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虹膜劈裂1例

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[摘　要] 患者因“左眼视物模糊20余年”就诊，20余年前曾行左眼小梁切除术，视力：右眼(oculus dexter，OD)无光感(no light perception，NLP)，左眼(oculus sinister，OS)光感(light perception，LP)光定位准确，右眼巩膜葡萄肿(鼻上)，前房浅约1/4 CT，瞳孔固定散大，晶状体脱位于玻璃体腔，左眼结膜上方滤过泡扁平，前房浅，约1/4 CT，虹膜层状分离漂浮于前房，上方虹膜切口引流通畅，C/D：0.4。眼压(intraocular pressure，IOP)示：右眼13.0 mmHg，左眼16.0 mmHg。超声生物显微镜(ultrasound biomicroscopy，UBM)示：右眼各象限前房角狭窄，晶体脱位；左眼前房浅，颞侧前房角狭窄，其余象限关闭，虹膜层状分离。B超示：右眼晶体脱离。诊断：左眼虹膜劈裂；右眼晶体脱位。

[关键词] 虹膜劈裂；虹膜角膜内皮综合征；继发性青光眼

A case of iridoshcisis

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Abstract The patient was treated with ‘left eye blurred vision for more than 20 years’. The patient underwent left trabeculectomy more than 20 years ago. Visual acuity oculus dexter (OD): no light perception (NLP), oculus sinister (OS): light perception (LP), and light positioning was accurate, right eye scleral staphyloma (nose), the anterior chamber was approximately 1/4 CT, the pupil was fixed and scattered, the lens was displaced into the vitreous cavity, and the left eye conjunctiva was filtered. The blister was flat, the anterior chamber was shallow, about 1/4 CT, and the iris layer was separated and floated in the anterior chamber. The upper iris incision led to smooth flow, C/D: 0.4. Intraocular pressure (IOP): R 13.0 mmHg, L 16.0 mmHg. Ultrasound biomicroscopy (UBM): in the right eye, anterior chamber angle was narrow in each quadrant, dislocation of the lens; anterior chamber of the left eye was shallow, anterior chamber angle of the temporal stenosis was narrow, the remaining quadrants were closed, iris lamellar separated. B-ultrasound: the right eye lens was displaced into the vitreous cavity. Diagnosis: left eye Iridoshcisis; right eye lens dislocation.

Keywords iridoshcisis; iridocorneal endothelial syndrome; secondary glaucoma

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虹膜劈裂临床上较为罕见，相关临床表现及诊断等报道较少，武汉爱尔眼科汉阳医院收治1例虹膜劈裂患者，现报告如下。

1 临床资料

患者，女，68岁，因“左眼视物模糊20余年”于2018年2月6日就诊于武汉爱尔眼科汉阳医院。患者20余年前曾行左眼小梁切除术，眼科查体：右眼(oculus dexter，OD)无光感(no light perception，NLP)，左眼(oculus sinister，OS)光感(light perception，LP)，光定位准确，右眼巩膜葡萄肿(鼻上)，角膜可见片状云翳，前房浅约1/4 CT，房水清，瞳孔固定散大，晶状体脱位于玻璃体腔，眼底模糊，隐约见视网膜色淡，血管闭塞，色素沉着(图1)，左眼结膜上方滤过泡扁平，角膜透明，前房浅，约1/4 CT，虹膜层状分离漂浮于前房，上方虹膜切口引流通畅，瞳孔光反应迟钝，晶体混浊(图2)，杯盘比(cup/disc ratio，C/D)：0.4。眼压(intraocular pressure，IOP)示：R 13.0 mmHg (1 mmHg=0.133 kPa)，L 16.0 mmHg。超声生物显微镜(ultrasound biomicroscopy，UBM)：右眼角膜混浊，各象限前房角狭窄，晶体脱位(图3)；左眼前房浅，颞侧前房角狭窄，其余象限关闭，虹膜层状分离，晶体混浊(图4)。B超：右眼晶体脱离，左眼玻璃体混浊。诊断：左眼虹膜劈裂；右眼晶体脱位。

