of the tendon from the eyelid tissue. This produces a rounding of the lateral angle and acquired blepharophimosis. The dark discoloration over the lateral canthus can precede the tendon dehiscence.

Blepharochalasis is an uncommon condition and Brazin commented that its occurrence unilaterally was extremely rare. This view is supported by Langley et al. Collin, however, reported a series of 30 cases where 14 cases were unilateral. This may reflect the referral pattern of diagnostically difficult cases to one centre.

No previously reported cases have described a localised example of blepharochalasis. Our patient had normal skin and periorbital in the medial aspect of the left upper and lower eyelids which did not require surgery. The main differential diagnosis in this case was of a vascular lesion but this was excluded at surgery together with other infiltrative lesions. The clinical features did not suggest lacrimal gland involvement.

The diagnosis of blepharochalasis can be difficult if the condition is localised or unilateral. Our case shows how characteristic changes in the skin and periorbita, together with a classic history and the exclusion of other causes of lid swelling, all help in the diagnosis of an atypical case of blepharochalasis.

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Superior oblique myokymia – a topical solution?

Kim Bibby, James S Deane, David Farnworth, John Cappin

Superior oblique myokymia (SOM) is a rare ocular motility disorder characterised by a monocular high frequency, low amplitude cyclo-
torsional tremor. It occurs intermittently, giving rise to sometimes obtrusive symptoms of oscillopsia and diplopia.

Case report

A 50-year-old woman presented to the eye casualty department, Leicester Royal Infirmary with a 13-month history. She described oscillopsia and a feeling of tremor in her left eye. The symptoms occurred periodically and were particularly troublesome when she was reading. On examination, visual acuity was 6/6 unaided. Anterior segments, pupil reflexes, and funduscop}
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