

## Anterior Migration and Spontaneous Posterior Relocation of an Ozurdex® Implant in an ACIOL, Vitrectomised Eye: A Case Report

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### Abstract

**Introduction:** Dexamethasone intravitreal implants (Ozurdex®) are widely used for managing macular oedema caused by uveitis, retinal vein occlusion, and postoperative inflammation. Anterior chamber migration is a recognised but uncommon complication, most often occurring in eyes with altered anatomy such as those with prior vitrectomy, capsular instability, or anterior chamber intraocular lenses (ACIOLs). Migration may lead to corneal endothelial damage and often prompts urgent surgical removal. This case highlights an uncommon scenario where the implant migrated into the anterior chamber but was safely managed conservatively, ultimately relocating posteriorly without corneal or pressure-related complications.

**Objectives:** To describe the clinical presentation and course of an Ozurdex® implant that migrated into the anterior chamber in a high-risk eye.

To demonstrate the effectiveness of conservative management—including cycloplegia and supine positioning—in enabling posterior relocation.

To reinforce that conservative treatment can be safe when there is no corneal touch and IOP remains controlled.

**Case Description:** A 75-year-old pseudophakic woman with a history of vitrectomy, dislocated intraocular lens, and subsequent ACIOL implantation received an intravitreal dexamethasone implant for cystoid macular oedema. Initial response was favourable, though she developed a marked steroid-induced intraocular pressure (IOP) rise to 44 mmHg on day six, resolving with medical therapy.

Two weeks post-injection, she reported noticing a mobile “white line” in her vision. Slit-lamp examination confirmed anterior migration of the Ozurdex® implant, lying horizontally at the pupillary plane anterior to the ACIOL. Importantly, there was no corneal endothelial contact, no corneal oedema, and IOP remained normal.

Given the absence of corneal touch, the patient was managed conservatively with cyclopentolate 1% twice daily and strict supine positioning. She was monitored frequently through clinic visits and telephone review.

**Results:** During the observation period, the implant demonstrated intermittent movement between the anterior segment and posterior chamber but consistently avoided endothelial contact. IOP stayed within normal limits on topical therapy. Over the following weeks, the implant gradually migrated posteriorly, ultimately remaining behind the iris without recurrence.

Optical coherence tomography confirmed complete resolution of macular oedema. The patient’s visual acuity improved compared with baseline. No surgical intervention was required, and no corneal or pressure-related complications occurred.

**Conclusion:** Anterior migration of Ozurdex® implants is a known complication in eyes with altered anatomy—particularly in vitrectomised eyes with ACIOLs. While surgical removal is traditionally recommended if corneal touch is present, this case demonstrates that conservative management can be safe and successful where the implant remains clear of the cornea and IOP is controlled. Cycloplegia and supine positioning played a key role in facilitating spontaneous posterior relocation. This case adds to the growing evidence supporting non-surgical management in carefully selected patients.

### Keywords

Ozurdex® migration, dexamethasone implant, anterior chamber, ACIOL, vitrectomy, cystoid macular oedema, corneal endothelium, ocular hypertension, conservative management.