcts. Post CVA, visual acuity (VA) and extraocular muscle movement (EOM) was normal. Three weeks later he presented with bilateral ptosis and diplopia with no diurnal variation. He had no recent illnesses, upper respiratory tract infection or fever. Examination revealed bilateral ptosis with symmetrical restricted extraocular movement (EOM) at all gazes. There was no fatigability and pupillary reflex was otherwise normal. Anterior and posterior segment examination was unremarkable. Neurological examination showed left upper limb intentional tremor, dysdiadochokinesia with full muscle strength and intact reflexes in all limbs. Romberg test was negative with absence of ataxia. MRI of the brain showed multifocal old infarcts with no new changes. Lumbar puncture revealed elevated Gamma immunoglobulin in cerebrospinal fluid while serology tests was positive for acetylcholine receptor antibody and negative for GQ1b antibody. The patient was treated as MFS and started on intravenous immunoglobulin 2 g/kg for 5 days. Following treatment, EOM and ptosis improved significantly.

Conclusion

MFS exhibits variability in its clinical presentation, and neuroimaging is typically normal, therefore, a high index of suspicion is necessary for early treatment. The GQ1b antibody may be negative in MFS, and the concurrence of Myasthenia Gravis with a positive acetylcholine receptor antibody is rare and requires further investigation.

ABSTRACT ID: 180

BILATERAL CAROTID-CAVERNOUS FISTULA: A RARE CASE WITH UNIQUE B-SCAN FINDING

Fatin Najwa Razali[1], Abbas Abd Hamid[1], Wan Nadiah Amir Hamzah[2]

[1]Hospital Tengku Ampuan Rahimah; [2]Universiti Sains Malaysia

Purpose

To discuss a patient with bilateral carotid-cavernous fistulas (CCFs), emphasizing the role of B-scan ultrasonography in diagnosis.

Methods

Case report.

Results

A 49-year-old female presented with acute left eye redness associated with pulsating pain, headache and nausea. Her left eye vision was 6/9 with an elevated intraocular pressure of 22mmHg. There was exophthalmos, with presence of corkscrew vessels. Fundus examination was otherwise unremarkable. B-scan ultrasonography was performed, revealing increased retrobulbar echogenicity, suggestive of orbital congestion and venous engorgement. Further imaging with computed tomography angiography (CTA) confirmed the presence of CCFs, with prominent cavernous sinus filling and arterialized venous outflow. Patient underwent digital subtraction ngiography (DSA), denoting right direct Barrow Type A and indirect Barrow Type C CCF, and left indirect Barrow Type D CCF. Endovascular coil embolization of left CCF was performed successfully, with resolution of right indirect CCF as well. Left eye symptoms and proptosis were significantly improved.

Conclusion

Bilateral CCFs are exceedingly rare and often result from trauma. The role of B-scan ultrasonography in diagnosing CCFs is significant, as it allows for real-time assessment of orbital structures and hemodynamic. Differentiation from other orbital pathologies, such as thyroid orbitopathy or orbital cellulitis, is crucial for prompt intervention.

ABSTRACT ID: 181
OCULAR SPOROTRICOSIS

Nurul Shafiqah Jamahiri[1], Ng Pey Yih[1]

[1]Kementerian Kesihatan Malaysia

Purpose

Sporotrichosis is a rare type of mycosis caused by Sporothrix schenckii. It usually presents as a subcutaneous infection, but in recent years, ocular sporotrichosis has been increasingly reported, especially in tropical and subtropical countries. It is believed that ocular sporotrichosis is underreported in Malaysia, as Malaysia's warm and humid climate creates ideal environent for it's growth. Ocular infection due to Sporothrix can manifest as lesions in the ocular adnexa, including the conjunctiva and lacrimal sac. It can also present as sight-threatening endophthalmitis.

Methods

Case report

Results

A 50-year-old lady, with underlying hypertension, presented with left eye discomfort and ipsilateral submandibular lymph node enlargement for about a month. Examination revealed a raised, non-tender, erythematous mass at left superior palpebral conjunctiva, together with left submandibular lymphadenopathy. Other ocular examinations were unremarkable. Both eyes vision was unaffected. She was treated as left ocular sporotrichosis and was started on T.Itraconazole 200 mg OD. Subsequently, the patient showed positive improvement.

Conclusion

The diagnosis of ocular sporotrichosis is based on suggestive ocular findings and mycological examination from ocular or skin samples. Itraconazole and potassium iodide are the most used and effective antifungal agents in treating sporotrichosis in the ocular adnexa, while amphotericin B is the antifungal agent for treating intraocular infection.

ABSTRACT ID: 191

THE EYE AS A DOOR: A CASE OF OPTIC DISC SWELLING SECONDARY TO ESSENTIAL THROMBOCYTOSIS

Maisarah Muhamad Shakir[1], Hazrati Ab Rahman[1], Krishnadevi Thiyagarajam[1], Ng Sok Lin[1]

[1]Hospital Taiping

Purpose

Essential thrombocytosis is a rare chronic myeloproliferative neoplasm that develops when megakaryocytes in the bone marrow produce an excess number of platelets in which subsequently can cause cerebral venous thrombosis.

Methods

Case report.

Results

A 29-year-old woman with underlying migraine, presented with right eye intermittent painless loss of vision for 3 months, with each episode lasted for 2-3 minutes. She also had numbness over right side of the face with otherwise intact cranial nerve examinations. Ocular examination showed bilateral visual acuity of 6/6 and no relative afferent pupillary reflex. Both anterior segments were normal. Both fundus showed Frisen Grade 3 optic disc swelling with normal optic nerve functions. Her blood investigations showed high levels of platelet count (1,232 000/L). CECT brain and orbit showed bilateral symmetrically enlarged and tortuous optic nerve sheath without space occupying lesion. She had positive anti-nuclear autoantibodies which was anti SCL70. Faint oligoclonal bands seen in serum and cerebrospinal fluid with normal levels of albumin and immunoglobulin G index. CT venogram of brain revealed long segment venous thrombosis from right internal jugular vein, right sigmoid to right proximal transverse sinus. She had positive Janus Kinase 2 (JAK2) but negative antiphospholipid syndrome (APLS) screening. She was seen by hematologist and started on oral hydroxyurea with rivaroxaban. She has been responding well to the treatment with improved visual symptoms.

Conclusion

Early thrombocytosis can be associated with ocular thrombotic complications. An early diagnosis with appropriate treatment can be a life saving step for these patient.

ABSTRACT ID: 195

ANTI-MOG ANTIBODY-POSITIVE BILATERAL OPTIC NEURITIS IN A 9-YEAR-OLD BOY WITH FAVOURABLE VISUAL OUTCOME.

Maisarah Atikah Mohd Zaki[1], Prema Chendran[1], Norlaila Talib[1], Othmaliza Othman[2]

[1]Hospital Sultan Idris Shah; [2]Universiti Kebangsaan Malaysia

Purpose

To report a paediatric case of optic neuritis (ON) associated with anti-MOG antibodies.

Methods

Case report

Results

A 9-year-old boy presented with a 3-day history of right eye blurring of vision, progressing from the inferior visual field to near-total visual loss by the third day. Associated symptoms included eye pain exacerbated by movement, right eye squint, headache, and vomiting. Examination revealed perception light vision in the right eye with relative afferent pupillary defect (RAPD), limited extraocular movements, and right optic disc swelling with hemorrhages. Vision in the left eye was preserved at 6/9, with normal findings on both anterior and posterior segment examination. MRI and CT imaging confirmed bilateral optic neuritis, right worse than the left. Initial workup ruled out infectious causes, and lumbar puncture was normal. Serological testing was positive for anti-MOG antibody and negative for anti-aquaporin-4 antibody. The patient was initially treated with intravenous (IV) ceftriaxone for suspected meningitis, which was later continued with oral antibiotics. Immunosuppressive therapy included IV methylprednisolone followed by oral prednisolone with a 20-weeks tapering regimen and IV immunoglobulin. Significant visual recovery was achieved, with best-corrected vision of 6/9 in both eyes at 2 months post-presentation.

Conclusion

This case underscores the importance of considering anti-MOG antibody-associated ON in pediatric patients presenting with atypical or visual loss. Early diagnosis and prompt immunosuppressive therapy can lead to favorable visual outcomes. Anti-MOG testing should be included in the diagnostic workup of pediatric ON to guide appropriate management.

ABSTRACT ID: 203

HIGHLIGHTING THE DIAGNOSTIC CHALLENGES OF MILLER FISHER SYNDROME: A CASE OF MISTAKEN IDENTITY WITH CAVERNOUS SINUS THROMBOSIS AND THYROID EYE DISEASE

Nur Azureen Mohd Ali[1], Farhana Ibrahim[1], Julieana Muhamed[2]

[1]Hospital Tuanku Ja'afar; [2]Universiti Sains Malaysia

Purpose

To emphasize the diagnostic difficulty of Miller Fisher Syndrome (MFS) due to its strong resemblance to Cavernous Sinus Thrombosis (CST) and Thyroid Eye Disease (TED).

Methods

Case report.

Results

A 65-year-old male, with underlying hyperthyroidism and chronic smoker, presented with a one-week history of bilateral eye (BE) pain, diplopia, right eye (RE) swelling, redness and drooping of eyelid. He also reported headache, vomiting, and an unstable gait. Visual acuity was 6/12 in the RE and 6/24 in the left eye (LE). There was no relative afferent pupillary defect and optic nerve function tests were normal. Ocular examination showed BE extraocular movement (EOM) restriction in all direction. There was complete ptosis on the right eye and axial proptosis on the LE, with conjunctival hyperemia. The anterior segment examination of BE was unremarkable with normal intraocular pressure. Fundus examination showed normal optic discs, macula, and retina. Neurological examination demonstrated the absence of all reflexes and involvement of the 3rd, 4th, 6th, and left 7th cranial nerves. Tandem gait and cerebellar signs were positive. A contrast-enhanced CT of the brain and orbits was unremarkable, yet lumbar puncture revealed positive CSF anti-GQ1B confirming the diagnosis of Miller-Fisher variant of AIDP with complete ophthalmoplegia. He was administered a five-day course of intravenous immunoglobulin alongside systemic antibiotics. After six weeks, the patient showed significant recovery, with improved RE ptosis and reduced LE proptosis. EOM were fully restored in BE, all reflexes and gait normalized and only a mild residual left 7th cranial nerve palsy remained.

Conclusion

MFS, a mimicker of CST and TED, highlights the diagnostic challenges, due to overlapping features, requiring a multidisciplinary approach.

ABSTRACT ID: 204
A PRECIOUS EYE GOING DARK – A CASE OF RECURRENT AMAUROSIS FUGAX PROGRESSING TO BRANCH RETINAL ARTERY OCCLUSION

Tan Shin Kiat[1], Wang Shir Yen[1], Koh I-Ern[1]

[1]Hospital Umum Sarawak

Purpose

Amaurosis fugax (AF) is transient vision loss caused by ischemia in the retina, choroid, or optic nerve, commonly caused by ipsilateral carotid artery disease with secondary thromboemboli or vasculitis. AF is a form of transient ischaemic attack, can signal impending stroke and requires urgent evaluation. We would like to report a case of monocular AF progressing to branch retinal artery occlusion (BRAO).

Methods

Case report.

Case Report

A 68-year-old gentleman with underlying hypertension, ischemic heart disease presented to us with a three-day history of episodic right eye (RE) painless vision loss, each lasting 30 minutes before recovering to baseline vision of 6/9. Ophthalmic examination showed unremarkable RE findings and no light perception in the left eye due to a failed penetrating keratoplasty. He was diagnosed with RE AF and was admitted for further evaluation. During admission, symptoms worsened with a prolonged episode of RE AF lasting two hours and visual deterioration to counting fingers, without recovery to baseline. CT angiography brain & carotid revealed artherosclerosis, prominent at carotid bulbs and siphons bilaterally with no significant strictures. Neurology team initiated intravenous alteplase (0.9 mg/kg) for suspected embolic event. No significant visual recovery occurred. Fundus photographs showed progression from a normal fundus to features of superotemporal BRAO. Emergent treatment with ocular massage, anterior chamber paracentesis, and intraocular pressure-lowering agents did not improve vision.

Conclusion

This case underscores the importance of recognizing AF, as it can progress to retinal arterial occlusion and stroke. A systemic approach to diagnosing the underlying cause with early referral to neurology is critical to prevent further disease progression.

ABSTRACT ID: 210
SUDDEN SURGE: FULMINANT INTRACRANIAL HYPERTENSION IN A YOUNG OBESE MAN

Leong Jia Hui[1], Dian Nadia Abu Talib[1], Nurul Ain binti Masnon[1], Koh Kong Yew[1]

[1]Hospital Kuala Lumpur

Purpose

Fulminant intracranial hypertension (FIH) is a rare form of idiopathic intracranial hypertension (IIH) with rapid and aggressive vision loss in less than 4 weeks and typically requires early surgical intervention. We highlight that although most cases often require surgical intervention, some patients may show improvement with medical management only.

Methods

Case report.

Results

A 30-year-old gentleman with morbid obesity presented with 4 days history of horizontal double vision and headache, with blurred vision in both eyes (RE 6/60 and LE 2/60). Clinically, he exhibited impaired optic nerve function and sixth nerve palsy in both eyes with severe haemorrhagic papilloedema. CECT brain and orbit showed no space occupying lesion. Blood tests excluded infective and inflammatory causes. A lumbar puncture revealed high opening pressure of 50 cmH_2O but normal cerebrospinal fluid analysis. Magnetic resonance imaging (MRI) scan of the brain revealed signs of IIH, including mild flattening of both posterior globes. He was treated with oral Acetazolamide on top of his intensive weight reduction programme. With maximum tolerated medical therapy, his headache resolved completely and he showed marked vision improvement to 6/12 bilaterally, resolution of abducens palsy, and improvement of papilledema after 3 weeks, hence not subjected to shunting procedure. At three-month follow-up, his vision remains 6/6 bilaterally, and he continues to show improvement in his body mass index

Conclusion

This case highlights the importance of early detection of FIH and prompt management with multidisciplinary team approach for vision preservation and minimizing associated long-term morbidity and mortality.

ABSTRACT ID: 212
PARINAUD SYNDROME MANIFESTATION OF PINEAL GLAND GERMINOMA

Nantini Micheal[1], Aasiah Ahmad Sharifuddin[1], Aliah Hassan[1]

[1]Hospital Enche Besar Hajjah Khalsom

Purpose

To report a case of pineal gland germinoma presented with parinaud syndrome.

Methods

Case report.

Results

A 20-year-old Malay man with no significant medical history presented with binocular diplopia during upward and downward gaze for the past one year. There were no signs of increased intracranial pressure. The ocular assessment revealed a best-corrected visual acuity of 6/9 in both eyes. The patient exhibited complete upward and downward gaze palsy, along with convergence-retraction nystagmus and light-near dissociation. Both the anterior and posterior segment examination of the eyes were normal. MRI of the brain identified a tumor in the pineal gland, quadrigeminal tectal plate, cerebral aqueduct, and both thalami, which resulted in obstructive hydrocephalus and external compression of the midbrain. The neurosurgical team performed an endoscopic third ventriculostomy and biopsy, which confirmed the diagnosis of a pineal gland germinoma. He was subsequently referred to oncology and subjected to chemotherapy.

Conclusion

Pineal gland germinoma is a rare central nervous system tumor that can present with neuro-ophthalmic manifestations. Early recognition of the disease is crucial for prompt diagnosis and treatment, as germinomas are sensitive to both radiotherapy and chemotherapy.

ABSTRACT ID: 216

ACUTE ONSET OF EXOTROPIA AND NYSTAGMUS IN A MIDDLE-AGED WOMAN: INSIGHTS INTO INTERNUCLEAR OPHTHALMOPLEGIA

Diajeng Rindang Galih Annisa[1], Riski Prihatningtias[1], Liana Ekowati[1]

[1]Diponegoro University

Purpose

To report a case of sudden onset exotropia and nystagmus as the presenting features of internuclear ophthalmoplegia in a middle-aged woman, emphasizing the importance of early diagnosis and interdisciplinary collaboration in managing this rare neuro-ophthalmological disorder.

Methods

Case report.

Results

A 48-year-old woman with underlying hypertension presented with sudden onset of right eye outward squint, an inability of the right eye to gaze inward, drooping of the right eyelid, and headache. Clinical examination revealed diplopia and nystagmus in both eyes. Neurological examination showed no deficits. CT-scan of the brain revealed no signs of infarction, mass, or increased intracranial pressure. MRI showed a subacute infarction of the tegmentum mesencephalon and a kinked, slightly thicker right optic nerve compared to the left. The patient was hospitalized and managed with timolol eye drops, dexamethasone followed by intravenous methylprednisolone, prostigmin, vitamin B12, antihypertensive, and antiplatelet medications. After 10 days of hospitalization, significant improvement was observed in her eye condition, leading to her discharge.

Conclusion

The acute onset of internuclear ophthalmoplegia in a patient with vascular risk factors suggests the likelihood of subacute mesencephalon infarction. Early diagnosis and interdisciplinary collaboration are essential for optimizing patient outcomes.

ABSTRACT ID: 217

A COMPLEX PATH TO RECOVERY: NON-INFECTIOUS CAVERNOUS SINUS THROMBOSIS AND THE ROLE OF CORTICOSTEROIDS

Nur Nazifah Norran[1], Akmal Haliza Zamli[1], Mohd Fadhil Ismail[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

Cavernous sinus thrombosis (CST) is a rare, life-threatening condition requiring early recognition and intervention. It can have infectious and non-infectious etiologies, and delayed diagnosis may result in severe complications, including vision loss and neurological deficits. This report describes a case of CST in an elderly woman with atypical symptoms, highlighting the importance of early diagnosis and the potential role of corticosteroid therapy in managing non-infectious CST.

Methods

Case report.

Results

A 73-year-old woman with diabetes, hypertension, hyperlipidemia, and a prior stroke presented with a three-day history of right periorbital swelling. She denied having eye pain or discharge and showed no signs of infection. Ophthalmic examination revealed right eye visual acuity of 6/60, total ophthalmoplegia, ptosis, and diffuse periorbital swelling. Computed tomography (CT) confirmed right CST. Despite initial treatment with antibiotics and anticoagulants, her condition progressed to central retinal vein occlusion (CRVO) and macular edema. Upon the initiation of oral prednisolone, periorbital edema and orbital congestion slightly improved. However, her visual acuity remained poor at 2/60 due to ischemic CRVO and optic neuropathy.

Conclusion

This case illustrates the diagnostic challenges and complex management of aseptic CST in elderly patients with vascular risk factors. While steroids reduced inflammation, their prothrombotic effects must be considered. Early diagnosis and timely intervention, including corticosteroids for non-infectious CST, are essential to preventing complications such as vision loss. However, once ischemic damage occurs, recovery is limited, emphasizing the need for prompt intervention to minimize long-term morbidity.

ABSTRACT ID: 233

THROUGH THE FOG - UNRAVELING THE MYSTERY OF BILATERAL OPTIC NEURITIS IN A YOUNG ADULT

Lock Kah Mun[1], Law Ngee Ling[1], Kumutha Muthusamy[1], Nor Fadzillah Abd Jalil[1], Juliana Jalaluddin[1]

[1]Hospital Melaka

Purpose

To report a rare case of parainfectious optic neuritis caused by Leptospirosis.

Methods

Case report.

Results

A healthy 25-year-old male presented with a one-week history of fever and frontal headache, followed by sudden bilateral blurring of vision for four days. There were no associated visual symptoms, pain with eye movement, neurological complaints, or signs of increased intracranial pressure. He denied recent travel, pet contact, vaccination or toxins exposure. On examination, best corrected visual acuity was 2/60 in both eyes. Both pupils were sluggish with reduced optic nerve function. There was bilateral optic disc swelling without retinal exudates, hemorrhage, or macular involvement. The anterior segment of both eyes was unremarkable, with normal intraocular pressure. Extraocular movements were full bilaterally, and the confrontation test was normal. Systemically, there were no focal neurological deficits or signs of myelopathy or meningism. Vital signs were normal. Investigation revealed a predominance of neutrophils in the white blood cell count, with positive leptospirosis immunoglobulin (IgM). Infective screening for tuberculosis, syphilis, and autoimmune markers were otherwise negative. A lumbar puncture showed normal cerebrospinal fluid (CSF) analysis, with negative oligoclonal bands. Optical coherence tomography (OCT) of the macula was normal. Contrast-enhanced computed tomography (CECT) of the brain and orbit suggested bilateral optic neuritis, with no signs of demyelination or space-occupying lesions. A multidisciplinary approach involving neuromedical and neuroophthalmology was initiated. Patient was started on intravenous ceftriaxone and showed rapid improvement of vision to 6/24 within 24 hours. His vision further improved to 6/12 after one week of antibiotics.

Conclusion

This case highlights a rare presentation of parainfectious bilateral optic neuritis due to leptospirosis. Early recognition and prompt antibiotic therapy led to significant visual recovery emphasizing the importance of timely diagnosis and intervention in such cases.

ABSTRACT ID: 239
EYELID MYOKIMA POST ENDOSCOPIC SINUS SURGERY

Tuan Muhamad Iqbal Tuan Bazly[1], Abdullah Ashraf Rafique Ali[1]

[1]Hospital Al-Sultan Abdullah, Universiti Teknologi MARA (UiTM)

Purpose

To report a case of persistent right eyelid myokymia following endoscopic sinus surgery.

Methods

Case report.

Results

A 26-year-old male with no significant medical history initially presented with generalized headache and pain in the nasal area. General and neurological examinations were unremarkable. Contrasted computed tomography of the brain ruled out intracranial pathology but revealed mucosal thickening of both ethmoid air cells suggestive of sinusitis. He was referred to otorhinolaryngology and subsequently underwent endoscopic sinus surgery which was uneventful. Postoperatively, he developed persistent right eyelid twitching predominantly in the lower lid. Subsequent ocular and oropharnyx examinations were normal. A contrasted magnetic resonance imaging of the brain and internal auditory meatus showed preserved VII nerve and a Type 1 left vascular loop of uncertain clinical relevance. Electro-neurophysiology test was normal. At 10 months of myokimia presentation, botulinum toxin injections were given into the upper and lower tarsal muscles, as well as lateral eyelid regions (2.5U each site). It resulted in a marked reduction of twitching, with minimal residual activity observed at two months post injection.

Conclusion

To the best of our knowledge, this is the first reported case of eyelid myokymia following endoscopic sinus surgery. Comprehensive neuroimaging and electro-neurophysiological studies are essential to exclude other etiologies. Botulinum toxin injections can be an effective therapeutic option, offering significant symptomatic relief and improving patient's quality of life.

ABSTRACT ID: 262

SEEING THE UNSEEN: DIAGNOSING LUNG CANCER IN A PATIENT WITH OCULAR SYMPTOMS

Khor Chia Kee[1], Chew Chia Chee[1]

[1]Hospital Bukit Mertajam

Purpose

To report a case of undiagnosed lung cancer presenting with eye symptoms.

Methods

Case report.

Results

A 67-year-old gentleman presented with left eye floaters and reduced vision for two months. His systemic review revealed dysphagia and generalized body weakness. His left eye vision was hand movement, and a relative afferent pupillary defect was present. The left eye also showed dilated and tortuous episcleral vessels at the superior temporal conjunctiva. The anterior chamber revealed occasional cells. The optic disc was swollen and hyperemic. Leopard skin pigmentation changes, measuring 6 disc diameters in size, were noted at the superior retina, extending to the macula. A choroidal fold with retinal detachment involved the macula and inferior retina. Blood tests showed elevated LDH, CEA, and CA19-9 levels. A contrast-enhanced computed tomography (CECT) scan of the brain and orbit revealed a left intraocular mass with cerebral metastasis. Meanwhile, a CECT scan of the thorax, abdomen, and pelvis showed a left lower lobe lung mass measuring 5.7 x 7.2 x 11.8 cm with multiple metastases. Upon the most recent review, the patient's left eye vision remained limited to hand movement, with stable fundus finding.The patient was referred to the chest team and advised to undergo a CT-guided biopsy. However, the patient expressed a preference for palliative treatment. Ultimately, the patient succumbed to complications of advanced lung carcinoma.

Conclusion

Lung cancer presenting with ocular symptoms as the first sign is rare. A thorough systemic examination and investigation are crucial for early diagnosis and treatment.

ABSTRACT ID: 285

UNSEEN DAMAGE : RETINOPATHIES LINKED TO SYSTEMIC ILLNESSES

Tharishini Chandra Segaran[1], Muzaliha Mohamed Nor[1]

[1]Hospital Sultanah Bahiyah

Purpose

To report on retinopathies linked to different systemic illnesses by elucidating their complex interplay, which aids in both the diagnosis and prognosis of an illness.

Methods

Case report.

Results

Case 1: A 34-year-old lady with underlying diabetes mellitus and undifferentiated connective tissue disease with immune thrombocytopenic purpura (ITP) was referred for ophthalmology assessment prior to initiating hydroxycloroquine. Fundus examination showed extensive Roth spots in all four quadrants, along with scattered cotton wool spots, flame shaped haemorrhages and a few dot and blot haemorrhages.

Case 2: A 62-year-old lady with diabetes mellitus, hypertension and dyslipidemia presented with right eye floaters and reduced vision for 1 month. Visual acuity in the right eye was counting fingers and left eye was 6/9. There was an anterior chamber reaction with vitritis and chorioretinitis. Cytomegalovirus genome was detected via vitreous biopsy and she was treated with intravitreal Ganciclovir.

Case 3: A 36-year-old lady with diabetes mellitus complained of bilateral progressive blurring of vision. Fundus examination revealed advanced diabetic eye disease with vitreous haemorrhages, subhyaloid haemorrhage and tractional retinal detachment. She underwent right eye vitrectomy with silicone oil tamponade and is planned for left eye vitrectomy soon.

Conclusion

Retinopathy indicates that a disease has damaged the retina. Thorough history, systemic and ocular examinations is crucial to recognize the retinopathies caused by various systemic illnesses as this not only aids in the diagnosis but also renders appropriate treatment to patients. Understanding the relationship between systemic diseases and their ocular involvement undoubtedly improves clinical practices by promoting an integrative approach to enhance patient outcomes.

ABSTRACT ID: 300

WHEN THE EYES REVEALS THE BRAIN: A CASE SERIES OF DIVERSE INTRACRANIAL TUMOURS

Nur Farhana Mohd Musthafa[1], Siti Amra Abd Rahman[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

Intracranial tumours often present with nonspecific neurological and ophthalmological symptoms, sometimes delaying diagnosis. This case series highlights three patients with different intracranial masses, each presenting with different but distinct features whereby emphasizing the need for early recognition, neuroimaging and multidisciplinary team management.

Methods

Case report.

Results

Case 1: A 23-year-old woman presented with two-week history of progressive headache, vomiting, unsteady gait, left eye squint and left hearing loss. Examination revealed left eye esotropia with restricted extraocular eye movements bilaterally, along with left facial and vestibulocochlear nerve palsies. MRI brain showed a large pontine glioma compressing brainstem.

Case 2: A 58-year-old woman with poorly controlled diabetes mellitus presented with 2-month history of severe left-sided headache, left eye pain and binocular diplopia. Examination revealed positive left relative afferent pupillary defect, left partial ptosis and anisocoria consistent with left surgical third cranial nerve palsy. CT imaging showed a suprasellar mass, suggestive of a cystic pituitary macroadenoma/craniopharyngioma.

Case 3: A 65-year-old man presented with progressive both eyes blurring of vision, intermittent headaches and unsteady gait. He had a prior history of head trauma. Ocular examination was unremarkable, but imaging revealed a posterior fossa extraaxial tumour with hydrocephalus, likely a meningioma/schwannoma.

Conclusion

This case series highlights the diverse presentation of intracranial masses, reinforcing the need for high index of suspicion in patients with progressive neurological or ophthalmological symptoms. Prompt imaging and a multidisciplinary approach are crucial for timely intervention and improved patient outcomes.

ABSTRACT ID: 302

A CASE SERIES OF ISOLATED 6TH CRANIAL NERVE PALSY PRESENTED IN UPPER INNER DIVISION OF SABAH

Mohd Fakhrurrozi Matdiris[1], Mohd Fariz Mohd Ali[1]

[1]Hospital Keningau

Purpose

To report cases of isolated 6th cranial nerve palsy.

Methods

Case report.

Results

Case 1: A 71-year-old presented with sudden left-sided binocular diplopia with limited left eye abduction. Imaging revealed an arteriovenous (AV) malformation at the right medial temporal lobe and thrombosis at A1 segment of the anterior cerebral artery. Patient was treated with anticoagulants, and the diplopia resolved after 2 months.

Case 2: A 48-year-old complained of sudden binocular diplopia, right neck mass, dysphagia, and reduced hearing with limited right eye abduction. Imaging showed nasopharyngeal mass infiltrating the right sphenoid sinus. HPE shows non-keratinizing nasopharyngeal carcinoma. Patient was referred to oncology and started on chemotherapy.

Case 3: A 72-year-old presented with left-sided binocular diplopia and limited left eye abduction. Imaging showed a right cerebellopontine angle tumor extending to the internal auditory canal. Patient was referred to neurosurgery but unfortunately refused any surgical intervention.

Case 4: A 65-year-old developed sudden onset of diplopia and occipital headache with limited left eye abduction. Brain imaging revealed chronic lacunar infarct in the left lentiform nucleus. Patient was treated with aspirin, ane her diplopia resolved after 6 months.

Case 5: A 22-year-old had recurrent binocular diplopia with limited left eye abduction. Previous imaging showed no abnormalities. Current imaging and laboratorary tests were inconclusive. No significant pathology was detected. Patient was managed conservatively for recurrent idiopathic left 6^{th} cranial nerve palsy. Continuous monitoring with Hess chart revealed slight improvement of symptoms over months.

Conclusion

This case series highlights various causes of isolated 6th CN palsy, emphasizing the need for thorough evaluation and tailored multidisciplinary management in each case.

ABSTRACT ID: 306

THE FROZEN EYE: A CASE OF KEARNS-SAYRE SYNDROME

Adnin Farha Fatahul Rashid[1], Sangeetha Tharmathurai[1], Norhafizah Hamzah[1]

[1]Hospital Tunku Azizah

Purpose

To report a rare case of Kearns Sayre Syndrome.

Methods

Case report.

Results

A 12 year-old boy with underlying mitochondrial disease presented 1 year ago with complaints of progressively slow movements, ataxia and weight loss. He also had drooping eyelids and restricted eye movements with occasional diplopia. There were no complaints of blurring of vision, deafness, shortness of breath, chest pain or dysphagia. On examination, child appears cachexic with short stature. Visual acuity was 6/9 on both eye; with presence of ptosis obscuring visual axis and a chin-up position. There was also lagophthalmos. Extraocular muscle movements were restricted in all gazes. Anterior segment was unremarkable. Fundus examinations revealed a pigmentary retinopathy suggestive of a ‘salt and pepper’ retina. Electromyography done was normal. Muscle biopsy was taken and child was referred to other specialties for further investigation and managed under multidisciplinary team.

Conclusion

Kearns-Sayre Syndrome (KSS) is defined by a classic triad of cardiac conduction, chronic progressive external ophthalmoplegia and pigmentary retinopathy. A multidisciplinary team is needed to manage these children including ophthalmologists, paediatrician and geneticists. Treatment is mainly supportive as there is no cure to be found yet.

ABSTRACT ID: 308

BIZZARE OPHTALMOPLEGIA WITHOUT DROOPING EYELIDS

Meighalah Arumugam[1], Raja Nor Farahiyah Raja Othman[1], Wan Mariny Wan Md Kasim[1]

[1]Hospital Sultan Idris Shah

Purpose

To report a bizarre presentation of ophthalmoplegia without ptosis as the first sign of ocular MG.

Methods

Case report.

Results

A 71-year-old Chinese man with underlying hypertension, dyslipidaemia, and cerebrovascular accident (CVA) presented with sudden-onset binocular diplopia, which worsened over two weeks. He denied any recent drooping eyelids. On examination, his visual acuity was 6/18 in the right eye and 6/24 in the left eye, with no relative afferent pupillary defect (RAPD). Bilateral dermatochalasis was noted, but there was no ptosis or proptosis. The right eye showed limited elevation and adduction while the left eye had limitations in elevation, depression, abduction, and adduction. Anterior segment and fundus examinations were normal. A CT scan showed a chronic left frontal lobe infarction, which did not account for his symptoms. The medical team wanted to rule out infection or cerebrovascular accident and recommended lumbar puncture. On day 3, he developed left eyelid drooping, and the ice pack test was positive. Blood sample for anti-acetylcholine receptor (anti-AChR) antibody were ordered, but results were still pending. Pyridostigmine 60 mg twice daily was initiated, and he showed a positive response.

