Urrets-Zavalia syndrome after deep anterior lamellar keratoplasty

Sindrom Urets-Zavalia nastao posle duboke prednje lamelarne keratoplastike

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Abstract

Introduction. Urrets-Zavalia syndrome is an uncommon complication of the deep anterior lamellar keratoplasty in keratoconus. The manifestations of this syndrome are an irreversible mydriasis, iris atrophy and secondary glaucoma.

Case report. Deep anterior lamellar keratoplasty was done for keratoconus with a presumably healed corneal hydrops in a 21-year-old Caucasian man. The graft remained clear, but the surgery was complicated by a fixed, dilated pupil, patches of iris atrophy, ectropium of the iris pigment layer and glaukomflecken in the lens. Conclusion. Although safer than penetrating keratoplasty, the deep anterior lamellar corneal transplantation is not devoid of complications. Urrets-Zavalia syndrome can be avoided by not trying to secure an unhealed Descemet's membrane with air. Instead, a new Descemet's membrane transplanted within a penetrating graft is a safer choice.

Key words: corneal transplantation; keratoconus; postoperative complications; syndrome.

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tion, a small scar was noted at the site of a presumably healed Descemet’s membrane (Figure 1) and a drop of aqueous protruded through a microperforation (Figure 2). An air-bubble injected into the anterior chamber enabled the removal of the remaining stroma and suturing an 8.0 mm graft with 16 interrupted 10-0 nylon sutures. Intravenous infusion of 100 mL 10% mannitol was started. Two hours later, approximately half of the bubble was aspirated, and the balanced salt solution was added. Dexamethasone and gentamycin were injected subconjunctivally at the end of surgery. Carbonic anhydrase inhibitor (acetozolamide, 500 mg) was given per os two hours after surgery. Intraocular pressure was checked digitally twice during the afternoon, and estimated to be normal. Another infusion of 100 mL 10% mannitol was given intravenously two hours before bedtime in order to prevent acute glaucoma during the night.

On the first postoperative day, the graft was clear, Descemet’s membrane was attached, intraocular pressure was 19 mmHg, and the pupil was round, about 4 mm in diameter. It reacted to light, but less promptly and completely as did the pupil in the intact eye. There was still a small air bubble in the anterior chamber. On the second postoperative day, the pupil was fixed and dilated, with uveal ectropium from 10–2 o’clock, and glaukomflecken in the lens (Figure 3). The therapy with 1% pilocarpin did not constrict the pupil. During the following two weeks, patches of iris atrophy became visible, but the intraocular pressure was never higher than 19 mmHg. At three months follow-up, intraocular pressure was 16 mmHg, correction for astigmatism $2.25 \times 120$, and BCVA was 20/50. These findings remained stationary during the following three months.

**Fig. 1 – A scar at the site of presumably healed Descemet’s membrane.**

**Fig. 2 – A drop of aqueous protruding through the unhealed microperforation in the Descemet’s membrane.**

**Fig. 3 – Fixed, dilated pupil, ectropium of the iris pigment layer, pathches of iris atrophy and glaukomflecken in the lens.**

**Discussion**

The presented patient developed all classic signs of UZS, except for the late secondary glaucoma from angle closure by peripheral synechiae. Yet, the patient might have got it after the follow-up period. The influence of mydriatics and cycloplegics on the irreversible mydriasis in this case can be excluded, as the patient did not receive any of these drugs either pre- or postoperatively. Also, we have no data to sup-
port other etiologies of UZS, proposed in the older literature: abnormal reaction of the dilator musculature of the iris 10, or a paralysis of parasympathetic nerves 11.

The trigger for the pathophysiological mechanism of UZS in this case seems to be an acute raise of intraocular pressure due to the pupillary block by air bubble during the first postoperative night, in spite of the therapy with mannitol and carbonic anhydrase inhibitor. *Glaukomflieken* in his lens are “the smoking gun” of acute glaucoma. The location of the patches of iris atrophy seems to correspond to the position where the air bubble exerted its pressure on the iris longer than elsewhere. This fits into the fluorescein and indocyanine green anterior segment angiography findings of ischemia of the iris 12. Although there are still cases of inexplicable etiology of UZS, like its development in only one eye after a bilateral trabeculectomy 13, and a postoperative IOT of 19 mmHg, a recent retrospective study points to a rise of postoperative IOT as a serious indicator of an imminent UZS 14. Even stronger confirmation of the significance of the pupillary block comes from a sudden rise of UZS after the use of air, gas or phakic intraocular lenses 9,15–17. Finally, two recent papers report more cases of UZS after DALK for various indications than the complete previous literature 8,9. A constant event in these cases is a prolonged presence of an air bubble in the anterior chamber in order to seal a microperforation of Descemet membrane. Antiglaucoma medications and/or iridectomy, do not seem to offer an absolute protection of UZS 13. Even if the pupillary block is not the sole explanation of the pathophysiology of UZS, it seems clear that its frequency is higher after a prolonged pressure of air on the iris 18.

**Conclusion**

Irreversible mydriasis, iris atrophy and secondary glaucoma (Urrets-Zavalia syndrome) are infrequent complications after DALK. Yet, the doom of the lasting effects of this syndrome should govern surgeons to lower the incidence of UZS by converting to penetrating keratoplasty when corneal microperforation is evident, or even suspected.

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