

This is not a Hypopyon!

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IMAGE IN MEDICINE

We report the case of a 42-year-old patient operated on for retinal detachment with advanced vitreoretinal proliferation (PVR) and stage 4 macular hole in the right eye. He underwent vitrectomy, PVR membrane peeling, internal limiting artery ablation, endolaser, and silicone oil tamponade. The immediate postoperative course was uneventful. Six months after surgery, the patient consulted for progressive decreases in visual acuity of the right eye. Ophthalmologic examination revealed uncorrected visual acuity reduced to hand movements. Ocular tone was 27 mmHg. Examination of the adnexa was unremarkable. Slit-lamp examination of the anterior segment revealed a silicone emulsion in the anterior chamber in suspension, obscuring half of the pupil, forming an inverse pseudohypopyon or silicone hyperoleon. The fundus was inaccessible. Examination of the contralateral eye was normal. The treatment consisted of anterior chamber lavage with silicone oil suction.

Intraoperative monitoring of the posterior segment showed a reattached retina, and ocular tone quickly normalized. Silicone oil removal is therefore the essential therapeutic measure for this complication of internal silicone oil tamponade.

Inverse hypopyon can form when the silicone oil used during viroretinal surgery becomes emulsified and enters the anterior chamber of the eye. The silicone oil floats in the aqueous humor to resemble a layered hypopyon in the upper part of the anterior chamber. Compare to the hypopyon where the leukocytes precipitate to the bottom of the anterior chamber; and this is due to the effect of gravity, hence the name inverse hypopyon. Treatment is based on washing the anterior chamber and suctioning out the silicone oil.



Figure 1: Appearance of emulsified silicone oil in the anterior chamber in reverse hypopyon

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