Conclusion

This case highlights the need to consider OMG in patients with atypical eye movements. Diagnosis is based on clinical evaluation and serologic tests for anti-AChR antibodies. The patient's positive response to pyridostigmine confirmed the diagnosis and enabled effective treatment. Early recognition and treatment can greatly improve outcomes in OMG.

ABSTRACT ID: 309

DOUBLE-EDGED SWORD: ORBITAL APEX SYNDROME DUE TO DUAL PATHOLOGY – A DIAGNOSTIC CHALLENGE

Nurhayati Yacob[1], Anis Fatiha Mazri[1], Norihan Ibrahim1, Wardati Hanisah Jami[1], Haslinda A Rahim[2], Nur Illani Mohd Asri[2]

[1]Hospital Sultan Ismail Petra; [2]Hospital Raja Perempuan Zainab II

Purpose

To describe the clinical presentation and diagnostic challenges of orbital apex syndrome.

Methods

Case report.

Results

A 69-year-old Malay male presented with diplopia for three months. On examination, he had a relative afferent pupillary defect in the right eye. His visual acuity was 6/12 in the right eye and 6/6 in the left eye. There was impairment of the right third, fourth, fifth, and sixth cranial nerves, along with partial ptosis of the right eye. Blood investigations revealed subclinical hyperthyroidism, with a TSH level of 0.16 mIU/L and a T4 level of 15.15 pmol/L. Computed tomography of the brain and orbit showed enlargement of the right lateral, medial, and inferior rectus muscles, sparing the tendons, with surrounding fat streakiness. Additionally, there was fullness of the left fossa of Rosenmüller with obliteration of the torus tubarius. Initially, the patient declined endoscopic evaluation and was started on intravenous methylprednisolone (500 mg weekly for six cycles) for dysthyroid optic neuropathy. However, there was no improvement. He later consented to nasal endoscopy, which revealed a histopathological diagnosis of non-keratinizing nasopharyngeal carcinoma. The final diagnosis was locally advanced nasopharyngeal carcinoma with intracranial extension and possible lung metastasis. The patient was initiated on palliative chemotherapy.

Conclusion

This case highlights the importance of utilizing multimodal diagnostic approaches to identify the underlying causes of orbital apex syndrome.

ABSTRACT ID: 324
RECURRENT ISOLATED OCULOMOTOR NERVE PALSY TRIGGERED BY VIRAL FEVER

Tee Pui Sin[1], Rebecca Jennifer Mary Louis[1]

[1]Hospital Sultan Haji Ahmad Shah

Purpose

To discuss the occurrence of recurrent left third cranial nerve palsy in relation to viral infections.

Methods

Case report.

Results

A 10-year-old Malay boy with known case of allergic rhinitis and recurrent isolated left third cranial nerve palsy resulting in secondary left eye occlusion amblyopia, presented with worsening left upper lid drooping, left eye downward and outward deviation and mydriasis. This was preceded by two days of fever, runny nose and cough. There was no blurring of vision or diplopia. This is the sixth episode since 2022, triggered by a viral infection. Previously investigated autoimmune workups and brain/orbit imaging were normal. On examination, visual acuity of the right eye was 6/6 while the left eye was 6/60, which did not improve with pinhole test. The left eye showed partial ptosis covering the visual axis with downward and outward deviation at primary gaze. The pupil was fixed and dilated at 6 mm. Extraocular movements were limited in elevation, adduction and extorsion. Fundoscopy, neurological examination and blood investigations were unremarkable. The patient was treated with an 8-week course of tapering doses of oral steroids. At the 2-month follow-up, his ptosis, pupil size and extraocular movement has recovered.

Conclusion

Recurrent isolated oculomotor nerve palsy secondary to viral fever is a rare clinical entity. Its presentation underscores the importance of considering viral infections as a potential etiology in patients with cranial nerve palsy, particularly when other common causes are excluded. Close follow-up is warranted to monitor for resolution and detect any potential recurrence or underlying pathology.

ABSTRACT ID: 327
HERPES ZOSTER OPHTHALMICUS (HZO) WITH CONCURRENT THIRD NERVE PALSY

Noorhayati M Nadzir[1], Safiyah Jameelah Mohd Yusof[2], Suriana Suaibun[2]

[1]Institut Kanser Negara; [2]Hospital Putrajaya

Purpose

Herpes Zoster Ophthalmicus (HZO), a reactivation of the varicella-zoster virus affecting the ophthalmic branch of the trigeminal nerve, is a rare but serious condition that can lead to significant ocular and neurological complications. In this case report, we present a case of HZO with concurrent third nerve palsy, a rare yet severe complication.

Methods

Case report.

Results

A 66-year-old female with underlying diabetes mellitus, hypertension, dyslipidemia and stage-4 chronic kidney disease, presented with painful vesicular rashes over the left V1 dermatome, along with progressive left eyelid swelling leading to complete ptosis. There was also a loss of ability to adduct, supraduct, and infraduct, as well as a dilated left pupil, suggesting involvement of the third cranial nerve. Clinical findings and imaging studies shows left preseptal cellulitis with inflammation of the left lacrimal gland with no orbital extension. Initial management included broad-spectrum antibiotics, antiviral therapy and analgesics. Given the patient's renal impairment, renal function was carefully monitored, and medications were tailored accordingly. Additionally, a left frontal lobe lacunar infarct was also noted during the CECT scan. Neuromedical team was consulted and oral steroids and antiplatelet was added to her treatment regime. Throughout admission she improved, however her neurological deficit remained after 3 weeks of follow-up.

Conclusion

This case shows the complexity of managing HZO with concurrent third nerve palsy and multiple comorbidities, highlighting the importance of early recognition, multidisciplinary care and careful medication management to reduce the risk of further complications and lasting neurological deficits.

ABSTRACT ID: 336
A CASE OF MILLER-FISHER SYNDROME (MFS): WHEN BELL'S PALSY ISN'T WHAT IT SEEMS

Ummu Salamah Ismail[1], Goh Chon Han[1], Gowri Supramaniam[1], Azhany Yaakub[2]

[1]Tuanku Ja'afar Seremban; [2]Universiti Sains Malaysia

Purpose

To report a case of MFS mimicking Bell's Palsy with spontaneous recovery.

Methods

Case report.

Results

A 42-year-old man with newly diagnosed hypertension visited the outpatient Ophthalmology clinic with a three-day history of acute left eye lagophthalmos, accompanied by left-sided facial asymmetry and paraesthesia, dysarthria, and left parietal headache. He also had left arm paraesthesia without weakness, preceded by prodromal flu-like symptoms a week earlier. An initial plain CT brain scan done at the primary hospital was normal, thus diagnosed as Bell's Palsy. He was discharged with oral prednisolone at 1mg/kg/day. Upon eye assessment revealed bilateral ophthalmoplegia without diplopia. Neurological evaluation showed symmetrical areflexia in the upper limbs with preserved muscle tone and power. Subsequent contrasted CT brain scan showed no infarction or lesions. After neurologist consultation, the diagnosis was revised to Miller-Fisher Syndrome (MFS), a rare variant of Guillain-Barré Syndrome that can mimic Bell's Palsy. Remarkably, his symptoms improved spontaneously and regained reflexes without typical treatment of intravenous immunoglobulin.

Conclusion

MFS is usually self-limiting, with spontaneous recovery in mild cases. It is crucial to recognize the key features of this rare syndrome and consider differential diagnoses when symptoms deviate from the usual pattern.

ABSTRACT ID: 345
ATYPICAL PRESENTATION OF OPTIC NEURITIS IN MULTIPLE SCLEROSIS

Wan Nur Hajar Atikah Wan Mad Husin[1], Adzleen Mohmood[1], Amirah Mohd Razali[2]

[1]OphthUniversiti Putra Malaysia; [2]Universiti Putra Malaysia

Purpose

To report a case of bilateral profound visual impairment due to optic neuritis secondary to multiple sclerosis

Methods

Case report.

Results

A 35-year-old lady with no known medical illness presented with 1-week history of bilateral blurring of vision, initially involving the right eye and then the left eye on the following day. It was preceded by 2 weeks history of fever, dizziness, unsteady gait and acute urinary retention. On examination, visual acuity was hand movement bilaterally. Both pupils were 6mm, sluggish and fundus examination revealed bilateral optic disc swelling with splinter disc hemorrhage over right eye. Anterior segment was unremarkable in both eyes. Neurological examination was unremarkable. Lumbar puncture revealed a normal opening pressure. Initial computed tomography of the brain and orbit was unremarkable, however magnetic resonance imaging of the brain, orbit and spine revealed multifocal infratentorial and cervical spinal cord lesions. Blood investigations for infection and connective tissue screening were negative. Cerebrospinal fluid analysis showed the presence of oligoclonal bands, while serum aquaporin-4 and MOG antibodies were negative. A final diagnosis of bilateral optic neuritis secondary to multiple sclerosis was made and she was treated with intravenous methylprednisolone 1g daily for five days followed by a tapering dose of oral prednisolone 1mg/kg. Her vision improved markedly, and at the 2-month follow-up, her visual acuity improved to 6/6 in both eyes, with restoration of her colour vision and contrast sensitivity.

Conclusion

Bilateral consecutive optic neuritis with profound visual impairment is a rare presentation for multiple sclerosis. It is essential to rule out other causes of optic neuritis and commence prompt treatment to ensure favourable outcome.

ABSTRACT ID: 373

FOSTER KENNEDY SYNDROME: RESTORING VISION, REVERSING DAMAGE

Nur Sofia Hafifi Zulkifly[1], Nadhirah Ahmad Fauzi[1], Zulhilmi Abdul Razak[1], Khairul Anwar Ibrahim[1], Aidila Jesmin Jabbari[1]

[1]International Islamic University of Malaysia

Purpose

To report a case of Foster Kennedy syndrome.

Methods

Case report.

Results

A 50-year-old woman with no significant medical history presented with left eye vision loss for 8 months. She presented to clinic after developing 2 weeks history of occasional headaches. She also reported to have anosmia, significant loss of weight and appetite. Generally, she was alert and conscious however having difficulty engaging in conversation. On ocular examination, a relative afferent pupillary defect (RAPD) was noted in the left eye. Her visual acuity was 6/24 in the right eye and no light perception in the left. Anterior segment examination was unremarkable. Fundus exam showed diffuse optic disc swelling in the right eye and a pale optic disc in the left. No other retinal lesions seen. Cranial nerves examination revealed loss of olfactory and optic nerve function. Other neurological examinations were intact. Urgent CECT revealed features of large olfactory groove meningioma which were further confirmed with MRI.The patient underwent emergency craniotomy and tumor excision. Three months post-operatively, her vision improved to 6/18 (6/9) in the right eye, and 2/120 in the left. The right optic disc swelling resolved, and the left optic disc remains pale.

Conclusion

True Foster Kennedy Syndrome is a condition when there is unilateral visual loss due to compressive optic neuropathy in one eye and contralateral papilloedema caused by increased intracranial pressure (ICP). Main etiology is frontal lobe tumor. Increased ICP symptom typically present later than visual symptom due to large anterior cranial fossa space. Prompt diagnosis and treatment is important for better visual and neurological outcome.

ABSTRACT ID: 374
PARAINFECTIOUS OPTIC NEURITIS IN PAEDIATRIC AGE GROUP

Siti Eliza Darussalam[1], Nadia Yaacob[1], Khairul Husnaini Mohd Khalid[1]

[1]Hospital Kuala Pilah

Purpose

To discuss a case of sudden onset visual loss in children.

Methods

Case report.

Results

A 12-year-old Malay girl with underlying bronchial asthma and allergic rhinitis presented with left eye sudden onset blurring of vision for 5 days associated with pain on eye movement. Examination of the left eye revealed perception of light vision in all 4 quadrants, positive relative afferent pupillary defect and hyperaemic swollen optic disc with blurred margin, sparring the temporal border. The right eye was unremarkable with good vision. Contrast enhance computed tomography of the brain and orbit confirmed left eye optic neuritis with acute sinusitis. The case was referred to the otorhinolaryngology and neuro-ophthalmology team for co-management. Intravenous antibiotic was commenced, along with intravenous methylprednisolone 300 mg three times per day for 5 days. Corticosteroid treatment was then continued with a tapering dose of oral prednisolone over 3 weeks. Patient condition improves significantly, with full recovery of optic nerve function and final vision of 6/6 in the left eye.

Conclusion

Optic neuritis, though rare in the pediatric population, presents with significant visual impairment initially but typically has a favorable prognosis. The condition is often associated with para-infectious factors, including preceding infections like upper respiratory tract infections as well as ongoing sinusitis in this case. Early recognition and appropriate management are essential for optimal visual recovery.

ABSTRACT ID: 377
THE HIDDEN STROKE: ISOLATED BILATERAL SUPERIOR RECTUS PALSY AS A RARE PRESENTATION OF MIDBRAIN INFARCT

Hurul Ain Zulkifli[1], Nik Najiha Ayesha Nik Noor Azmi[1], Noor Amalina Saidi[1], Ainul Basirah Ibramsah[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To report a rare case of midbrain infarct presented with isolated bilateral superior rectus palsy.

Methods

Case report.

Results

A 39-year-old lady with poorly controlled diabetes, hypertension, and hyperlipidemia presented with bilateral retro-orbital pain, conjunctival injection, and a three-day history of worsening ophthalmoplegia. She experienced nausea, vomiting, and peripheral neuropathy but denied diplopia. Ocular examination revealed treated proliferative diabetic retinopathy, bilateral hypotropia with restricted upgaze, and horizontal nystagmus in the right eye. Despite elevated intraocular pressure, there was no proptosis or lagophthalmos. Other neurological examinations were unremarkable except for bilateral superior rectus palsy. Initial computed tomography (CT) was unremarkable, but magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) revealed chronic small vessel ischemia in the right corona radiata and an old microhemorrhage at the right cerebral peduncle. She was diagnosed with a right midbrain infarct and managed with antiplatelets and statins. Her ophthalmoplegia showed minimal improvement at three-month follow-up.

Conclusion

This case underscores that midbrain infarcts can rarely present as isolated bilateral superior rectus palsy, mimicking peripheral nerve pathology. A normal CT scan does not exclude a brainstem lesion, making MRI crucial for further evaluation in patients with unexplained ophthalmoplegia. Recognizing this rare stroke presentation is essential, as early diagnosis and targeted intervention can help prevent long-term neurological deficits and optimize recovery.

ABSTRACT ID: 379

TOLOSA-HUNT SYNDROME: A DIAGNOSIS OF EXCLUSION IN THE CASE OF ORBITAL APEX SYNDROME AND OPTIC NEURITIS

Gan Sin Hui[1], Amira Alisha Azhan[1], Ch'ng Han Nie[1], Che Mahiran Che Daud[1]

[1]Hospital Sungai Buloh

Purpose

To report a cse of Tolosa-Hunt Syndrome (THS, a rare neurological condition marked by severe unilateral periorbital pain and ophthalmoplegia due to inflammation of the cavernous sinus or superior orbital fissure.

Methods

Case report.

Results

A 36-year-old lady with no known medical illness presented with diplopia and right eye progressive loss of vision for the past 2 months. Examination revealed right eye no perception of light (NPL), left eye 6/9. Presence of relative afferent pupillary defect (RAPD), extraocular movements restricted in all gazes and optic nerve function test affected over the right eye. Besides, noted right eye slightly proptosed when compared to left eye. Fundus examination was normal on both eyes. Cranial nerve examination affected over optic nerve (CNII), oculomotor nerve (CNIII), trochlear nerve (CNIV) and trigeminal nerve V1 (CNV1). Infective screening, tumor markers, TB, cerebrospinal fluid (CSF) and autoimmune workup were done, all results were normal. MRI brain revealed enhancing right temporal dural thickening with extension into orbital apex, superior orbital fissure, right Merkel's cave, right anterior temporal region and encased the right trigeminal nerve, and right optic neuritis with inflammation of right extraocular muscles. IV methylprednisolone started for 3 days followed by oral prednisolone with a tapering regime. Currently, her vision remained NPL however proptosis and extraocular movement improved after steroid therapy

Conclusion

This case highlights the need to consider Tolosa-Hunt Syndrome in patients with unilateral periorbital pain and ophthalmoplegia. Early diagnosis through differential diagnosis and prompt corticosteroid therapy are essential to prevent long-term complications and optimize patient outcomes.

ABSTRACT ID: 380

MYELIN OLIGODENDROCYTE GLYCOPROTEIN ANTIBODY DISEASE (MOGAD) MASKING INFECTIVE OPTIC NEURITIS- A TREATMENT CHALLENGE

Amira Alisha Azhan[1], Gan Sin Hui[1], Ch'ng Han Nie[1], Che Mahiran Che Daud[1]

[1]Hospital Sungai Buloh

Purpose

Infective optic neuritis is inflammation of the optic nerve caused by various infections, while MOGAD is an autoimmune disorder marked by antibodies against myelin oligodendrocyte glycoprotein (MOG), leading to central nervous system demyelination and inflammation, primarily affecting the optic nerves, spinal cord, and brain. We aimed to report an unusual case of an atypical MOGAD presentation in a young patient.

Methods

Case report.

Results

A 21-year-old male with bronchial asthma presented with sudden bilateral blurred vision for one week, following fever and frontal headache. Visual acuity was 1/60 in the right eye and counting fingers in the left. Light brightness and red saturation were reduced in the left eye, and Ishihara test was 0/17 for both eyes. Fundus examination revealed optic disc swelling, more pronounced in the left eye. OCT of the optic nerve head showed bilateral optic nerve swelling, while the OCT macula showed disruption of the ellipsoid layer. CT of the brain and orbit was unremarkable. The patient later developed a syncopal episode with chills and rigors, prompting intravenous Rocephin initiation and further workup. Blood culture grew Escherichia coli, sensitive to Meropenem, leading to antibiotic adjustment. Anti-MOG serology were also positive. Corticosteroid treatment was initiated after completing antibiotics, although vision, optic nerve function, and optic disc swelling improved significantly with antibiotics alone.

Conclusion

This case shows that a patient can have two concurrent pathologies, stressing the need for thorough evaluation. A comprehensive assessment is essential before starting treatment to ensure an accurate diagnosis and avoid worsening symptoms or complications.

ABSTRACT ID: 390
OCULOMOTOR CRANIAL NERVE PALSY SECONDARY TO MOYAMOYA DISEASE

Siti Eliza Darussalam[1], Brindha Gulendran[1], Khairul Husnaini Mohd Khalid[1]

[1]Hospital Kuala Pilah

Purpose

To report a rare case of 3rd cranial nerve palsy secondary to Moyamoya disease.

Methods

Case report.

Results

A 57-year-old Chinese female with underlying hypertension presented with sudden onset left eye drooping of eyelid, worsening for the past 5 days. There were no associated complaints of double vision, neurological deficits, symptoms of increased intracranial pressure, or any history of falls or trauma. On examination, visual acuity in the right eye was 6/12, and in the left eye was 6/24 with a dilated pupil measuring 5mm. There was complete left eye ptosis with limitation in extraocular movement in all directions except horizontal lateral gaze. Anterior and posterior segment examination was unremarkable in both eyes. The optic nerve function tests including reverse RAPD, light brightness, red saturation, confrontation and ishihara were all normal bilaterally. Other cranial nerves and peripheral nerve examination was also intact, with no cerebellar signs. Blood investigation reveals thrombocytopenia with platelet of 32, thus patient was treated as Immune Thrombocytopenia Purpura under medical team. A computed tomography angiography (CTA) revealed multiple acute on chronic subdural hematomas, with possible terminal internal carotid artery occlusion and extensive leptomeningeal collaterals, suggestive of Moya-Moya disease. The case was referred to the neurosurgical team for co-management.

Conclusion

Moyamoya syndrome is a rare, chronic cerebrovascular occlusive disorder involving terminal portion of bilateral internal carotid artery or proximal cerebral arteries. The longstanding ischemia results in the formation of multiple irregular vascular networks at the base of brain. These condition usually presented in adults as intracranial bleeding due to the rupture of these collateral vessels as compared to ischemic episodes.

ABSTRACT ID: 396

HIDDEN NODULES IN NEUROFIBROMATOSIS TYPE 1

Tan Teik Wei[1], Tan Chek Kuan[1], Ivan Lai Yoon Kit[1], Mahani Mastor[1]

[1]Hospital Selayang

Purpose

To report a case of bilateral choroidal nodules in neurofibromatosis type-1 (NF1).

Methods

Case report.

Results

A 20-year-old Malay female with NF1 and bilateral secondary open-angle glaucoma came for routine eye clinic follow-up. The patient was asymptomatic with visual acuity of 6/9 in both eyes. Intraocular pressure was 16 mmHg bilaterally. Anterior segment showed presence of Lisch nodules in both eyes. Fundus examination of bilateral eyes was unremarkable apart from glaucomatous changes of cup-to-disc ratio of 0.6. Near-infrared reflectance optical coherence tomography (OCT) of retinal nerve fiber layer (RNFL) was performed to assess the thickness, and it was normal. However, incidental findings of multiple choroidal nodules, possibly choroidal neurofibromatosis were found bilaterally, which were not seen during the fundus examination. These nodules appeared as hyperreflective, patchy choroidal abnormalities surrounding the optic disc and at the macula.

Conclusion

Choroidal nodules are poorly visible on clinical slit lamp examination and fundus photo. Multimodal imaging should be advocated to detect choroidal neurofibromatosis to supplement the diagnosis of NF1, especially when the diagnosis is in doubt.

ABSTRACT ID: 397

AN ATYPICAL PRESENTATION OF STEVENS-JOHNSON SYNDROME WITH ISOLATED EYELID LESIONS

Shakurthi Raj Partheeban[1], Ting Xiao Wei[1], Farah Rasyiqah Mahamud[1], Tan Wei Jun[1]

[1]Hospital Tawau

Purpose

To present a case of systemic Steven Johnson Syndrome (SJS) with isolated upper eyelid lesions without conjunctival involvement.

Methods

Case report.

Results

A 60 year old lady, with underlying chronic kidney disease, was admitted to the medical ward for acute pulmonary oedema and SJS secondary to chlorpheniramine (oral Piriton) that had been prescribed for itchiness over her lower limbs. She initially presented with bilateral upper and lower eyelid swelling, along with bullous rashes over bilateral upper limbs and trunk. Ocular examination revealed normal visual acuity in both eyes. Multiple irregular eyelid margin lesions associated with discharge was seen in both eyes. However, conjunctiva was not hyperemic, no pseudomembrane was noted, cornea was clear. Anterior and posterior segment examinations were unremarkable. She was diagnosed with SJS by the dermatology team. The oral Piriton was immediately discontinued, and she was started on oral prednisolone 30mg OD. She was also treated with ointment Maxitrol over both upper and lower eyelids. She was closely monitored and did not develop any ocular complications of SJS. Two weeks following treatment, she had recovered systemically, and the eyelid margin lesions resolved.

Conclusion

Isolated eyelid involvement without conjunctival involvement is rare in the presentation of SJS. However, prompt diagnosis and early treatment is imperative to avoid devastating and blinding complications.

ABSTRACT ID: 399

THE ATYPICAL PRESENTATION OF OPTIC NEURITIS: RECURRENT OPTIC NEURITIS WITH MYELIN OLIGODENDROCYTE GLYCOPROTEIN ANTIBODY-ASSOCIATED DISEASE

Nik Farridiyyah Subiha Nik Zaibidin[1], Mohd Fariz Mohd Ali[1]

[1]Hospital Keningau

Purpose

To report a case of myelin oligodendrocyte glycoprotein antibody-associated disease (MOGAD) with recurrent optic neuritis (ON).

Methods

Case report.

Results

A 49 years old, male, with underlying hypertension and dyslipidemia with a previous history of 2 episodes of steroid responsive ON presented with loss of central vision, bilateral eye pain and headache. Vision on presentation was no perception of light bilaterally. Relative afferent pupillary defect (RAPD) was positive with Bjerrum test revealed enlarged blind spot bilaterally. Anterior segment examination was normal with intraocular pressure of 14 bilaterally. Fundus examination over both eyes revealed oedematous optic discs with mottled macula. The investigations had ruled out infective causes. Computed tomography of the brain/orbit showed thickening of bilateral optic nerves. Magnetic Resonance Imaging showed high T2W signal in the perineural region of the bilateral optic nerves extending till the optic chiasm, optic chiasm and optic tracts are normal with no focal enhancing lesions over the brain or spinal cord. Aquaporin-4 receptor antibody was negative, but Myelin oligodendrocyte glycoprotein (MOG) antibody was positive. His symptoms have improved after 5 days of IV Methylprednisolone and oral prednisolone. His visual acuity over right eye was counting fingers and his left eye was 6/21.This patient is co-managed by a medical and a neuromedical team.

Conclusion

MOGAD is a rare and severe inflammatory autoimmune disease of the central nervous system (CNS). ON can presented primarily as demyelinating CNS disease connected to Multiple Sclerosis, Neuromyelitis Optica Spectrum Disorder, or MOGAD. Patients presented solely with ON can lead to a diagnosis challenge. Multidisciplinary approaches play an important role in diagnostic challenges.

ABSTRACT ID: 411
CHALLENGES IN MANAGEMENT OF HYPERSENSITIVITY REACTION INDUCED CORNEA COMPLICATION

Nur Sofia Hafifi Zulkifly[1], Khairul Anwar Ibrahim[1], Khairidzan Mohd Kamal[1]

[1]International Islamic University of Malaysia

Purpose

To report a case of Sturge-Weber syndrome (SWS) with associated retinal lesions due to phakomatosis and to explore their implications for patient outcomes and treatment strategies.

Methods

Case report.

Results

A 26-year-old woman with underlying SWS, diagnosed at age 18, presented with progressive vision loss in the right eye in September 2023. She denied experiencing floaters, flashes of light, or any history of trauma or eye surgery. On general examination, a port-wine stain was observed over the right forehead extending to the lower eyelid. Ocular examination revealed a right relative afferent pupillary defect (RAPD) grade 1. Visual acuity in the right eye was reduced to hand movements, while the left eye retained 6/6 vision. Intraocular pressure was measured at 12.7 mmHg in the right eye and 15.8 mmHg in the left eye, using air-puff tonometry. A bluish-purple discoloration of the right conjunctiva was noted, with the cornea, anterior chamber, and lens remain clear. Fundus examination of the right eye revealed extensive subretinal fibrosis involving the optic disc and posterior pole, without any subretinal fluid, hemorrhage, or feeder vessels. The left eye showed no significant findings. A CT scan of the brain and orbit was planned, however she defaulted on subsequent follow-up

Conclusion

SWS is a rare disorder with significant ocular and neurological implications. Retinal lesions, such as subretinal fibrosis, are common and can cause visual disturbances, as seen in this patient. Timely detection and monitoring of retinal involvement are critical for managing vision loss. This case highlights the importance of early imaging and regular follow-up to prevent further complications

ABSTRACT ID: 416

A RARE PRESENTATION OF POEMS SYNDROME: VITREOUS HEMORRHAGE WITH RETINAL NEOVASCULARISATION

Nur Azrin Azidin[1], Nor Fadhilah Mohamad[1], Marium Jamaluddin Ahmad[1]

[1]University of Malaya Medical Centre

Purpose

To report a rare case of vitreous haemorrhage associated with POEMS syndrome.

Methods

Case report.

Results

A 23-year-old man with a history of POEMS syndrome and previously resolved bilateral optic disc swelling presented with sudden-onset blurring of vision in his left eye during a routine follow-up. His baseline visual acuity was 6/7.5 bilaterally. On examination, the left eye had no light perception, whereas the right eye maintained a vision of 6/9. A relative afferent pupillary defect was noted in the left eye. Anterior segment examination of the left eye was unremarkable, with an intraocular pressure of 11mmHg. Fundoscopic examination revealed a vitreous haemorrhage in the left eye, with an obscured optic disc due to a fibrovascular proliferation band extending to the superotemporal region. There was a localised traction, which did not involve the macula. Intraretinal haemorrhages were observed over and temporal to the macula. The right eye examination was unremarkable. Optical coherent tomography of both maculae showed no abnormalities. Fluorescein angiography of the left eye revealed areas of leakage at superotemporal arcade. A diagnosis of left eye vitreous haemorrhage, likely secondary to ischaemia, was established. The patient is currently treated with left eye panretinal photocoagulation.

Conclusion

Vitreous haemorrhage is a rare ocular manifestation of POEMS syndrome. Clinicians should maintain vigilance during follow-up assessments to detect signs of ischaemic ocular involvement early.

ABSTRACT ID: 420
TOLOSA HUNT SYNDROME

Goh Yong Hui[1], U Kern Rui[1], Rupini Yogesvaran[1]

[1]Hospital Selayang

Purpose

To report a rare case of Tolosa Hunt Syndrome, successfully treated by steroid,

Methods

Case report.

Results

A 67-year-old gentleman with underlying hypertension and diabetes mellitus presented with right sided headache, right eyelid drooping and diplopia. Examination revealed cranial nerve III and IV palsy, with hypoaesthesia of the ophthalmic and maxillary division of the trigeminal nerve. The right eye showed partial ptosis that covered the visual axis, along with white chemosis of the conjunctiva. Other ocular findings were unremarkable. Subsequent serum investigations to exclude infectious, autoimmune, and connective tissue diseases were unremarkable. CECT of the brain showed no evidence of dural venous sinuses or cavernous sinuses thrombosis. The patient then underwent MRI of the brain and orbit, which revealed thickening and enhancement of the right perioptic nerve sheath, along with inflammatory changes in the intraconal fat, suggestive of right optic nerve neuritis with perineuritis. A lumbar puncture was performed, and cerebrospinal fluid studies showed normal glucose, normal protein, and unremarkable results for other relevant CSF tests. The patient was started on corticosteroid therapy, following which there was significant improvement in the right eye pain, ptosis, and visual acuity within 48-72 hours.

Conclusion

Tolosa Hunt syndrome is the nonspecific granulomatous idiopathic, sterile inflammation featured by infiltration of lymphocytes and plasma cells around the cavernous sinus, superior orbital fissure or orbital apex. It often presented as unilateral idiopathic painful ophthalmoplegia involving the third, fourth, or sixth cranial nerve. It is a diagnosis of exclusion, with clinical presentation, normal investigations, magnetic resonance imaging findings, and response to steroid therapy or resolves spontaneously but can relapse and remit.

ABSTRACT ID: 441

ARACHNOID CYST PRESENTING AS TRANSIENT VISUAL OBSCURATION IN A CHILD: A CASE REPORT

Muhammad Rizqy Abdullah[1], Dicky Lukman Rangkuti[1], Lukisiari Agustini[2]

[1]Universitas Airlangga; [2]Soetomo General Academic Hospital

Purpose

To describe a case of an arachnoid cyst presenting as a transient visual obscuration with preserved visual acuity in a 16-year-old girl.

Methods

Case report.

Results

A 16-year-old girl presented with transient visual obscuration and headaches for the past two months, occurring multiple times per month. Her visual acuity was 5/6 in both eyes, and color vision testing with Ishihara plates was normal. Fundoscopic and slit-lamp examinations were unremarkable. However, Humphrey visual field testing revealed visual field defects as bilateral paracentral scotomas. Other cranial nerve examinations were normal. Brain and orbital MRI revealed a Grade I arachnoid cyst in the left temporal lobe.The patient was referred to neurosurgery and started on acetazolamide. After five months of medical therapy, her visual field defects have improved, as demonstrated by follow-up Humphrey visual field testing. Acetazolamide, known for reducing intracranial pressure, likely contributed to this improvement.

Conclusion

A thorough evaluation is essential in patients presenting with transient visual obscuration accompanied by headaches. Early diagnosis facilitates timely and appropriate management, potentially preventing further visual impairment.

ABSTRACT ID: 449

VISUAL RECOVERY IN A PATIENT WITH SEVERE BILATERAL ATYPICAL OPTIC NEURITIS AND SERONEGATIVE RHEUMATOID ARTHRITIS: A CASE REPORT

Anita Dwi Rachmawati[1], Riski Prihatningtias[1]

[1]Diponegoro University

Purpose

To report a case of severe bilateral atypical optic neuritis associated with seronegative rheumatoid arthritis.

Methods

Case report.

Results

A 61-year-old woman with a known history of seronegative rheumatoid arthritis presented with sudden, severe bilateral vision loss. Ophthalmologic examination revealed a visual acuity of no light perception (NLP) in the right eye and 1/60 in the left eye. Posterior segment examination of both eyes showed optic disc swelling. Optical Coherence Tomography (OCT) demonstrated significant thinning of the retinal nerve fiber layer. A diagnosis of bilateral papilloedema, suspected optic neuritis, and a differential diagnosis of compressive optic neuropathy was considered. The patient was hospitalized and treated with high-dose intravenous methylprednisolone followed by oral corticosteroids, which led to significant improvement in visual acuity during follow-up evaluations. MRI showed no optic nerve thickening but revealed T2 hyperintensity and contrast enhancement in the optic nerves, supporting the diagnosis of optic neuritis.

