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Pseudophakic Rhegmatogenous Retinal Detachment: A Case Series at Sultan Ahmad Shah Medical Centre, Kuantan

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Abstract

Purpose: Pseudophakic rhegmatogenous retinal detachment (PRRD) is a sight-threatening condition and one of the most common emergency complications following cataract surgery, requiring prompt surgical intervention. This study aimed to describe the clinical and demographic characteristics of patients with PRRD who presented to the Ophthalmology Clinic at Sultan Ahmad Shah Medical Centre (SASMEC), Kuantan, Malaysia.

Materials and Methods: A retrospective case series was conducted at SASMEC. Electronic medical records from October 2022 to January 2025 were reviewed to identify patients diagnosed with PRRD. Demographic data, systemic and ocular comorbidities, presenting symptoms, axial length (AXL), management, and visual outcomes up to 12 months post-treatment were analysed.

Results: Five eyes from five male patients with a mean age of 61.4 years were included in the study. All cases involved macular detachment, with 80% affecting the right eye. Floaters were the most common presenting symptom (80%). All patients had systemic comorbidities, particularly diabetes mellitus, hypertension, and hyperlipidaemia. The mean AXL was 25.3 mm, with most patients demonstrating a long axial length (≥ 25 mm), a known risk factor for PRRD. Four patients underwent pars plana vitrectomy with internal tamponade, and all achieved improvement of at least two Snellen lines at 12 months postoperatively. One patient declined surgery and showed no visual improvement, maintaining poor vision. Only one postoperative complication was reported, which resolved following appropriate management.

Conclusions: PRRD is an uncommon but vision-threatening complication following cataract surgery. In this series, long axial length, male sex, and systemic comorbidities appeared to be associated risk factors. Prompt diagnosis and early surgical intervention were associated with better visual outcomes. Strengthening postoperative surveillance and patient education may help reduce PRRD-related visual loss in Malaysia.

Keywords: cataract, pseudophakic, rhegmatogenous retinal detachment, pseudophakic rhegmatogenous retinal detachment

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Introduction

Cataract is the leading cause of preventable blindness worldwide. It causes visual impairment that interferes with patients' daily activities and contributes significantly to the healthcare burden[1]. The definitive treatment for cataract is surgical removal of the opacified crystalline lens with implantation of an intraocular lens using various surgical techniques[2]. One of the sight-threatening complications following cataract surgery is rhegmatogenous retinal detachment (RRD), which occurs when the neurosensory retina separates from the underlying retinal pigment epithelium due to a retinal tear or hole[3]. Pseudophakic rhegmatogenous retinal detachment (PRRD) is a significant cause of visual loss and may lead to blindness if not treated promptly.

PRRD is a recognized complication following cataract surgery, with varying incidence rates reported worldwide. The incidence of retinal detachment after cataract surgery has been estimated at 0.6–1.7% during the first postoperative year and persists thereafter, with an overall incidence of approximately 0.7%[4]. In comparison, the incidence of RRD in the general population ranges from 0.0065% to 0.0179%, indicating that cataract surgery increases the risk of retinal detachment by at least fourfold[5]. Although PRRD is relatively uncommon, the overall number of cases remains substantial due to the large volume of cataract surgeries performed globally. Driven by an ageing population and increasing demand for cataract surgery, the pseudophakic population in the United States was projected to increase by nearly 60%, reaching approximately 9.5 million by 2020[6]. In Asia, a study conducted in Singapore reported a mean annual incidence of 10.5 per 100,000 population, with the highest age-adjusted incidence observed among Chinese individuals (11.6 per 100,000), followed by Malays (7.0 per 100,000) and Indians (3.9 per 100,000)[7]. To date, no published study has specifically explored PRRD in the Malaysian population.

The incidence of PRRD is associated with multiple risk factors[4,5,8]. Demographic factors such as age, sex, and ethnicity may significantly influence the risk of developing RRD following cataract surgery. Ocular risk factors include myopia, retinal detachment in the fellow eye, and proliferative diabetic retinopathy[4]. Additional contributing factors include long axial length (AXL)[5] and posterior vitreous detachment (PVD) with retinal breaks[8].

This study aimed to describe the demographic and clinical characteristics of PRRD following cataract surgery at Sultan Ahmad Shah Medical Centre (SASMEC) and to emphasize the importance of early diagnosis and treatment in reducing vision-threatening complications.

