discoloration of the endothelium and deep stroma is visible. Removal of the foreign body can ameliorate the discoloration (Video 15-3). If left untreated, ocular siderosis can cause permanent damage to the retinal pigment epithelium and inner retinal layers and ultimately induce optic nerve atrophy.

Closure of iris lacerations may decrease the formation of anterior or posterior synechiae while reducing glare and polyopia from severe corectopia; however, it may be difficult to achieve during the primary procedure. Iridodialysis may cause monocular diplopia and an eccentric pupil if left untreated. If corneal opacity prevents safe repair of internal ocular injury, repairs can be performed secondarily. The McCannel technique and the Siepser knot are popular approaches for repair of an iris defect (Video 15-4; Fig 15-36).

Prophylactic intraoperative antibiotics to cover both gram-positive and gram-negative organisms may be given by subconjunctival injection at the conclusion of the repair. Intravitreal antibiotics such as vancomycin 1 mg and ceftazidime 2.25 mg can be considered for contaminated wounds involving the vitreous.

**Postoperative management**

Postoperatively, therapy is directed at preventing infection, suppressing inflammation, controlling IOP, and relieving pain. Patients may be given intravenous antibiotics (eg, a cephalosporin and an aminoglycoside) for 48 hours or an oral antibiotic with good vitreous penetration, such as moxifloxacin 400 mg per day for 3–5 days. Topical antibiotics
are generally instilled 4 times a day for 7 days or until epithelial closure of the ocular surface is complete. Topical corticosteroids may be given 4–8 times a day, depending on the amount of inflammation or the risk of infection. Corticosteroid eyedrops and cycloplegics are slowly tapered as the inflammation subsides. A fibrinous response in the anterior chamber may respond well to a short course of systemic prednisone. IOP should