Conclusion

This report highlights the critical role of prompt intervention in managing optic neuritis and underscores the importance of recognizing and monitoring patients with autoimmune disorders, such as rheumatoid arthritis, for the possible development of atypical optic neuritis.

ABSTRACT ID: 453
A CHILD WITH DIPLOPIA AND OTALGIA - ATYPICAL GRADENIGO SYNDROME

Chang Yi Xin[1], Tham Han Shu[1], Azlyn Azwa Jazman[1]

[1]Hospital Sultan Ismail

Purpose

To report a case of Gradenigo syndrome with incomplete triad of symptoms, presenting with acute otitis media and acute diplopia, without pain in the trigeminal territory.

Methods

Case report.

Results

A ten-year-old Malay girl with underlying bronchial asthma was referred to us by emergency department with 2-weeks history of fever, right otalgia and diplopia for one day. Examination revealed right abducent nerve palsy. Assessment by the otorhinolaryngology team suggested right acute otitis media. Laboratory results were unremarkable. Contrast Enhanced Computed Tomography brain demonstrated features of right acute otitis media with right petrous apicitis, confirming the diagnosis of Gradenigo Syndrome. She was treated with intravenous steroids and prolonged antibiotic therapy, resulting in resolution of symptoms and radiological improvement.

Conclusion

Gradenigo syndrome, though rare, warrants prompt recognition and prolonged antibiotic therapy to prevent severe complication. The complete triad of symptoms become less common in this modern era of antibiotics. Neuroimaging plays a crucial role in prompt diagnosis in this atypical case.

ABSTRACT ID: 459

FATE OR COINCIDENCE: CONTRAST OR STROKE INDUCED VISION LOSS?

Kuhapriya Selvarajah[1], Thivyashini Muthaiah[1], Ummi Faradiana Abdul Rahim[1]

[1]Hospital Raja Permaisuri Bainun

Purpose

To report a case of sudden bilateral vision loss following contrast-enhanced angiography.

Methods

Case report.

Results

A 69-year-old Indian gentleman with underlying diabetes mellitus, hypertension, ischaemic heart disease and chronic kidney disease experienced a sudden onset painless vision loss in both eyes, described as large central scotoma following a contrast-enhanced angiogram procedure for acute coronary syndrome. Examination revealed visual acuity of 1/60 in the right eye and 4/60 in the left eye. Fundus examination revealed blurred disc margins, attenuated and tortuous vessels, and dot-blot hemorrhages. Magnetic resonance imaging (MRI) of the brain showed a right cerebellar tonsil infarct with cerebral atrophy. There was elevated renal markers (urea and creatinine) and hydration was initiated. As the renal markers improved, his visual acuity was also improved.

Conclusion

Transient cortical blindness (TCB) is a rare complication of cerebral angiography, characterized by sudden, reversible vision loss without structural abnormalities in the eyes. It's related to the neurotoxic effects of the contrast medium used. The presence of cerebral atrophy and elevated renal markers indicate underlying vascular risk factors, which can increase the risk of stroke and contrast-induced nephropathy. Thus, bilateral vision loss in this case could be attributed to contrast-induced transient cortical blindness or a stroke affecting the visual pathways. TCB has been observed directly after angiography, with visual impairment resolving within several hours.

ABSTRACT ID: 477

A CASE OF CENTRAL RETINAL ARTERY OCCLUSION WITH CILIORETINAL ARTERY SPARRING IN A POLYCYTHEMIA VERA PATIENT

Youta Heng Lee[1], Sharifah Azira Mohd Taufik[1], Zairah Zainal Abidin[1]

[1]Hospital Ampang

Purpose

To report a case of central retinal artery occlusion (CRAO) with cilioretinal artery sparring in a patient with polycythemia vera.

Methods

Case report.

Results

A 52-year-old male with underlying hypertension, major depressive disorder and polycythemia vera presented with acute painless blurred vision in the left eye (LE) for one day, preceded by a presyncopal attack and a transient episode of expressive aphasia lasting for two minutes. He also complained of right upper limb weakness and numbness for a day. On examination, visual acuity in the LE was hand movements (HM) with positive relative afferent pupillary defect (RAPD). The LE anterior segment was normal, and intraocular pressure was 14 mmHg. Fundus examination revealed a pink optic disc with a cup-to-disc ratio of 0.3. The superior and inferior maculae were pale, extending towards the superior and inferior arcades, sparing a small island of normal macula about one disc diameter in size at the papillomacular bundle. The peripheral retina was otherwise normal. There was dull foveal reflex, and attenuated arteries and silver wiring were noted, though no obvious calcified vessels or new vessels seen. The right eye examination was unremarkable. Haematological investigations revealed increased haemoglobin and haematocrit, thrombocytosis and leukocytosis with normal erythrocyte sedimentation rate (ESR). Contrast-enhanced computed tomography (CECT) of the brain showed a hypodense area in the left frontal lobe, consistent with an acute infarct. He was started on single antiplatelet therapy. A full blood picture was taken to investigate further and rule out myeloproliferative neoplasm.

Conclusion

This case highlights the importance of thorough systemic and hematological workup in patients with CRAO.

ABSTRACT ID: 479

SPHENOID WING MENINGIOMA MASQUERADING AS AN ORBITAL DISORDER: A CASE OF EYELID SWELLING AND PROPTOSIS

Nurul Jihan Othman[1], Noor Amalina Saidi[1], Faridah Mat Amin[1], Nur Aimi Najiah Sukur[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To report a case of sphenoid wing meningioma presenting with ocular symptoms, emphasizing the importance of early recognition and multidisciplinary management.

Methods

Case report.

Results

A 47-year-old woman with no known medical history presented with a painless swelling of her right upper eyelid for three months, followed by progressive proptosis of the right eye over one month. She denied visual disturbances, diplopia, or headaches. Examination revealed a best-corrected visual acuity of 1/60 in the right eye, with no relative afferent pupillary defect. Axial proptosis and restricted extraocular movements in all directions were noted. The anterior segment was unremarkable, but fundus examination revealed optic disc pallor without choroidal masses. The left eye examination was normal. A brain CT scan confirmed right sphenoid wing meningioma. The patient was co-managed with the neurosurgical team, and tumor debulking surgery was planned.

Conclusion

Sphenoid wing meningiomas can initially present with isolated ocular symptoms, mimicking primary orbital pathology. This case highlights the critical role of ophthalmologists in early recognition, as timely diagnosis can prevent irreversible optic neuropathy. Given the potential for visual impairment, a high index of suspicion is necessary when evaluating patients with unexplained proptosis. Multidisciplinary collaboration ensures optimal management and patient outcomes.

ABSTRACT ID: 482

FROZEN EYES, RISING PRESSURE: A RARE CASE OF BILATERAL INTERNUCLEAR OPHTHALMOPLEGIA IN IDIOPATHIC INTRACRANIAL HYPERTENSION

Choong Chi Chun[1], Law Ngee Ling[1], Maya Sapira Hanapi[1], Nor Fadzillah Abd Jalil[1]

[1]Hospital Melaka

Purpose

To report a rare case of wall-eyed bilateral internuclear ophthalmoplegia (WEBINO) in a patient with idiopathic intracranial hypertension (IIH).

Methods

Case report.

Results

We report a case of a 22-year-old woman with no known medical history, presented with a sudden onset of binocular diplopia for four days, accompanied by headache and neck discomfort. She had a preceding history of an upper respiratory tract infection. Clinical examination revealed right eye exotropia (~15° deviation). Visual acuity was 6/9 in both eyes. The right eye exhibited limited abduction and adduction, while the left eye's extraocular movements were normal. Optic nerve function test was normal but fundus showed bilateral optic disc swelling with splinter hemorrhages and obscuration of vessels at all four quadrants. Her symptoms further worsened after three days, progressing to bilateral adduction paralysis with abduction nystagmus in the contralateral eye, consistent with bilateral INO. Contrast enhanced computed tomography (CECT) scan of brain was normal. Lumbar puncture demonstrated an opening pressure of 45 cm H2O, without pleocytosis and normal cerebrospinal fluid (CSF) composition. CSF cultures were all negative for infection.

Conclusion

This case highlights a rare presentation of IIH with bilateral INO, emphasizing the importance of thorough neuro-ophthalmic evaluation in patients with IIH. A high index of suspicion is required when encountering progressive ophthalmoplegia in the setting of increased intracranial pressure.

ABSTRACT ID: 530

SPONTANEOUS SUBCONJUNCTIVAL HEMORRHAGE SECONDARY TO SPONTANEOUS BILATERAL CAROTID-CAVERNOUS FISTULA.

Shikin Nabilah Mohd Shakri[1], Maimun Bashir[1], Shazwani Azmi[1], Amirah Hassan[1], Zalifa Zakiah[1]

[1]Hospital Cyberjaya

Purpose

To highlight a case of spontaneous subconjunctival hemorrhage secondary to spontaneous bilateral carotid-cavernous fistula (CCF).

Methods

Case report.

Results

A 57-year-old lady presented with bloodshot right eye for one week associated with a loud pulsating noise in her ears. She had no history of trauma or eye surgery, and denies eye pain, discharge, or any blurring or double vision. She was not on any blood thinning medications or never had any bleeding tendencies. On examination, visual acuity of both eyes was 6/9 with no relative afferent pupillary defect. There was no restriction of extraocular movements and no proptosis. Anterior segment examination of the right eye showed generalised subconjunctival hemorrhage with prominent, tortuous and dilated underlying episcleral veins. There was loud bruit heard during orbital auscultation. Otherwise, the anterior chamber was deep, no hyphema, no blood in Schlemm's canal was observed on 2-mirror gonioscopy and posterior segment examination was unremarkable. No significant findings over the left eye. Neurological examinations were normal. Contrasted computed tomography angiography (CTA) of the brain showed dilatation and enhancement of the bilateral superior ophthalmic vein and spheno-parietal sinuses with early enhancement of both cavernous sinuses in the arterial phase and multiple dilated collaterals in both infratemporal fossa, suggestive of CCF. Patient was referred to neurosurgery team and embolization was performed.

Conclusion

Patients with CCF can present with various nonspecific symptoms, however, they commonly present with ophthalmic manifestations including subconjunctival hemorrhage due to venous drainage of the orbit from the cavernous sinus. Early diagnosis and appropriate management is essential to avoid vision and life-threatening complications.

ABSTRACT ID: 533

OCULAR MYASTHENIA GRAVIS WITHOUT PTOSIS

Amirah Hanoum Amin Ariff[1], Abdullah Ashraf Rafique Ali[1], Nor Azimah Abd Aziz[1]

[1]Universiti Teknologi MARA

Purpose

To report a case of ocular myasthenia gravis that presented with decompensated esophoria, without any ptosis or restriction in ocular movements.

Methods

Case report.

Results

A 38-year-old female with underlying hypertension complained of intermittent diplopia for four months, which gradually became persistent. She initially had her first episode of double vision three years ago during childbirth but the symptom resolved spontaneously. The diplopia recurred in the current episode. The symptoms typically occur after prolonged computer use, during driving, and primarily affect far vision. Notably, the diplopia resolves with rest. She denies any systemic neurological symptoms. Visual acuity was 6/6 OU and her eyes were orthophoric with full ocular movements. Patient had binocular diplopia peripherally and inferiorly, but results were inconsistent and variable. There was no ptosis and the fatigability test was negative. Cover test showed right esotropia at distance and orthophoria at near, while the Hess test showed decompensated esophoria pattern. Serum anti-acetylcholine receptor antibody level was raised, and single-fiber electromyography showed increased jitter of the right orbicularis oculi, consistent with ocular myasthenia gravis. The symptoms improved after she was started on oral pyridostigmine.

Conclusion

Ocular myasthenia can present solely with intermittent diplopia without ptosis or any apparent restriction in ocular motility. Although variable ptosis is the most common sign, isolated diplopia with fluctuating symptoms should prompt further diagnostic investigations to rule out ocular myasthenia gravis.

ABSTRACT ID: 544

TWO CASES, ONE OCULAR MYSTERY – UNVEILING THE SECRET OF SUDDEN BILATERAL VISION LOSS IN YOUNG PATIENTS

Lock Kah Mun[1], Jeffrey Ong Wei Kiat[1], Seow Sieng Teng[1], Kumutha Muthusamy[1], Nor Fadzillah Abd Jalil[1], Juliana Jalaluddin[1]

[1]Hospital Melaka

Purpose

To report two cases of bilateral sudden vision loss in young patients.

Methods

Case report.

Results

Case 1: A 28-year-old woman, para 3, post-partum, with a history of gestational diabetes mellitus, complained of intermittent throbbing headaches accompanied by nausea and projectile vomiting since day 2 post-delivery. She also experienced sudden painless vision loss for 1 day, without any neurological deficits. Her visual acuity (VA) was perception of light in both eyes. There was no relative afferent pupillary defect. Bilateral eyes examination was unremarkable with normal intraocular pressure. Contrast enhanced computed tomography (CECT) of the brain and venography (CTV) showed inferior sagittal sinus thrombosis, left occipital and parietal acute venous infarct, and subarachnoid bleed. The patient was started on anticoagulant and after 24 hours of treatment, she regained VA of 6/6 with no residual optic nerve function deficit

Case 2: A 17-year-old healthy male, presented with a 2-week history of throbbing headache, followed with diplopia, nausea, and vomiting for 2 days, without other neurological deficit. On examination, bilateral VA was counting fingers (pinhole 6/18), but optic nerve function test was normal. Extraocular movement was limited on lateral gazes. Fundus examination revealed bilateral blurred optic disc margin with no spontaneous venous pulsation. Bilateral eyes anterior segment and intraocular pressure was otherwise normal. Blood investigations showed leukocytosis. CT angiography (CTA) of the brain showed small irregular filling defects within torcular herophili. The patient was started on anticoagulant and subsequently regained final vision 6/6.

Conclusion

These cases highlight the importance of considering cerebral venous thrombosis in young patients with atypical presentations and no clear neurological deficits. Timely diagnosis and prompt anticoagulation therapy are crucial in preventing long-term visual and neurological complications.

ABSTRACT ID: 556

MYELIN OLIGODENDROCYTE GLYCOPROTEIN (MOG) OPTIC NEURITIS CASES IN HOSPITAL SULTAN ISMAIL, JOHOR BAHRU, MALAYSIA: INCIDENCE AND RESPONSE TO STEROID THERAPY

Lee Sze Hoy[1], Nik Nazihah Nik Azis[1], Reena Kaur Balbir Singh[1], Azlyn Azwa Jasman[1], Nurul `Ain Masnon[2]

[1]Hospital Sultan Ismail; [2]Hospital Kuala Lumpur

Purpose

To report two first presentations of Myelin Oligodendrocyte Glycoprotein (MOG) optic neuritis, highlighting incidence and response to corticosteroid therapy.

Methods

Case report.

Results

Case 1: A 31-year-old Malay woman with no medical history presented with a one-month history of headache and progressive right eye (RE) blurring of vision. Her RE vision was counting finger (CF) and left eye (LE) vision was 6/12. The optic nerve function test (ONFT) in the RE showed grade 1 relative afferent pupillary defect (RAPD), 30% reduction in both red saturation and light brightness, and failed Ishihara test. The anterior and posterior segment examination of both eyes and LE ONFT were normal. Contrasted CT scan showed a swollen RE intra-orbital optic nerve. Her serum MOG antibody was positive. She responded well to high-dose intravenous methylprednisolone (IVMP), with RE vision improving to 6/12 (6/9), light brightness and red saturation improving to 97%, and passing the Ishihara test.

Case 2: A 53-year-old Malay woman with hypertension and dyslipidemia developed sudden LE vision loss with bilateral papilloedema. Her RE visual acuity was 6/24, while LE was perception of light (PL) with grade 3 RAPD and impaired ONFT. The ONFT in the RE was normal. MRI of the brain and orbit revealed an abnormal signal at the tectum of the midbrain, indicating possible demyelination. Serum MOG antibody was positive. She improved with high-dose IVMP with final visual acuity of 6/18 (6/9) in both eyes, and complete recovery of the left ONFT.

Conclusion

MOG optic neuritis in both cases presented without other neurological deficits and showed significant vision recovery with corticosteroids. However, the possibility of recurrence and related neurological symptoms need to be counselled to patients especially in the first year of diagnosis.

ABSTRACT ID: 561
HOAGLAND SIGN IN A CHILD WITH EPSTEIN-BARR VIRUS INFECTION

Rubahshini Gunaseelan[1], Siti Nur Amira Abu Kassim[1], Nor Fadzillah Abd Jalil[1]

[1]Hospital Melaka

Purpose

To report a case of a child with Epstein-Barr virus (EBV) infection who shows early presentation as bilateral upper eyelid edema (Hoagland sign).

Methods

Case report.

Results

A two-year-old girl presented with a week history of localised bilateral upper eyelid swelling. It was associated with fever, reduced urination, and maculopapular rashes over the face and trunk. Ocular assessment revealed bilateral painless non-erythematous upper eyelid edema with normal other ocular findings. Initial basic investigations revealed leukocytosis and scalloping cytoplasm which are usually seen in infectious mononucleosis. EBV serology was sent later, and immunoglobulin-G (IgG) and immunoglobulin-M (IgM) were detected. The child was co-managed with pediatricians and was treated with adequate hydration and intravenous antibiotics for ten days. Eyelid edema was then recovered alongside other clinical parameters.

Conclusion

Hoagland sign is a rare but important manifestation that should be considered as a possible sign of infectious mononucleosis. Recognizing this symptom can aid in early diagnosis and life-saving treatment.

ABSTRACT ID: 563

A CASE OF BOTH EYES PRERETINAL HAEMORRHAGE WITH RETINOPATHY IN A PATIENT WITH ACUTE PROMYELOCYTIC LEUKEMIA

Youta Heng Lee[1], Sharifah Azira Mohd Taufik[1], Zairah Zainal Abidin[1]

[1]Hospital Ampang

Purpose

To report a case of both eyes preretinal haemorrhage with retinopathy in a patient with acute promyelocytic leukemia (APML).

Methods

Case report.

Results

A 39-year-old male with no known medical illness, presented with acute left eye blurring of vision for 3 days, described as large central scotoma. He denied any floaters, flashes of light, eye pain or red eye. Prior to this, he had experienced lethargy for 1 month with generalized body weakness and reduced effort tolerance. He also noticed right neck swelling for the past 2 weeks, which had decreased in size after a course of antibiotics. Additionally, he had multiple episodes of gum bleeding upon brushing his teeth. On examination, palpable right cervical lymphadenopathy (2cm x 2cm) and a 2/5th palpable splenomegaly were noted. His visual acuity was 6/24 (6/18) OD and counting fingers (CF) OS. The RAPD was negative and anterior segment of both eyes was normal. Fundus examination showed a preretinal hemorrhage covering macula (about 1.5DD) the right eye and a large subhyaloid hemorrhage (about 4DD) in the left eye, with roth spots and flames shape hemorrhage over superior and inferior arcades in both eyes. Haematological investigations revealed pancytopenia. He was investigated by hematology team and diagnosed with APML. Treatment with chemotherapy (Idarubicin) and maintenance therapy (Methotrexate, Mercaptopurine, and Altra) was initiated. He was also started on Gutt Nepafenac TDS and Gutt Pred Forte QID in both eyes. On subsequent review, his hematological parameters has stabilized, and as the size of the preretinal hemorrhage decreased, his vision improved.

Conclusion

This case highlights the importance of thorough systemic and hematological workup in patients with both eyes preretinal hemorrhage

ABSTRACT ID: 564
REVERSE BLINDNESS IN A RARE CASE OF CRANIOPHARYNGIOMA IN ELDERLY

Seetha Krishnamoorthy[1]

[1]Hospital Sultan Idris Shah

Purpose

To present a rare case of bilateral vision loss due to craniopharyngioma in an elderly patient that completely resolved after surgical intervention.

Methods

Case report.

Results

A 51-year-old lady presented with sudden onset of painless bilateral blurring of vision over the past 2 weeks. Symptoms initially started in the left eye (LE) and later progressed to the right eye (RE). She also reported a frontal headache for the past 1 month. At initial presentation, visual acuity (VA) was 6/60 in the RE and hand movements in the LE, with a positive RAPD in the LE and impaired optic nerve function (LE > RE). Anterior segment was normal except for bilateral immature cataract, with no significant findings in the posterior segments. Cranial nerve examination was intact. Humphrey visual field (HVF) test showed RE tunnel vision. Due to poor vision, HVF testing could not be completed for the LE. Contrast-enhanced CT (CECT) of the brain and orbit showed a non-enhancing hypodense suprasellar lesion, suggestive of a Rathke's cleft cyst or craniopharyngioma. The case was referred to neurosurgery, and the patient underwent craniotomy. Upon follow-up, one month after the surgery, her unaided VA was 6/7.5 in the RE and 6/6 in the LE, with no RAPD and normal optic nerve function tests. HVF testing showed no scotoma in either eye.

Conclusion

Craniopharyngioma in elderly patients is rare. Earlier clinical suspicion and imaging by ophthalmologist can contribute to prompt surgical intervention which in turn can have a very good visual prognosis .

ABSTRACT ID: 567
AN ATYPICAL CASE OF GRADENIGO SYNDROME

U-Nee Lam[1], Chandramalar T. Santhirathelagan[1], Siti Nor Roha Daman Huri[1]

[1]Hospital Sungai Buloh

Purpose

To report an atypical presentation of Gradenigo syndrome in an adolescent boy.

Methods

Case report.

Results

A 12-year-old boy with no known medical illness presented with right esotropia and horizontal gaze diplopia for 3 days. He had a prior history of right otitis media which was treated with oral antibiotics. On examination, his vision was 6/12 (6/9) OU. There was no RAPD and other optic nerve function was intact. Anterior segment examination was unremarkable for both eyes. However, there was limited abduction of the right eye with bilateral optic disc hyperemia on fundus examination. The Hess chart correlated with the clinical finding of right lateral rectus muscle underaction and overaction of the left medial rectus muscle. Computed tomography (CT) of the brain, paranasal sinuses, petrous bone and orbit showed right otomastoiditis and filling defects at right transverse and sigmoid sinuses suggestive of venous sinus thrombosis. Magnetic resonance imaging (MRI) of the brain and venography (MRV) confirmed the right otomastoiditis and right dural venous sinuses and internal jugular venous (IJV) thrombosis. Four doses of subcutaneous enoxaparin and oral warfarin 5 mg daily was administered, alongside intravenous antibiotics. Patients symptoms resolved after a month of treatment.

Conclusion

The classical triad of ear symptoms, lateral gaze palsy and trigeminal neuralgia seen in Gradenigo syndrome may not always be present. Hence, a high level of suspicion along with diligent history taking is essential in diagnosis and effective treatment. This case highlights the importance of appropriate antibiotic therapy in treating these cases as its complications lead to high morbidity and mortality.

ABSTRACT ID: 569

A TINY PINCH THAT HURTS THE EYE - A CASE REPORT ON DIRECT TRAUMATIC OPTIC NEUROPATHY

Zunaina Embong[1], Wan Nadiah Amir Hamzah[12], Sarojini Krishnan[2], Aiman Mardhiyyah Mohd Yazid[1], Nor Ismarudi Ismail[2]

[1]Universiti Sains Malaysia; [2]Hospital Tengku Ampuan Rahimah

Purpose

To highlight optic nerve decompression as part of the management in direct traumatic optic neuropathy.

Methods

Case Report.

Results

A young male with no significant medical or ocular history was involved in a motor vehicle accident, sustaining a traumatic brain injury, multiple facial bone fractures, a right periorbital hematoma, and non-marginal eyelid lacerations. Upon initial assessment, his Glasgow Coma Scale (GCS) score was 13, no relative afferent pupillary defect (RAPD), while other optic nerve function could not be assessed as the patient was uncooperative. However, subsequent evaluations revealed traumatic optic neuropathy (TON), with a positive RAPD in the right eye, a visual acuity of 6/60, and other clinical signs of optic nerve dysfunction. A computed tomography (CT) scan of the brain identified direct TON, with a bony fragment from the fractured lesser wing of the right sphenoid impinging on the right optic nerve. The otorhinolaryngology team was consulted, and optic nerve decompression was planned following the administration of high-dose steroids. Surgery was performed via an endoscopic endonasal approach, during which the bony fragments impinging on the optic nerve were successfully resected without complications. Postoperatively, the patient demonstrated significant improvement in visual acuity and optic nerve function.

Conclusion

TON should be assessed via CT scan to identify potential direct causes which may require urgent decompression to salvage optic nerve function. A multidisciplinary approach is essential in establishing the diagnosis along with surgical management of direct TON.

ABSTRACT ID: 570

JUNCTIONAL SCOTOMA AS A PRESENTING SIGN OF CRANIOPHARYNGIOMA: A CASE REPORT

T.Thanam Tamil Chelvan[1], Cheng Teck Chee[1], Jemaima Che Hamzah[1]

[1]Universiti Kebangsaan Malaysia

Purpose

To describe a case of adamantinomatous craniopharyngioma manifesting with a subtle junctional scotoma.

Methods

Case report.

Results

A 29-year-old Malay female with no known comorbidities experienced a gradual onset of right eye blurring of vision over central field which was associated with occasional headache for three months. Examination revealed right eye vision of 6/9 and left eye vision of 6/6, with a positive relative afferent pupillary defect (RAPD) over the right eye. Anterior segment examination of both eyes was unremarkable while fundoscopy revealed bilateral normal optic disc and macula. Humphrey visual field testing showed right central scotoma and left superotemporal quandrantanopia which is typical of a junctional scotoma. A magnetic resonance imaging (MRI) of the brain was performed which revealed a calcified cystic sellar mass causing local compression on the optic chiasm and superior displacement of the right post-chiasmatic region, indicating a craniopharyngioma. The location and extension of the tumour was consistent with her presentation and visual field defect. She subsequently underwent craniotomy and tumor excision by the neurosurgical team, with histopathological examination confirming adamantinomatous craniopharyngioma. Postoperatively, the patient has also completed radiotherapy cycles. She remained under surveillance without worsening visual symptoms.

Conclusion

Visual field assessment is essential in diagnosing chiasmal lesions, especially in patients presenting with central scotoma despite a normal-appearing optic disc and macula. Timely and effective management of craniopharyngioma can preserve both vision and life.

ABSTRACT ID: 579
THE INVISIBLE MONSTER BENEATH THE SKIN

Lee Yee Lin[1], Siti Zakiah Md Khair[1], Shahrul Bariah Mohd Ghazali[1], Nor Amalina Abdul Rahman[2]
[1]Hospital Pakar Sultanah Fatimah; [2]Universiti Sains Malaysia

Purpose

To report a sight-threatening neurocutaneous condition, Herpes Zoster Ophthalmicus (HZO) requiring urgent ophthalmology consultation.

Methods

Case Report.

Results

A 21-year-old, Malay male with no underlying comorbid presented with history of alleged insect bite over his left cheek. He presented 4 days after trauma complaining of left facial skin exfoliation and swelling. There were multiple skin eruption and vesicular rashes on the left side of his face, involving the ophthalmic, maxillary and mandibular distributions. Notably, there was reduced left-sided grimace, drooping of the left lower lip, and multiple oral ulcers, particularly on the left oral mucosa. His presenting vision in the left eye was 6/18 (6/12), and 6/9 in the right eye, with left positive RAPD (grade I). The Hutchinson sign was present, along with slight limitation of left eye elevation. Anterior segment examination of the left eye showed injected conjunctiva, reduced corneal sensation, small localized stromal infiltrate with surrounding edema at 10 o'clock peripheral cornea. There was no epithelial defect, keratic precipitates, dendritic lesions, or cells/hypopyon in the anterior chamber. The left fundus was normal. Anterior and posterior segment examinations of the right eye were normal. Intraocular pressures were normal bilaterally. He was treated as left preseptal and facial cellulitis with optic neuropathy secondary to Herpes Zoster infection. He received oral antiviral therapy for 2 weeks, topical antivirals over left eye and antibiotics for secondary bacterial infection. He was also referred to OMFS, Dermatology and ENT for comprehensive managements. He recovered well with scarring over facial skin and improved optic nerve function.

Conclusion

Early recognition of HZO and prompt managements are critical in preventing debilitating condition.

Orbit & Oculoplastic

ABSTRACT ID: 8

BEYOND THE EYES: A FORNIX SURPRISE UNRAVELLING TUBERCULOSIS ACROSS THE EYE, SKIN AND LYMPH NODES

Siti Aeisyah Ayob[1], S Kala Sumugam[1], Sharifah Intan Hosnaliza[1], Sellymiah Adman[1]

[1]Hospital Kuala Lumpur

Purpose

To report a case of a conjunctival mass as the initial manifestation of disseminated extrapulmonary tuberculosis.

Methods

A case report

Results

A 67-year-old lady with resolving smear-positive pulmonary tuberculosis (TB) presented with a right-eye conjunctival mass. The right upper and lower lids had a thickened salmon-pink fleshy mass in the fornix. Examination of the anterior and posterior segments of the affected eye was unremarkable. The fellow eye was unaffected. Incisional biopsy of the conjunctival mass revealed chronic granulomatous changes, suspicious of a similar infective aetiology. Systemic examination showed enlarged pre and postauricular lymphadenopathy with the presence of a hyperkeratotic plaque on the right cheek. Her chest X-ray showed no further indication of an active pulmonary TB infection. She was referred to the Otolaryngology and Dermatology team, where biopsies were performed on the lesions, demonstrating chronic granulomatous changes, supporting the diagnosis of disseminated extrapulmonary TB.

Conclusion

This case highlights the importance of considering disseminated extrapulmonary tuberculosis in diverse clinical presentations. The rarity of conjunctival involvement, particularly in the fornix, emphasises the importance of meticulous examination of patients with a history of tuberculosis. Recognition of such atypical manifestations is crucial for early diagnosis and appropriate management, preventing potential complications, and aiding timely therapeutic interventions.

ABSTRACT ID: 11
A RARE CASE OF ORBITAL MYIASIS: A CASE REPORT

Hee Zi Xin[1], Edwin Pheng Chin Meng[2]

[1]Hospital Sibu; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To highlight the clinical features and management of orbital myiasis, emphasizing the importance of proper management and wound care.

Methods

A case report.

Results

A 94-year-old male with diabetes mellitus and history of left eye enucleation following wood stick trauma 5 years ago presented with a chronic, non-healing wound over his left eye socket. He had defaulted follow-up care, performing self-dressing at home. He reported worsening of the wound with the appearance of maggots in the wound for 3 days. On examination, a 6x6cm cavitated lesion with necrotic margins, sloughy base and surrounding erythematous skin was noted in left orbital cavity, extending to the nasal area. The socket cavity was filled with numerous maggots. Initial contrast-enhanced CT scans revealed soft tissue density extending into the left nasal cavity, maxillary, ethmoid, sphenoid, and frontal sinuses, with a 2.4x2.4x2.7cm septated collection in the maxillary sinus, along with adjacent bone. The left rectus muscle was unaffected, and no intracranial extension or right orbital lesions was identified. A multidisciplinary team including Othorhinolaryngology, Oral and Maxillofacial Surgery, and Wound Care were involved. The patient underwent mechanical maggot removal, followed by daily dressing. He was started on intravenous broad-spectrum antibiotics in which the patient responded well. During the routine follow-up, the wound healed well.

Conclusion

This case highlights that advanced age and chronic unhealing wound are significant risk factors for orbital myiasis. Early intervention with larval removal can prevent deeper tissue invasion and reduce both morbidity and mortality.

ABSTRACT ID: 12

BENEATH THE SURFACE: THE MYSTERY OF A PRESEPTAL STONE

Lock Kah Mun[1], Seow Sieng Teng[1], Nor Fadzillah Abd Jalil[1], Juliana Jalaluddin[1]

[1]Hospital Melaka

Purpose

To report a case of retained ocular foreign body in a young male following a motor vehicle accident.

Methods

A case report.

Results

A young male presented to the Emergency Department following a motor vehicle accident. Post-trauma, he experienced loss of consciousness and retrograde amnesia, with no ocular complaint. On examination, both eyes had visual acuity 6/6, with no relative afferent pupillary defect. There was no periorbital hematoma or open wound besides a scab measuring 40mm x 20mm below the temporal region of the right lower eyelid. Both anterior and posterior segments were unremarkable with normal intraocular pressure. No foreign bodies were detected upon exploring the upper and lower eyelids. Extraocular muscle movements were full, with no diplopia. Computed tomography of the brain revealed a subcutaneous foreign body in the lateral aspect preseptal space of the right orbit with no evidence of intracranial hemorrhage. Upon further examination after removing the scab, a small deep laceration wound size 10mm x 10mm was discovered. Exploration of the deep wound further revealed a stone measuring 4mm x 6mm x 5mm underneath it.

