ment in VA. As there was no apparent direct trauma to the eye, the mechanism of injury is presumed to be blunt force transmitted to the retina attributable to rapid deceleration of ocular tissues. Previous investigations using fluorescein angiography have shown no abnormality.[1] Goldmann perimetry has found an absolute central scotoma. Multifocal ERG has shown reduced amplitudes in traumatic maculopathy.[3] OCT has demonstrated that the abnormality in acute traumatic maculopathy consists of swelling of the outer retina, with preservation of inner retinal structure including the foveal pit. The second case (Figure 2, Bottom) suggests the presence of neurosensory retinal detachment at the fovea. This is not clearly displayed in the first case (Figure 2, Top). Higher resolution OCT imaging may provide more information on the interpretation of the low signal triangular area at the fovea. We are not aware of previous reports showing these OCT findings in cases of acute traumatic maculopathy.

THE AUTHORS INDICATE NO FINANCIAL SUPPORT OR FINANCIAL conflict of interest in this study. Involved in design and study (T.Q.P.); Involved in collection, management, analysis and interpretation of data, and preparation of the data (T.Q.P., B.C.); Involved in collection of data (T.Q.P., B.C.); and involved in management, statistical analysis and interpretation of the data, and preparation of the manuscript (T.Q.P., B.C., M.G., P.M.).

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A Self-stabilizing Lens Ring for 25-Gauge Vitrectomy Surgery

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PURPOSE: **To design an improved self-stabilizing lens ring for 25-gauge vitrectomy.**
DESIGN: **Device report.**
METHODS: **A lens ring was designed to be fixated to the globe using 25-gauge transconjunctival cannulas.**
RESULTS: **This ring consists of a single plastic component with multiple concavities at the ring margin to fit 25-gauge cannulas. The ring can accommodate conventional standard and panoramic vitrectomy lenses.**

Supplemental Video available at AJO.com

Accepted for publication Sept 12, 2006.
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CONCLUSIONS: **A lens ring has been designed for 25-gauge vitrectomy and to hold conventional contact lenses. Stability of the lens ring is achieved without the need for sutures and instead is achieved by the three point fixation provided by the existing 25-gauge cannula system.** **(Am J Ophthalmol 2007;143:350–351.** **© 2007 by Elsevier Inc. All rights reserved.)**

SELF-STABILIZING LENS RINGS AND VITRECTOMY CONtact lenses with integrated footplates are available.[1] The disadvantage of these lens systems is that they float on the surface of the cornea and so are easily displaced from the visual axis when the eyeball is tilted or when there is contact with the lid margin or lid speculum. The greater mass of panoramic contact lenses increases this tendency for displacement. Lens rings, which are sewn onto the eyeball, are more stable but require the additional step of suturing, which can produce subconjunctival hemorrhages in what would otherwise be a white eye after 25-gauge vitrectomy.

We describe a new lens ring designed to be secured by the cannulas inserted through the sclera used in 25-gauge vitrectomy. The lens ring is machined from clear or black Delrin and is autoclavable. It is designed with 12 concavities at the ring margin (Figure 1). Each concavity is designed to fit a 25-gauge cannula when the cannula is inserted 3.5 mm posterior to the limbus of the average cornea (Figure 2). The lens ring is anchored at three points by the close fit between the cannulas and the concavities of the ring. The clarity of a clear lens ring material allows the vitrectomy surgeon to recognize a smaller or larger cornea and to adjust accordingly. The ring is designed to hold conventional panoramic or direct viewing vitrectomy lenses made by Ocular Instruments, Inc, Bellevue, Washington, USA, Alcon Grieshaber A.G., Schaffhausen, Germany, or Volk Optical, Inc, Mentor, Ohio, USA.

In clinical use, we have found that this ring provides considerable stability of the contact lens system and maintenance of visualization even when top heavy panoramic contact lens are used or when scleral depression is used for vitreous based dissection (see Supplemental Video available at AJO.com) illustrates this stability. The patient's head should be positioned so that the ring does not contact the lid margin or lid speculum, which may cause displacement of the ring despite fixation by the 25-gauge cannulas. I now use this ring extensively for 25-gauge pars plana vitrectomy and use it exclusively for posterior pole surgery such as macular hole surgery, macular pucker surgery, vein sheathotomy, and submacular surgery. In cases which require scleral depression, there should be enough clearance between edge of this ring and the lid speculum or lid margin to accommodate the scleral depressor without touching the ring. This new ring offers the convenience and excellent postoperative clinical appearance of floating lens rings

FIGURE 1. Self-stabilizing lens ring. The ring consists of a single plastic component with multiple concavities at the ring margin. Twenty-five gauge transconjunctival cannulas fit within the concavities to provide stable three point fixation.