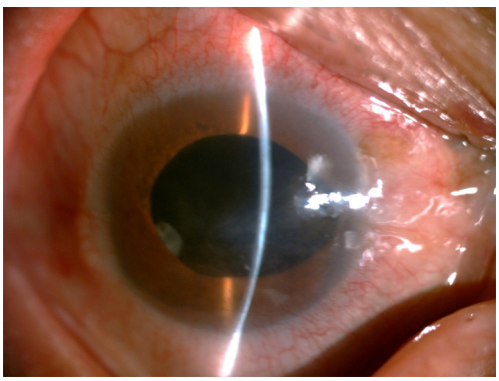

图1 右眼瞳孔散大，晶体缺如

Figure 1 The pupil of the right eye is separated dilated and the lens is absent

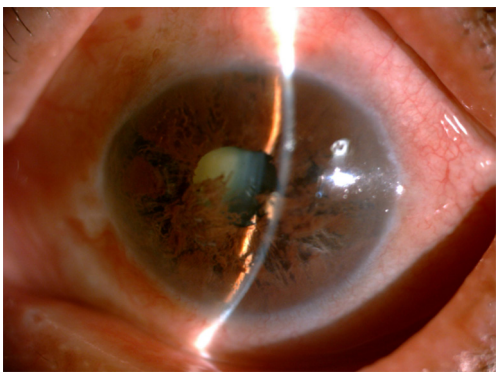

图2 下方虹膜层状分离漂浮于前房

Figure 2 The iris under the left eye is separated and floated in the anterior chamber