Conclusion

It is crucial to consider the possibility of a retained foreign body in all orbital trauma cases. Hence, a thorough examination with a high level of suspicion for a foreign body in the evaluation of all wounds, including scab removal and wound exploration, and prompt use of imaging studies are essential to prevent the devastating complication of retained ocular foreign body.

ABSTRACT ID: 14
A CASE OF EPISCLERAL OSSEOUS CHORISTOMA IN A YOUNG GIRL

Elaine Gan JY[1], Dahziela Y[1], Hanida Hanafi[1], Sylves P[2]

[1]Hospital Queen Elizabeth; [2]Universiti Malaysia Sabah

Purpose

To report a case of a 14-year-old girl with episcleral osseous choriotoma.

Methods

A case report.

Results

A 14 year-old girl presented with right eye foreign body sensation for one year. On examination of the right eye, a yellowish, nonmobile and hard mass measuring 8 mm x 5 mm was seen at the superotemporal quadrant. She underwent an excision biopsy. Intraoperatively, a 5.5 mm x 5.5 mm episcleral lesion was identified and adhered tightly to the sclera. The surgical excision was succesful with no complication. Histopathological examination finding revealed an osseous choristoma.

Conclusion

We report a rare case of episcleral osseous choristoma in our population. Computed tomography is helpful in the diagnosis and treatment plan but it is not always necessary. Meticulous surgical skills are crucial for successful excision without complication.

ABSTRACT ID: 35

SURGICAL INSIGHTS: A CASE SERIES ON PALPEBRAL CONTRACTURE WITH LATERAL CANTHOPEXY AND COMBINED CANTHOPEXY TECHNIQUES

Rasyidia Laskmita Putri[1], Trilaksana Nugroho[1]

[1]Diponegoro University, Indonesia

Purpose

To report an output of different techniques of lateral canthopexy and combined canthopexy in management of palpebral contracture.

Methods

A case series.

Results

In this case series, both patients complained that their eyelids were difficult to open wide before surgery. The first patient underwent lateral canthopexy surgery. The first patient's preoperative Inner Intercanthal Distance (IICD) and Marginal Reflex Distance 1 (MRD-1) measurements were 32 mm and 4 mm, respectively. A postoperative assessment of the first patient revealed that IICD value increased to 34 mm and MRD-1 was 3 mm. The second patient had two stages of combined canthopexy surgery. A lateral canthopexy was done in the initial phase. Medial canthopexy was the second surgical procedure, which was performed about 1.5 months following the first. The preoperative assessment of the second patient revealed that IICD was 26 mm and MRD-1 was 4 mm. The examination results after the initial stage of canthopexy surgery showed that the second patient's IICD value was 28 mm and MRD-1 was 1 mm. Additionally, the IICD value was 30 mm and MRD-1 was 5 mm following the second stage of canthopexy. The patient's problems subsided and both were able to open his eyes widely following canthopexy surgery.

Conclusion

Palpebral contracture management approaches may be based on ophthalmological status. The intended results and the mechanism of deformity will have a significant impact on the treatment strategy.

ABSTRACT ID: 42

BEYOND CAFÉ-AU-LAIT SPOTS: A CHALLENGING CASE OF NF1-ASSOCIATED ORBITAL PLEXIFORM NEUROFIBROMA

Kavitha R.Saravanamuthu[1], Nurul 'Ain Masnon[1], Nasuha Idris[1 2], Othmaliza Othman[2]

[1]Hospital Kuala Lumpur; [2]Hospital Canselor Tunku Muhriz Universiti Kebangsaan Malaysia

Purpose

To report a case of Right eye upper lid plexiform neurofibroma complicated with complete mechanical ptosis.

Methods

A case report.

Results

A 4-year-old Malay girl with Neurofibromatosis Type 1 (NF1) presented with right eye swelling since birth and progressively worsening with proptosis. Ophthalmologic examination revealed reverse RAPD in the right eye, right eye vision counting finger and left eye vision 6/6.There was S-shaped upper lid swelling with complete mechanical ptosis, non-axial proptosis, with dystopia. Additionally right eye cornea was buphthalmic and hazy with evidenced by persistent high intraocular pressure(IOP) despite trabeculotomy, maximum antiglaucoma medications and transscleral cyclophotocoagulation (TSCPC). Right eye posterior segment examination revealed glaucomatous optic disc changes with CDR 0.9. Left eye examination was unremarkable. MRI findings showed extensive plexiform neurofibromas involving the right orbit, both cavernous sinuses, and multiple left-sided facial structures. Right upper eyelid neurofibroma was surgically excised due to significant disfigurement and risk of possibility of increase in severity. It was an approach via blepharoplasty incision, horizontal wedge resection, and lateral canthal fixation.

Conclusion

In conclusion, the surgical treatment resolved her right eye complete mechanical ptosis. This approach enable patient to open and close the eye although visual prognosis is poor due to underlying complicated right eye glaucoma.

ABSTRACT ID: 44
SCLERAL BUCKLE INDUCED ORBITAL CELLULITIS AND SCLERITIS

Chong Ying Sze[1], Nadhir Nuwairi[1], Norlaila Talib[1]

[1]Hospital Sultan Idris Shah

Purpose

To report a case of an elderly patient who developed orbital cellulitis and scleritis after scleral buckling and cryotherapy procedure done 15 years ago.

Methods

A case report.

Results

A 76 years old gentleman with underlying hypertension and history of scleral buckle SB) done 15 years ago for rhegmatogenous retinal detachment, presented with sudden onset of right periorbital swelling and redness for two days associated with difficulty opening of his right eye (RE). No fever, sinusitis symptoms or history of eye trauma were elicited. Visual acuity of both eyes were 6/18 and RAPD was negative. Examination of RE showed mechanical total ptosis, generalized chemosis with injected conjunctiva and limited extraocular movement of -2 in all directions except lateral gaze. Cornea was clear with quiet anterior chamber. No extrusion of scleral buckle was seen. Intraocular pressure was normotensive. Dilated fundus examination was unremarkable other than presence of chorioretinal scars from previous cryotherapy. Blood parameters revealed white cell count of 9 and C-reactive protein of 30. Contrasted tomography angiography (CTA) of orbit and brain suggestive of right orbital cellulitis and pansinusitis. The patient responded well after a two weeks course of Augmentin and Metronidazole.

Conclusion

This is a case of orbital cellulitis and scleritis with history of SB was managed with broad spectrum antibiotics without necessitating buckle removal. We recommend long follow up of patients with SB as complications may occur even with years after the surgery. Co-management between medical and vitreoretinal subspecialty team is important to ensure best outcome for the patient as removal of SB may impose risk of redetachment.

ABSTRACT ID: 72
ORBITAL PYOMYOSITIS MIMICKING THIRD CRANIAL NERVE PALSY

Nor Ismarudi Ismail[1], Abbas Abd Hamid[1], Wan Nadiah Amir Hamzah[12], Zunaina Embong[2], Aiman Mardhiyyah Mohd Yazid[2]

[1]Hospital Tengku Ampuan Rahimah; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To highlight the importance of prompt investigation and diagnosis in case of sudden onset ptosis with painful ophthalmoplegia.

Methods

A case report.

Results

A middle-aged lady with underlying migraine, presented with acute onset painful ophthalmoplegia and ptosis of the right eye (RE). She had history of house dust entered the RE a week before. She subsequently developed eyelid swelling and eye redness which partially resolved after instilling topical antibiotic bought over-the-counter. Upon clinical examination, RE visual acuity (VA) was 6/9 with intact optic nerve function. Bilateral pupils were 3 mm and reactive. There was ptosis covering visual axis of RE, along with presence of chemosis, circumlimbal conjunctiva injection and corkscrew vessels. RE elevation, dextro- and levoelevation was limited, with otherwise full extraocular muscles movement in other directions. There was no proptosis, palpable thrill or auscultated bruit. Thyroid function blood tests were unremarkable, however she has elevated septic parameters. Contrasted computed tomography of brain and orbit was performed, denoting heterogenous lesion with rim enhancement and internal septation of anterior aspect of right superior rectus muscle, with mass effect indentation on superior wall of right globe. She completed one week course of intravenous Ceftriaxone followed by oral Cefuroxime for one week. Patient had complete resolution of the symptoms and signs upon concluding antibiotic course.

Conclusion

Acute onset ptosis with painful ophthalmoplegia should warrant us to exclude the most life threatening and visual threatening diagnoses, with the aid of prompt availability of radiological imaging. Orbital pyomyositis and diagnoses on the idiopathic orbital inflammatory diseases (IOID) spectrum remain as diagnosis of exclusion.

ABSTRACT ID: 74
A DIAGNOSTIC ENIGMA IN THE ORBIT

Saranyaa Manohar[1], Noorlaila Baharuddin[1], Suriana Suaibun[1]

[1]Hospital Putrajaya

Purpose

To highlight the diagnostic challenges in differentiating between orbital cellulitis and orbital lymphoma.

Methods

A case series.

Results

Case 1 : 56-year-old Chinese male presented with right eye painless proptosis and rhinorrhea for three weeks. Vision was perception of light (PL) with a relative afferent pupillary defect (RAPD), diffuse injection with chemosis, axial proptosis and restricted extraocular movements in all gazes. Unresponsive to intravenous (IV) broad-spectrum antibiotics, functional endoscopic sinus surgery (FESS) was performed and intraoperative samples revealed high-grade T-cell lymphoma.

Case 2 : 60-year-old Bajau man with diabetes and hypertension, presented with fever and progressive painless erythematous right eyelids swelling for one month after an insect bite. Vision was 6/9, with non-axial proptosis and restriction in elevation. Progression despite few courses of oral and IV antibiotics. Nasal endoscopy showed mass, further FESS and tumour excision revealed a T-cell lymphoma.

Case 3 : 53-year-old Indian man with retroviral disease presented with rapidly worsening right painful periorbital swelling for one week. Vision was PL with RAPD, diffuse injection with chemosis, axial proptosis and complete ophthalmoplegia. After unresponsive course of IV antibiotics, FESS was done and biopsy confirmed anaplastic large cell lymphoma.

Conclusion

Orbital malignancies can mimic orbital cellulitis, further diagnostic workout with early multi-speciality involvement is essential when conventional treatments failed for prompt accurate treatment to save vision and life.

ABSTRACT ID: 77

A CASE OF THE UNSEEN CULPRIT: DACRYOADENITIS MASQUERADING AS ORBITAL CELLULITIS

Beh Jien Chien[1], Ummi Faradiana Abdul Rahim[1], Wan Mariny W Md Kasim[2]

[1]Hospital Raja Permaisuri Bainun; [2]Hospital Sultan Idris Shah

Purpose

To report a case of dacryoadenitis mimicking orbital cellulitis.

Methods

A case report.

Results

A 26-year-old man with schizophrenia and bronchial asthma presented with worsening left eye (LE) swelling and redness for two days. He had been hospitalized a week prior for bilateral orbital cellulitis. Examination showed swollen, erythematous LE upper and lower lids with mechanical ptosis, conjunctival injection temporally with chemosis, and restricted superior gaze. He was diagnosed with partially treated LE orbital cellulitis and admitted for intravenous antibiotics and contrast-enhanced computed tomography (CECT) of the brain and orbit. CECT revealed unchanged bilateral pre- and postseptal cellulitis with soft tissue extension into the extraconal space (left more than right), with no clear plane with the lacrimal glands, superior and lateral recti muscles bilaterally but no bulky extraocular muscles or orbital collection. Despite one week of intravenous ceftriaxone and metronidazole, he showed no improvement. The oculoplastic team revised the diagnosis to LE dacryoadenitis, suspecting malignancy. An incisional biopsy of the lacrimal gland revealed an enlarged, inflamed orbital and palpebral lobe. Histopathology confirmed chronic inflammation without granulomas or malignancy. He was started on tapering oral prednisolone, leading to clinical improvement, with reduced lid swelling, resolution of mechanical ptosis, and restored extraocular movements.

Conclusion

Persistent orbital inflammation despite appropriate antibiotic therapy should prompt clinicians to reconsider the initial diagnosis. Dacryoadenitis, though less common, can mimic orbital cellulitis and lead to delayed treatment if unrecognized. Imaging and biopsy are key to confirming the diagnosis and excluding malignancy for timely and accurate management.

ABSTRACT ID: 79

WHEN FOLLICLES TURN MALIGNANT: PRIMARY CONJUNCTIVAL LYMPHOMA PRESENTED AS CHRONIC CONJUNCTIVITIS

Fatin Diyanah Mazlan[1], Nurhafizah Abdullah[1], Zairah Zainal Abidin[1]

[1]Hospital Ampang

Purpose

To report a case of bilateral low grade conjunctival lymphoma.

Methods

A case report.

Results

A 57-years-old Malay male with underlying hypertension, chronic renal failure and ischemic heart disease presented with a 6-month history of tearing with discomfort. Initially was diagnosed with involutional entropion planned for surgical correction. He complained of worsening symptoms during subsequent follow up, but denied any ocular pain, changes in vision or any systemic complaints.There was presence of multiple large follicles on upper and lower tarsal conjunctiva which was not present before resulting in worsening entropion. Other ocular and systemic examinations were unremarkable with no lymphadenopathy. He was diagnosed with bilateral chronic follicular conjunctivitis. History, examination and infective workout failed to lead us towards the cause of his worsening chronic conjunctivitis. Despite being treated empirically with a 2-week course of oral Doxycycline, topical steroid and antibiotics eye drops, no improvement noted. Conjunctival excision biopsy was performed. Histopathological examination and immunohistochemical testing disclosed features suggesting low grade B-cell lymphoma, favouring follicular lymphoma. Contrasted CT orbit showed enhancing soft tissue mass over lower eyelid and inferior orbital wall area. He was co-managed with a hematologist and oncologist. As the lymphoma confined to the ocular area, he underwent 12-cycles of limited radiotherapy treatment. Post radiotherapy, the follicles and swelling resolved with residual minimal entropion bilaterally.

Conclusion

Conjunctival lymphoma is a rare but important ocular malignancy that requires prompt recognition and thorough evaluation. It is crucial to maintain a high index of suspicion, ensuring timely intervention and optimal patient care.

ABSTRACT ID: 130

A RARE CASE OF SINONASAL MALIGNANCY PRESENTED WITH ORBITAL APEX SYNDROME

Low Chin Shin[1], Niki Ho Wai Wye[1], Othmaliza Othman[1], Cheng Teck Chee[1], Rona Asnida Nasaruddin[1], Jemaima Che Hamzah[1]

[1]Hospital Canselor Tunku Muhriz Universiti Kebangsaan Malaysia

Purpose

To highlight the importance of a high index of suspicion for a rare but aggressive tumor which might present as orbital apex syndrome.

Methods

A case report.

Results

A 56 years old Malay gentleman with chronic rhinosinusitis presented to our eye clinic with unilateral, painless progressive vision loss and proptosis for two months associated with diplopia and ptosis for three weeks. The patient also had a history of recurrent epistaxis and hyposmia in the last four months. On presentation, visual acuity over the left eye (LE) was only counting fingers (CF). There was a presence of relative afferent pupillary defect (RAPD) grade 3 in the LE with reduced red desaturation and light brightness. Both anterior segments and fundoscopy were normal. The extraocular movements (EOM) showed limitation in all gazes except depression with non-axial proptosis. Hertel's exophthalmometry at 111mm : 20mm in the RE and 21mm in the LE.Magnetic resonance imaging (MRI) of brain and orbit revealed locally aggressive sphenoid sinus mass measuring approximately 4.9 x 4.5 x 3.7cm (AP x W x CC) with cavernous and left orbital apex extension as well as encasement of intracanalicular segment of left optic nerve. Biopsy of mass and histopathological evaluation confirmed the diagnosis of lymphoepithelial carcinoma (LEC). The patient was started on induction chemotherapy and followed by concurrent chemoradiotherapy.

Conclusion

Sinonasal LEC is a rare malignant tumor with paucity of literature. This case was reported to highlight the importance of a high index of suspicion for timely diagnosis and treatment of this aggressive tumor.

ABSTRACT ID: 145

UNVEILING THE MASK: A NEGLECTED CASE OF ORBITOFACIAL NEUROFIBROMATOSIS TYPE 1

Wong Joon Leek[1], Muhammad Aizuddin Ahmad[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

Reporting a neglected case of Orbitofacial Neurofibromatosis Type 1 (NF1) with severe disfigurement and functional impairment .

Methods

A case report.

Results

A 16-year-old girl presented with a massive, pendulous orbitofacial mass covering the left side of her face, associated with contact bleeding and progressively increasing in size since childhood. The patient had never sought medical attention due to her parents' negligence. Examination revealed a soft, non-tender swelling involving the periorbital, maxillary, and mandibular regions, causing severe facial asymmetry and deformity. However, the patient did not have any neurocutaneous manifestations. Neurological assessment showed no motor deficits, but the patient exhibited emotional distress and social withdrawal. Contrast-enhanced computed tomography (CECT) of the brain and orbit showed an extensive soft tissue lesion infiltrating the orbital cavity, the left optic nerve, and the medial and superior recti muscles, leading to proptosis of the left globe. Widening of the left optic canal, left pterygopalatine fossa, and flattening of the left lamina papyracea were noted. The patient was referred to the oculoplastic team and was scheduled for biopsy of the lesion.

Conclusion

Neglected cases of orbitofacial NF1 present significant psychosocial challenges. The extensive nature of the tumor, coupled with delayed intervention, complicates treatment. Early diagnosis and multidisciplinary management can prevent severe deformities and improve quality of life. Public awareness and accessible healthcare services are crucial in preventing neglect and ensuring timely medical intervention. This case underscores the importance of early recognition and intervention in NF1 with orbitofacial involvement. Addressing social barriers to treatment can prevent disease progression and improve outcomes.

ABSTRACT ID: 150

WHEN LIFE-SAVING MEASURES LEAVE A MARK: NON-TRAUMATIC SUBPERIOSTEAL ORBITAL HEMATOMA AFTER CARDIOPULMONARY RESUSCITATION

Chong Yong Yuin[1], Joan Marie Palikat[2], Sylves Patrick[3]

[1]Hospital Wanita dan Kanak-Kanak Sabah; [2]Hospital Queen Elizabeth; [3]Universiti Malaysia Sabah

Purpose

To report a case of NTSOH associated with cardiopulmonary resuscitation (CPR).

Methods

A case report.

Results

This is a case of a 48-year-old female who developed cardiac arrest while undergoing hemodialysis. CPR was performed for 24 minutes, successfully achieving the return of spontaneous circulation. A contrast-enhanced CT of the brain incidentally revealed a unilateral mixed-density orbital lesion with a smooth lateral border, confined to the subperiosteal space along the roof of right orbit, suggestive of an acute hematoma. The patient's coagulation profile and full blood count were within normal range bilaterally. Upon examination, there was mild proptosis with lid swelling over the right eye. Relative afferent pupillary defect was absent. The intraocular pressure were within normal range. Conservative management was adopted as there were no signs of compartment syndrome.

Conclusion

Subperiosteal orbital hematoma may occur following CPR, possibly due to the associated raised central venous pressure and intrathoracic pressure from chest compressions. In the process of this life-saving measure, clinicians should be aware that CPR may also result in ophthalmic complications which could potentially be sight-threatening.

ABSTRACT ID: 156

PEDIATRIC SPOROTRICHOSIS PRESENTING AS NASOLACRIMAL DUCT OBSTRUCTION AND FUNGAL SINUSITIS: A CASE REPORT

Law Jin Xing[1], Rohana Ab Rashid[1], Akmal Haliza Zamli[1], Noor Atikah Saini[12]

[1]Hospital Tengku Ampuan Afzan; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To present a rare case of sporotrichosis-associated nasolacrimal duct obstruction (NLDO) with conjunctival mass and fungal sinusitis in a pediatric patient, emphasizing the diagnostic challenges and management strategies.

Methods

A 7-year-old boy with left eye redness, discharge, and fever for one week. Persistent symptoms despite antibiotic treatment. Clinical examination revealed medial canthal swelling, conjunctival lesions, and nasolacrimal sac distension. CT scans suggested dacryocystitis, preseptal cellulitis, and fungal sinusitis. A history of contact with a cat diagnosed with sporotrichosis raised suspicion. Biopsies and fungal cultures confirmed *Sporothrix schencki* growth. The patient underwent conjunctival biopsy, probing, syringing, and functional endoscopic sinus surgery (FESS). Antifungal treatment included intravenous amphotericin B, itraconazole, and topical antifungals.

Results

The patient's symptoms improved following the surgical interventions and antifungal treatment, with resolution of the nasolacrimal duct obstruction and conjunctival masses.

Conclusion

This case underscores the importance of early recognition and comprehensive management of zoonotic fungal infections, like sporotrichosis, to achieve favorable outcomes, especially in pediatric ocular infections.

ABSTRACT ID: 174

CENTRAL RETINAL ARTERY OCCLUSION (CRAO) SECONDARY TO ACUTE RHINO-SINUSITIS WITH SUBPERIOSTEAL ABSCESS

Puvaneswary Tangga Rajoo[1], Haslinda Md Said[2]

[1]Hospital Sultan Idris Shah; [2]Hospital Tengku Ampuan Rahimah

Purpose

To report a rare case of central retinal artery occlusion (CRAO) secondary to acute rhino-sinusitis with subperiosteal abscess.

Methods

A case report.

Results

This case report presents a rapid progressive acute rhinosinusitis with orbital cellulitis complicated with CRAO in previously healthy individual. A 49 years old male presented with sudden painful swelling of Left eye(LE) for one day accompanied by symptoms of nasal congestion, rhinorrhea, cacosmia, and left sided headache. Ophthalmic examination revealed LE axial proptosis with visual aquity of 6/9, normal optic nerve function with unremarkable fundus. He was referred to Otorhinolaryngology team and noted to have left maxilary sinus pus discharge. Intravenous Rocephine 1g BD was initiated. Day three ophthalmic examination revealed a pale retina with cherry-red spot consistent with CRAO. Imaging studies demonstrated severe inflammation in the paranasal sinuses with orbital cellulitis. Retroorbital fat stranding noted with collection extending to subperiosteal space and superior extraconal space in the absence of thromboembolic sources. No intracranial extension was noted.He underwent Left FESS with subsequent anterior orbitotomy surgical drainage. Orbital compartment syndrome was likely the cause for the CRAO.

Conclusion

Orbital compartment syndrome is characterized by increased pressure within orbit causing compression or occlusion of central retinal artery leading to retinal ischemia. Prompt imaging and surgical drainage is important to prevent this blinding visual complication.

ABSTRACT ID: 177

TRANSCUTANEOUS RETROBULBAR AMPHOTERICIN B (TRAMB) INJECTION IN ACUTE INVASIVE RHINO-ORBITAL-CEREBRAL MUCORMYCOSIS (ROCM)

Chan Shi Ying[1], Ng Qx[1], Hanida Hanafi[1], Sylves Patrick[2]

[1]Hospital Queen Elizabeth; [2]Universiti Malaysia Sabah

Purpose

To report a case of acute invasive ROCM treated conservatively with TRAMB injection with successful avoidance of more radical and disfiguring orbital surgery.

Methods

A case report.

Results

A 27-year-old man with uncontrolled diabetes mellitus, hypertension and Hepatitis C presented with a one-month history of right facial swelling, numbness, nasal blockage, and blurred vision. Ocular examinations revealed right eye (RE) visual acuity was HM (hand movement) and left eye was 6/12. RE relative afferent pupillary defect was positive, limited lateral gaze, eyelid swelling with mechanical ptosis, and exposure keratopathy. Both eyes had proliferative diabetic retinopathy. Systemic examination revealed right facial swelling with nasal crusting, patches of palate necrosis and multiple cranial nerve palsies (I, II, V1, V2, VI, VIII). Tissue culture from sinus surgery grew Rhizopus sp. Contrast-enhanced computed tomography revealed right-sided fungal paranasal sinusitis with right orbital and intracranial extension. He received a course of intravenous Amphotericin B and oral Itraconazole. Otorhinolaryngology and oromaxillofacial teams planned for endoscopic debridement and partial right maxillectomy once severe anaemia was optimized. He was treated conservatively by the ophthalmology team with six doses of TRAMB injections. The eyelid swelling had improved, and the orbital conditions were not worsening. Unfortunately, he was discharged at his own risk (AOR) without planned surgery able to be done.

Conclusion

Retrobulbar injections with Amphotericin B can be considered as an alternative therapy for a patient with acute invasive ROCM to avoid orbital exenteration that is more radical and disfiguring, which may lead to poor quality of life.

ABSTRACT ID: 201

CONJUNCTIVAL MELANOMA IN A YOUNG ADULT: A CASE OF GLOBE-PRESERVING SURGERY AND TOPICAL MITOMYCIN C ADJUVANT THERAPY

Maisarah Atikah Mohd Zaki[1], Nur Aqilah Salleh[1], Norlaila Talib[1], Othmaliza Othman[2]

[1]Hospital Sultan Idris Shah

[2] Hospital Canselor Tunku Muhriz Universiti Kebangsaan Malaysia

Purpose

To report a case of globe-preserving surgery in young patient with conjunctiva melanoma.

Methods

A case report.

Results

A 26-year-old male presented with a progressively enlarging pigmented conjunctival lesion in the left eye, present since age 12. Clinical examination revealed a 10.5mm x 11.5mm pigmented mass with feeder vessels involving the limbus. Incisional biopsy initially indicated malignant melanoma with melanoma in situ. Due to the patient's young age and preference for globe preservation, local excision was performed and intraoperatively, the residual lesion was completely excised using non touch technique and final histopathology revealed a compound naevus. Postoperatively, the patient underwent six cycles of topical Mitomycin C (MMC) 0.04% therapy. Baseline ultrasound hepatobiliary system was normal. At six-month follow-up, visual acuity remained 6/9 bilaterally, scar tissue formation at the surgical site with no residual pigmentation or feeder vessels seen.

Conclusion

This case highlights the diagnostic challenges of conjunctival pigmented lesions, the importance of histopathological correlation, and the successful use of globe-preserving surgery combined with adjuvant MMC in achieving favorable outcomes. Close follow-up is essential to monitor for recurrence.

ABSTRACT ID: 208

BILATERAL PERIORBITAL NECROTISING FASCIITIS (NF) FOLLOWING A MINOR SKIN TRAUMA

Tze Shen Sim[1], Tan Qi Xian[1], Adeline Kueh Mei Ling[1]

[1]Hospital Umum Sarawak

Purpose

To report a case of bilateral periorbital NF with rapid progression after a minor skin trauma.

Methods

A case report.

Results

A 51-year-old incarcerated male with poorly controlled diabetes mellitus sustained a left supraorbital laceration following an alleged fall. He underwent primary wound closure. One week later, he developed left periorbital necrosis, bilateral diffuse periorbital edema, erythema, and left facial swelling. His best-corrected visual acuity (BCVA) was 6/45 in the right eye and 1/60 in the left eye. He presented in septic shock with metabolic acidosis. Bacterial cultures isolated Staphylococcus aureus and group A beta-hemolytic Streptococcus pyogenes. The patient underwent multiple surgical debridements involving both the ophthalmology and plastic surgery teams. NF of the left periorbital region extended across the nasal bridge to the right periorbital area, left cheek and forehead. He received daily wound care, bedside debridement, topical antibiotics. Bandage contact lens and temporary tarsorrhaphy applied for left exposure keratopathy. Systemic stabilization was achieved through stringent glycemic control and targeted parenteral antibiotic therapy. Following the resolution of NF, full-thickness skin grafting was successfully performed over bilateral periorbital regions. The patient's BCVA subsequently improved to 6/6 in the right eye and 6/18 in the left eye.

Conclusion

NF, a fatal and rare disease, necessitates thorough comprehension, particularly concerning immunocompromised patients and uncommon facial involvement, notably periocular. Prompt recognition and early surgical debridement are crucial in limiting its morbidity and mortality. A multidisciplinary approach is essential for optimizing patient outcomes through comprehensive and coordinated management.

ABSTRACT ID: 222

UNILATERAL PROPTOSIS IN AN ADULT-ONSET ALVEOLAR RHABDOMYOSARCOMA: A CASE REPORT

Jaslinder Kaur Param Jit Singh[1], Saidatulakma Shariff[1], Shaifulnizam Mamat[1]

[1]Hospital Sultan Haji Ahmad Shah

Purpose

To report a case of an unusual highly aggressive adult-onset RMS in the sinonasal region with rapid progression of unilateral proptosis, its clinical approach, and successful outcome.

Methods

A case report.

Results

A 31-year-old previously healthy gentleman, initially presented with progressively worsening left cheek and neck swelling and anosmia for the past 1 month associated with left eye proptosis with blurring of vision. Examination revealed rapid deterioration of left eye vision from 6/9 to hand movement within 3 weeks. The anterior segment showed left eye chemosis, proptosis with a frozen eye. Further, multidisciplinary evaluation depicted a firm, non-tender left neck swelling over left neck with multiple cervical lymph nodes swelling. An urgent Contrast-Enhanced Computed Tomography (CECT) of the neck depicted sinonasal mass features with left orbital extension. Incisional biopsy of nasal mass by the Otorhinolaryngology team and histopathological examination revealed small round blue cell tumors with rhabdomyoblastic differentiation. Early chemotherapy with the VAI regime (Vincristine, Actinomycin, Ifosfamide) was initiated. After completion of 4 cycles of chemotherapy, his proptosis completely resolved despite permanent loss of left eyesight.

Conclusion

Rhabdomyosarcoma is a highly aggressive malignancy that should be considered in any

rapid progressive ocular proptosis. A multidisciplinary approach is imperative for early diagnosis and initiation of treatment. Despite the poor prognosis of adult-onset alveolar RMS, early treatment commencement is life-saving and has a better prognosis.

ABSTRACT ID: 231
CAROTID-CAVERNOUS FISTULA MIMICKING CONJUNCTIVITIS IN A CHILD

Chih Chung Loh[1], Khairuddin Othman[1]

[1]Hospital Sultanah Bahiyah

Purpose

To report a case of traumatic indirect CCF with mimicking as conjunctivitis in a child.

Methods

A case report.

Results

A 12 year old girl who referred from primary health care for conjunctivitis presented with right eye redness with right sided headache for 2 weeks duration 4 month after motor-vehicle accident sustaining traumatic right temporoparietal extradural hemorrhage. She had past surgical history of right decompressive craniectomy and evacuation of blood clot immediately post trauma followed by right autologous cranioplasty 2 month post craniectomy. She denied any diplopia , blurring of vision , buzzing sound heard or tinnitus . There was no neurological deficit or ophthalmoplegia. On examination, she had dilated episcleral vessel and subtle proptosis over right eye with discrepancy of intraocular pressure measurement comparing to other eye. Cerebral angiogram showed connection between branch of right internal maxillary artery and right cavernous sinus with dilated superior ophthalmic vein.

Conclusion

Prompt identification with ominous history and clinical sign would raise suspicious of CCF especially in paediatric age group. Cerebral angiogram remains the gold standard imaging modality in diagnosis of CCF before offering treatment options .

ABSTRACT ID: 234

AS RARE AS A PHOENIX REBORN: A CASE OF CAVERNOUS SINUS THROMBOSIS COMPLICATED BY CONTRALATERAL SPHENOID AND MAXILLARY SINUSITIS

Ong Shu Chyi[1], Sruban Suparmaniam[1]

[1]Hospital Teluk Intan

Purpose

To report a rare case of unilateral cavernous sinus thrombosis caused by contralateral sphenoid and maxillary sinusitis.

Methods

A case report.

Results

A 64-year-old gentleman presented to us with a severe right-sided headache, accompanied by acute proptosis and profound vision loss. Radio-imaging showed right CST complicated by contralateral left sphenoid and maxillary sinusitis. Multidisciplinary approach was required as part of the prompt medical treatment including appropriate antibiotics and functional endoscopic sinus surgery (FESS) due to the atypical presentation of this case. Upon discharge, he had complete resolution of signs and symptoms with no evidence of sequelae found during his subsequent follow up.

Conclusion

Contralateral cavernous sinus thrombosis is rare and often missed. Early recognition and aggressive medical treatment are the cornerstones of successful management of this life-threatening complication.

ABSTRACT ID: 261
CONGENITAL ABSENCE OF INFERIOR RECTUS

Al Nikc Ally Abdul Rahim[1], Poorani Karuppan[1], Siew Hong Wai[1], Ooi Say Ting[1], Ng Sok Lin[1]

[1]Hospital Taiping

Purpose

To report a congenital absence of the inferior rectus muscle detected in an adult, which is an extremely rare anomaly that disrupts this harmony, leading to progressive hypertropia, functional impairment, and cosmetic concerns.