Materials and Methods

Study design

This was a retrospective case series conducted at SASMEC, Kuantan, Pahang, Malaysia. Data were collected from electronic medical records (EMR) between October 2022 and January 2025.

Participants

Patients diagnosed with PRRD were identified, and their medical records were reviewed through the EMR system. Inclusion criteria comprised patients diagnosed with PRRD within the study period who completed regular follow-up for at least 3 months post-treatment. Exclusion criteria included patients with RRD without prior cataract surgery, as well as those who underwent combined surgery involving vitrectomy, corneal surgery, or glaucoma surgery.

Data collection

Data were retrieved and reviewed from the EMR system using the keyword "pseudophakic rhegmatogenous retinal detachment". Collected variables included demographic characteristics (age, sex, and race), systemic and ocular comorbidities, presenting ocular symptoms, visual acuity at baseline and presentation, slit-lamp examination findings, AXL measurements, treatment modalities, and visual outcomes within the first 12 months after treatment. Post-treatment complications were also documented and analyzed.

This case series did not contain any personally identifiable information and therefore did not require institutional review board approval. Consequently, informed consent was not obtained.

Results

Case presentation

Case 1

A 65-year-old man with underlying hypertension presented with sudden-onset, painless reduced vision in the right eye (RE) six months after uncomplicated phacoemulsification with intraocular lens implantation. The visual loss was preceded by floaters. Visual acuity in the RE dropped from 6/6 to 2/60 upon presentation, while the left eye (LE) visual acuity remained at 6/6. There was no relative afferent pupillary defect, and intraocular pressure (IOP) was within the normal range. Fundus examination of the RE revealed a superior RRD involving the macula, with a horseshoe tear located at the 2 o'clock position (Figure 1). Examination of the LE was unremarkable. Biometric assessment demonstrated an AXL of 25.00 mm, while other parameters were within normal limits. The patient underwent immediate pars plana vitrectomy (PPV), endolaser photocoagulation, retinotomy, cryotherapy, and internal tamponade with 12% perfluoropropane (C3F8). No intraoperative or postoperative complications were noted. At 1 year postoperatively, his visual acuity improved to 6/30.

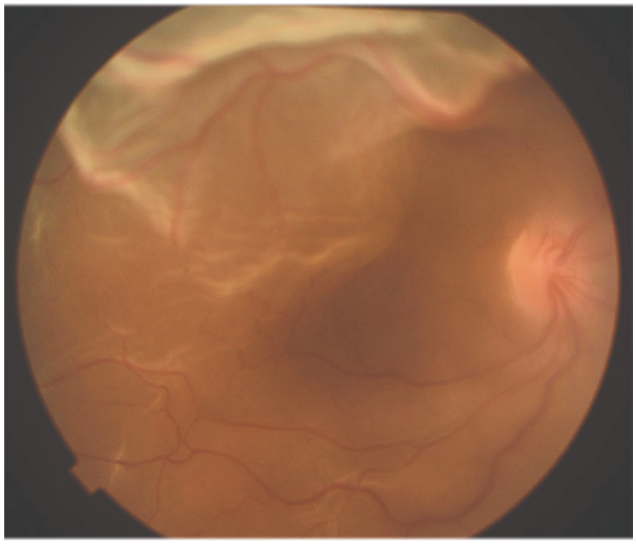


Figure 1 Fundus photograph of Case 1 showing superior rhegmatogenous retinal detachment involving the macula in the right eye.

Case 2

A 67-year-old man with underlying diabetes mellitus (DM), hypertension, hyperlipidaemia, benign prostatic hyperplasia (BPH), and chronic obstructive pulmonary disease (COPD) presented with floaters in the RE nine months after uncomplicated phacoemulsification with intraocular lens implantation. On presentation, the visual acuity was 2/60 in the RE, with unremarkable anterior segment findings. Posterior segment examination revealed an inferior bullous retinal detachment involving the macula, with a retinal break identified at the 1 o'clock position (Figure 2). Biometric assessment demonstrated an AXL of 23.57 mm. However, the patient declined further therapeutic surgical intervention.