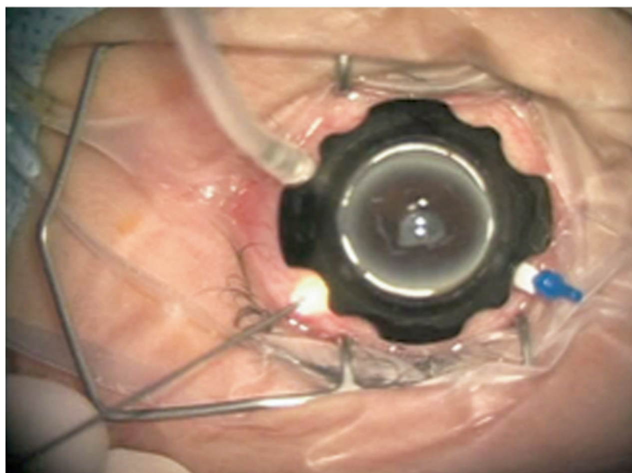

FIGURE 2. Self-stabilizing lens ring on eye of patient undergoing 25-gauge pars plana vitrectomy.

and the stability of a sutured contact lens in an autoclavable package. This ring is currently being considered for manufacture and distribution by an ophthalmic device manufacturer.

THE AUTHORS INDICATE NO FINANCIAL SUPPORT OR financial conflict of interest in this study. Involved in design of study (L.P.C., M.M., C.D.B., A.B.); Involved in collection, management, analysis and interpretation of data, and preparation of the data (L.P.C., M.M., C.D.B., A.B.); Involved in collection of data (L.P.C., M.M., C.D.B.); and involved in management, statistical analysis and interpretation of the data, and preparation of the manuscript (L.P.C.).

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Choroidal Detachment Following the Use of Tamsulosin (Flomax)

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PURPOSE: To report choroidal detachment following tamsulosin (Flomax, an α_{1A}-adrenoceptor antagonist) treatment of benign prostatic hyperplasia (BPH).
DESIGN: Case report.
METHODS: Chart review, serial examination.
RESULTS: A 65-year-old man underwent uncomplicated cataract extraction and placement of a posterior chamber intraocular lens. The patient subsequently developed three separate episodes of choroidal detachments in the operated eye. Each episode was preceded by treatment with an α_1-adrenoceptor antagonist.
CONCLUSIONS: Tamsulosin may cause adverse ocular effects including recurrent choroidal detachments. α_{1A} is the dominant α-adrenoceptor in the rabbit choroid, and the mechanism for choroidal detachment in this patient could include some effect of antagonists like tamsulosin on these receptors. (Am J Ophthalmol 2007;143: 351–353. © 2007 by Elsevier Inc. All rights reserved.)

TAMSULOSIN (FLOMAX) IS AN α_{1A}-ADRENOCEPTOR ANtagonist used to treat benign prostatic hyperplasia (BPH) in adult males.[1] Recently, Chang and associates linked tamsulosin (Flomax) treatment to intraoperative floppy iris syndrome (IFIS).[2] We present a case report of recurrent choroidal detachments in a patient using tamsulosin for BPH following uncomplicated cataract extraction. This brief report is in compliance with the University of California San Francisco Committee on Human Research guidelines and conforms to all Health Insurance Portability and Accountability Act (HIPAA) requirements.

A 65-year-old male with pinhole visual acuity of 20/60 OS (left eye) and intraocular pressure (IOP) 22 OS underwent uncomplicated cataract extraction with placement of a posterior chamber lens in the left eye. One week postoperatively, the patient's visual acuity improved to 20/25, and intraocular pressure (IOP) remained 22 OS. The patient subsequently developed three distinct episodes of left eye choroidal detachments, each following treatment by an α_1-adrenoceptor antagonist.

Accepted for publication Sept 12, 2006.
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