Methods

A case report.

Results

A 32-year-old male with no known medical illness presented with worsening bilateral hypertropia. The patient had bilateral eye hypertropia since childhood, which right eye progressed to complete hypertropia by the age of 20, obscuring the cornea. The left eye showed progression since early 2024. There was no pain, trauma and redness. Systemically was unremarkable. On examination, both eyes exhibited hypertropia with severe restriction in downward gaze (-4). Right eye cornea was not visible. Visual acuity was 6/60 (pinhole 6/60) in the right eye and 6/30 (pinhole 6/24) in the left eye. Fundus examination were normal bilaterally. Blood investigations were normal including Tuberculosis workout, autoimmune, thyroid function test. MRI showed bilateral absent of inferior rectus muscles. The patient was referred for a squint surgery.

Conclusion

Congenital extraocular muscle anomalies is a rare condition. Secondary causes of hypertropia should be considered before reaching the diagnosis of congenital absent of bilateral inferior rectus. Early imaging and multidisciplinary management are essential to optimize functional and aesthetic outcomes.

ABSTRACT ID: 275

SINUSITIS-ASSOCIATED SUBPERIOSTEAL ABSCESS OF THE ORBIT: A CASE SERIES

Chang Mun Yee[1], Raja Nor Farahiyah Raja Othman[1], Wan Mariny W Md Kasim[1], Tajunisah Iqbal[2]

[1]Hospital Sultan Idris Shah; [2]Pusat Perubatan Universiti Malaya

Purpose

To highlight the role of sinusitis as a primary risk factor for subperiosteal abscess (SPA) of the orbit and to review clinical presentation, imaging findings, microbiological profile, surgical management, and outcomes.

Methods

A case series.

Results

All three cases demonstrated a strong correlation between sinusitis and SPA development. Case 1 involved a 17-year-old male with acute rhinosinusitis complicated by right orbital SPA. CT orbit revealed subperiosteal collection, and Streptococcus anginosus was isolated. Case 2, a 14-year-old male with allergic rhinitis, developed left orbital SPA with associated maxillary and ethmoid sinusitis. Despite negative cultures, surgical drainage led to clinical improvement. Case 3, a 49-year-old male, had severe left periorbital cellulitis with SPA and pansinusitis, leading to rapid vision loss. Citrobacter koseri was isolated. Despite urgent drainage and functional endoscopic sinus surgery (FESS), vision remained NPL.

Conclusion

Sinusitis is a significant predisposing factor for SPA, emphasizing the need for early recognition and intervention. Delayed diagnosis may result in complications, including permanent vision loss. Prompt imaging, appropriate surgical drainage, and targeted antibiotic therapy are crucial in managing SPA and preventing orbital and intracranial sequelae. A multidisciplinary approach involving ophthalmology and otolaryngology is essential for optimal patient outcomes.

ABSTRACT ID: 280

"WHY ARE HIS EYES WIDE? I KNOW (INO)!" A VARIANT OF WALL-EYED BILATERAL INTRANUCLEAR OPHTHALMOPLEGIA (WEBINO) SECONDARY TO PONTINE BLEED: A CASE REPORT

Grace Tan Zhen Wen[1], Jasvinjeet Kaur Sidhu[1], Akmal Haliza Zamli[1]

[1]Hospital Tengku Ampuan Afzan

Purpose

To report a sporadic encounter of WEBINO secondary to haemorrhagic cerebrovascular accident.

Methods

A case report.

Result

A 54-year-old Malay gentleman with poorly controlled hypertension presented to the emergency department with a sudden onset of right sided body weakness, slurred speech and left sided facial asymmetry. He had altered mental status and experienced multiple episodes of seizures prior to presentation. Upon arrival, his blood pressure was 190/111mmHg. A plain computed tomography (CT) scan of the brain revealed a pontine haemorrhage with intraventricular extension and obstructive hydrocephalus. The repeated CT Brain 48 hours later showed resolving obstructive hydrocephalus with a stable pontine bleed. On day 3 of admission, he regained consciousness and was extubated. Then, he complained of diplopia on all gazes and the inability to close his left eye. Neurological examination revealed right eye exotropia, bilateral internuclear ophthalmoplegia (INO) with impaired convergence and left-sided facial paralysis. His ocular motility impairment was confirmed by Hess Chart. No neurosurgical intervention was performed in view of the resolving hydrocephalus. The patient was educated on blood pressure optimization and the potential for ocular motility improvement over time. In addition, he was prescribed with ocular lubricants and advised to patch his left eye to prevent exposure keratopathy.

Conclusion

Comprehensive management, including risk factor optimization and rehabilitation, plays a crucial role in recovery, as well as prevention of future cerebrovascular events.

ABSTRACT ID: 297
EXTRANODAL NATURAL KILLER (NK) CELL LYMPHOMA MIMICRY

Nur Farhana Kamardin[1], Noorlaila Baharuddin[1], Suriana Suaibun[1], Evelyn Tai Li Min[2]

[1]Hospital Putrajaya; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To highlight the diagnostic challenges of malignancy mimicry.

Methods

A case report.

Results

Extranodal natural killer (NK) cell lymphoma is a rare and rapidly progressive type of malignancy. It can mimic orbital cellulitis due to tumour invasion that causes orbital soft tissue inflammation, hence the diagnostic challenges. Orbital cellulitis that are unresponsive to broad spectrum antibiotics warrants further diagnostic workout.

Case Presentation: A 60-year-old Sabahan male with underlying diabetes mellitus and hypertension, initially presented with mild right painless erythematous upper eyelid swelling for one week and was treated with 2 courses of different broad spectrum oral antibiotics 5 days apart. However, follow up review showed worsening right upper eyelid swelling with high-grade fever. His visual acuity was 6/9 with non-axial proptosis and restriction in elevation. There was rapid progression of the eyelids swelling and worsening

extraocular movements despite on broad-spectrum intravenous antibiotics. Computed Tomography revealed pre-septal collection, swelling of the right medial rectus muscle and fullness of all right sided paranasal sinuses. Full functional endoscopic sinus surgery (FESS) was performed, uncovering an infected sinonasal tumour. Histopathological analysis confirmed the diagnosis of T-cell lymphoma. He was managed by multi-speciality and responded to chemotherapy.

Conclusion

The overlap between infectious and oncological presentations in the orbit underscores the importance of vigilance in diagnosis. Recognizing lymphoma early can dramatically alter management and prognosis to save vision and life.

ABSTRACT ID: 307

THE DIAGNOSTIC CONUNDRUM: DISTINGUISHING CAROTID CAVERNOUS FISTULA FROM ORBITAL CELLULITIS

Meighalah Arumugam[1], Mohd Khairul Abd Majid[1], Norlaila Talib[1]

[1]Hospital Sultan Idris Shah

Purpose

To describe a case of carotid-cavernous fistula (CCF) that mimics orbital cellulitis.

Methods

A case report.

Results

A 43-year-old female with poorly controlled diabetes, hypertension, and dyslipidaemia presented with left eye redness, pain and swelling for a month, worsening over 10 days. She also experienced diplopia, blurred vision and mild headache. On examination, her left eye visual acuity was reduced (6/60), with a positive relative afferent pupillary defect (RAPD), left eye was proptosed with restricted ocular motility (abduction -2, adduction -2, elevation -3, depression-3), reduced optic nerve function test. Anterior segment shows conjunctiva injected, chemosis and corkscrew vessels with elevated intraocular pressure. Right eye had normal findings. Fundoscopy revealed bilateral eyes proliferative diabetic retinopathy, glaucoma suspect and hypertensive retinopathy. Initially, she was treated for left eye orbital cellulitis with intravenous antibiotics, however her symptoms worsened and prompting consideration of CCF. A CTA/CTV orbit brain confirmed a left indirect CCF. The patient was referred to the neurosurgical and interventional radiology team for further definitive treatment.

Conclusion

CCF is a potentially life-threatening condition that can lead to a range of serious symptoms, including visual disturbances, cranial nerve palsies and headaches. In this case the symptoms mimic orbital cellulitis as she has multiple risk and comorbidity. Radiological imaging confirms a diagnosis of the left CCF. Early diagnosis and intervention are crucial to prevent permanent damage.

ABSTRACT ID: 320
LOWER EYELID SEBACEOMA: A CASE REPORT

Mahaviviandev M[1], Chan WS[1], Nik Nurfarhana Nik Mohd Noor[1], Adlina Abdul Rahim[1]

[1]Hospital Sultanah Bahiyah

Purpose

To describe a case of sebaceoma of the lower eyelid.

Methods

A case report.

Results

A 65 years old lady, presented with a rapidly increasing swelling on the tarsal conjunctival aspect of her LE (left eye) for 3 weeks duration. She had a strong family history of malignancies.

It was initially treated as pyogenic granuloma with topical dexamethasone for 2 weeks. However, it was not responsive and she represented due to a progressively enlarging lesion.

Upon review, swelling was only apparent with eversion of the left lower eyelid. It was a well vascularised, pedunculated lesion measuring 6.8mm(length) X 2.5mm(width), that arose from the medial third tarsal plate. The lesion breached the inferior palpebral conjunctiva. Systemic examination was unremarkable, with no constitutional symptoms. An incisional biopsy was done and the histopathological examination revealed polypoidal tissue that was covered by squamous epithelium. There were dermal lesions composed of predominantly basaloid cells admixed with irregular lobules of sebocytes, which were typified by scalloped nuclei with multivacuolation. There were no features of malignancy. She was further planned for an excisional biopsy and left lower eyelid reconstruction.

Conclusion

We present a rare case of sebaceoma which has low incidence and can only be ascertained by histopathological examination, but still carried the risk of malignancy in association with Muir-Torre syndrome.

ABSTRACT ID: 333

FROM TRAUMA TO ENUCLEATION: THE HARSH REALITY OF GLOBE LUXATION WITH TOTAL OPTIC NERVE AVULSION

Nor Hamizah Ahyaudin[1], Noor Sheereen Ab[1], Suriana S[1]

[1]Hospital Putrajaya

Purpose

This case report highlights the challenges in managing globe luxation with optic nerve avulsion following high-impact facial trauma and the decision-making process leading to primary enucleation.

Methods

A case report.

Results

A 26-year-old male was involved in a motor vehicle accident and sustained severe facial trauma. Examination revealed a complete luxation of right globe with no evidence of globe rupture and multiple deep eyelid lacerations with upper and lower canalicular involvement. CT imaging confirmed right globe prolapse with extrusion from the orbit, severed optic nerve from right globe with multiple comminuted fracture involving the superior, medial and inferior wall of right orbit. Right eye globe prolapse with total optic nerve avulsion was observed during surgical exploration. Hence, primary enucleation was performed in view of extensive ocular damage with total avulsion of optic nerve.

Conclusion

Traumatic globe luxation is a rare critical emergency that requires immediate intervention. Although the primary goal of management is to preserve the globe, primary enucleation is necessary in selected cases with extensive ocular trauma such as severe globe damage and complete avulsion of optic nerve as in this case.

ABSTRACT ID: 339

WHITE EYE, DEEP TROUBLE: AN ATYPICAL CASE OF ORBITAL CELLULITIS

Luqman Amri[1], Wardati Hanisah Jami[1], Huwaina Abdul Satar[1], Nor Hasnida Ab Gani[1], Norihan Ibrahim[1], Aini Izzati Abd Gaffar[1]

[1]Hospital Sultan Ismail Petra

Purpose

To report an unusual case of orbital cellulitis presenting without the classic inflammatory signs, emphasizing the need for further evaluation in immunocompromised patients.

Methods

A case report.

Results

A 24-year-old Bangladeshi gentleman with poorly controlled diabetes mellitus presented left eye pain for five days. On examination, His left eye was proptosed, otherwise his visual acuity was 6/6 with absence of relative afferent pupillary defect. Superior and medial rectus muscle movements were slightly limited (-1). The anterior segment examination was normal, with no chemosis or conjunctival injection. Both eye fundus examinations were unremarkable. Blood investigations showed increase of C-Reactive Protein (18), Erythrocyte Sedimentation Rate (19) with normal total white cells count and thyroid function. Blood culture came out negative. Computed tomography of brain and orbit revealed bulky and homogenously enhanced left superior rectus and medial rectus muscles with streakiness of adjacent intraconal and extraconal fat. There were also total opacification of left frontal sinus and left ethmoid sinus that were suggestive of sinusitis. The patient was referred to otolaryngologist for nasal endoscopy, which showed findings consistent with acute sinusitis. He received intravenous Rocephine 2g OD for two weeks and his glycaemic control was optimised. His symptoms improved with medical management.

Conclusion

This case underscores the importance of thorough evaluation, particularly in immunocompromised patients, who may present with atypical symptoms.

ABSTRACT ID: 356
OPTIC DISC MELANOCYTOMA MIMICKING MELANOMA: A CASE OF SUDDEN VISUAL LOSS

Maya Sakthi A/P N Vijayan[1], Sujaya Singh[1], Fazliana Ismail[1]

[1]Pusat Perubatan Universiti Malaya

Purpose

To report a case of optic disc melanocytoma presenting with sudden visual loss, mimicking optic disc melanoma.

Methods

A case report.

Results

A 28-year-old healthy man presented with sudden left eye (LE) visual loss for two weeks, following a month of progressive visual blurring and headaches. There was no history of trauma, eye pain, or redness. On examination, LE visual acuity was no perception of light in the superior quadrant and perception of light elsewhere. Right eye (RE) was 6/6. LE relative afferent pupillary defect was positive grade 3. Fundoscopy showed an elevated hyperpigmented mass overlying the optic disc, approximately three-disc diameter in size, with pale retina and cherry-red spot appearance. There were tortuous retinal veins and dot-blot haemorrhages in all quadrants. The RE fundus was normal. B-scan ultrasonography showed a dome-shaped optic disc mass (5.5 mm width × 2.97 mm height). Computed tomography(CT) orbit demonstrated a dense left optic nerve head lesion with no optic nerve extension. Based on clinical findings, a diagnosis of optic disc melanocytoma with secondary central retinal artery and vein occlusion (CRAO/CRVO) was made. The patient was started on oral prednisolone (1 mg/kg), leading to lesion size reduction within two weeks; however, vision remained unchanged. He is monitored closely with gradual corticosteroid tapering and surveillance for CRAO/CRVO-related complications.

Conclusion

Optic disc melanocytoma can mimic melanoma and present with sudden visual loss due to vascular compression rather than malignant transformation. Differentiating melanocytoma from melanoma is critical, as treatment strategies differ significantly. Regular monitoring is essential to assess disease progression, visual prognosis, and potential complications.

ABSTRACT ID: 360

WHEN THE SINUS STRIKES THE ORBIT - A RARE CASE OF ORBITAL CELLULITIS IN RETROVIRAL DISEASE

Lock Kah Mun[1], Sangeetha Manoharan[1], Nor Fadzillah Abd Jalil[1], Juliana Jalaluddin[1]

[1]Hospital Melaka

Purpose

To report a case of orbital cellulitis in an immunocompromised adult.

Methods

A case report.

Results

A 44years old Malay Male, with underlying dyslipidemia and retroviral disease on treatment, presented with sudden onset right eye swelling and pain for 2days, associated with blurring of vision and headache. On examination, both eyes best corrected vision 6/6. No relative afferent pupillary defect, optic nerve function test was normal. Right eye was proptosed with hypotropia. Right upper lid was swollen, erythematous, warmth, mechanical ptosis, pain on movement with conjunctiva mildly injected and remaining examination was unremarkable. Extraocular muscle movement limited over right eye upon abduction and elevation but there was no diplopia. Left eye anterior segment finding was unremarkable. Bilateral intraocular pressure were normal. Both eyes fundus were normal. Contrast enhanced computed tomography (CECT) brain and orbit revealed hyperattenuating right frontal sinus opacification with bony erosion, extraconal orbital extension, proptosis, periorbital inflammation, minimal intracranial extension. Patient was diagnosed with right eye orbital cellulitis secondary to frontal sinus mass for investigation. Nasoendoscopy performed highlighted a suspicious whitish patch at the right ostiomeatal complex. Biopsy was performed to assess sinonasal mass with suspected fungal sinusitis. Empirical intravenous ceftriaxone 1g twice daily initiated while awaiting histopathology results.

Conclusion

Retroviral disease increased susceptibility to opportunistic infections like orbital cellulitis. In immunocompromised patients, high index of suspicion and early intervention with antibiotics, antifungals, and possible surgical management are crucial to prevent vision loss and intracranial complications.

ABSTRACT ID: 371
UPPER EYELID RECONSTRUCTION FOLLOWING DEGLOVING INJURY: A CASE REPORT

Hawwa Najiza[1], Evelyn Tai Li Min[1], Julieana Muhammed[1]

[1]Hospital Pakar Universiti Sains Malaysia

Purpose

Eyelid injuries, often caused by motor vehicle accidents (MVA) or assaults, require timely treatment to restore function, protect the eye and improve aesthetics. This report illustrates a case of degloving eyelid injury successfully managed with reconstructive surgery.

Methods

A case report.

Results

A 42-year-old male presented to the emergency department following MVA. He sustained a forehead laceration, full-thickness laceration of left lower eyelid involving the lid margin and lateral canthus, and degloving injury of the left upper eyelid with lid margin loss. No additional ocular injuries were noted. Emergency primary repair of the forehead laceration and suturing of the lower lid and lateral canthus laceration was performed by on call team. He was referred to oculoplastic team on the next day for further management. Semi-emergency repair of the laceration was done within 48 hours post-trauma. The procedure included repair of the lateral canthal angle and replacement of the anterior lamellar with semicircular flap. A full-thickness skin graft obtained via a blepharoplasty of the contralateral eyelid. A new lid margin was reconstructed at the lateral upper eyelid and temporary tarsorrhaphy was performed for stabilisation. The eye was padded with antibiotic ointment for five days postoperatively with systemic antibiotic coverage. The patient recovered well with complete skin healing. An ankyloblepharon was noted on his post-op 3-month review, which was released under local anaesthesia.

Conclusion

This case illustrates that in severe degloving injury, a variety of surgical techniques, sometimes performed in a staged approach, are required to achieve optimal functional and aesthetic outcomes.

ABSTRACT ID: 375

A RARE CASE OF ORBITAL MYIASIS IN NEWLY DIAGNOSED RUPTURED BASAL CELL CARCINOMA OF LEFT UPPER EYELID

Nurul Afzan Mustapha[1], Wai Yong Zheng[1], Nurhayati Abd Kadir[1], Chiang Wai Seng[1], Hanida Hanafi[2], Sylves Patrick[23]

[1]Hospital Duchess Of Kent; [2]Hospital Queen Elizabeth; [3]Universiti Malaysia Sabah

Purpose

To report a rare case of orbital myiasis in newly diagnosed ruptured basal cell carcinoma of left upper eyelid.

Methods

A case report.

Results

Orbital myiasis is the infestation of the orbital tissues by maggots or fly larvae which can be predisposed by malignant disease, surgery ischemia or infection. We report a case of a 79-year-old woman with painless swelling of left upper eyelid for 4 years, which then subsequently became ulcerative and infiltrating lesion with maggots infestation 2 weeks prior to the presentation. The wound improved following daily wound dressing, manual removal of the maggots using turpentine oil and intravenous antibiotics. The diagnosis of basal cell carcinoma was confirmed by excisional biopsy from the lesion. Patient was then undergone excisional biopsy with lid reconstruction (glabellar flap, lateral canthotomy and cantholysis, full thickness skin graft from the contralateral upper lid).

Conclusion

Orbital myiasis is a rare and preventable ocular morbidity, which can complicate the malignancy resulting in widespread tissue destruction. Proper wound care help to prevent additional tissue destruction which can facilitate corrective surgery later.

ABSTRACT ID: 385

BEYOND DACRYOCYSTITIS: A RARE CASE OF INFECTED LACRIMAL MUCOCELE MIMICKING NASOLACRIMAL DUCT OBSTRUCTION

Nik Najiha Ayesha Nik Noor Azmi[1], Hurul Ain Zulkifli[1], Noor Amalina Saidi[1], Nur Nadia Ahmad Tarmizi[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To report a case of an infected lacrimal mucocele masquerading as acute dacryocystitis.

Methods

A case report.

Results

Infected lacrimal mucoceles are rare but can mimic periorbital infections or neoplastic lesions due to their mass effect. While often associated with chronic dacryocystitis, their potential for orbital compression and recurrent infections necessitates early recognition. Delayed diagnosis may lead to complications such as orbital cellulitis, abscess formation, or intracranial extension. A 59-year-old woman presented with progressive swelling and tenderness over the left medial canthus (5.0 × 5.0 cm). She had chronic dacryocystitis but had previously declined dacryocystorhinostomy. Initially diagnosed with a lower eyelid abscess and acute dacryocystitis, she underwent incision and drainage. However, pus cultures showed no bacterial growth, suggesting a sterile abscess or antibiotic-altered flora.

Due to persistent swelling and an atypical presentation, contrast-enhanced CT was performed, revealing a well-defined, peripherally enhancing lesion (2.2 × 1.6 × 2.4 cm) at the lacrimal sac, consistent with an infected mucocele. The lesion caused mild compression of the medial rectus muscle. The patient was treated with systemic antibiotics, resolving the acute infection. However, given her history of recurrent infections, she was scheduled for definitive surgical intervention by the oculoplastic team.

Conclusion

This case underscores the importance of recognizing infected lacrimal mucoceles as a potential masquerade for nasolacrimal duct obstruction. Early imaging in atypical cases prevents misdiagnosis and delays in treatment. A multidisciplinary approach is crucial to optimizing outcomes and preventing vision-threatening complications.

ABSTRACT ID: 391

A WOLF IN SHEEP'S CLOTHING: CONJUNCTIVAL LYMPHOMA MASQUERADING AS ORBITAL CELLULITIS

Nik Najiha Ayesha Nik Noor Azmi[1], Hurul Ain Zulkifli[1], Noor Amalina Saidi[1], Mohd Alif W. Mohd[1]

[1]Hospital Sultanah Nur Zahirah

Purpose

To report a conjunctival lymphoma case masquerading as orbital cellulitis.

Methods

A case report.

Result

Conjunctival lymphoma is an ocular malignancy that often presents subtly, mimicking benign or inflammatory conditions. Misdiagnosis can lead to delays in appropriate management, underscoring the need for early recognition and histopathological confirmation. A 72-year-old Malay male with underlying hypertension, bipolar mood disorder, and Parkinson's disease presented with a one-week history of painless, rapidly progressive right periorbital swelling and blurred vision, without fever or constitutional symptoms. Visual acuity in the right eye was counting fingers, while the left eye maintained 6/6 vision. Notable findings included right eye proptosis with multiple firm, lobulated lesions involving both the upper and lower palpebral conjunctiva, with no relative afferent pupillary defect. Fundoscopic examination was unremarkable. The left eye appeared normal. Laboratory tests revealed mild anemia and an elevated erythrocyte sedimentation rate, with normal leukocytes count and lactate dehydrogenase levels. Orbital CT imaging showed a well-defined, homogeneously enhancing periorbital mass without involvement of the globe, bones, or extraocular muscles. Within a week, the lesion rapidly enlarged, obscuring the cornea. A conjunctival biopsy was performed, and histopathological analysis confirmed the diagnosis of mantle cell lymphoma with a diffuse pattern. Systemic staging was planned but was unfortunately uncompleted as the patient succumbed.

Conclusion

This case highlights the diagnostic challenges of conjunctival lymphoma, particularly when masquerading as orbital cellulitis. Given its potential for systemic involvement, clinicians must maintain a high suspicion index for lymphoma in atypical conjunctival lesions. Prompt biopsy and imaging are essential for early diagnosis and timely intervention to optimize patient outcomes.

ABSTRACT ID: 405

BILATERAL CAROTID-CAVERNOUS FISTULA: DIAGNOSTIC DILEMMA

Tan Chek Kuan[1], Tan Teik Wei[1], Hanizasurana Hashim[1], Nazima Shadaht Ali[1], Nurul 'Ashikin Abdullah[1], Siti Zaitihani Hamdan[1]

[1]Hospital Selayang

Purpose

To report a rare case of spontaneous bilateral carotid-cavernous fistula (CCF).

Methods

A case report.

Results

A 45-year-old Indonesian lady with underlying systemic hypertension presented with bilateral eyes redness, swelling, pain and reduced vision for 3-weeks. The symptoms worsened with cough and Valsalva maneuver. Otherwise, she denied diplopia, recent illnesses or infection. During presentation, her visual acuity was 6/60, pin-hole 6/24 in both eyes. Relative afferent pupillary defect was negative. She had bilateral exophthalmos with minimal lid swelling but no pulsatile proptosis or carotid bruit. The extraocular movements were restricted in all directions of gaze in both eyes. Bilateral anterior segment examinations revealed conjunctival chemosis and injection with remarkable dilated “corkscrew” episcleral vessels, both eye intraocular pressure measured 28mmHg. Dilated fundus examination showed pink, well defined optic discs, no dilated or tortuous retinal vessels, macula flat and no choroidal folds bilaterally. Systemic examination was unremarkable and there were no signs of Grave’s disease. Computerized Tomography (CT) brain and orbit demonstrated bulging of bilateral cavernous sinuses, enlarged bilateral superior ophthalmic veins, bilateral proptosis with extraocular muscles enlargement. Subsequent CT angiogram showed cavernous segment of both ICA are well-opacified with associated engorgement of cavernous sinus and multiple dilated and tortuous vessels. She subsequently received endovascular treatment by interventional radiologist, post-embolization one month showed remarkable improvement with resolution.

Conclusion

A thorough evaluation is essential when encountering a patient with exophthalmos, restricted extraocular movements, and elevated intraocular pressure. The presence of “corkscrew” episcleral vessels in the absence of trauma suggests indirect CCF. Imaging such as CT scans are essential for appropriate diagnosis and management.

ABSTRACT ID: 422

A RARE OCULAR CRISIS: INTRAORBITAL HEMORRHAGIC VENOLYMPHATIC MALFORMATION CAUSING BLINDNESS IN PREGNANCY

Kavitha Saravanamuthu[1], Tan Li Faung[1], Sharifah Intan Hosnaliza Syed Osman[1], Chiun Pei Rong[12], Wan Haslina Wan Abdul Halim[2]

[1]Hospital Kuala Lumpur; [2]Hospital Canselor Tunku Muhriz Universiti Kebangsaan Malaysia

Purpose

To report a case of intraorbital hemorrhagic venolymphatic malformation (VLM) resulting in blindness during pregnancy and its management.

Methods

A case report.

Results

A 24-year-old woman at 29 weeks gestation with no medical illness was referred for right eye (RE) severe proptosis and central retinal artery occlusion (CRAO). She reported a two-week history of mild RE proptosis, which acutely worsened, resulting in CRAO. However, the intraocular pressure (IOP) was brought down from 44mmHg to 10mmHg with IOP-lowering agents, and the proptosis was reducing. A subsequent episode of sudden worsening of proptosis happened after bouts of vomiting, which led to severe proptosis and increased IOP. On examination, RE visual acuity (VA) was light perception (PL) and left eye (LE) was 6/6. Extraocular movements (EOM) were restricted in all gazes except nasally. IOP was 22mmHg and reduced to 12mmHg after treatment with IOP-lowering agents. High dose of intravenous methylprednisolone 1g OD was commenced, followed by intralesional sclerosant therapy after the second dose of methylprednisolone. Magnetic Resonance Imaging of the brain and orbits revealed a right intraconal hemorrhagic cystic lesion with a fluid-fluid level, confirming intraorbital venolymphatic malformation (VLM). RE canthotomy and cantholysis with ultrasound guided 3ml aspiration of intraorbital haemorrahgic VLM was performed with subsequent injection of 3ml of gel foam superotemporally and 1 ml inferotemporally. Post-treatment, proptosis reduced from 24mm to 22mm and EOM improved, although VA remained PL.

Conclusion

Intralesional orbital sclerosant of gel foam is an effective treatment in haemorrhagic VLM during pregnancy.

ABSTRACT ID: 442
A VISION CHANGING DENTAL VISIT

Lee YJ[1], Kuan HC[1], Rohana Taharin[1]

[1]Hospital Bukit Mertajam

Purpose

To report a case of orbital cellulitis with cavernous sinus thrombosis and ophthalmic artery occlusion post dental procedure.

Methods

A case report.

Results

A 50-year-old Indian male migrant with underlying poorly controlled diabetes mellitus, presented with painful sudden vision loss over right eye (RE). He had a dental extraction two weeks ago which was complicated with right facial cellulitis. Upon assessment, his right cheek and lids were swollen, with right partial ptosis but no proptosis. RE extra-ocular movements were limited and painful in all gazes. His RE vision was NPL with a positive RAPD. Fundus examination revealed pale right optic disc and retina, with boxcarring of vessels of all 4 quadrants. Computed tomography venogram of brain and orbit revealed right periorbital and orbital cellulitis with inferior orbital subperiosteal abscess, right facial cellulitis with phlegmon changes, and right cavernous sinus thrombosis. He underwent right subperiosteal abscess drainage and his eye movement normalized after treatment. He is currently on anti-coagulant for cavernous sinus thrombosis as planned by medical counterparts.

Conclusion

Miscellaneous ophthalmic and life-threatening complications could arise from dental procedure. A high clinical suspicion is crucial for prompt diagnosis and treatment initiation to prevent further devastating events.

ABSTRACT ID: 450

ISOLATED EYELID SCHWANNOMA – A RARE LID TUMOUR

Tan Chin Ling[1], Yap Yi Hao[1], Adeline Kueh Mei Ling[1]

[1]Hospital Umum Sarawak

Purpose

To report a rare case of lid tumour - Schwannoma.

Methods

A case report.

Results

A 58 years old lady with underlying diabetes mellitus and hypertension presented to eye clinic with a complaint of left lower lid swelling for more than 10 years. It was initially pimple-sized, progressively increasing in size, painless in nature and there were no visual symptoms. On examination, left eye's visual acuity was 6/9 with mild cataract and moderate non-proliferative diabetic retinopathy on slit lamp examination. The swelling was located at lateral one third of the left lower eyelid. It was firm, mobile, non-tender, with a smooth surface measuring 9 × 7 mm, no overlying skin changes. The eye movements were full. Neurological examination was normal. Excisional biopsy of the lesion was done under local anesthesia. Histopathological examination showed an encapsulated tumour mass with biphasic pattern consisting of cellular (Antoni A) areas alternating with focally paucicellular areas (Antoni B). There was bland spindle cells arranged in short fascicles and presence of Verocay bodies. No necrosis or mitotic figures noted. Blood vessels showed thickened hyalinized wall. These tumour cells were expressing diffuse S100 immunoreactivity.

Conclusion

Primary eyelid schwannoma is extremely rare. However, it should be included as one of the differential diagnoses of eyelid tumour. Early diagnosis through excisional biopsy is vital for further management of the patient.

ABSTRACT ID: 451
OCULAR YING AND YANG

Hayati Abd Aziz[1], Nur Najwa Saat[12], Henry Ngoo Qi Zhe[2]

[1]Hospital Sultanah Aminah; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To highlight a case of ciliary body spindle cell melanoma in 55 years old male.

Methods

A case report.

Results

A 55-year-old man presented with left eye sudden onset temporal side visual field loss. It was progressively worsened. The right eye was asymptomatic. He did not mention any previous illness. On examination, the left visual acuity was 6/24 ph 6/18, while the right eye visual acuity was 6/9. The patient was found to have subtotal choroidal detachment. Unable to locate the optic disc. B-scan showed intraocular mass with subretinal opacity and subretinal bleeding. Neuroimaging revealed a well-defiled intraocular lesion along the superomedial aspect of the left eye, demonstrate hyperintense on T1W and hypointense in T2W and mild homogenous enhancement post gadolinium. There was a posteroinferior hemorrhagic retinal detachment with subacute bleeding. The patient underwent left eye enucleation with intraoperative finding showed no extra scleral extension of mass. Histopathology revealed a well circumscribed unencapsulated pigmented tumor arising from ciliary body and part of retina and was confirmed stage pT3b disease. No adjuvant treatment given to the patient in view of there was no extra scleral extension.

Conclusion

Ciliary body spindle cell melanoma is very rare and diagnosis and confirmation of the disease require histopathology and imaging for nodal staging and surveillance. Early diagnosis, proper treatment and long-term surveillance are key factors for long term local and distant control.