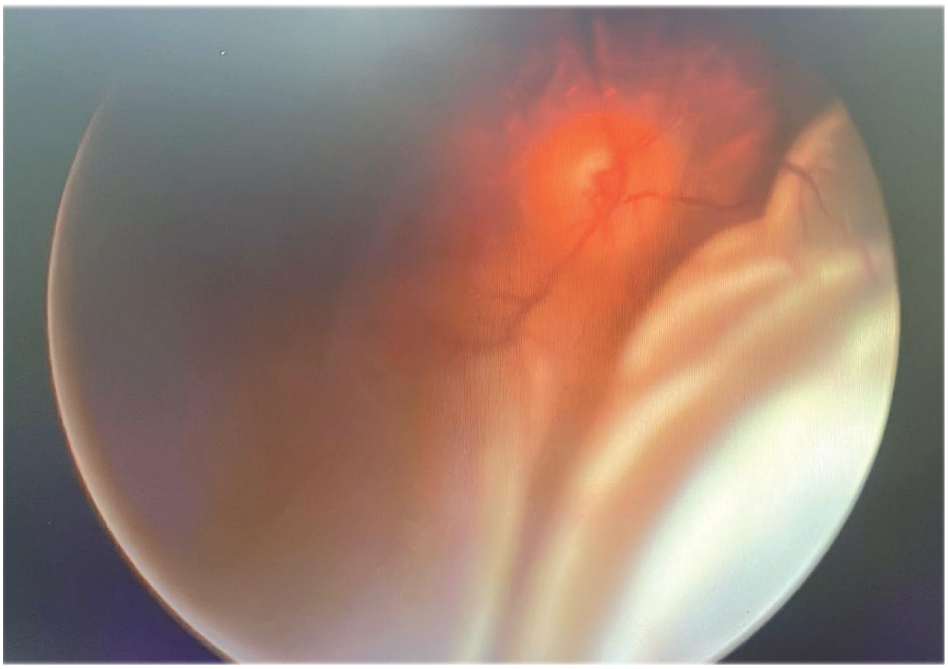


Figure 2 Fundus photograph of Case 2 showing inferior bullous retinal detachment involving the macula, with a retinal break at the 1 o'clock position in the right eye.

Case 3

A 57-year-old man with underlying DM, hypertension, and hyperlipidemia presented with a curtain-like visual field defect in the RE two months after uncomplicated phacoemulsification with intraocular lens implantation. Visual acuity in the RE was 6/18 at presentation. Anterior segment examination was unremarkable. Posterior segment examination of the RE revealed superior RRD with retinal holes located at the 2 and 10 o'clock positions, with possible macular splitting (Figure 3). The AXL of the RE was 26.30 mm. The patient underwent PPV, endolaser photocoagulation, and silicone oil tamponade without any postoperative complications. The best-corrected visual acuity in the RE during the last follow-up was 6/9.

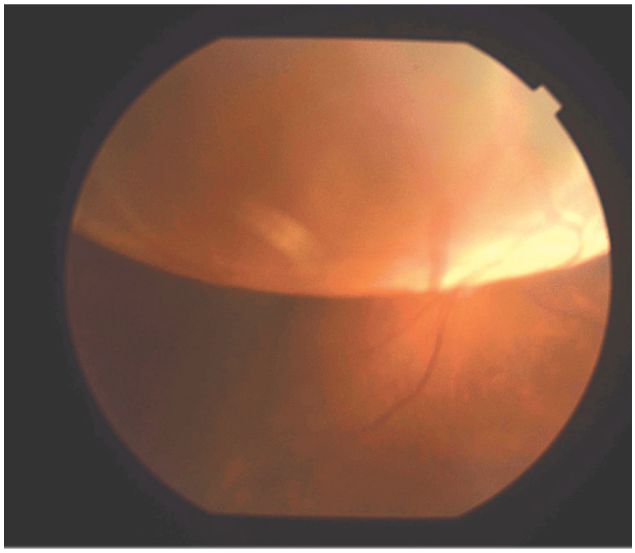


Figure 3 Fundus photograph of Case 3 showing superior rhegmatogenous retinal detachment with possible macular splitting in the right eye.

Case 4

A 64-year-old man with underlying DM and ischemic heart disease (IHD) presented with sudden reduced vision in the RE associated with floaters. He had undergone uncomplicated cataract surgery in the RE 16 years earlier. Visual acuity in the RE at presentation was 6/60, with unremarkable anterior segment findings. Posterior segment examination revealed inferior RRD involving the macula from the 1 to 9 o'clock positions, with retinal holes extending from the 2 to 5 o'clock positions (Figure 4). The AXL of the RE was 27.13 mm. The patient subsequently underwent PPV, endolaser photocoagulation, decalin-assisted retinal flattening, cryotherapy, inferior surgical peripheral iridotomy, and silicone oil tamponade. Visual acuity in the RE improved to 6/21 following surgery.

