

Correspondence

Multiple cotton wool spots following bone marrow transplantation

SIR, B. Gloor *et al.* assert in their very interesting paper¹ that, to the best of their knowledge, 'multifocal ischaemia of retina with multiple cotton-wool spots has not yet been reported as a complication of bone marrow transplantation.'

We would like to point out to the authors that we reported in 1983² a similar case with extensive retinal and choroidal ischaemia, histopathologically confirmed, diagnosed eight months after a bone marrow graft. In this patient a thrombotic microangiopathy (Moschowitz disease) was found shortly afterwards. Then two more cases were observed (not yet published), both with retinal and choroidal ischaemia. One of them certainly had a thrombotic microangiopathy.

None of these three patients received cyclosporin A. Therefore it seems that this drug is not implicated. We think in such cases we may be in presence of ocular manifestations of thrombotic microangiopathy. This may be induced by various and combined factors: skull and/or total body irradiation, immunological disorders in relation to the graft, graft-versus-host disease, chemotherapy.

We note that choroidal involvement was found in the three cases to be associated with retinal disease. In these three cases visual impairment was the inaugural symptom, though the patients seemed to be in good health. As regards our patients the time between graft and visual symptoms is longer than in the patients of Gloor *et al.* Our three patients died shortly after eye disease developed.

In conclusion, we agree with Gloor *et al.* that 'it is clearly desirable that all patients submitted to bone marrow transplantation should be examined by an ophthalmologist.'
Hôpital Henri Mondor,
51 avenue du Maréchal de Lattre de Tassigny,
94010 Creteil,
France

References

- 1 Gloor B, Gratwohl A, Hahn H, *et al.* Multiple cotton wool spots following bone marrow transplantation for treatment of acute lymphatic leukaemia. *Br J Ophthalmol* 1985; **69**: 320-5.
- 2 Binaghi M, Sterkers M, Vernant JP, Coscas G. Micro-angiopathie thrombotique et ses manifestations oculaires: complication inhabituelle d'une greffe de moëlle osseuse. *J Fr Ophtalmol* 1983; **6**: 881-8.

SIR, We think that it is very important that Dr Binaghi informs us that in their case of extensive retinal and choroidal ischaemia, which appeared eight months after a bone marrow graft, a thrombotic microangiopathy (Moschowitz disease) has been found at necropsy and that this patient and two others, whose data are not published, did not receive cyclosporin-A. This is reassuring. What these authors found in the pathological specimen could be the possible explanation of the phenomena observed in the retina also in our cases. Nevertheless it has also to be

remembered that in no patient could any evidence of systemic thrombotic microangiopathy be found and that in all cases of our series at necropsy the vessels of the retina and the kidneys were free of obstructive disease. But this was three months to more than two years after the retinal disease had resolved.

We did not quote Dr Binaghi and co-workers' very informative paper for the following reason: we submitted the paper to the *British Journal of Ophthalmology* on 5 September 1983, before Dr Binaghi and co-workers' article appeared. We apologise that we neglected to quote the work of Binaghi and co-workers when we had to revise our paper. When it comes to priorities, we do not think that this is so important, even if we brought the first case to the attention of the haematologist with a letter to the editor in the *New England Journal of Medicine* 1983; **308**: 1101 (5 May 1983) and at the Washington University Eye Alumni Meeting, St Louis, MO, on 29 April 1983. In complete agreement with Dr Binaghi and co-workers, the main goal is to watch the fundus of the eye of all patients submitted to bone marrow transplantation, to get enough information on a large sample to enable the differentiation between true disease and possible side effects of drugs, e.g., cyclosporin-A.

Universitätsspital Zürich,
Augenklinik,
Rämistrasse 100,
8091 Zürich,
Switzerland

B GLOOR

Ia antigen

SIR, I read with some interest the article by Roussel and Coster.¹ I doubt that the human lymphocytes that they describe were positive for Ia antigen, as these antigens are coded for by the I region of the mouse H-2 histocompatibility complex (see, for example, Hobart and McConnell²). Perhaps the authors would care to comment and correct their article.

Department of Ophthalmology,
Bristol Eye Hospital,
Lower Maudlin Street,
Bristol BS1 2LX

CHARLES CLAOUÉ

References

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- 2 Hobart MJ, McConnell I. *The immune system*. Oxford: Blackwell. 1975:232.

SIR, Although the terms Ia antigen (simply an abbreviation for immune-associated antigen) was first used to describe a system of cell-surface glycoproteins in the mouse, it has been and indeed is still widely used in the literature to refer to homologous series of antigens in other species including man.¹⁻³ The monoclonal antibody FMC 14⁴, used in this study to detect a monomorphic determinant on human Ia (probably HLA-DR) molecules, certainly does not define mouse Ia antigen. However, we take Dr Clauoué's point.



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M Binaghi

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