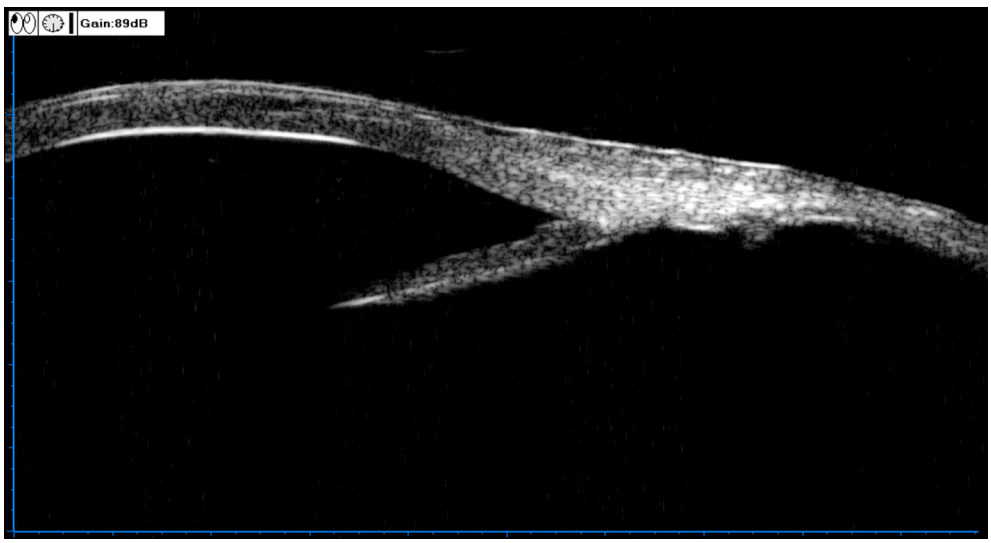

图3 右眼UBM示：右眼晶体脱位

Figure 3 UBM of right eye shows right eye lens dislocation

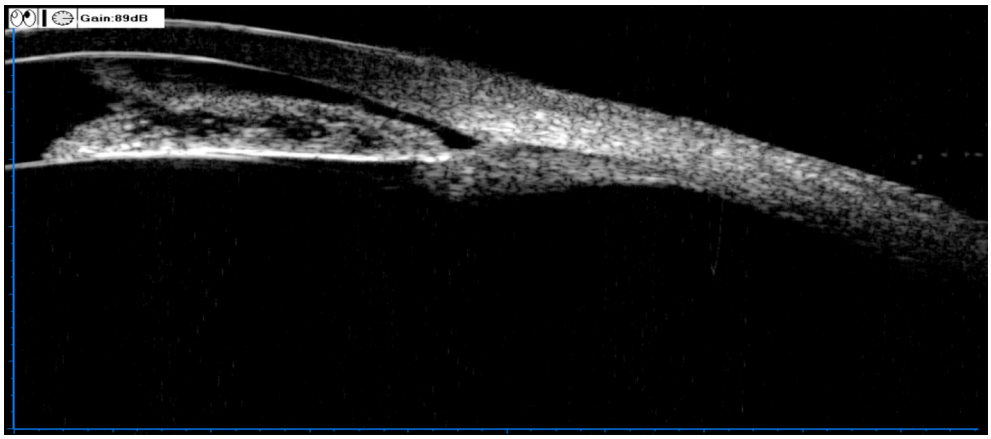

图4 左眼UBM示：左眼虹膜层状分离，房角狭窄

Figure 4 UBM of left eye shows left eye iris layered, narrow angle

2 讨论

虹膜劈裂症为罕见眼病，1922年Shcimit[1]首次描述，将其称为“虹膜分开”。1945年Loewenstein等[2]首次报告了虹膜劈裂症的病理学改变，并命名为“虹膜劈裂症”(Iridoshcisis)。目前临床上又将其称为“虹膜层裂”“虹膜层裂症”。本病65岁以上多见，单眼或双眼患病，多为双眼，无性别差异；病因不明，最初多数学者认为是虹膜基质层生理性老年性萎缩或血管闭塞性疾病，伴虹膜基质层退行性变[3-5]。而1988年Carnevalini等[6]使用虹膜荧光造影技术发现劈裂部位的虹膜血流灌注正常，否认了以往认为是缺血导致虹膜萎缩的观点。本病多表现为自发性的虹膜基质层碎裂、松解，分为2层，并漂浮于前房，多见于下方虹膜，瞳孔正常。

虹膜劈裂症应注意与虹膜角膜内皮综合征鉴别，前者主要见于65岁以上患者，常双眼发病，病因不明，角膜与虹膜接触部位可有水肿，虹膜基质层状分离，膨胀堵塞房角，瞳孔无明显改变，常继发闭角型青光眼及晶体半脱位，本病无需特殊治疗，主要是对症治疗；而后者主要见于30岁左右的女性，单眼发病，角膜广泛内皮细胞形态改变，密度降低，虹膜基质萎缩，周边虹膜前粘连，房角关闭，瞳孔常有移位变形，表现为“多瞳症”常继发闭角型青光眼，治疗主要为高渗剂、角膜接触镜、角膜移植、青光眼药物或手术治疗。

本例患者右眼晶体脱位于玻璃体腔，文献[7-8]中也报道过相同体征，可以考虑为虹膜劈裂的并发症，但本例患者右眼虹膜未表现出劈裂的典型体征，右眼是否诊断虹膜劈裂有待商榷，虽然虹膜劈裂常双眼发病，但也有单眼发病的报道[7,9]，其发病机制值得进一步深入研究。考虑到患者目前病情稳定，眼压正常，行白内障手术有可能造成角膜内皮损伤、虹膜损伤等并发症，且操作难度大，采取保守治疗。国外有研究[10]报道：白内障术中采用黏弹性眼科植入装置，注入前房，将病变的虹膜与手术区域阻隔，保证虹膜损伤尽可能减少，效果较好。还有研究[11]利用虹膜拉钩将病变虹膜固定，这都是不错的方法，希望未来能应用到虹膜劈裂合并白内障的手术中。

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