Another theory proposes that a macular cyst caused by blunt trauma may later evolve into a macular hole.

The purpose of this paper is to report two cases of traumatic macular hole treated surgically.

Case reports

The study protocol was approved by the Institutional Ethics Review Board of the Hospital São Rafael (CAAE: 14929313.4.0000.0048) and conducted by the Retina and Vitreous Service of the same institution.

Case 1

Male patient, 12 years old, soccer player, with history of blunt trauma in the right eye with soccer ball 6 months ago, attending with low visual acuity (LVA) of this same eye. At ophthalmologic examination showed visual acuity of count finger at 1 meter in the right eye (OD) and 20/20 in the left eye (OS). Biomicroscopy without abnormality and tonometry within normal limits in both eyes. At funduscopy, the patient had a macular hole in the OD and an examination compatible with normality in OS.

Optical coherence tomography (OCT) was performed to confirm the macular hole seen at the fundus examination (Figure 1). The patient was surgically treated with posterior pars plana vitrectomy and peeling of the internal limiting membrane with the aid of the Brilliant Blue dye, followed by tamponade with SF6 gas. It progressed satisfactorily after surgery, with improvement of visual acuity and absence of macular hole at funduscopy. About 1 year after the procedure, the patient presented visual acuity of 20/80 with the best correction in OD and no evidence of macular hole to the OCT (Figure 2).

Case 2

A 43-year-old male patient with a history of trauma with fireworks in the OD 8 months ago, with LVA and “dark spot in vision” since then. Denies previous ophthalmological comorbidities. At ophthalmologic examination: visual acuity of 20/200 in OD and 20/20 in OS. Biomicroscopy showing posterior subcapsular cataract in OD and without abnormalities in OS. 10 and 14 mmHg aplanation tonometry in OD and OS, respectively. Funduscopy presented with macular hole and choroidal rupture in OD and without abnormality in OS (Figure 3). OCT examination of the macular region of the patient’s right eye (Figure 4) confirmed the fundoscopic finding.
He underwent phacoemulsification of the lens with intraocular lens implantation in the capsular bag, followed by posterior pars plana vitrectomy and peeling of the inner limiting membrane with the aid of brilliant blue dye and SF6 gas. On the 12th postoperative day the macular hole was closed, seen at funduscopy (Figure 5) and confirmed in the OCT exam (Figure 6). The visual acuity with the best correction on that day was of count finger at 3 meters, without the presence of the central scotoma previously mentioned.

**Discussion**

The OCT is a complementary examination of great value, being able to differentiate cases of complete MH from those with partial involvement of the internal layers of the retina, even with pseudocyst formations and increased macular thickness. In the described cases the OCT examination confirmed the diagnosis and made easy patient orientation and follow-up after surgical treatment.

**Conclusion**

Visual results may be good if there is no damage to the pigmented epithelium of the subfoveal retina or Bruch’s membrane. Spontaneous closure of TMH is not uncommon, with expectant management an option in the first 4 to 6 months after trauma. Vitrectomy seems to be a procedure with high surgical success for TMH closure, with important visual improvement. In the presented cases, the patients already arrived with more than six months of evolution, time in which the spontaneous closure already could have occurred. Therefore surgical treatment was chosen and the result was anatomic and functional improvement of the retina in both cases.

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**Conflicts of interest**

Author declares is conflicts of interest towards this article.

**References**


