TITLE OF OPERATION:,1. Pars plana vitrectomy.,2. Pars plana lensectomy.,3. Exploration of exit wound.,4. Closure of perforating corneal scleral laceration involving uveal tissue.,5. Air-fluid exchange.,6. C3F8 gas.,7. Scleral buckling, right eye.,INDICATION FOR SURGERY: , The patient was hammering and a piece of metal entered his eye 1 day prior to the procedure giving him a traumatic cataract corneal laceration and the metallic intraocular foreign body was lodged in the posterior eye wall. He undergoes repair of the open globe today.,PREOP DIAGNOSIS: , Perforating corneal scleral laceration involving uveal tissue with traumatic cataract and metallic foreign body lodged in the posterior eye wall, right eye.,POSTOP DIAGNOSIS: , Perforating corneal scleral laceration involving uveal tissue with traumatic cataract and metallic foreign body lodged in the posterior eye wall, right eye.,ANESTHESIA:, General.,SPECIMEN:, None.,IMPLANTS:,1. Style number XXX silicone band reference XXX , lot number XXX , exploration 11/13.,2. Style number XXX Watzke sleeve reference XXX , lot number XXX , exploration 04/14.,PROCEDURE: , The risk, benefits, and alternatives to the procedure were reviewed with the patient and his wife. All of their questions were answered. Informed consent was signed. The patient was brought into the operating room. A surgical time-out was performed during which all members of the operating room staff agreed upon the patient's name, operation to be performed, and correct operative eye. After administration of general anesthesia, the patient was intubated without incident.,The right eye was

prepared and draped in the usual fashion for ophthalmic surgery. A wire lid speculum was used to separate the eyelids of the left eye. A 9 o'clock anterior chamber paracentesis was created with Supersharp blade and the anterior chamber was filled with Healon. The clear corneal incision was superior to the visual axis and was closed with three interrupted 10-0 nylon sutures with the knots buried. A standard three-port pars plana vitrectomy _____ was initiated by performing partial conjunctival peritomies in the superonasal, superotemporal, and inferotemporal quadrants with Westcott scissors. Hemostasis was achieved with bipolar cautery. A 7-0 Vicryl suture was preplaced in the mattress fashion, 3 mm posterior to the surgical limbus in the inferotemporal quadrant. A microvitreoretinal blade was used to create a sclerotomy at this site and a 4-mm infusion cannula was introduced through the sclerotomy and tied in place with the aforementioned suture. The presence of the tip of the cannula was confirmed to be within the vitreous cavity prior to initiation of posterior infusion. Two additional sclerotomies were created superonasally and superotemporally, 3 mm posterior to the surgical limbus with microvitreoretinal blade.,The vitreous cutter was used to perform the pars plana lens actively preserving peripheral anterior capsule. The pars plana vitrectomy was performed with the assistance of the BIOM non-contact lens indirect viewing system using the light pipe illuminator and the vitreous cutter. The vitreous was trimmed to the vitreous base. A posterior vitreous detachment was created and extended 360 degrees with the assistance of

triamcinolone for staining.,The foreign body appeared to exit the posterior pole along the superotemporal arcade and apparently severed a branched retinal artery resulting in an area of macular ischemia with retinal whitening along its course. The exit wound was explored. No intraocular foreign body or mural foreign body was observed with the assistance of intraocular forceps. The intraocular magnet was then inserted through the sclerotomy and no foreign body was again identified.,An air-fluid exchange was performed with the assistance of the soft-tip extrusion cannula and the retinal periphery was examined with scleral depression. No retinal breaks or defects were noted in the periphery. The plugs were placed in the sclerotomies and the conjunctival peritomy was extended at 360 degrees. Each of the rectus muscles was isolated on a 2-0 silk suture and a #XXX band was threaded beneath each of the rectus muscle and fixed to itself in the inferonasal quadrant with the Watzke sleeve. The buckle was sutured to the eye wall with 5-0 Mersilene sutures in each quadrant in a mattress fashion. The buckle was trimmed and the height of the buckle was inspected internally and noted to be adequate.,Residual intraocular fluid was removed with a soft-tip extrusion cannula and the sclerotomies were closed with 7-0 Vicryl sutures. A 12% concentration of C3F8 gas was flushed through the eye. The infusion cannula was removed and the sclerotomy was closed with the preplaced 7-0 Vicryl suture. All of the sclerotomies were noted to be airtight. The intraocular pressure following injection of 0.05 mL each of vancomycin (0.5 mg) and ceftazidime (1 mg) were injected

through the superotemporal pars plana, 30-gauge needles.,The conjunctiva was closed with 6-0 plain gut sutures with the knots buried. Subconjunctival injections of Ancef and Decadron were delivered inferotemporally. The lid speculum was removed. Pred-G ointment and atropine solution were applied to the ocular surface. The eye was patched and shielded, and the patient was returned to the recovery room in stable condition, having tolerated the procedure well. There were no complications.,I was the attending surgeon, was present and scrubbed for the entirety of the procedure.