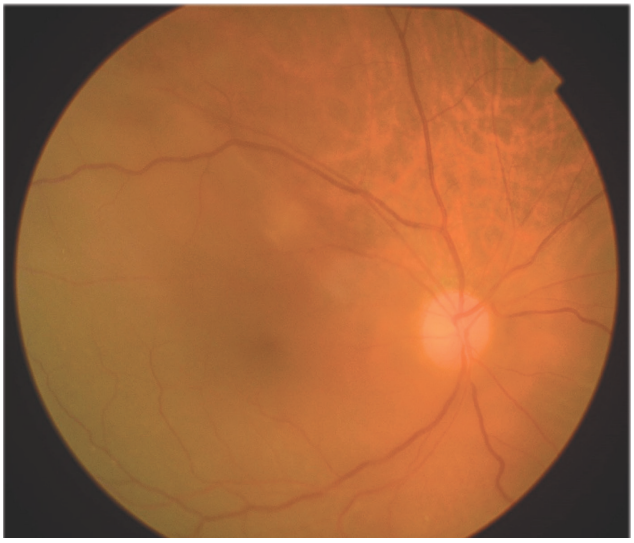


Figure 4 Fundus photograph of Case 4 showing inferior rhegmatogenous retinal detachment involving the macula in the right eye.

Case 5

A 54-year-old man with underlying hypertension presented with floaters in the LE associated with gradual nasal visual field loss for two weeks. He had undergone phacoemulsification in the LE one year earlier, which was complicated by posterior capsular rent, followed by sulcus intraocular lens implantation. Visual acuity in the LE had decreased from 6/6 postoperatively to hand movement (HM) at presentation. Anterior segment examination of the LE was unremarkable. Posterior segment examination revealed inferior bullous RRD involving the macula from the 2 to 9 o'clock positions (Figure 5), with no obvious retinal hole or break identified. The AXL of the LE was 24.46 mm. The patient underwent immediate PPV, endolaser photocoagulation, decalin-assisted retinal flattening, inferior surgical peripheral iridotomy, and silicone oil tamponade. Postoperatively, the course was complicated by elevated IOP and wound leak, which were subsequently managed with silicone oil removal. His best-corrected visual acuity improved to 6/30 following treatment.

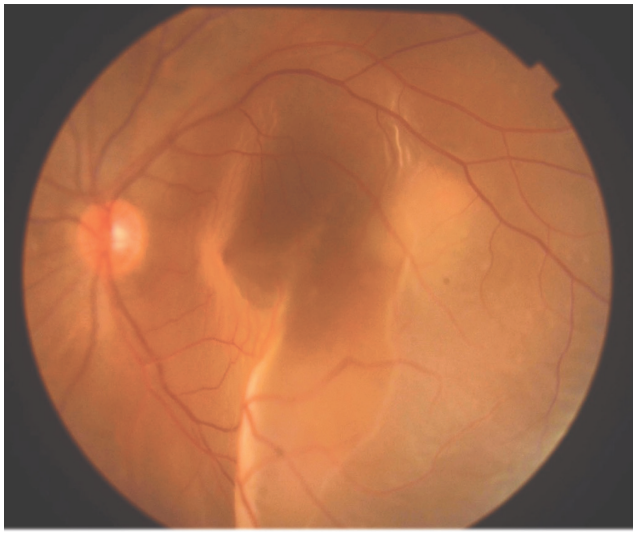


Figure 5 Fundus photograph of Case 5 showing inferior bullous rhegmatogenous retinal detachment involving the macula in the left eye.

Demographic data

This study included five eyes from five patients diagnosed with PRRD between October 2022 and January 2025. The mean age of the patients was 61.4 ± 5.1 years, with all patients being male. Visual acuity at presentation ranged from 6/18 (Case 3) to HM vision (Case 5). All patients underwent slit-lamp examination prior to the diagnosis of PRRD. In all cases (100%), the retinal detachment involved the macula.

Systemic and ocular comorbidities

All patients (100%) had associated systemic comorbidities, including DM, hypertension, hyperlipidemia, IHD, COPD, and BPH. Regarding ocular comorbidities, no associated ocular conditions were documented in most patients, except for Case 5, who had a history of complicated cataract surgery.

Table 1 Summary of demographic and clinical characteristics of the five cases.