ABSTRACT ID: 456

AGGRESSIVE METASTASIS OF EYELID SEBACEOUS CARCINOMA: A CASE REPORT

Asma Abdul Razak[1], Kavitha Saravanamuthu[1], Sharifah Intan Hosnaliza Syed Osman[1], Evelyn Tai Li Min[2]

[1]Hospital Kuala Lumpur; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To highlight the rapid progression of eyelid sebacious gland carcinoma (SGC) metastasizing to distant lymph nodes and organs.

Methods

A case report.

Results

A 61-year-old male smoker presented with a one-month history of progressive swelling of the right lower eyelid, associated with pain and minimal discharge. It was initially treated as unresolved internal hordeolum with an erythematous solitary mass measuring 12mmx10mm at lateral mid-half of right lower lid, involving lid margin. No eyelash loss or ulceration was seen. Posterior segment was unremarkable. However, the lesion became more erythematous, vascularized with contact bleeding, and continued to enlarge, resulting in mechanical ectropion. Incisional biopsy was suggestive of poorly differentiated SGC of right lower eyelid. Urgent excision biopsy and frozen section with Hughes tarsoconjunctival flap and cheek advancement were done. Five months post-excisional biopsy, neck lymphadenopathy was noted. Computed tomography of the neck, thorax, abdomen, and pelvis demonstrated cervical, mediastinal, abdominopelvic, and inguinal lymphadenopathy, with multiple lesions involving the brain, lung, liver, pancreas, spleen, adrenal glands, and peritoneum, signifying an alarming progression of the disease. Despite being scheduled for adjuvant chemotherapy, the patient succumbed to rapid disease progression in one month.

Conclusion

A high index of suspicion is crucial for early diagnosis of periocular SGC, which is associated with poor prognosis, resulting in increased morbidity and mortality. Upon diagnosis of SGC, pre-emptive neoadjuvant chemotherapy or adjuvant chemotherapy is required for a better long-term outcome.

ABSTRACT ID: 457

OCULAR FIRECRACKER INJURY: A CASE REPORT

Hayati Abd Aziz[1], Nur Najwa Saat[12], Henry Ngoo Qi Zhe[2]

[1]Hospital Sultanah Aminah; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To highlight a case of firework injury causing a ruptured globe.

Methods

A case report.

Results

A 26-year-old man presented with left eye sudden onset vision loss, eye pain and left eye active bleeding immediately post firecracker injury. He was a bystander. The right eye was asymptomatic. On examination, the left eye visual acuity was non perception of light (NPL) while right eye visual acuity was 6/6. The patient was found to have a burn over the left upper lid and a full thickness laceration wound involving left lid margin. There was multiple ocular foreign bodies and devastating eye injury. The hazy media precluded fundus assessment. The right eye finding was unremarkable. Skull X-ray showed no intraocular foreign body. Examination under anesthesia revealed a large globe rupture with no uveal and vitreous tissue. The left eye was non salvageable and it was eviscerated.

Conclusion

Firework related ocular trauma can lead to multiple complications. Regulatory measures to mitigate this injury are imperative to prevent such incidents and to preserve visual health.

ABSTRACT ID: 488

INFANTILE RIGHT EYE VENOLYMPHATIC MALFORMATION WITH OPTIC NEUROPATHY: A CASE REPORT

Siti Basyrina Farhana Bahari[1], Nurfahzura Mohd Jamil[1], Rona Asnida Nasaruddin[2]

[1]Hospital Sungai Buloh; [2]Hospital Canselor Tunku Muhriz Universiti Kebangsaan Malaysia

Purpose

To report a case of infantile right eye venolymphatic malformation with optic neuropathy.

Methods

A case report.

Results

We report a case of 8 months old malay baby boy with underlying G6PD deficiency, presented with worsening right upper lid hematoma preceded by history of fall facing downwards knocked on floor. Relative afferent pupillary defect (RAPD) was positive, right eye limited extraocular movement and high intraocular pressure (IOP) 34 mmhg. Examination of the right eye revealed non axial proptosis, dystopia, soft upper lid swelling and hematoma with small punctate subconjunctival hemorrhage temporally. CT brain reported right periorbital and retrobulbar hematoma with bulky right lateral rectus muscle. He was treated as right eye retroorbital hemorrhage secondary to fall with high IOP. Subsequently, lid swelling worsening and decision for magnetic resonance imaging (MRI) brain and orbit was made. Well circumscribed lesion with 'layering' hyperintense and hypointense areas observed on MRI at right intraconal retrobulbar region extending anteriorly to the superolateral aspect measuring 2.3x1.5x2.5cm (APxWxCC). MRI revealed larger lesion with mass effect. Subsequently,he was co-managed with oculoplasty and paediatric ophthalmology team Hospital Kuala Lumpur for further management. The final diagnosis of right eye venolymphatic malformation with optic neuropathy was made. Subsequent visits showed improving condition with normal IOP and negative RAPD, and further planned for repeated ultrasound and sclerotherapy once right upper lid hematoma resolved.

Conclusion

Orbital venolymphatic malformation commonly presented with proptosis and orbital swelling,however in some cases include orbital hemorrhage and aggravated by injury. High index of suspicion should be maintained for persistent lid swelling with proptosis and earlier detection is crucial as this condition can develop and expand quickly causing mass effect with guarded visual prognosis in children.

ABSTRACT ID: 493

UNILATERAL ORBITAL CELLULITIS SECONDARY TO PANSINUSITIS IN 8 YEARS OLD CHILD: A CASE REPORT

Hanis Zuhaimy[1], Hayati Abd Aziz[1], Nur Najwa Saat[1 2], Henry Ngoo Qi Zhe[2]

[1]Hospital Sultanah Aminah; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

To highlight a case of orbital cellulitis secondary to pansinusitis in an 8-year-old child.

Methods

A case report.

Results

An 8-year-old girl with presented with progressively worsening of left eyelid swelling for 2 days preceded with fever and runny nose. It was progressively worsened. Both visual acuity were 6/9 with no relative afferent pupillary defect. There was a diffuse left periorbital oedema and erythema which quickly progressed to involved both lids and forehead. The following day associated with restricted up gaze. Computed Tomography orbit and paranasal sinuses revealed left orbital cellulitis with pansinusitis. Emergency Functional Endoscopic Sinus Surgery with orbital decompression was performed. The patient received intravenous ceftriaxone for 1 week duration. There was marked improvement in both ocular and general condition upon completion of the treatment.

Conclusion

This case emphasizing that urgent imaging should be considered for any child with orbital cellulitis. Prompt and aggressive treatment combining both surgical and medical approaches in managing the orbital cellulitis with pansinusitis to prevent widespread of the disease and ensure good prognosis.

ABSTRACT ID: 496

A RARE CASE OF ALVEOLAR SOFT PART SARCOMA OF CONJUNCTIVA: A DIAGNOSIS DILEMMA

Zcho Huey Lee[1], Adeline Low[1], Adam Malik Ismail[1], Adeline Kueh Mei Ling[1], Nor Fadhilah Mohamad[2]

[1]Department of Ophthalmology, Hospital Umum Sarawak, Sarawak; [2]Department of Ophthalmology, Pusat Perubatan Universiti Malaya, Kuala Lumpur

Purpose

To report a rare case of conjunctival alveolar soft part sarcoma and highlight its diagnostic challenges.

Methods

Case report

Results

Alveolar soft part sarcoma (ASPS) is an extremely rare soft tissue malignancy with no characteristic clinical findings, that accounts for less than 1% of all sarcomas. Herein we describe an unusual case of a 45-year-old man with conjunctival ASPS. The patient presented with a painless, rapidly enlarging left temporal conjunctival mass over four months. He had no history of ocular trauma or foreign body exposure. Despite the mass, his visual acuity remained at 6/18 in the left eye, with no relative afferent pupillary defect. The mass was non-tender, firm and lobulated, involving the limbus from 2 to 5 o'clock with feeder vessels, measuring about 15mm x 20 mm, resulting in mechanical lagophthalmos. Contrast-enhanced computed tomography scan revealed a heterogeneously enhancing mass at the anterolateral aspect of the left globe measuring 2.0 x 1.6 x 2.9cm, with no extension into the left eye globe, extraocular muscle or optic nerve. Histopathology examination of the conjunctiva biopsy demonstrated a fibrocollagenous tumour tissue composed of neoplastic cells arranged in organoid and nest-like pattern with compressed delicate capillary vasculature and areas of hemangiopericytoma like vessels. The neoplastic cells displayed high grade epithelioid sarcoma appearance, with strong nuclear staining for TFE3 suggestive of alveolar soft part sarcoma. The patient underwent exenteration of his left eye.

Conclusion

Due to its rarity and lack of distinctive clinical features, ASPS histological examination with immunohistochemical staining remains crucial for definitive diagnosis.

ABSTRACT ID: 535
AN UNSUAL PRESENTATION OF ORBITAL LYMPHOMA

Syahirah Yusoff[1], Fatin Hanisah Firman[1]

[1]Hospital Al-Sultan Abdullah Universiti Teknologi MARA

Purpose

To report a case of orbital lymphoma that manifested with severe uveitis in the contralateral eye.

Methods

A case report.

Results

A 41-year-old male with no significant medical history presented with blurred vision in the left eye for 3 days, accompanied by redness. Additionally, he had painless right eye bulging and inferior displacement for the past year, which did not bother him. He was otherwise healthy. On examination, inferior dystopia was observed in the right eye. Extraocular movement was full in both eyes, with diplopia noted in superior and inferior gazes. The conjunctiva of the right eye revealed salmon patch nasally and superotemporally. The left eye exhibited severe anterior uveitis. His left eye was treated with topical steroids and showed improvement on follow-up. A CT scan revealed a large, enhancing intraorbital mass on the right, predominantly involving the intraconal and superior extraconal space. The mass displaced the right optic nerve medially and inferiorly. The patient was subsequently scheduled for an MRI of the brain and orbit with contrast.

Conclusion

Based on the clinical signs of painless dystopia, salmon patch, normal systemic findings along with characteristic radiological features, this presentation is highly indicative of orbital lymphoma. It is unusual for orbital lymphoma to present initially with anterior uveitis. MRI imaging and diagnostic confirmation through biopsy is mandatory in further managing this patient.

ABSTRACT ID: 537
'SINS' OF ORBITOTOMY

Jasmine Binti Abd Rashid[1], Hanida Hanafi[1], Sylves Patrick[12]

[1]Hospital Queen Elizabeth; [2]Universiti Malaysia Sabah

Purpose

To report a rare case of surgically induced necrotizing scleritis (SINS) post orbital surgery.

Methods

A case report

Results

A 40-year-old lady with underlying diabetes mellitus presented with progressive, painless right eye (RE) swelling and blurred vision for three months. Ocular examination revealed RE axial proptosis with limited extraocular muscle movement in all directions. Her RE visual acuity was 6/15 with positive relative afferent pupillary defect and fundus examination showed choroidal folds. Contrast-enhanced computed tomography of brain and orbit revealed a right orbital heterogenous intraconal mass located lateral to the optic nerve. She then, underwent a successful excisional biopsy via orbitotomy with superior and lateral rectus muscle disinsertion. She was discharged well with a course of antibiotics and dexamethasone. Histopathology examination confirmed an orbital cavernous venous malformation. However, she had multiple clinic visits postoperatively due to severe RE pain, especially on lateral gaze but was treated symptomatically. At 18 weeks postoperative, a white patch of superior avascular conjunctival area with marked surrounding hyperaemia was noted. Magnetic resonance imaging of brain and orbit revealed a thickened posterior sclera with lateral rectus muscle enlargement. She was started on oral prednisolone (40mg/day) with a weekly taper and methotrexate (20mg/week). Over 14 weeks, the avascular area reduced in size with vascularization, and the patient was more comfortable and had less pain.

Conclusion

SINS must be considered as a differential diagnosis of patients with persistent pain following orbital surgery. Early diagnosis and treatment are vital to prevent devastating complications.

ABSTRACT ID: 541
A CARD IN MY EYE

Nurul Wahida Md Zuki[1], Mohd Khairul Abd Majid[1], Rozita Ismail[1]

[1]Hospital Sultan Idris Shah

Purpose

To report a case of traumatic ocular injuries in airbag associated open globe injury post motor vehicle accident

Methods

A case report.

Results

We present a case of a 32-year-old Indian male with underlying hypertension who was brought-in by ambulance following a motor vehicle accident. The patient reportedly experienced microsleep while driving, causing him to collide with a lamp post. The vehicle's airbag deployed after the collision. Initial examination revealed a positive relative afferent pupillary defect and the ability to perceive light. The patient presented with a shallow anterior chamber (AC), hyphaema, and a penetrating foreign body in the temporoscleral region extending towards the anterior chamber, approximately 5-6 mm. The patient underwent right eye examination under anesthesia, during which corneal, scleral, and eyelid margin lacerations were debrided and sutured under general anesthesia.Intraoperatively, two pieces of acrylic material were found penetrating the sclera, most likely from a card. The patient was subsequently referred to the vitreoretinal team for management of traumatic rhegmatogenous retinal detachment, persistent vitreous hemorrhage, and subhyaloid hemorrhage. A vitrectomy with silicone oil tamponade was performed.However, the patient developed extensive retinal fibrosis and aphakia postoperatively, leading to a final visual outcome of counting fingers.

Conclusion

This case highlights the complexity and severity of ocular trauma associated with airbag deployment in a motor vehicle accident. Early recognition and prompt management of open globe injuries are crucial to preserving vision. Despite multiple surgical intervention, patient experienced poor visual outcomes due to the development of retinal fibrosis and aphakia. This underscores the importance of a multidisciplinary approach in managing traumatic ocular injuries.

ABSTRACT ID: 549

FROM 'VAGUE PERCEPTION OF LIGHT' TO '6/9': A JOURNEY OF REFRACTORY DYSTHYROID OPTIC NEUROPATHY

Lee YJ[1], Rohana Taharin[1], Tan SY[1]

[1]Hospital Bukit Mertajam

Purpose

To present a case of refractory dysthyroid optic neuropathy with significant vision improvement following delayed orbital decompression.

Methods

A case report.

Results

In May 2024, a 72-year-old Malay man with underlying hypertension, dyslipidemia, and hyperthyroidism presented with two months history of binocular diplopia and left eye (LE) blurred vision. Examination showed LE vision was vague perception of light in 1 quadrant only, grade 1 relative afferent pupillary defect, reduced light brightness and red saturation. Right eye vision was 6/12. Both eyes (BE) showed proptosis and restricted extraocular movements (EOMs) sparing downgaze, eyelid puffiness, conjunctival injection, caruncle inflammation, IOP 16mmHg, others unremarkable. BE fundus showed pink optic disc with cup-disc-ratio 0.3, normal macula and vessels. Systemic review and thyroid function test showed clinical hyperthyroidism. Contrast-enhanced computed tomography orbit revealed bilateral enlarged extraocular muscles sparing tendinous junctions. He was diagnosed with RE moderate thyroid eye disease (TED) and LE severe TED with dysthyroid optic neuropathy. After first methylprednisolone pulse therapy, BE EOMs improved and LE vision improved to 1/60. Second pulse therapy was given, however no further improvement. Bilateral endoscopic orbital decompression was planned, however delayed due to uncontrolled hyperthyroidism. Third pulse therapy was administered in July, which resulted in no clinical improvement. He ultimately underwent surgery in September 2024 (six months after initial presentation). Post-operatively, LE optic nerve functions improved with vision of 6/9.

Conclusions

Surgical expansion of the orbital apex remains the gold standard treatment for refractory dysthyroid optic neuropathy. This case illustrated a good outcome even when surgery was delayed for six months.

ABSTRACT ID: 573
ORBITAL MELANOMA WITH CALCIFICATIONS IN A TEENAGER, A DIAGNOSTIC DILEMMA

Shakurthi Raj Partheeban[1], Ting Xiao Wei[1], Farah Rasyiqah Mahamud[1]

[1]Hospital Tawau

Purpose

We aim to describe a rare case of primary orbital melanoma(POM) in a teenager, with initial radiological findings of calcification, posing a diagnostic dilemma.

Methods

A case report.

Results

A 16 year old boy presented with complaints of gradual and painless loss of vision over three months associated with proptosis. Upon examination, left eye vision was no perception to light, examination revealed an injected conjunctiva with hazy cornea, cells of 4+, posterior synechiae and a shallow anterior chamber with a high intraocular pressure of 40. B-scan showed dense vitritis with a subretinal mass. Computed tomography of the orbit revealed an intraocular enhancing mass with heterogenous density and calcifications. The patient defaulted further treatment due to financial constraints. However, he presented ten months later with a huge fungating orbital mass. Subsequently, he underwent left orbital tumour debulking. Histopathological examination showed sheets of pleomorphic melanocytes in nests and sheets with vesicular nuclei and some with prominent nucleoli in keeping with malignant melanoma. Patient was referred to oncology team for further treatment.

Conclusion

POM is rare, even more so among young adolescents. Spontaneous calcifications are also rarely noted in the imaging of primary orbital melanoma. Although rare, POM should be a differential in orbital mass presenting with calcification to allow for prompt treatment.

ABSTRACT ID: 577

EYE CAN'T BELIEVE IT : A RARE CASE OF PROPTOSIS WITH A BLOODY SURPRISE

Jamuna Lachumanan[1], Lekkha Yuvaraj[1], Shalini Rajamany[1], Deivanai Subbiah[1]

[1]Hospital Selayang

Purpose

To report a case of traumatic subperiosteal orbital hematoma in a healthy child presented with unilateral non-axial proptosis

Methods

A case report.

Results

A 10 years old boy presented with sudden onset of right eye (RE) protrusion, pain and monocular diplopia for four days with a history of blunt trauma over his forehead against the wall one week prior to onset of symptoms. On examination, bilateral eyes vision was 6/9. Both pupils were equal, reactive to light and no relative afferent pupillary defect. There was marked non axial RE proptosis with no pulsation or bruit. Hertel exophthalmometer readings were 21 mm in the RE and 15mm in the LE at the base of 100.The RE extraocular muscle movement were limited upon elevation and adduction. Otherwise, the anterior segment and fundus examination were normal. His blood investigation including coagulation profile and inflammatory markers were unremarkable. Contrast Enhanced CT Brain and Orbit showed a right superior extraconal space non enhancing collection causing mass effect onto the right superior rectus and superior oblique muscles with RE proptosis. Diagnosis of RE extraconal hematoma secondary to blunt trauma was made. He was managed conservatively as there was no optic nerve compression. After three weeks of follow up, he recovered completely with no ocular complaints and complete eye movements in all gaze.

Conclusion

This case highlights that subperiosteal orbital hematoma should always be considered as a differential diagnosis of proptosis after an episode of blunt head or facial trauma especially in children. Hence, careful assessment and history taking are crucial to prevent delayed diagnosis.

Paediatric Ophthalmology & Strabismus

ABSTRACT ID: 16

Challenges in Managing Advanced Retinoblastoma in a 3-Year-Old Girl: A Case Report

Karimmah Wahit[1], Shatriah Ismail[1]

[1]Universiti Sains Malaysia

Purpose

To report a case of advanced bilateral retinoblastoma with trilateral involvement and obstructive hydrocephalus, emphasizing the challenges of late presentation, parental noncompliance, and reliance on traditional medicine in achieving optimal outcomes.

Methods

A case report

Results

The patient presented with right eye leukocoria in February 2022, but diagnosis and treatment were delayed for a year due to parental noncompliance and reliance on traditional medicine. In February 2023, bilateral retinoblastoma was confirmed, with fundus examination showing vitreous haze, retinal detachment, and masses in both eyes. By July 2024, the disease had advanced to right eye proptosis, ulceration, and gangrene, with obstructive hydrocephalus and intracranial extension confirmed on MRI.

Ocular examination classified the right eye as Group E with extensive intraocular involvement, while the left eye was Group C-D, with a smaller posterior mass. Ultrasonography revealed intraocular masses in both eyes, with the right extending to the ciliary body and lens.

Urgent management included VP shunting for hydrocephalus and palliative chemotherapy. Although chemotherapy reduced the intracranial lesion, left eye proptosis worsened, reflecting the tumor's aggressive nature.

Conclusion

Advanced retinoblastoma with extraocular and intracranial spread carries a poor prognosis, especially with delayed diagnosis and parental noncompliance. This case highlights the critical need for early detection, parental education, and psychosocial support to improve survival and quality of life in advanced retinoblastoma cases. Multidisciplinary approaches remain essential in managing complications and providing palliative care in such aggressive malignancies.

ABSTRACT ID: 31

Healing With Plasma Power: A Game Changer for Persistent Orbital Implant Exposure In A Case of Retinoblastoma

Chan Sin Lin[1], Sangeetha Tharmathurai[1], Norhafizah Hamzah[1]

[1]Hospital Tunku Azizah

Purpose

To demonstrate the potential use of allogenic plasma tears as an effective treatment option to promote healing for exposed implant post-enucleation.

Methods

A case report

Results

This is a case of persistent orbital implant exposure after enucleation that was treated with allogeneic plasma tears and conjunctival autography. A 3-year-old boy with underlying hyperactive airway and eczema was diagnosed with left eye unilateral retinoblastoma group E. His left eye was then enucleated. One month post-enucleation, there was a central (1mm X 0.5mm) exposure of the implant. Subsequently, the patient underwent scleral patch with amniotic membrane transplantation. Unfortunately, 3 weeks later, there was persistent exposure of the implant. Thus he was prescribed with allogenic plasma tears hourly. Allogenic plasma tears were obtained via the donor's whole blood and were centrifuged to separate the plasma. The plasma was then diluted with saline to the desired concentration. It was stored in a sterile microhematocrit tube under negative 40 degrees Celsius. Each segment of plasma was then defrosted and collected into a sterile bottle for the patient to use as eye drops. One month after treatment, the exposed area healed well. Allogenic plasma eye drops was given only for one month due to the risk of infection and hypersensitivity reactions.

Conclusion

Allogeneic plasma tears for exposed orbital implants offer a promising therapeutic approach for enhancing healing. Care should be taken to watch for its side effects.

ABSTRACT ID: 39

ROPER : The Rare Intersection of ROP and FEVR in a Neonate

Jaya Selan A/L Rajendran[1], Sangeetha Tharmathurai[2]

[1]Hospital Tengku Ampuan Afzan; [2]Hospital Tunku Azizah

Purpose

This case report explores a rare instance of a neonate diagnosed with both Retinopathy of Prematurity (ROP) and Familial Exudative Vitreoretinopathy (FEVR) (termed ROPER)

Methods

A Case Report

Results

A premature baby girl born at 32 weeks with birth weight of 1.5 kg. She had underlying Turner's syndrome and multiple systemic complications. At 64 weeks corrected gestational age (CGA), the right eye (RE) exhibited Stage 2 ROP, while the left eye (LE) had regressed Stage 1 ROP with complete vascularization. Subsequently, at 67 weeks CGA the RE developed exudation over the supero-nasal retina and neovascularization. LE was stable. A diagnosis of retinopathy of prematurity with exudative retinopathy (ROPER) was made. She underwent laser and was followed up till 5 months of age. Despite laser, there was still persistent exudation and dilated tortuous vessels temporally. Fundus Fluorescein Angiography (FFA) done revealed leakage at terminal end of vessels. Intravitreal ranibizumab 0.2 mg in 0.02 mL was then injected. 3 months post injection, there was reduced exudation and vessels were less tortuous and dilated.

Conclusion

Effective early detection of ROPER involves thorough retinal examinations and FFA to identify key retinal findings such as persistent exudation and vascular abnormalities. This will aid in timely management of this rare entity.

ABSTRACT ID: 53

Juvenile Iridoschisis with White Cataract in Severe Atopic Eczema: A Rare Case Report

Haw Qian Zhi[1], Nur Shahirah Amir Hamzah[1], Safinaz Mohd Khialdin[1], Mae-Lynn Catherine Bastion[1]

[1]Hospital Canselor Tuanku Muhriz UKM

Purpose

We report a rare case of juvenile iridoschisis associated with a white cataract and atopic eczema.

Methods

A Case report

Results

A 12-year-old Malay boy with severe atopic eczema, requiring oral steroid and Azathioprine for disease control, presented with progressive left eye blurring over one year. His mother noted unilateral leukocoria, prompting an ophthalmology consultation. He denied habitual eye rubbing or trauma.

Examination revealed hand movement vision in the left eye with no RAPD. The cornea was clear, with prominent corneal nerves. The anterior chamber was shallow (Van Herick grade 1–2) with 3–4+ pigmented cells. Intraocular pressure was 18 mmHg. Sectoral iridoschisis was observed from 6 to 9 o'clock at the mid-iris, with strands contacting the corneal endothelium but no iris atrophy. The left eye had a mature, intumescent cataract, and dilation was avoided to prevent pupillary block. Otherwise there was no keratic precipitate, iris nodule or posterior synechiae to suggest previous uveitis. B-scan showed a flat retina. The right eye was normal, with 6/6 vision, no iridoschisis, and no cataract.

The patient was scheduled for cataract extraction with intraocular lens implantation, but surgery was postponed due to an eczema flare.

Conclusion

To date, only one other case of concurrent pediatric iridoschisis and cataract in an eczema patient has been reported. Chronic inflammation and frequent eye rubbing have been proposed as contributing factors, though the exact mechanism remains unclear. This case highlights the importance of considering ocular complications in patients with severe atopic eczema and the challenges in surgical planning for such cases.

ABSTRACT ID: 55

Born without a Nose: A Rare Case of Bosma Arrhinia Microphthalmia Syndrome (BAMS)

Lee Wan Qing[1], Sangeetha Tharmathurai[1], Norhafizah Hamzah[1]

[1]Hospital Tunku Azizah

Purpose

To report a rare case of Bosma Arrhinia Microphthalmia Syndrome (BAMS) in Malaysia.

Methods

Case report

Results

A newborn baby girl was born tern via spontaneous vertex delivery with an uneventful antenatal history. The mother denies consanguinity and previous detailed scan was normal. On examination, the ocular findings include telecanthus, narrow palpebral fissures, and bilateral microcornea with retinal hemorrhages, which responded to topical nepafenac and prednisolone. In addition, she had a right unilateral dacryocele, which was treated conservatively with systemic cefuroxime, topical levofloxacin, and warm compression. However, there was no cataract or coloboma of the lens, iris, retina, or choroid. Systemically, she was born without a nose (arhinia) and immediately underwent a tracheostomy performed by the otorhinolaryngology team due to respiratory compromise. She is currently undergoing further investigation including genetics and radio-imaging such as ultrasonography of brain, echocardiogram, and computed tomography. As BAMS involves multisystem, it is crucial that it be co- managed by the neonatology, otorhinolaryngology, and genetics teams to ensure multidisciplinary care.

Conclusion

Bosma Arrhinia Microphthalmia Syndrome (BAMS) is an extremely rare condition characterized by nasal and orbital abnormalities with endocrine dysfunction. It is a clinical diagnosis, often associated with mutations in Structural Maintenance of Chromosomes Flexible Hinge Domain (SMCHD1) gene. Management of this rare case can aid in insights into the clinical management of affected individuals.

ABSTRACT ID: 68
SURGICAL CORRECTION OF MARCUS GUNN JAW-WINKING PTOSIS AND CONCURRENT STRABISMUS: A CASE REPORT

Farah Salsabilla[1], Liana Ekowati[1], Trilaksana Nugroho[1], Arnila Novitasari Saubig[1]

[1]Diponegoro University, Dr. Kariadi Hospital

Purpose

To report the outcome of surgical correction in a patient with Marcus Gunn Jaw-Winking ptosis and concurrent strabismus.

Methods

This is a case report of a patient with Marcus Gunn Jaw-Winking Ptosis and concurrent strabismus who underwent surgical correction.

Results

The patient presented with a congenital drooping eyelid that improved upon opening the mouth. He also complained of diplopia and a squint in his right eye. His visual acuity was 4/60 in the right eye, which could be corrected to 6/7.5 with no further improvement, and 6/60 in the left eye, which could be corrected to 6/6. Extraocular motility and anterior segment examinations were normal in both eyes. The Krimsky test showed 30 PD exotropia in the right eye, both with and without eyeglasses. Ptosis examination of the right eye revealed a Marginal Reflex Distance 1 (MRD-1) of 1 mm and a Levator Function Test (LFT) measurement of 10 mm. The patient underwent 7 mm Lateral Rectus recession and 5.5 mm Medial Rectus resection for strabismus correction, followed by ptosis surgery using the levator plication technique three weeks later. Postoperatively, the patient was orthophoric, MRD-1 increased to 4 mm, and LFT improved to 12 mm. The degree of jaw winking was reduced from 2 mm to 1 mm. Additionally, complaints of jaw winking and diplopia improved.

Conclusion

Surgical correction is an effective treatment for Marcus Gunn Jaw Winking ptosis with concurrent strabismus when vision is impaired.

ABSTRACT ID: 90

BILATERAL ABDUCENT NERVE PALSY AS A PRESENTATION FOR RELAPSE OF PAEDIATRIC ONSET MULTIPLE SCLEROSIS

Dzulkhairuddin bin Dzulkefli[1], Adzleen Mohmood[1], Amirah M Razali[1]

[1]Universiti Putra Malaysia

Purpose

To report a case of bilateral abducent nerve palsy as a presentation for relapse of pediatric-onset multiple sclerosis (POMS)

Methods

A Case report

Results

A 7-year-old boy with underlying asthma presented with a 3-day history of binocular diplopia. 8 months prior, he was treated for post-infectious acute disseminated encephalomyelitis and was given intravenous methylprednisolone followed by a tapering dose of oral prednisolone. On examination, his visual acuity was 6/6 bilaterally and the relative afferent pupillary defect was negative. Hirschberg revealed left esotropia. There was alternating esotropia at distance on cover testing and a mild esophoria with fast recovery at near. Diplopia was present at all gazes except for dextroversion, dextroelevation and dextrodepression. There was horizontal nystagmus on horizontal and up gaze. The other ocular examination was unremarkable with normal anterior and posterior segment findings. Neurological examination revealed a positive tandem test. HESS chart demonstrated under-action of bilateral lateral rectus muscle. Magnetic resonance imaging of the brain and spine demonstrated recurrent demyelinating disease with new brainstem and cervical cord lesions. Cerebrospinal fluid studies showed the presence of faint oligoclonal bands. Serum aquaporin-4 and MOG antibodies were negative. The patient was treated with intravenous methylprednisolone followed by oral prednisolone, with resolution of both bilateral abducent nerve palsy and nystagmus two weeks after treatment.

Conclusion

POMS is a rare condition, especially under 10 years old. This case highlights the diagnostic complexities of POMS and emphasizes that early diagnosis and treatment are essential to mitigate long-term disability in these very young patients

ABSTRACT ID: 91

A Child's Vision in Peril: How Delayed and Inconsistent Treatment of Pseudomembrane Conjunctivitis Led to a Corneal Ulcer

Chan Sin Lin[1], Siti Ilyana binti ghani[1], Norhafizah Hamzah[1]

[1]Hospital Tunku Azizah

Purpose

To highlight the progression of pseudomembrane conjunctivitis into a partially treated corneal ulcer in a child due to inconsistencies and lapses in treatment.

Methods

A Case Report

Results

This is a case of pseudomembrane conjunctivitis that developed into a partially treated corneal ulcer due to inconsistent treatment. A 1-year-3-month-old boy with no known medical history presented to us with generalized corneal opacity in the right eye. Initially, he was treated at a private hospital emergency department for conjunctivitis with right eye redness and given only artificial tears, but symptoms did not resolve. He was then seen by an ophthalmologist at another private hospital for pseudomembrane conjunctivitis, treated with daily rodding and levofloxacin eye drops (QID). On day 4 of levofloxacin, cornea ulcer was noted, and he was referred to another hospital and was admitted. There, he was started on hourly levofloxacin and fluorometholone eye drops (TDS). Due to the festive season, the child was discharged and requested to continue treatment at another private hospital under a different ophthalmologist. Upon presentation to our hospital, the child had generalized dense corneal scarring and vascularization over the superior and inferior cornea. A minimal epithelial defect (2 x 1 mm) remained at the paracentral area 11-12o'clock. The child's vision was limited to blinking to light.

Conclusion

This case demonstrates the dangers of inconsistent treatment, where delays led to the progression from pseudomembrane conjunctivitis to a corneal ulcer. Timely and continuous care is essential to prevent serious complications and preserve vision.

ABSTRACT ID: 101

When squint and proptosis signal more: A case of paediatric Myelin Oligodendrocyte (MOG) Optic Neuritis

Thiam Hou Lim[1], Siti Norzalehawati Sepian[1], Nor Amalina binti Abdul Rahman[12], Ngoo Qi Zhe[2]

[1]Hospital Sultanah Nur Zahirah; [2]Universiti Sains Malaysia

Purpose

We are reporting a case of paediatric MOG optic neuritis with uncommon ocular manifestations.

