Resolution of an external layer macular hole associated with an optic nerve pit after laser photocoagulation

us to believe that there was indeed a treatment effect.
Since reattachment of the retina and resolution of the macular hole was achieved solely with laser photocoagulation, we believe this should be the initial procedure in the management of these patients.


A case of presumed congenital herpes zoster ophthalmicus

J Singh, J M Gibson

Herpes zoster ophthalmicus is a disease occurring in the elderly but it only rarely occurs in children. We report an unusual case of presumed herpes zoster ophthalmicus occurring in a newborn infant. It is postulated that maternal infection with chicken pox during the second trimester of pregnancy has led to in utero transmission of the varicella virus resulting in presumed congenital herpes zoster ophthalmicus. This is the first report of such a case to our knowledge.

Case report
A mother who contracted chicken pox at the beginning of the second trimester of pregnancy, gave birth to a 7 week preterm infant boy, weighing 2.1 kg. Maternal chicken pox infection was confirmed by the presence of a typical generalised rash in association with significantly raised IgM titre suggesting a recent infection.
At birth it was found that the boy had a large full thickness skin defect exposing the skull bones in the distribution of the ophthalmic...
division of the trigeminal nerve (Fig 1). Associated with this was a cicatrizing skin lesion affecting the upper eyelid, and a small degree of ptosis of the upper eyelid. The left pupil was dilated and unreactive to light, but it had a normal afferent pupil reflex. Fundus examination, after dilating the pupil showed normal optic discs, retinal vessels, and retinas when examined with the binocular indirect ophthalmoscope, and there was no significant refractive error present. The scalp defect slowly started to heal and by 5 months of age was already much smaller (Fig 2).

The child suffered recurrent attacks of conjunctivitis in the left eye and Staphylococcus aureus was cultured during one of these episodes; the conjunctivitis settled quickly with gentamicin eye drops. At age 6 months the child developed a vesicular rash around the left side of the trunk in a dermatomal distribution with a few generalised vesicles on the arms and face. These lesions resolved spontaneously. Serological tests were performed but did not show any rise in antibody production. Unfortunately fluid from the vesicles was not taken for virus identification.

By the age of 9 months the scalp defect had completely healed, leaving a prominent scar on the left side of the forehead, which represented the mid-line (Fig 3). At this age it was also noted that iris atrophy and heterochromia of the iris were present on the left side, the right iris being brown and the left blue. Corneal sensation was found to be absent on the left side and his mother reported that no tears were produced in the left eye on crying.

At age 19 months the visual acuity measured with the Catford Oliver drum was 6/9 equivalent right eye and 6/12 left eye. No squint was present. The child was regularly reviewed and at age 26 months vision was 6/6 right eye and only 6/36 left eye, with the Kay picture tests. A central corneal ulcer was present in the left eye, with a mild anterior uveitis with cells + and flare +. The eye was treated with acyclovir ointment five times daily for 5 days and after 1 week the ulcer had healed leaving a small axial corneal scar, and a quiet eye.

After the ulcer had healed, visual acuity had deteriorated to 3/60 in the left eye with Kay picture tests and this was assessed as being partly due to the corneal scarring and perhaps partly due to stimulus deprivation amblyopia. Once the eye had settled he received occlusive treatment to the right eye, and by age 28 months vision was 6/60 in the left eye and at age 30 months 6/24 with the Kay picture tests.

The vision has continued to improve, despite subsequent further episodes of keratitis that have been promptly treated with acyclovir ointment and have responded well. At his most recent review, aged 3 years 9 months, visual acuity with the Sheridan-Gardner test, was recorded as 6/6 right and 6/12 left. There is no obvious squint present on cover test examination and his ocular movements are full. There is a small thickened and erythematous area on his upper eyelid, but otherwise most of the prominent scar on the forehead is covered by normal hair. Corneal sensation is absent, and there is fine staining of the cornea with fluorescein in the interpalpebral fissure and the eye is clinically dry. The anterior chamber is quiet, the intraocular pressure is normal (by non-contact tonometry), and fundus examination shows no abnormalities. He is being treated with hypromellose eye drops and Simple ointment at night to the left eye.