Case	Age (years)	Sex	Eye	Systemic risk factors	Ocular risk factors	Duration from cataract surgery to presentation of PRRD	Axial length (mm)	Initial BCVA	Treatment	Final BCVA
1	65	Male	RE	HT	-	6 months	25.00	2/60	PPV + endolaser + retinotomy + cryotherapy + 12% C3F8	6/30 at 1 year
2	67	Male	RE	DM, HT, HLP, COPD, BPH	-	9 months	23.57	2/60	No surgical intervention	Not improved
3	57	Male	RE	DM, HT, HLP	-	2 months	26.30	6/18	PPV + endolaser + silicone oil	6/9
4	64	Male	RE	DM, IHD	-	16 years	27.13	6/60	PPV + endolaser + decalin + cryotherapy + inferior PI + silicone oil	6/21
5	54	Male	LE	HT	Complicated cataract surgery (PC rent, IOL in sulcus)	1 year	24.46	HM	PPV + endolaser + decalin + inferior PI + silicone oil	6/30

BCVA: best-corrected visual acuity, BPH: benign prostate hyperplasia, COPD: chronic obstructive pulmonary disease, DM: diabetes mellitus, HLP: hyperlipidemia, HM: hand movement, HT: hypertension, IHD: ischaemic heart disease, IOL: intraocular lens, LE: left eye, PC: posterior capsular, PI: peripheral iridotomy, PPV: pars plana vitrectomy, PRRD: pseudophakic rhegmatogenous retinal detachment, RE: right eye

Ocular presentation

In terms of laterality, 80% of cases involved the RE, while the remaining 20% involved the LE. Four cases (80%) presented with sudden-onset floaters as the chief complaint, whereas one case (20%) presented with a curtain-like visual field defect. The median duration from cataract surgery to presentation at the clinic was 9 months, ranging from 2 months to 16 years postoperatively. Examination of the fellow eyes was unremarkable in all cases (100%).

Management and visual outcomes

Of the five cases, four underwent surgical intervention consisting of PPV, endolaser photocoagulation, and internal tamponade using either gas or silicone oil. One patient (Case 2) declined surgical intervention. Regarding visual outcomes within 1 year of follow-up, four treated patients demonstrated improvement in visual acuity of at least two Snellen lines following treatment. Case 2 showed neither improvement nor deterioration in vision. All four treated patients completed the 12-month follow-up period, with a mean follow-up duration of 19.5 months.

Complications

Among the four cases that underwent surgical therapeutic intervention, only one patient (Case 5) developed postoperative complications, including elevated IOP and wound leak. The patient was managed appropriately, and no further sequelae were observed. The remaining cases had uncomplicated postoperative courses.

Discussion

The development of retinal detachment following cataract surgery is influenced by multiple risk factors, which may be categorized into preoperative, intraoperative, and postoperative factors. Regarding preoperative risk factors, the present case series from SASMEC included five cases with a mean age of 61.4 years. This finding is consistent with a population-based study reporting that PRRD predominantly occurs in older adults, as cataract surgery is more frequently performed in this age group[4]. In a study by Sheu et al. conducted in Taiwan, the incidence of retinal detachment during a 6-year follow-up period was reported to be 0.56% in women and 1.90% in men, indicating that men are at a higher risk of developing PRRD[9]. All patients in the present series were male, which supports previous findings suggesting male sex as a risk factor for PRRD[10].

Other preoperative risk factors contributing to the development of PRRD include anatomical variations such as long AXL. The mean AXL in this study was 25.30 mm, which aligns with a previous study identifying an AXL of 23–25 mm as a significant risk factor for PRRD[4]. This finding is further supported by another study demonstrating that an AXL greater than 26 mm carries an even higher risk for PRRD[5]. Ninn-Pedersen and Bauer reported that each 1 mm increase in AXL increased the risk of retinal detachment by approximately 1.3-fold[11]. Long AXL is commonly associated with high myopia. Although refractive status was not assessed in the present case series, several studies have highlighted the relationship between myopia and PRRD. A study conducted by Williams et al. in Ireland between 1995 and 1999 evaluated retinal detachment in post-cataract surgery patients with myopia (AXL > 25 mm) and reported a RRD incidence of 2.4% following cataract extraction[12].

Systemic risk factors such as DM and hypertension have been reported to be associated with the development of PRRD in a previous study[13]. The coexistence of hypertension and diabetes may exert a synergistic effect by exacerbating retinal thinning and creating a vulnerable retinal environment, thereby

increasing the likelihood of retinal tears and subsequent RRD[14]. However, a more recent study has found that these conditions are no longer significant risk factors among patients with PRRD[15]. Another prior study has reported that DM may exert a protective effect against PRRD[16], in contrast to its well-established role in the development of other retinal pathologies. This protective association may be related to diabetes-induced biochemical and structural alterations in the vitreous and vitreoretinal interface. Nonetheless, the relationship between DM and PRRD remains controversial, as three out of five patients in the present study had underlying DM.

