DESCRIPTION OF OPERATION:, The patient was brought to the operating room and appropriately identified. Local anesthesia was obtained with a 50/50 mixture of 2% lidocaine and 0.75% bupivacaine given as a peribulbar block. The patient was prepped and draped in the usual sterile fashion. A lid speculum was used to provide exposure to the right eye.,A limited conjunctival peritomy was created with Westcott scissors to expose the supranasal and, separately, the supratemporal and inferotemporal quadrants. Calipers were set at 3.5 mm and a mark was made 3.5 mm posterior to the limbus in the inferotemporal quadrant.,A 5-0 nylon suture was passed through partial-thickness sclera on either side of this mark. The MVR blade was used to make a sclerotomy between the pre-placed sutures. An 8-0 nylon suture was then pre-placed for later sclerotomy closure. The infusion cannula was inspected and found to be in good working order. The infusion cannula was placed in the vitreous cavity and secured with the pre-placed sutures. The tip of the infusion cannula was directly visualized and found to be free of any overlying tissue and the infusion was turned on.,Additional sclerotomies were made 3.5 mm posterior to the limbus in the supranasal and supratemporal quadrants. The light pipe and vitrectomy handpieces were then placed in the vitreous cavity and a vitrectomy was performed. There was moderately severe vitreous hemorrhage, which was removed. Once a view of the posterior pole could be obtained, there were some diabetic membranes emanating along the arcades. These were dissected with curved scissors and judicious use of the

vitrectomy cutter. There was some bleeding from the inferotemporal frond. This was managed by raising the intraocular pressure and using intraocular cautery. The surgical view became cloudy and the corneal epithelium was removed with a beaver blade. This improved the view. There is an area suspicious for retinal break near where the severe traction was inferotemporally. The Endo laser was used to treat in a panretinal scatter fashion to areas that had not received previous treatment. The indirect ophthalmoscope was used to examine the retinal peripheral for 360 degrees and no tears, holes or dialyses were seen. There was some residual hemorrhagic vitreous skirt seen. The soft-tip cannula was then used to perform an air-fluid exchange. Additional laser was placed around the suspicious area inferotemporally. The sclerotomies were then closed with 8-0 nylon suture in an X-fashion, the infusion cannula was removed and it sclerotomy closed with the pre-existing 8-0 nylon suture.,The conjunctiva was closed with 6-0 plain gut. A subconjunctival injection of Ancef and Decadron were given and a drop of atropine was instilled over the eye. The lid speculum was removed. Maxitrol ointment was instilled over the eye and the eye was patched. The patient was brought to the recovery room in stable condition.