**Comment**

Varicella and herpes zoster viruses are thought to be homogeneous and although antigenically different both viruses cause the same cytopathic effect. The primary response to varicella is chicken pox and reactivation of dormant virus in a sensory root ganglion leads to herpes zoster (shingles). The time from primary infection to reactivation in the vast majority of cases is many years so that shingles is usually a disease of the elderly.

There are a number of reports of herpes zoster occurring in children. A large number of these particular cases have shown that the primary infection was maternal chicken pox with probable reactivation as herpes zoster in the offspring. The onset of herpes zoster in these children shows a very difficult time scale to adults, being very much shorter. This may be explained by a lack of immunity in infants allowing reactivation of varicella acquired antenatally. Impaired cellular immunity may also explain other features of varicella zoster, namely, inability to produce antibody to this virus and the occurrence of recurrent herpes zoster infections. The child in this case report may have had impaired cellular immunity explaining negative serological tests despite clinical evidence of a second dermatomal zosteriform eruption.

Herpes zoster affecting the trigeminal nerve has also been described in infants including one case in which all three divisions of the fifth cranial nerve were involved. All these cases report a typical dermatomal skin rash; however, there is no case where this skin lesion is associated with an ocular abnormality in infants.
Ophthalmologists will be interested in another distinct teratogenic effect of varicella zoster. The virus once acquired in pregnancy is able to cross the placenta causing systemic and ocular problems in the offspring. This association was first noted in 194710 and has subsequently been recognised as the congenital varicella syndrome or the fetal varicella syndrome.10–16 The ocular associations of congenital varicella and shingles are depicted in Table 1. The case we have described does not show many of the ocular findings in congenital varicella syndrome but does illustrate many of the clinical features of adult herpes zoster ophthalmicus: a dermatomal skin lesion in the distribution of the ophthalmic division of the trigeminal nerve, absent cornéal sensation, recurrent keratitis and uveitis, iris atrophy, and abnormal direct pupil response. Other conditions that may cause skin defects are direct pressure on the fetus in utero or cutaneous polyarteritis, a rare vasculitis in children.9 However, the dermatomal distribution and ocular features make these latter two conditions unlikely.

In conclusion, we suspect that the mother’s varicella infection in pregnancy and the child’s congenital conditions are causally related. The varicella zoster virus probably crossed the placenta to lie dormant in the child’s trigeminal ganglion. At some time before birth the virus was reactivated10 and led to this unique case of ‘presumed herpetic zoster ophthalmicus’ in utero which was present at birth. The clinical findings are so unusual and similar to adult herpes zoster ophthalmicus, that this seems the most likely explanation.

5 Lyday JH. Report of severe herpes zoster in a 13½ year old boy whose chicken pox infection may have been acquired in utero. Pediatrics 1972; 50: 930–1.

Table 1 A comparison of ocular features of congenital varicella syndrome and herpes zoster ophthalmicus

<table>
<thead>
<tr>
<th>Ocular features of congenital varicella syndrome</th>
<th>Ocular features of herpes zoster ophthalmicus</th>
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<tr>
<td>Cicatrizing dermatomal skin lesions</td>
<td>Cicatrizing dermatomal skin lesions and proptosis</td>
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<tr>
<td>Chorioretinitis</td>
<td>Mucopurulent conjunctivitis and episcleritis</td>
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<td>Optic atrophy</td>
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<td>Anisocoria</td>
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<tr>
<td>Heterochromia</td>
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</table>

Orbital multiple myeloma mimicking acquired angio-oedema

Rebecca L Snider, Bruce H Thiers, Gene R Howard

Multiple myeloma is characterised by malignant plasma cells in the bone marrow and excessive production of specific immunoglobulins or immunoglobulin components. Ocular involvement may result from myelomatous infiltration or may occur secondarily to haematological abnormalities. Virtually any ocular structure can be involved, including the conjunctiva, cornea, sclera, lens, retina, uveal tract, optic nerve, lacrimal glands, and orbit.1 Involvement of periorbital skin is unusual. To our knowledge this is the first reported case of metastatic multiple myeloma presenting as periorbital swelling with angio-oedema-like features.

Case report
A 58-year-old white woman presented to her
A case of presumed congenital herpes zoster ophthalmicus.

J. Singh and J. M. Gibson

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