Intraoperative risk factor includes vitreous loss during cataract surgery[17,18]. This is supported by a study conducted by Javitt et al, which reported that patients who underwent cataract extraction with anterior vitrectomy had a 4.5-fold increased risk of developing retinal detachment within 4 years, with an incidence of 5%, compared to only 1.1% among patients who did not require anterior vitrectomy[17]. Posterior capsular rupture has also been associated with an increased risk of PRRD. Tielsch et al reported that patients with posterior capsular rupture during cataract surgery had a 13-fold increased risk of developing retinal detachment subsequently[18]. In the present case series, one out of five cases had posterior capsular rent during cataract surgery, which may have contributed to the development of PRRD.

Regarding postoperative risk factors, previous studies have suggested that neodymium-doped yttrium-aluminium-garnet (Nd:YAG) posterior capsulotomy may increase the risk of retinal detachment[18,19]. It is believed that disruption of the anterior vitreous face during the procedure may predispose patients to RRD[19]. This occurs because the anterior vitreous surface is continuous with the vitreous base; therefore, disruption of this structure may increase vitreoretinal traction at the ora serrata, leading to secondary retinal tears[20]. The incidence of RRD following Nd:YAG capsulotomy has been reported up to 4.8%[19]. A large nested case-control study identified Nd:YAG laser capsulotomy as a significant risk factor for retinal detachment, with an odds ratio (OR) of 3.8 (95% confidence interval [CI], 2.4–5.9)[18]. Another study reported cumulative RRD risk rates of 2.0% at 5 years following Nd:YAG posterior capsulotomy[21]. Although Nd:YAG capsulotomy is a well-established postoperative risk factor for PRRD, none of the patients in the present case series had undergone this procedure prior to presentation.

Ripandelli et al also demonstrated a significant postoperative increase in the incidence of PVD and RRD after cataract surgery[22]. In their study, PVD occurred in 107 of 141 (75.88%) eyes without preoperative PVD or lattice degeneration after cataract surgery. PVD occurred in 41 of 47 eyes (87.23%) with preoperative lattice degeneration and no PVD. Furthermore, eyes with both preoperative lattice degeneration and postoperative PVD demonstrated a substantially higher incidence of RRD after cataract surgery (21.27%) compared to eyes without preoperative PVD or lattice degeneration (0.70%)[22].

Our case series found that the most commonly reported symptoms were floaters, visual field defects, and curtain-like vision loss, all of which are characteristic presentations of RRD. Notably, all cases involved macular detachment, a condition known to be associated with poorer visual prognosis. The duration between cataract surgery and presentation with PRRD varied considerably, with some patients developing retinal detachment within months, while others presented years after surgery. Clinical examination demonstrated that retinal tears were predominantly located in the superior quadrant.

The prognosis of PRRD varies, and visual outcomes are often guarded. In the present case series,

some patients demonstrated significant postoperative visual improvement, such as improvement from 2/60 to 6/21 at 1 year postoperatively, whereas others experienced limited visual recovery, particularly those with delayed presentation or extensive retinal detachment at diagnosis. One patient declined surgical intervention, highlighting the challenges related to patient compliance and decision-making in the management of retinal detachment. Delayed or refused treatment is frequently associated with poor visual outcomes, underscoring the importance of patient education regarding the urgency of early intervention.

Conclusions

This case series provides insight into the demographic and clinical characteristics of PRRD in a Malaysian tertiary centre. Despite the small sample size, several findings were consistent with those reported in the literature. All patients were male and had underlying systemic comorbidities, with DM, hypertension, and hyperlipidemia being the most common. The mean AXL of 25.30 mm further supports the association between increased ocular AXL and susceptibility to retinal tears and detachment following cataract surgery.

Overall, PRRD remains a vision-threatening but potentially treatable postoperative complication. Early identification of high-risk individuals, enhanced patient counselling, and long-term postoperative surveillance are important in reducing disease-related morbidity and improving visual outcomes. Larger prospective studies are warranted to further refine risk stratification strategies and guide preventive care in the Malaysian population.

Financial Disclosure

The authors have no conflict of interest to declare.

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