CORRESPONDENCE

Magnetic resonance imaging and the dangers of orbital foreign bodies

EDITOR,—A 39-year-old man was seen in our casualty department with a lump in his left upper eyelid. About 3 months previously, he had been hit just above his left orbit by a small piece of the end of a hammer.

When coming close to a magnetic resonance imaging (MRI) scanner to comfort a friend having a scan, he felt a sudden pain shooting across the left side of his head. He could feel a small metallic object move from the skin of his left forehead into his left upper eyelid.

An ophthalmic opinion was sought because he could now constantly feel this small metallic fragment in the skin of the eyelid. An orbital radiograph demonstrated the presence of the metallic foreign body in the soft tissue of the eyelid margin (Fig 1). This was removed by a single surgical procedure.

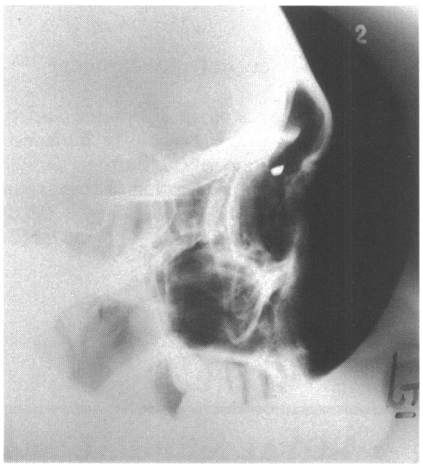

Figure 1 Small metallic object seen in left upper eyelid.

MRI involves the use of a strong magnetic field that has the potential, as demonstrated in this case, to cause movement of foreign magnetic bodies in and around the tissues of the orbit.[1] Detection of any inert foreign bodies by orbital radiographs in patients before MRI can be aided by taking a clear history of previous foreign body exposure.[2]

This case highlights the need to identify the possibility of retained metallic foreign bodies in any person coming near to a MRI scanner. At present a thorough history is probably the most accurate means of fulfilling this. However, the need for metal detectors such as those used for security purposes should be considered.

Movement of a small metallic foreign body is demonstrated in the direction of least resistance along the tissue plane of the upper eyelid. Movement of deeper orbital foreign bodies could have a much more devastating effect on the eyeball itself.

MANOJ KULSHRESTHA
Birmingham and Midland Eye Hospital, Birmingham B3 2NS

GARY MISSON
Solihull and Birmingham and Midland Eye Hospital

1 Kaufman DI. Recent advances in neuro-imaging and the impact on neuro-ophthalmology. *Curr Opin Ophthalmol* 1994; **5**: 52–62.
2 Kulshrestha MK, Byrne PO. Detection of an orbital foreign body by a skull radiograph prior to magnetic resonance imaging. *Eye* 1994; **8**: 716.

Bilateral sudden visual loss in Albright's syndrome

EDITOR,—Dowler and colleagues are right to alert clinicians to the possibility of visual loss in Albright's syndrome secondary to a mucocele.[1]

A 20-year-old woman presented to our eye casualty department with a 1 month history of right retro-orbital pain. Albright's syndrome had been diagnosed at age of 7. Examination revealed 6/5 vision bilaterally, with normal colour vision, full visual fields, and no relative afferent pupillary defect (RAPD). Her eyes were quiet with no globe or periorbital tenderness but she did have 1 mm of right axial proptosis and subtle bony fullness of her lateral orbital wall. A magnetic resonance imaging (MRI) scan had been performed 2 months previously demonstrating fibrous dysplasia involving the sphenoidal bone with proptosis. The pain was attributed to this process and treated with non-steroidal anti-inflammatory drugs with some relief of symptoms. She re-presented 2 weeks later with a 3 day history of right visual loss and pain on eye movement. Examination again revealed 1 mm of axial proptosis with full eye movements and no globe tenderness. Her visual acuities were 1/60 right and 6/5 left with a dense right RAPD. Funduscopy was normal with healthy optic discs. An urgent MRI scan demonstrated a right posterior ethmoidal mucocele compressing the right optic nerve (Fig 1). An endoscopic ethmoidectomy was

Figure 1 T2 weighted magnetic resonance image showing right posterior ethmoidal mucocele with optic nerve compression and involvement of surrounding bone by fibrous dysplasia.

performed with drainage of the mucocele. Immediately after the operation her vision had improved to 6/9 and by day 2 it was 6/5.

Patients with a history of Albright's syndrome, presenting with periocular pain especially if associated with visual loss, should have orbital imaging performed to diagnose paranasal sinus mucoceles which, as these two reports demonstrate, are amenable to drainage and a successful return of vision.

D H W STEEL
M J POTTS
Bristol Eye Hospital, Bristol BS1 3NP

1 Dowler JGF, Sanders MD, Brown PM. Bilateral sudden visual loss due to sphenoid mucocele in Albright's syndrome. *Br J Ophthalmol* 1995; **79**: 503–4.

NOTICES

Royal Society of Medicine, Section of Ophthalmology

REGISTRAR'S PRIZE WINNER

This year the RSM Section of Ophthalmology Registrar's prize winner is Mr S Beatty, senior house officer, Birmingham and Midland Eye Hospital, Birmingham B3 2NS.

MEETINGS

The following meetings (beginning at 5 pm) are open to RSM members and their guests only.

CHRISTMAS MEETING, 14 December 1995

A vision of sport; Dr Charles Kelman – the pedigree's chum?; Traditional Chinese medicine and its application to ophthalmology; The eyes, windows to the soul.

BLINDING DISEASE IN THE DEVELOPING WORLD, 11 January 1996

Update and magnitude and causes of blindness; Latest strategies against onchocerciasis; Risk factors and interventions for cataract in developing countries; Current thinking in childhood blindness.

TOXOPLASMOSIS, 8 February 1996

Epidemiology of toxoplasmosis; Representing people affected by toxoplasmosis; The diagnosis of ocular toxoplasmosis; Clinical aspects of toxoplasmosis.

LANG LECTURE, 14 March 1996

New perspective; corneal grafting Professor David Easty.

NEW HORIZONS IN THERAPEUTICS, 9 May 1996

The identification of human tumour antigens: a strategy for developing tumour vaccines; New developments in the management of CMV retinitis; The development of ophthalmic drugs; The challenge of gene therapy in the context of eye diseases.

Further details: Alyson Taylor, Sections Officer, Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. (Tel: 0171 290 2985; fax: 0171 290 2989.)

REGISTRARS' MEETING, 13 June 1996, 2 pm

For registrars to present research work and case reports. Papers to be considered for publication. Abstracts should be submitted (max 200 words) for the attention of P Murray, The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. Closing date for entries is 12 April 1996.

Wellcome General Overseas Travelling Research Fellowships 1994–95

The purpose of these fellowships is to allow postdoctoral scientists and medical graduates to gain further research experience by working in leading laboratories in the UK or the

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Manoj Kulshrestha and Gary Misson

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