Methods

A Case report

Results

A 4-year-old boy presented with one-week history of intermittent outward deviation and mild swelling of the right eye, along with a history of pneumonia one month prior. There was no associated pain, redness or recent trauma. Examination revealed a visual acuity (Cardiff) of 2/60 in the right eye and 6/12 in the left eye respectively, with right relative afferent pupillary defect (RAPD), mild proptosis, and restricted extraocular movements. Funduscopy showed swollen optic disc in the right eye and slight hyperemia in the left. Systemically, he exhibited mild lethargy with shotty lymphadenopathy. He was initially treated with intravenous ceftriaxone and oral azithromycin while undergoing further imaging. Contrast-enhanced computed tomography (CECT) of the brain showed right optic nerve enlargement and enhancement, along with multiple white matter hypodensities. Blood tests ruled out infections, though erythrocyte sedimentation rate (ESR) was elevated (96mm/hr). He was subsequently started intravenous methylprednisolone and intravenous immunoglobulin (IVIG). Further testings revealed a borderline serum anti-MOG antibody level. MRI findings were suggestive of myelin oligodendrocyte glycoprotein antibody-associated disease (MOGAD) with slight improvement of brain lesions. Upon discharge, his vision improved (6/12 right eye, 6/9 left eye), optic disc swelling resolved and extraocular muscle movement normalized.

Conclusion

Acute-onset squint and proptosis are rare in paediatric MOG optic neuritis, requiring comprehensive evaluation and treatment for optimal recovery

ABSTRACT ID: 132

The Twin Factor: Aggressive Retinopathy of Prematurity in Twin Neonates

Siti Aeisyah Binti Ayob[1], Sangeetha Tharmathurai[2]

[1]Hospital Kuala Lumpur

[2] Hospital Tunku Azizah

Purpose

To report the occurrence of severe retinopathy of prematurity (ROP) in twin infants and highlight its presence in those with relatively higher birth weight (BW) and gestational age (GA).

Methods

Retrospective review of 8 premature twin infants diagnosed with severe ROP (stage 3 or worse and any stage with Plus disease). Data on neonatal and maternal factors, including BW, GA, oxygen dependency and perinatal complications were collected and analyzed.

Results

The cohort had a mean GA of 29 weeks and a mean BW of 1.29kg. Notably, 50% of the cases had a GA ≥ 32 weeks or BW > 1.5kg. Neonatal risk factors included prolonged oxygen therapy, with an average of 33 days, sepsis (100%) and respiratory distress syndrome (100%). Apnoea was observed in 83.3% and blood transfusions were required in 66.7%. All infants developed advanced stages of ROP, with more than 50% diagnosed with AROP. Treatments include laser photocoagulation (66.7%), intravitreal ranibizumab (82.3%) and vitrectomy in one case.

Conclusion

This case series highlights the occurrence of AROP in twin infants with higher BW or GA compared to the traditional risk population. The findings emphasize the need for vigilant screening and early intervention in twin gestations, regardless of birth parameters to prevent severe visual outcomes.

ABSTRACT ID: 184

The Effectiveness of VIVID Vision, A Virtual Reality (VR) Training in Treating Amblyopia with Toxoplasmosis: A Case Study

Liaw Pei Xin[1], Michelle[1], Azarina Abdullah[1], Nur Hafidza Asiff[1], Azhar Sulaiman[1], Nur Sabrina Subri[2]

[1]VISTA Eye Specialist; [2]Universiti Teknologi Mara

Purpose

Toxoplasmosis infection often leads to macular scarring, complicating standard amblyopia treatment and limiting visual outcomes. VR-based dichoptic exercises have been shown to enhance neural plasticity, prompting both eyes to collaborate in visually demanding tasks, even in the presence of significant macular scarring. This case study aimed to report the efficacy of VR-based amblyopia therapy in patients with macular scarring, examining outcomes in visual acuity (VA), stereopsis, and patient engagement throughout the therapy.

Methods

A 9-year-old girl with bilateral amblyopia and dense macular scar due to toxoplasmosis underwent 43 sessions of in-office VIVID Vision virtual reality (VR) therapy over three months and three weeks. Before and after each session, habitual VA and stereopsis were measured. The VR program incorporated gamified binocular tasks, encouraging both eyes to work together for improved visual function.

Results

VA improved from 6/30 to 6/12+2 in the right eye and from 6/10–1 to 6/6–1 in the left eye after completing all sessions. Additionally, stereopsis measured with the Frisby Stereo Test improved from 170" of arc to 50" of arc. These results underscore the potential for VR therapy in managing challenging amblyopia cases.

Conclusion

VIVID Vision VR therapy effectively enhanced both VA and stereopsis in this amblyopic patient despite the macular scarring in 3 months. Dichoptic stimulation through gamified tasks accelerated improvements in visual function, suggesting broader clinical applicability and proven efficacy.

ABSTRACT ID: 200

A Race Against Time: The Ophthalmic and Systemic Ramifications of Neonatal Vein of Galen Malformation

Nur Azureen Mohd Ali[1], Farhana Ibrahim[1], Julieana Muhamed[2]

[1]Hospital Tuanku Jaafar; [2]Universiti Sains Malaysia

Purpose

This study aims to highlight the ophthalmic manifestations of VGAM, emphasizing their role in early diagnosis and understanding the systemic vascular implications of this rare condition.

Methods

A Case report

Results

A neonate was delivered at 36 weeks and 5 days via emergency caesarean section due to abnormal cardiotocography (CTG) and severe fetal growth restriction, with a birth weight of 1.88 kg. Following birth, she was admitted to the neonatal intensive care unit (NICU) for close monitoring. Magnetic resonance imaging (MRI) revealed an acute subpial hemorrhage in the right temporal lobe, complicated by a temporal lobe infarct, midline shift, and obstructive hydrocephalus.

Neurosurgical evaluation was sought, but the parents opted against surgical intervention, favoring conservative management. The neonate subsequently developed seizures, presumed secondary to the underlying cerebrovascular pathology. Echocardiographic findings included situs solitus, right and left ventricular hypertrophy, a small patent foramen ovale (PFO), a small patent ductus arteriosus (PDA), and an ejection fraction of 64%, reflecting the hemodynamic burden imposed by VGAM.

Ocular examination revealed bilateral iris vascularization at the pupillary margin. Fundoscopic examination demonstrated pink optic discs with good foveal reflex, and a temporal avascular area. No immediate ocular intervention was administered, and at the one-week follow-up, the iris vascularization had resolved completely, indicating a possible transient vascular phenomenon.

Conclusion

The resolution of ocular findings suggests a dynamic vascular component, emphasizing the need for further studies on the ophthalmic manifestations of VGAM.

ABSTRACT ID: 219

A Close Catch: A Case Report on Non-Visually Debilitating Fishhook Ocular Injury In Pediatric Patient

Lim Thiam Hou[1], Wan Nadiah Binti Amir Hamzah[1,2], Zunaina Embong[2], Aiman Mardhiyyah Mohd Yazid[2]

[1]Hospital Tengku Ampuan Rahimah Klang; [2]Universiti Sains Malaysia

Purpose

To highlight on the importance of prompt and well-planned management of fishhook ocular injury in paediatric patient

Methods

A Case Report

Results

A 6-year-old boy was allegedly standing behind his 10-year-old brother, who was casting fishing rod into a river, when the fishhook struck the patient's right eye. He sustained a through-and-through laceration of the upper eyelid, with the fish hook still in-situ upon arrival at the emergency department. Initial assessment revealed a single-barbed metal fishhook dangling from the right upper lid. There was no active bleeding. Pupil was round, of 4 mm size and reactive. Subconjunctival haemorrhage was observed on the lateral bulbar conjunctiva, but no obvious signs of globe perforation were present. A prompt plain computed tomography of orbit confirmed that the globe was intact with no evidence of an intraocular foreign body. The child underwent examination under anaesthesia, during which the fishhook was removed using the advance-and-cut technique. Intraoperatively, a 4mm vertical conjunctival laceration was identified, with the Tenon’s capsule and sclera intact. Both conjunctival and upper lid laceration were repaired with vicryl 7/0. Postoperatively, the wound healed well, and the patient’s vision remained good.

Conclusion

Prompt management of paediatric fishhook ocular injuries is essential to prevent significant morbidity. CT imaging and careful assessment of the hook type are key to planning the appropriate surgical approach.

ABSTRACT ID: 241

A rare presentation of Optic Neuritis

Han Shye Wei[1], Ting Xiao Wei[1]

[1]Hospital Tawau

Purpose

Optic neuritis is an inflammation of the optic disc which commonly manifests in adults. We aim to present a rare case of bilateral optic neuritis in a pediatric patient.

Methods

A Case report

Results

An 8 year-old girl presented with one month of gradual onset blurring of vision and floaters of bilateral eyes. One month prior to her presentation, she had an episode of upper respiratory tract infection. Visual acuity upon examination was counting fingers with grade 1 relative afferent pupillary defect. Anterior segment examination was unremarkable. Intraocular pressure was 14 mmHg. Fundus examination revealed bilateral papilloedema and systemic examination showed palpable lymph nodes on the left anterior triangle of her neck. Computed Tomography scan of brain and orbit showed diffuse enlargement of bilateral lacrimal glands with normal bilateral optic nerves & calcified left parotid space subcutaneous lesion. Serum melioidosis IgM was positive and other blood investigations were normal. The diagnosis of bilateral eye optic neuritis secondary to melioidosis was made. Oral prednisolone and ciprofloxacin therapy was initiated. The papilloedema and visual acuity of bilateral eyes improved to 6/6 two months post treatment.

Conclusion

The presentation bilateral optic neuritis in children may be misleading and poses a diagnostic dilemma. High index of suspicion and thorough investigation is imperative to allow for proper diagnosis.

ABSTRACT ID: 278

Blurred Beginnings: Unravelling a Left Optic Nerve Glioma in Early Infancy

Yong See Yen[1], Tajunisah Iqbal[1], Fazliana Ismail[1], Nurliza Khaliddin[1]

[1]Universiti of Malaya

Purpose

To report a rare case of early onset optic nerve glioma in a 3- month- old infant.

Methods

A Case report

Results

We report a case of a 3- month- old infant who was referred to us with one month history of progressive left eye protrusion. Examination revealed a positive Left RAPD with associated lagophthalmos, limited extraocular movement and florid disc swelling with tortuous retina vessels. There is absence of visual evoked potential waveform over the left eye. MRI imaging showed diffuse thickening of the optic nerve with minimal but homogenous enhancements surrounding the perineural tissue. The overall size of the tumor was 4.4cm (AP) x 1.4cm(W) x 2.1cm(H). A left optic nerve incisional biopsy was done and histopathology report confirmed a low-grade (WHO grade 2) optic nerve glioma. Molecular testing of the tissue confirmed a BRAFV600E mutation. The patient was started on targeted BRAF inhibitor (Dabrafenib). MRI brain and orbit repeated 5 months later showed positive response to treatment with smaller tumor size reported.

Conclusion

Early-onset optic nerve glioma is rare but should be considered in infants with progressive proptosis and optic nerve dysfunction. Molecular testing for BRAFV600E mutation allows targeted therapy, as seen in our case where Dabrafenib led to significant tumour regression. In Malaysia, data on paediatric optic nerve gliomas are scarce, highlighting the need for early diagnosis and intervention. Precision treatment offers promising outcomes in managing these rare but challenging cases.

ABSTRACT ID: 284

A case report of a painless retention of intraocular foreign body for 4 years in a paediatric patient.

Ng Zhi Yun[1], Ling Hwee Minn[1], Chow Kit May[1]

[1]Hospital Sultan Haji Ahmad Shah

Purpose

Intraocular foreign body (IOFB) poses a significant concern in paediatric ocular trauma as it may lead to significant visual impairment, either directly from the trauma itself or indirectly through the development of amblyopia. The aim of this case report is to enhance the understanding of paediatric patient with IOFB, including the clinical presentation, diagnosis, management and visual prognosis.

Methods

A Case report

Results

A 12-year-old girl presented with insidious, painless right eye blurring of vision for 6 months associated with right eye outward deviation. Further history revealed that she had self-inflicted injury over the right eye by a hair pin 4 years ago. Her best corrected visual acuity was hand movement in right eye and 6/9 in left eye. Slit lamp examination noted corneal scar at 5 o'clock and white cataract. There was no fundus view. B-scan showed no loculations and retina was flat. Computed tomography (CT) of orbit showed retained IOFB in the vitreous at posterior globe. She then underwent right eye lensectomy, par plana vitrectomy and removal of IOFB. Sulcus intraocular lens implantation was performed in another setting. Despite the surgery, her best corrected visual acuity at 6 weeks post operation was only hand movement.

Conclusion

The primary factor contributing to poor visual outcome in this missed IOFB case was the development of amblyopia. Paediatric eye trauma warrants a meticulous history taking, thorough examination, aided by imaging for early diagnosis and treatment of IOFB to prevent the development of amblyopia.

ABSTRACT ID: 413

The Great Masquerader, The Silent Killer

Lim Hui Wen[1], Siti Ilyana Ghani[1], Nor Akmal Bahari[1], Sharifah Intan Hosnaliza Binti Syed Osman[1], Envira Lee Zhi Yin[12], Wan Haslina Wan Abdul Halim[2]

[1]Hospital Kuala Lumpur; [2]Universiti Kebangsaan Malaysia

Purpose

Intraocular medulloepithelioma is a rare embryonal neoplasm arising from non-pigmented ciliary body epithelium, ranks the second most common primary intraocular tumor in children. The rarity and non-specific presentation leading to misdiagnosis, delayed treatment and poorer prognosis.

To highlight the diagnostic challenge of a case of Teratoid Malignant Medulloepithelioma (TMM) which.

Methods

A Case report

Results

A 9-years-old boy with history of the evisceration of right eye (RE) presented with progressive proptosis and conjunctiva chemosis after being treated as persistent fetal vasculature (PFV) complicated with neovascular glaucoma (NVG).

He underwent RE lens aspiration and intraocular lens implantation at 4 years old. Post operation, his vision improved and the fundus finding was normal.

Seven months later, RE developed posterior capsule membrane (PCO), progressively thickened and became vascularized which obscured fundus view, leading to light perception vision. B-scan revealed open funnel retinal detachment while MRI suggested residual PFV with a right posterior chamber lesion suggestive of hematoma. He developed painful blind eye due to NVG and necessitated evisceration.

Due to current symptoms, MRI brain and orbit was done, revealed right multilobulated intraorbital lesion with optic nerve involvement. RE exenteration and craniotomy were performed. Histopathological examination confirmed TMM with intracranial extension. He is undergoing systemic chemotherapy and under close surveillance for recurrence.

Conclusion

Medulloepithelioma may masquerades PFV, retrolental vascularized membrane, or glaucoma, delaying diagnosis and treatment. With early and accurate diagnosis, enucleation could have prevented extraocular extension and improved prognosis. These should prompt clinician to pick up atypical presentations and salient clues.

ABSTRACT ID: 414

Ocular Manifestations That Develop Over Time for Hunter

Rathinamsvannie Selvam[1], Lim Hui Wen[1], Chan Li Yen[1], Jamalia Rahmat[1], Envira Lee Zhi Yin[12], Wan Haslina Wan Abdul Halim[2]

[1]Hospital Kuala Lumpur; [2]Universiti Kebangsaan Malaysia

Purpose

Mucopolysaccharidosis type II (MPS-II; Hunter syndrome) is a rare X-linked recessive lysosomal storage disorder, resulting in accumulation of acid mucopolysaccharides in different tissues and organs. The prevalence of MPS-II in Malaysia was 26% with a mean age of 5 years old. Ocular manifestations are commonly observed, and their presentation varies according to subtypes. This case highlights the ocular manifestation and progression in a patient diagnosed with MPS-II.

Methods

A Case Report

Results

A 6-year-old child was diagnosed with MPS-II with typical features of coarse facies, kyphoscoliosis, stiff joints and developmental delay was started on enzyme replacement treatment (ERT). Early years eye assessment only exhibited mild refractive error–hyperopia. At age 15, the patient developed fine peripheral pigmentary retinopathy resembling retinitis pigmentosa. At age 20, incidental findings of optic disc hyperemia and swelling were noted in both eyes. The patient remained clinically asymptomatic with visual acuity 6/9. Optic nerve function tests, intraocular pressure and extraocular movements were all normal. Radiologic imaging confirmed communicating hydrocephalus and cervical myelopathy which warranted surgical intervention, of which the patient's family declined due to high surgical risk. Aside ocular progression, systemically progression with adenotonsillar hypertrophy, bilateral hearing loss, thickened mitral and aortic valve were also observed during documented period of follow-up.

Conclusion

The complexity of MPS and progressive nature highlight the need for multidisciplinary follow up. In cases with papilloedema, reversible causes like increased intracranial pressure and hydrocephalus must be ruled out. With time, it may progress to optic atrophy with subsequent visual impairment.

ABSTRACT ID: 436

Unveiling Congenital Toxoplasmosis : A Serendipitous Discovery through ROP screening

Nur Farahim binti Daud[1], Hanisah binti Abdul Hamid[1], Nurulhuda binti Abd Sukor[1], Nurul Izza binti Roslan[1], Seow Shu Yee[2]

[1]Hospital Sultan Abdul Halim; [2]Hospital Kuala Lumpur

Purpose

To report an active congenital ocular toxoplasmosis in preterm infant.

Methods

A case report.

Results

A female 26 weeker preterm twin (2nd twin) was 1st reviewed at 31st week of corrected gestational age (CGA) was found to have left eye (LE) retinitis within posterior pole of the retina involving macula upon retinopathy of prematurity (ROP) screening. Further history noted her mother's immunoglobulin G (IgG) and immunoglobulin M (IgM) was reactive for toxoplasma. In addition, her 1st twin succumbed to death at 3 hours of life due to congenital toxoplasma. Due to this, we highly suspected this baby of having toxoplasma infection as well despite initial IgM was negative. Repeated IgG/IgM was positive and CT brain showed multiple hypodense areas in both cerebral hemispheres with multiple intracranial calcification. Other than intracranial calcifications there were no other systemic signs such as rash, jaundice, hepatosplenomegaly, hydrocephalus and seizure in this child. Diagnosis of congenital toxoplasmosis was made. The case was co-managed with paediatric team including pediatric infectious disease specialist and also pediatric ophthalmologist. She was started on oral Sulfadoxine 54mg + Pyrimethamine 2.7mg every 10 days, oral folinic acid 45mg every 7 days and oral prednisolone 1mg BD in which she responded well to the treatment. Her LE retintis resolved with formation of scar at posterior pole. Currently the baby is at 43 weeks CGA. She is thriving well and birth weight has increased to 2.26kg.

Conclusion

The swift initiation of anti-toxoplasmosis treatment following the incidental discovery of retinitis through ROP successfully prevented further complications, allowing the infant to survive.

ABSTRACT ID: 490

The critical role of IOP control in the race to preserve vision in a case of bilateral juvenile glaucoma with asymmetrical visual loss

Sabrina Kon Shu-En[1], Kenneth Teow Kheng Leong[1]

[1]Hospital Bintulu

Purpose

Paediatric glaucoma (PG) presents subtly, often delaying diagnosis until significant damage has occurred. This case highlights the importance of shifting conventional focus of early detection, to aggressive intervention in preserving the remaining functional eye. We report a case of advanced bilateral juvenile glaucoma, where timely intraocular pressure (IOP) control is the key determinant of his visual prognosis and quality of life.

Methods

A case report

Results

An 11-year-old boy with no prior medical illnesses, presented with sudden vision loss in his left eye for two weeks, with intermittent frontal headaches. Examination revealed a stark asymmetry. 6/6 vision in the right eye with a pink optic disc and a cup-disc-ratio (CDR) of 0.8. The left eye had no perception of light with the left disc fully cupped and deeply excavated, indicating advanced glaucomatous damage. IOP was 64 mmHg bilaterally. He was immediately started on quadruple topical antiglaucoma therapy and referred for urgent surgical intervention.

Conclusion

This case highlights that the consequences of delayed intervention in PG are profound and lifelong. Unlike adult glaucoma, where progression may unfold over years, PG demands immediate surgical intervention following maximum medical therapy to halt further deterioration. Losing vision at such a young age has profound effects on the child, and inevitably extends to the family.

This case underscores the delicate balance in PG management, where the difference between sight and blindness hinges on the speed and decisiveness of intervention. Given the aggressive nature of the disease, recognizing the critical window for treatment is paramount in ensuring that these children retain the vision they have left.

ABSTRACT ID: 518
ANTERIOR SEGMENT DYSGENESIS: WHAT NEXT?

Sharvina a/p Ramesh Rao[1], Premalatha Santhiran[1], Khairul Husnaini[1]

[1]Hospital Tuanku Ampuan Najihah

Purpose

To predict the possible diagnosis of anterior segment dysgenesis.

Methods

This study is based on the case report on this patient written by the researchers.

Results

A newborn baby girl was referred to our Ophthalmology Clinic for eye assessment, given her antenatal history. Her mother was diagnosed to have cytomegalovirus, toxoplasmosis and rubella infection. The mother's pregnancy showed the child had intrauterine growth restriction with oligohydramnios. A detailed antenatal scan revealed that the child had minimal pericardial effusion. The baby girl was delivered via elective caesarean due to intrauterine growth restriction. On examination, her pupils were dilated bilaterally with diffuse patchy opacities measuring less than 10mm and superficial vascularization on the cornea. There is no epidefect present in bilateral eyes. Iris details were unable to be visualised in both eyes. Using Tonopen and speculum, intraocular pressure in the right eye was 14mmHg, whereas in the left eye was 22mmHg. She had clear lens bilaterally. On fundus examination, bilateral eyes had pink optic disc with a cup-disc ratio of 0.2 with a hazy fundus view. No obvious choroiditis, retinitis and vasculitis are seen in both eyes. Systemic examination revealed no syndromic features in this patient.

Conclusion

A wide range of potential diagnoses fall under the umbrella of anterior segment dysgenesis. A few possible diagnoses would be congenital hereditary endothelial dystrophy, infantile congenital glaucoma and sclerocornea. Thorough investigation of its causative factors is essential to achieve an accurate diagnosis, which will guide the selection of appropriate treatment for the patient.

Surgical Retina

ABSTRACT ID: 29

SINKER'S STRIKE, I LOST MY VISION: A CASE REPORT OF BLUNT OCULAR INJURY FROM FISHING SINKER

Asma Abdul Razak[1], Nur Hafeela Mohamad Rusli[1],Choo Swee Ying[1], Jamalia Rahmat[1], Evelyn Tai Li Min[2]

[1]Hospital Kuala Lumpur; [2]Hospital Pakar Universiti Sains Malaysia

Purpose

Ocular trauma from fishing sinkers can lead to significant visual impairment, including blindness. We report a case involving a fishing sinker injury that resulted in complications, long-term ocular morbidity, and discuss preventive measures for such injuries.

Methods

Case Report

Results

A 21-year-old male presented with pain and blurred vision after being struck in the left eye (LE) by a high-velocity fishing sinker. Visual acuity (VA) LE was limited to counting fingers at 1 foot (CF1ft). Relative afferent pupillary defect was present, with abnormal light reflex and reduced red saturation. Ocular examination revealed subconjunctival haemorrhage, conjunctival laceration, and iridodialysis inferotemporally. Anterior chamber appeared shallow nasally, with 4+ cells. Fundus examination and optical coherence tomography (OCT) identified multilayer haemorrhages, macular hole, and commotio retinae inferotemporally. Diagnoses of left blunt ocular trauma with traumatic optic neuropathy, subfoveal haemorrhage, traumatic macular hole, iridodialysis, and traumatic uveitis was made. Despite initial management, no improvement in VA 1-week post-trauma. Follow-up OCT showed retinal pigment epithelium discontinuity, choroidal rupture, and subretinal bleeding. Intravitreal anti-vascular endothelial growth factor (anti-VEGF) was planned but deferred in view of high intraocular pressure (IOP) (48mmHg) with nasal angle recession. Anti-VEGF injection was commenced after the IOP normalized with anti-glaucoma medications. Two-months post-trauma, LE VA improved to 6/120, with reduced sub-macular haemorrhage size and macular scarring. Latest OCT revealed decrease in subretinal bleeding with thinning of inferotemporal retina.

Conclusion

Preventive measures, such as wearing eye protective gear, should be emphasized when engaging in high-velocity sports like fishing to prevent severe ocular injuries and long-term complications.

ABSTRACT ID: 115

CLOSURE OF MACULA HOLE WITH TOPICAL TREATMENT

Ng Xin Gen[1], Josephine Lee En Hui[1], Ng Hong Kee[1]

[1]Hospital Raja Permaisuri Bainun

Purpose

To describe a case of macula hole closure with topical treatment

Methods

Case Report

Results

A 75-year-old man with bilateral pseudophakia, underlying hypertension and diabetes mellitus, presented to our outpatient clinic with complaint of left eye (LE) central blurring of vision for the past two months. There was no history of trauma. Patient sought a second opinion after being started with topical treatment from a private centre one month earlier as he was afraid about undergoing potential costly surgical intervention. The optical coherent tomography (OCT) scan from private centre revealed a full thickness macula hole.

On examination, the right eye (RE) visual acuity (VA) was 6/6. LE VA was 6/24. Anterior segment examination was normal with posterior capsular intraocular lens. Both eyes' intraocular pressure was 11 mm Hg. Fundus examination showed peripapillary atrophy with tessellated fundus. LE has dull fovea reflex with epiretinal membrane with a negative Watzke-Allen test.

The patient had been treated with combination of topical non-steroidal anti-inflammatory drug, steroid and carbonic anhydrase inhibitor for the past one month. OCT revealed that there is a lamellar hole with epiretinal membrane. Patient report a subjective improvement of vision after started with topical treatment.

Conclusion

Full thickness macula hole, particularly stage 2 may respond to topical therapy as a non-invasive option for patient who are not keen for surgical intervention.

ABSTRACT ID: 256

PNEUMATIC DISPLACEMENT FOR SUBMACULAR HAEMORRHAGE IN HOSPITAL KUALA LUMPUR

Yuvithra Devi Shanmugam[1], Jason Allan Cheah Seng Soon[1], Choo Swee Ying[1]

[1]Hospital Kuala Lumpur

Purpose

To report the outcome of pneumatic displacement surgery

Methods

Case Report

Results

Two records of patients with Idiopathic Polypoidal Choroidal Vasculopathy (IPCV) who developed submacular hemorrhage were evaluated. One patient presented with a sudden onset of blurred vision in the left eye for 3 days, while the other presented with a 2-week history of sudden blurred vision in the left eye, both patients presented with visual acuity of counting fingers (CF) in the affected eye. They were treated with intravitreal anti-Vascular Endothelial Growth Factor (anti-VEGF) injections followed by pneumatic displacement with pure Perfluoropropane (C3F8 100%) to displace the submacular hemorrhage. The patients were advised to maintain a strict face-down position. The submacular hemorrhage was noted to have displaced away from the macula by postoperative day 3. However, during the 2-week postoperative period, both patients developed breakthrough vitreous hemorrhage, with a subsequent drop in visual acuity. As a result, they underwent cataract surgery and pars plana vitrectomy. Both patients were followed up for at least 2 months postoperatively and showed improvement in visual acuity with no new submacular hemorrhage or vitreous hemorrhage. One patient attained visual acuity of 6/48 with a dense macular scar and showed no new bleeding or retinal fluid. The other patient had a visual acuity of CF at 2 feet with central scotoma and subretinal fibrosis.

Conclusion

Pneumatic displacement of submacular hemorrhage is effective in preventing retinal toxicity in large submacular haemorrhage. Its success depends on bleeding duration, hemorrhage level, and patient posture compliance postoperatively.

ABSTRACT ID: 276

THE LODGED INTRUDER: CLINICAL IMPLICATIONS OF RETAINED INTRAOCULAR FOREIGN BODY

Yoon Kit Ivan Lai[1], Yi Lin Chua[12], Penny Pooi Wah Lott[2]

[1]Hospital Selayang; [2]University Malaya

Purpose

To report a case of retained intraocular foreign body (IOFB) in a 40-year-old male.

Method

Case Report

Results

A 40-year-old male who was previously well developed progressive blurring of vision in his left eye (LE) over two months. He had a history of trivial ocular trauma eight months prior where his left eye was hit by a steel fragment while cutting metal. He had no deterioration of vision post-injury, but at presentation to our clinic, his LE vision had deteriorated to hand movement (HM) with a positive relative afferent pupillary defect (RAPD). Anterior segment showed LE cornea siderosis and fundus examination revealed an IOFB at the 9 o'clock position and sclerosed vessels with optic atrophy. B scan showed an LE IOFB impacting the retina measuring 1.41mm (h) x 3.66mm (v), no loculation seen. OCT macula LE showed ellipsoid zone disruption.

CT imaging revealed a linear hyperdensity within eye globe abutting the left side of the sclera, with no extension into both the extraconal and intraconal compartments. The retrobulbar region appeared normal, with no evidence of proptosis, and the extraocular muscles and optic nerves were intact bilaterally. Patient was referred to vitreoretinal team for surgical management.

Conclusion

Early removal of IOFB is warranted to prevent ocular complications such as ocular siderosis. If siderosis worsens, delayed intervention may still be of benefit.

ABSTRACT ID: 277

CLINICAL FEATURES OF POLYPOIDAL CHOROIDAL VASCULOPATHY WITH BREAKTHROUGH VITREOUS HAEMORRHAGE AND SOCIAL OTHMAN

Tharishini a/p Chandra Segaran[1], Khairuddin Othman[1]

[1]Hospital Sultanah Bahiyah

Purpose

To study the clinical features of Polypoidal Choroidal Vasculopathy (PCV) with breakthrough Vitreous Hemorrhage (VH) and its visual outcome after pars plana vitrectomy (PPV).

Methods

Retrospective case series.

Results

Records of patients with PCV-related VH who underwent PPV from January 2020 to December 2024 were review. The main outcome measures were best corrected visual acuity (BCVA) and OCT findings post-surgery and within 1 year.

34 eyes of 34 patients with VH were enrolled. The mean follow-up period was 6 months post-surgery. We found that the preoperative vision does not strongly predict postoperative vision outcomes ($P>0.05$) and that the peak prevalence occurs in the sixth and seventh decades. Among the eyes, 38.2% achieved final BCVA of ≥ 20/200 compared to 2.9% prior to PPV. The findings showed that there were improvements in both the BCVA and retinal structure, indicated by fluid resolution. However, demographic factors such as age, gender and laterality showed no significant correlation with post operative visual outcomes, suggesting that the clinical parameters might have a more substantial role.

Conclusion

The visual prognosis in eyes with PCV-related breakthrough VH is variable after vitrectomy with some eyes showing significant recovery over time. Early vitrectomy may be beneficial for visual recovery after PCV-related VH. Clinical factors including severity of PCV at presentation, duration of hemorrhage before intervention, and preoperative retinal status, were likely better predictors of visual recovery than age, gender, and side of presentation.

ABSTRACT ID: 350

SPONTANEOUS CLOSURE OF TRAUMATIC MACULA HOLE FOLLOWING BLUNT TRAUMA

Shaira Haziera Samsu[1], Chua Lausanne[2], Kiu Kwong Yew[2], Tengku Ain Kamalden[3]

[1]Universiti Malaya Medical Centre; [2]arawak General Hospital; [3]Universiti Malaya

Purpose

To report a case of spontaneous resolution of traumatic macula hole (TMH) in a young child.

Methods

Case report

Results

An 8-year-old girl with background of mild myopia, presented with acute blurring of vision following impact to her left eye by a deployed airbag in a motor vehicle accident.

At presentation, her uncorrected visual acuity was 6/24 OD and CF OS, with no relative afferent pupillary defect. Examination of the left eye revealed periorbital hematoma, central corneal abrasion, Grade 1 hyphema, and vitreous haemorrhage. B-scan ultrasonography of the affected eye excluded presence of retinal detachment. Plain Computed Tomography (CT) of the orbit showed an intact globe with no orbital wall fractures. Examination of the right eye was unremarkable.

At one week post trauma, favourable response was observed with topical steroids and antibiotics resulting in resolution of hyphema, healed cornea abrasion and improved left eye vision to 6/36. Further reassessment of the fundus disclosed an inferior commotio retinae, resolving vitreous haemorrhage and a full thickness macula hole.

In view of improving visual functions, close observation and expectant management were opted. At 5-month follow-up, visual acuity improved to BCVA of 6/12, with complete closure of macula hole.

Conclusion

TMH is a known complication following blunt ocular injury. While TMH is well-documented in adults, reports of spontaneous resolution in children are limited. Management options include observation or retinal surgery. This case adds to the literature on spontaneous recovery in paediatric patients, highlighting significant recovery outcomes in younger children. Regular OCT imaging is crucial for predicting outcomes and detecting signs of spontaneous closure.

ABSTRACT ID: 378
BLUNT TRAUMA CAUSING INTRICATE CLOSE GLOBE INJURY

Siti Eliza Darussalam[1], Nadia Yaacob[1], Khairul Husnaini Mohd Khalid[1]

[1]Hospital Kuala Pilah

Purpose

To report a case of blunt trauma with anterior and posterior segment ocular injuries.

Methods

Case Report

Results

A case of 66 years old Malay man, alleged hit by stone while mowing grass. He did not use protective eyewear and post trauma complaint of right eye pain and blurring of vision. On examination, right eye vision was hand movement with reverse RAPD positive otherwise no limitation in extraocular movement. There was right lower lid full thickness lid margin laceration. Anterior segment reveals, conjunctival laceration, hazy cornea and elevated intraocular pressure. Anterior chamber shallow with hyphema covering pupil, iridodialysis from 6-9 o'clock and lens subluxated anteriorly. B scan shows vitreous haemorrhage inferiorly otherwise retinal flat. Subsequently patient undergone right eye plain intracapsular cataract extraction, iridodialysis repair, anterior vitrectomy, surgical peripheral iridotomy and left aphakia. He has underlying atrial fibrillation thus intravenous methylprednisolone was not started for traumatic optic neuropathy. Around 1 month post operation as vitreous haemorrhage reducing, noted rhegmatogenous retinal detachment nasally thus referred to vitreoretinal subspecialty and planning for right eye vitrectomy.

Conclusion

Ocular trauma is one of the leading causes of ocular morbidity with 2.5 million eye injuries recorded in United States yearly. 30% of this injury was due to blunt trauma with rocks and baseballs are one of the most common objects associated with it . Ocular trauma can lead to variety ocular pathology with risk of vision threatening consequences. Therefore, it is very important to do a thorough examination to not missed vision threatening injuries that might requiring urgent surgical intervention.

ABSTRACT ID: 431

BEYOND THE IMPACT: DELAYED SEQUELAE OF AIRBAG-RELATED OCULAR TRAUMA

Naveenahrani A/P Selvam@Ganesan[1], Seow SY[1], Jason A Cheah[1], Choo SY[1]

[1]Hospital Kuala Lumpur

Purpose

To highlight potential long-term complications following an airbag-related eye injury.

Methods

Case report.

Results

A 22-year-old woman presented with blurring of vision, floaters, and periorbital hematoma following a motor vehicle accident in July 2024. She sustained a blunt ocular injury to her left eye (LE) when the car airbag deployed and burst in her face. Initial examination revealed poor LE vision with vitreous hemorrhage and a large peripheral traumatic choroidal rupture. She underwent LE pars plana vitrectomy with endolaser treatment and air endotamponade. Postoperatively, her diagnosis was revised to Chorioretinitis Sclopetaria. Seven months later, her LE vision worsened, with visual acuity declining from 6/60 to 6/120. Optical Coherence Tomography (OCT) confirmed a grade 4 full-thickness macular hole (FTMH), and she is currently scheduled for elective LE Pars Plana vitrectomy and macular hole repair.

Airbag-related injuries range from mild corneal abrasions to severe globe injuries. Chorioretinitis Sclopetaria in this case indicates a coup injury from airbag impact. Fortunately, the damage was in the anterior retina. However, traumatic FTMH is a known consequence of blunt trauma and carries a fair visual prognosis.

Conclusion

Although airbag injuries result in immediate trauma, delayed retinal complications and macular holes may occur. The prognosis in post-airbag-related injury cases can vary from poor to good. Hence, it is important for thorough examination, early recognition and timely management to optimize visual outcomes.

ABSTRACT ID: 469
SIMULTANEOUS BILATERAL RHEGMATOGENOUS RETINAL DETACHMENT – A RARE PRESENTATION

Allan Tang Chong Su[1], Kiu Kwong Yew[1]

[1]Sarawak General Hospital

Purpose

Rhegmatogenous retinal detachment is a sight-threatening condition which typically presents unilaterally, with an incidence of approximately 1 in 10000. In comparison, simultaneous bilateral rhegmatogenous retinal detachment is rare. It accounts for 2.3% of all retinal detachment cases. The annual incidence is 0.35 patients per 100,000 population. We present our experience in managing a case of simultaneous bilateral rhegmatogenous retinal detachment.

Methods

Case report

Results

A 46-year-old female with high myopia complained of left curtain-like peripheral visual field defect. There was no history of trauma. The left and right eye visual acuities were 6/18 and 6/9. Anterior segment and intraocular pressure were normal bilaterally. Both eyes were phakic. Left fundus showed retinal detachment involving macula from 11 to 5 o'clock and retinal holes were seen at 12 and 4 o’clock with lattice degeneration at 4 to 5 o'clock. Although right eye was asymptomatic, the fundus showed retinal detachment from 6 to 8 o'clock without macular detachment and retinal hole was seen at 7 o'clock with lattice degeneration at 5 to 7 o'clock. A diagnosis of simultaneous bilateral rhegmatogenous retinal detachment was made. Scleral buckle and cryotherapy was done for both eyes. At postoperative 6 months, the best corrected vision was 6/9 bilaterally. Fundus examination and optical coherence tomography showed retina was flat for both eyes.

Conclusion

Timely treatment for simultaneous bilateral rhegmatogenous retinal detachment is crucial. Scleral buckle alone can achieve good outcome as well which had been shown in our case.

ABSTRACT ID: 499

A WOLF IN SHEEP'S CLOTHING: AN ATYPICAL PATHOGEN IN CORNEAL ULCER AND ENDOPHTHALMITIS

Muhammad Faiz Nordin[1], Nur Sakinah Bahaman Shah[1], Abdul-Hadi Rosli[1], Aidila Jesmin Jabari[1]

[1]International Islamic University Malaysia

Purpose

Corneal ulcers with concurrent exogenous endophthalmitis can cause significant vision loss. We report a rare case caused by *Burkholderia cenocepacia*, an uncommon and highly resistant pathogen.

Methods

Case report

Results

A 68-year-old male with a history of complicated left eye cataract surgery and postoperative endophthalmitis treated with vitrectomy (baseline vision 6/120) five years ago presented with a six-day history of left eye redness, pain, and decreased vision. He denied recent trauma. Visual acuity was 6/6 in the right eye and hand movements in the left. The left eye had conjunctival injection, generalized corneal edema, a paracentral immune ring with stromal infiltrates (2.6 mm × 3.2 mm), an epithelial defect (2 mm × 2 mm) with nasal thinning, and a hypopyon. The anterior chamber was deep with 3+ cells; the ACIOL was well positioned, and the peripheral iridotomy was patent at 10 o'clock. The fundus was obscured by media haze, and B-scan ultrasonography confirmed dense vitritis with a flat retina. Corneal scraping and culture identified *Burkholderia cenocepacia*, resistant to ciprofloxacin but sensitive to ceftazidime. A vitreous tap was performed, followed by intravitreal injections of ceftazidime (2 mg/0.1 mL) and vancomycin (2 mg/0.1 mL) every 72 hours for three doses. Oral ciprofloxacin and topical antibiotics were also initiated. Although the corneal ulcer and endophthalmitis improved, vision remained at hand movements.

Conclusion

Corneal ulcer with exogenous endophthalmitis due to *Burkholderia cenocepacia* is a rare, severe infection with limited treatment options and poor visual prognosis. Early recognition, aggressive antimicrobial therapy, and close monitoring are critical.

ABSTRACT ID: 500

BEYOND SILICONE OIL: MANAGING SUPRACHOROIDAL HAEMORRHAGE IN A PSEUDOPHAKIC EYE WITH RHEGMATOGENOUS RETINAL DETACHMENT

Muhammad Faiz Nordin[1], Abdul-Hadi Rosli[1], Aidila Jesmin Jabari[1]

[1]International Islamic University Malaysia

Purpose

To highlight the challenges of managing suprachoroidal hemorrhage in a highly myopic eye undergoing silicone oil removal and the critical intraoperative decisions required to manage the complication effectively.

Methods

Case report

Results

A 60-year-old gentleman with bilateral pseudophakia and pathological myopia, complicated by posterior staphyloma, macular scarring, and treated myopic choroidal neovascularization, had a history of open-funnel rhegmatogenous retinal detachment in the left eye. He underwent pars plana vitrectomy, endolaser, inferior peripheral iridotomy, and silicone oil tamponade (1000 cSt) one year prior, achieving a postoperative visual acuity of 6/120. He was planned for removal of silicone oil.

Intraoperatively, the procedure was complicated by a suprachoroidal hemorrhage following silicone oil removal. The inferotemporal infusion cannula inadvertently entered the suprachoroidal space, causing extensive temporal choroidal detachment and vitreous hemorrhage. The infusion port was repositioned, sclerotomies were sutured, and intraocular pressure remained stable.

On postoperative day one, vision declined to light perception. B-scan ultrasonography confirmed a temporal suprachoroidal hemorrhage extending inferonasally, including the macula, without kissing choroidals. Given the guarded visual prognosis and significant ocular comorbidities, a conservative management approach was adopted with systemic and topical steroid, topical antibiotics, and intraocular pressure-lowering agents. Serial follow-ups showed gradual resolution of suprachoroidal hemorrhage. Retinal attachment was maintained with a final best-corrected visual acuity of 6/60.

Conclusion

Suprachoroidal hemorrhage is a rare but severe intraoperative complication in highly myopic eyes. Increased axial length and choroidal vascular fragility heighten the risk of hemorrhagic events. This case underscores the need for meticulous surgical planning and prompt intraoperative adjustments to minimize complications and optimize outcomes.

ABSTRACT ID: 504

RIGHT EYE RHEGMATOGENOUS RETINAL DETACHMENT WITH INFERIOR MACULA INVOLVEMENT COMPLICATED WITH HYPERTENSIVE UVEITIS AND HIGH INTRAOCULAR PRESSURE

Siti Nur Baizury binti Hassan[1], Khairuddin bin Othman[1], Nor Falina binti Ahmad Tajuddin[1], Nurshahirah binti Ahmad Shukri[1], Nur Aimi Solehah binti Azmi[1]

[1]Hospital Sultanah Bahiyah

Purpose

To report a rare case of rhegmatogenous retinal detachment with inferior macular involvment complicated with hypertensive uveitis and high intraocular pressure.

Methods

Case report.

Results

A 23-year-old man presented with sudden right eye blurring of vision for one week. There was no pain, redness or discharge. He denied any high-risk behavior, drug abuse or trauma to the eye.

On examination, right eye visual acuity was 6/24. The eyelids, cornea and conjunctiva were unremarkable. However right eye anterior chamber reaction noted cells 2-3+ and intraocular pressure (IOP) was gradually increasing from 21 mmHg at initial presentation to 30 mmHg two hours later and then reaching 50 at 7 hours after initial presentation. Right eye fundus examination showed a pink disc with cup-disc ratio of 0.4 and clear margin. There was retinal detachment from 4 till 9 o'clock involving the macula. However, 3-mirror examination was unable to detect any breaks. There was no retinitis, vasculitis and choroiditis.

High intraocular pressure management and uveitic workout were initiated. All uveitis workout came back negative, including anterior chamber tapping for PCR.

The patient was seen again after 3 weeks. The right eye status remained unchanged and subsequently reexamined. Right eye scleral indentation performed noted retinal detachment from 4-9 o'clock with macula off with 1 horseshoe break at ora serrata at 8 o'clock. Patient subsequently underwent surgery.

Conclusion

We highlight a rare case of rhegmatogenous retinal detachment with ora serrata break with initial presentation of anterior uveitis and high intraocular pressure. It is important to assess patient with proper scleral indentations to detect any potential ora serrata break.

Video Abstracts

Advocacy/Public Awareness

ABSTRACT ID: 229
STRAIGHTENING VISION, RESTORING CONFIDENCE

Ooi Shu Yii[1], Ang Ee Ling[1], Ng Wei Loon[1]

[1]Hospital Pulau Pinang

Purpose

Aims to educate the public about squint, impact on daily life, and the importance of early intervention. This video highlights the challenges faced by a child with squint, explores treatment options, and encourages timely eye screenings.

Brief Summary

The video follows the journey of a child with squint who faces teasing from peers and relatives due to their eye misalignment, affecting their confidence and social interactions. Initially, the parents do not realize the emotional impact on the child. However, as they notice changes in behaviour—such as avoiding social situations or feeling self-conscious—they seek medical advice.

At the clinic, an ophthalmologist diagnoses squint and reassures the parents that it is a treatable condition. The doctor explains the available treatment options, including glasses, patching therapy, and surgery.

Following treatment, the child's appearance and confidence improve. The final scene shows them engaging comfortably in social activities and interacting happily with friends.

ABSTRACT ID: 552

AGE-RELATED MACULAR DEGENERATION: RISK FACTORS AND PREVENTION

Pee Xu Kent[1], Nor Azita Ahmad Tarmidzi[1], Hamisah Ishak[2]

[1]Hospital Kuala Lumpur; [2]The Eye Specialist Southkey

Purpose

To promote public awareness on lifestyle prevention of age-related macular degeneration onset and progression

Brief Summary

This is a short video on advocating methods on preventing onset and progression of age-related macular degeneration.

Clinical Assessment/Technique

ABSTRACT ID: 465

PARK 3-STEP TEST: A DIAGNOSTIC APPROACH FOR SUPERIOR OBLIQUE PALSY

Muhammed Danial Bin A. Razak[1], Nor A A Wahab[1], Maria M Muhayadin[1]

[1]Hospital Kuala Lumpur

Purpose

Understanding fundamental clinical method for diagnosing vertical strabismus and identifying the affected extraocular muscle.

Brief Summary

Superior oblique (SO4) palsy affects ocular motility, leading to vertical misalignment, torsional instability, and diplopia. The Park 3-Step Test is a key diagnostic tool to localize the affected extraocular muscle in cases of vertical strabismus. The test follows three steps:

1. Determine Hypertropia in Primary Gaze – Identify which eye is higher when the patient looks straight ahead.
2. Assess Hypertropia in Lateral Gaze – Observe if hypertropia worsens in right or left gaze.
3. Evaluate Head Tilt Effect – Identify hypertropia worsens in right or left head tilt.

In SO4 palsy, hypertropia worsens in contralateral gaze and ipsilateral head tilt, confirming superior oblique dysfunction. This test is crucial for distinguishing SO4 palsy from other vertical strabismus causes, guiding appropriate management, including prism correction, therapy, or surgery.

ABSTRACT ID: 494

THE PRISM COVER TEST

Zcho Huey Lee[1] , Jamalia Rahmat[1], Nor Aishah A Wahab[1], Nor Fadhilah Mohamad[2]

[1]Hospital Kuala Lumpur; [2]Universiti Malaya

Purpose

To demonstrate the prism cover test and common errors.

Brief Summary

The prism cover test is the gold standard for measuring strabismus objectively. This educational video demonstrates the procedure, explaining how to measure both horizontal and vertical deviations of the eyes by using prisms of different powers and alternately cover each eye. The video provides a structured approach to ensure accurate measurement, including maintaining proper patient fixation, using the correct prism orientation and interpreting eye movements effectively. It also highlights common mistakes – such as misaligning the prism, improper testing speed, or failing to control accommodation. By following these practices, clinicians could achieve reliable results, leading to improved management of strabismus in clinical practice.

ABSTRACT ID: 531
TACKLING CONVERGENCE INSUFFICIENCY WITH SIMPLE EXERCISES

Norsyamimi binti Mhd Halil[1], Nor Aishah A. Wahab[1], Kew Fui Hsien[1]

[1]Hospital Kuala Lumpur

Purpose

To illustrate exercises to target convergence insufficiency

Brief Summary

Struggling with eye strain, headaches, or difficulty focusing on near objects? You may have convergence insufficiency—a condition where the eyes struggle to work together for close-up tasks like reading and screen use.

Targeted exercises can help strengthen eye coordination and improve visual comfort. Pencil Push-ups train the eyes to converge by slowly moving a pencil toward the nose. Jump Convergence builds flexibility by switching focus between near and far objects. The Remy Dot Card and Brock String exercises enhance alignment and improve the ability of the eyes to work together. For a more advanced challenge, the Cat Stereogram uses 3D images to enhance depth perception and convergence skills.

With consistent practice, these exercises can reduce symptoms and improve your ability to focus on everyday tasks. Early intervention can make a significant difference in eye health and overall visual function.

Education

ABSTRACT ID: 548
LID HYGIENE TUTORIAL

Lee Yijing[1], Lee YJ[1], Rohana bt Taharin[1], Tan SY[1]

[1]Hospital Bukit Mertajam

Purpose

To improve patient's lid hygiene technique, reduce cataract surgery cancellation due to meibomianitis.

Brief Summary

Meibomianitis and blepharitis are associated with dry eye disease and higher risk of postoperative endophthalmitis after cataract surgery. It is the leading cause of postponement of cataract surgery in our center. Live demonstration of lid hygiene technique during clinic consultation is time-consuming, yet information is poorly retained by patients. We created a simplified video to demonstrate the proper steps of lid hygiene, which can be viewed by patients and their care-takers while carrying out lid hygiene at home. This video is available in three languages (english, malay and chinese).

Surgical Procedures

ABSTRACT ID: 37
MANAGING DESCEMATOCELE & CORNEAL PERFORATIONS IN RESOURCE-LIMITED SETTINGS: THE ROLE OF TENON PATCH GRAFTS

Wai Yong Zheng[1], Nurhayati Abdul Kadir[1], Chiang Wai Seng[1], Elicia Chieng Tze Zhing[2], Ibtihal Bayaanah Iskandar[3], Chong Kar Yong[4]

[1]Hospital Duchess of Kent Sandakan; [2]Universiti Malaya; [3]Universiti Sains Malaysia; [4]Hospital Sultanah Aminah

Purpose

Tenon patch grafts are a valuable technique for managing descemetocele or corneal perforation, especially in settings with limited access to amniotic membranes or corneal grafts. This video presents two cases where tenon patch grafts successfully salvaged the globe in a district hospital with constrained resources.

Brief Summary

The first case involves a descemetocele following pterygium excision. Due to resource limitations, a tenon patch graft was used, with surgical steps demonstrated in the video. The patient recovered without complications, and a 1-year follow-up revealed complete healing with the graft intact. The second case features a 2mm corneal perforation from a corneal ulcer at a previous phacoemulsification wound. A tenon patch graft was applied, resulting in conjunctivalization and ulcer healing with topical antibiotics. At 6 months post-op, the globe remained intact with residual astigmatism.

These cases highlight tenon patch grafts as an effective alternative for ophthalmologists in resource-limited settings.

ABSTRACT ID: 154

CHALLENGES AND COMPLICATIONS OF MACULA-SPARING TEMPORAL INTERNAL LIMITING MEMBRANE FLAP TECHNIQUE IN MACULAR HOLE REPAIR

Subasni Sukumaran[1], Wan Haslina Wah[1], Mlc Bastion[1]

[1]Hospital Canselor Tuanku Muhriz Ukm

Purpose

The purpose of this video submission is to highlight the key difficulties encountered during the macula-sparing temporal Internal Limiting Membrane (ILM) flap technique in macular hole surgery.

Brief Summary

The temporal flap technique, often employed for macular hole closure involves repositioning retinal tissue from the temporal retina to cover the hole. While this method has been proven effective, failure can occur due to several factors. This video demonstrates macula hole repair surgery underwent by two patients with full thickness macula hole. We detail the surgical steps undertaken, including flap creation and placement, and the potential drawbacks that contributed to unsuccessful outcome, such as inadequate flap positioning and tissue apposition. Clinicians can enhance surgical results and reduce visual impairment in patients having macular hole repair by understanding these failure mechanisms. We hope that this video will offer insights and suggestions that will help surgeons refine their approach to this technique.

ABSTRACT ID: 205

LENTICULAR NEEDLESTICK : CATARACT SURGERY PEARLS FOR POSTERIOR CAPSULAR INJURY IN PATIENTS AFTER INTRAVITREAL INJECTION

Mohamad Azlan Bin Zaini[1], Mohamad Azlan Zaini[2], Mae-Lynn Catherine Bastion[2]

[1]National University of Malaysia Medical Centre; [2]Hospital Canselor Tuanku Muhriz National University of Malaysia

Purpose

To demonstrate a step-by-step approach to safely perform cataract surgery in patients with posterior capsule injury following intravitreal injection

Brief Summary

Posterior capsule (PC) injury is a rare but significant complication following intravitreal injection. This video presents two cases of suspected PC injury post-injection, each requiring a different surgical approach. The first case, an undetected preoperative PC injury, resulted in posterior capsule rupture with a tilted lens during hydrodissection, necessitating conversion to extracapsular cataract extraction with sulcus intraocular lens implantation. The second case, where PC injury was identified preoperatively at the slit-lamp, was managed by a polar cataract approach, allowing successful completion of surgery without complications. This video highlights the importance of early detection of PC injury post IVT injection, the risks that can arise during surgery, and the preventative measures that can be applied to ensure safe surgery and better visual outcomes postoperatively.

ABSTRACT ID: 245
CAIRS SEGMENT SUCCESS: QUICK FIX TRICKS

Keziah Mary Thomas[1], J K Reddy[1], Vandhana Sundaram[1]

[1]Sankara Eye Hospital

Purpose

In this video, we present two effective tricks to simplify the insertion of allogenic intrastromal ring segments, aimed at reducing surgical time and easing the learning curve for novice surgeons.

Brief Summary

First,we dehydrate the segment.After segment preparation, it is air-dried for 45 minutes. The cornea is composed of approximately 78% water by volume, dehydration makes it more compact and stiffer like a PMMA segment. This enhanced stiffness facilitates smoother insertion. Additionally, this method allows for the insertion of thicker segments, which is particularly useful when a greater degree of corneal flattening is required. Then we use a corkscrew lamellar dissector to aid in further entry of segment into the stromal channel. After dehydration, the segment is placed on dry recipient corneal surface and gently pushed into the prepared stromal channel with a sinkey hook. Once the segment enters the channel, lamellar dissector assists in further advancement of segment to position.

ABSTRACT ID: 319

ANTERIOR SEGMENT RECONSTRUCTION OF TRAUMATIC OCULAR PENETRATING INJURY: A COMBINED SCLERAL FIXATED INTRAOCULAR LENS IMPLANTATION , IRIDOPLASTY AND PENETRATING KERATOPLASTY

Alene Liu Wan Yi[1], Lam Cs[1,2], Wan Haslina Wah[1,2], Mazaya M[1,2,3]

[1]Hospital Cancelor Tuanku Muhriz; [2]University Kebangsaan Malaysia; [3]Universiti Putra Malaysia

Purpose

To report successful case of concurrent scleral-fixated intraocular lens (IOL) implantation, iridoplasty and penetrating keratoplasty in post-traumatic anterior segment reconstruction surgery

Summary

A 69-year-old male sustained severe ocular trauma from a glass pot explosion, resulting in penetrating injury, intraocular foreign body and iris tear in his pseudophakic right eye. Primary corneal repair performed, followed by trans pars plana vitrectomy and intraocular foreign body removal.

six months postoperatively, secondary intervention was performed to restore vision. The subluxated PCIOL was explanted and replaced with scleral fixation of three-piece polyvinylidene fluoride (PVDF) IOL using the Yamane technique, followed by pupilloplasty and penetrating keratoplasty. The patient achieved best-corrected visual acuity of 6/12 at six months postoperatively.

This case highlights the complexity of anterior segment trauma and its reconstruction for the purpose of visual rehabilitation. It underscores the importance of a staged approach to achieving optimal anatomical and functional outcomes in traumatic ocular injuries.

ABSTRACT ID: 325

VISUAL RESTORATION SURGERY IN POST ANTERIOR SEGMENT TRAUMA EYE : A CASE OF COMBINED PENETRATING KERATOPLASTY AND SCLERAL FIXATED IOL

Aiman Ifwat Bin Samsolbari[1], Ap Wan Haslina Wan Abdul Halim[12], Mazaya Binti Mahmud[3]

[1]Universiti Kebangsaan Malaysia; [2]Hospital Canselor Tuanku Muhriz; [3]Universiti Putra Malaysia

Purpose

to present the steps of visual restoration surgery in an eye post anterior segment trauma with corneal scar and Aphakia.

Brief Summary

This is a patient post penetrating trauma who sustained corneal scar and aphakia. Primary suturing was initially performed with subsequent corneal scar with surgically indunced astigmatism and aphakia. He underwent combined penetrating keratoplaty (PK) and secondary Intraocular lens (IOL) implantation. The video highlights the challenges in scleral fixated IOL implantation in an opacified cornea.

Prior anterior capsular removal and anterior vitrectomy was performed visually assisted with triamcinolone acetate. The IOL implantation was done under partially trephined cornea. And was fixated to the sclera using Yamane method.

Surgical steps are presented and described in the video with post operative anterior segment image and visual outcome attached.

ABSTRACT ID: 393

PIECING TOGETHER THE PUPIL: SURGICAL TRIUMPH IN TRAUMATIC CATARACT WITH IRIDODIALYSIS

Gurpreet Singh[1], Anil Solanki[1], Nikita Dash[1]

[1]Sir Ganga Ram Hospital,New Delhi

Purpose

To demonstrate a comprehensive surgical approach for managing a complex case of traumatic cataract with vitreous prolapse and iridodialysis in a high myope, aiming to restore anatomical integrity and improve visual function.

Brief Summary

A 35-year-old female patient,high myope, presented with decreased vision and photophobia in the right eye after blunt trauma. Slit-lamp examination revealed a traumatic cataract with iridodialysis measuring 1-2 clock hours at 11-1 o'clock position, 1 clock hour at 1-2 o'clock position and another at 4-5 o'clock position resulting in irregularly dilated pupil. Surgical intervention included lens extraction, pars plana vitrectomy with pupilloplasty. Postoperative visual and anatomical outcomes were assessed. This video highlights the stepwise surgical technique, intraoperative challenges, and key considerations for optimizing patient outcomes in similar complex trauma cases.

ABSTRACT ID: 464

POSTERIOR CAPSULAR RENT AFTER SINGLE PIECE INTRAOCULAR LENS IMPLANTATION: HOW TO MANAGE WITHOUT MAKING MORE MESS?

Kee Tze Huei[1] , Rohanah Alias[1], Ooi Yong Lin[2]

[1]Hospital Kuala Lumpur; [2]Hospital Pulau Pinang

Purpose

To highlight technique of managing posterior capsular rent and intraocular lens exchange during phacoemulsification.

Brief Summary

This is a cataract surgery recording video showing the posterior capsule was ruptured by injector plunger during implantation of intraocular lens following an uneventful phacoemulsification. The intraocular lens was salvaged from dropping posteriorly, folded in the anterior chamber using a spatula and straight suture tying forceps, and then it was explanted carefully without having to extend the corneal wound or cut the intraocular lens. A three piece intraocular lens was then implanted in the sulcus with optic capture.

ABSTRACT ID: 501

RESCUING VISION: VITREORETINAL SURGERY FOR NUCLEUS DROP POST-CATARACT SURGERY

Muhammad Faiz Bin Nordin[1], Abdul-Hadi Rosli[1], Aidila Jesmin Jabari[1]

[1]International Islamic University Malaysia

Purpose

To highlight the surgical intervention for nucleus drop following complicated cataract surgery.

Brief Summary

A 76-year-old man with diabetes mellitus and hypertension was referred to the vitreoretinal team for nucleus drop following complicated cataract surgery for Morgagnian cataract. He underwent trans pars plana vitrectomy, lens fragmentation, sulcus intraocular lens implantation, and surgical peripheral iridectomy. Intraoperatively, the entire nucleus was found resting on the posterior pole. Trans pars plana vitrectomy was performed and posterior vitreous detachment was induced. Subsequently, nucleus was removed using a fragmatome. No retinal break, tear, or detachment seen. A sulcus intraocular lens was implanted, and a surgical peripheral iridecomy was performed at 11 o'clock. Postoperatively, serial follow-ups showed significant visual improvement from hand movements to a best-corrected visual acuity of 6/9.

ABSTRACT ID: 502

FROM DETACHMENT TO RECOVERY: SURGICAL REPAIR OF TOTAL RHEGMATOGENOUS RETINAL DETACHMENT

Muhammad Faiz Bin Nordin[1], Abdul-Hadi Rosli[1], Aidila Jesmin Jabari[1]

[1]International Islamic University Malaysia

Purpose

To highlight the vitreoretinal intervention for total rhegmatogenous retinal detachment (RRD).

Brief Summary

A 57-year-old man with underlying hypertension presented with sudden, painless blurring of vision in the right eye for six days, preceded by heavy weight lifting. Best corrected visual acuity was 6/120 OD and 6/9 OS. Anterior segment examination revealed a nasal grade 2 pterygium. Right fundus showed total RRD with macula off, and proliferative vitreoretinopathy (PVR) grade B. Multiple retinal tears were seen at 2, 10, and 12 o'clock. He underwent trans pars plana vitrectomy, endolaser, cryotherapy, drainage of subretinal fluid and 14% C3F8 tamponade. Intraoperatively, vitrectomy was performed and retinal reattached successfully. Postoperatively, serial follow-ups confirmed retinal reattachment, with a best-corrected visual acuity of 6/60.

ABSTRACT ID: 526

BEYOND SIGHT: SURGICAL APPROACH TO GLOBE PRESERVATION IN SEVERE OCULAR TRAUMA

Sahel Akmal bin Che Mohd Hazidi[1], Khairul-Anwar Ibrahim[1], Abdul-Hadi Rosli[1], Khairidzan Mohd Kamal[1]

[1]International Islamic University Malaysia, Pahang

Purpose

To illustrate a surgical approach aimed at preserving globe integrity in a young patient with a perforated cornea and anteriorly dislocated lens.

Brief Summary

A 16-year-old Orang Asli girl presented with a history of right eye trauma due to an alleged foreign body insertion. Examination under anaesthesia (EUA) confirmed corneal perforation with an anteriorly dislocated lens. Surgical intervention was performed to extract the dislocated lens, assess the corneal wound, and reinforce structural integrity using a scleral patch graft. The procedure prioritized stabilizing the eye to prevent further complications, including phthisis bulbi. This video highlights key surgical techniques, intraoperative challenges, and considerations in managing severe ocular trauma in a young patient. Early intervention and meticulous surgical planning were crucial in preserving the eye globe and preventing long-term morbidity.

ABSTRACT ID: 527

CLEARING THE HAZE: DUAL STRATEGY OF PHACOEMULSIFICATION AND VITRECTOMY IN PERSISTENT VITREOUS HEMORRHAGE CASE

Sahel Akmal bin Che Mohd Hazidi[1], Abdul-Hadi Rosli[1], Aidila Jesmin Jabbari[1]

[1]International Islamic University Malaysia, Pahang

Purpose

To demonstrate a combined phacoemulsification and vitrectomy approach in managing persistent vitreous hemorrhage in proliferative diabetic retinopathy.

Brief Summary

A 68-year-old patient with bilateral proliferative diabetic retinopathy and persistent vitreous hemorrhage in the right eye underwent phacoemulsification with intraocular lens (IOL) implantation, trans pars plana vitrectomy (TPPV), endolaser photocoagulation, and intraocular gas tamponade. Phacoemulsification facilitated intraoperative visualization, while vitrectomy effectively cleared hemorrhage and stabilized the retina. Endolaser was applied to induce neovascular regression, followed by gas tamponade for retinal stabilization. This video highlights the stepwise execution of the procedure, emphasizing surgical precision in managing complex diabetic eye disease. The combined approach optimizes visual rehabilitation and reduces the risk of complications, demonstrating its effectiveness in similar cases.

ABSTRACT ID: 572

THE AINUR METHOD: SINGLE INCISION, NO DEHYDRATION CAIRS TECHNIQUE

Ainur Rahman bin Anuar[1], Fatimah Az-Zahra binti Shukran Jamil[1]

[1]Ara Damansara Medical Centre

Purpose

This video demonstrates the femtosecond laser-assisted Corneal Allogenic Intrastromal Ring Segment (CAIRS) technique, known as "The Ainur Method," for the insertion of KeraNatural implants.

Brief Summary

The procedure is performed through a single incision, eliminating the need for two incisions traditionally used in the process. This approach significantly reduces surgery time by avoiding dehydration of corneal tissue. The technique utilizes KeraNatural implants from VisionGift, which are made from sterilized donor corneal tissue. This streamlined method enhances efficiency while maintaining the effectiveness of the traditional CAIRS procedure. The video highlights the simplicity and speed of the technique, offering an alternative for improving corneal shape and visual outcomes in patients with keratoconus. The Ainur Method promises to optimize the CAIRS procedure, reducing time and complexity for both the surgeon and the patient.

www.myjo.org

Malaysian Journal of Ophthalmology