LETTERS TO
THE EDITOR

Isolated focal melanocytes collection in the lacrimal sac

EDITOR,—Although the presence of melanocytes located within and under the epithelium of the nasal cavity and paranasal sinuses has been reported, it appears to be a rare finding. Further, only 17 cases of malignant melanoma of the lacrimal sac have been reported.1 We came across unusual, and unaccounted for, focal collections of melanocytes in the lacrimal sac of a patient and report this finding.

CASE REPORT
A 55 year old woman presented to the ophthalmology department of the Schieffelin Leprosy Research and Training Centre with a left sided lacrimal mucocele. Since she also had a cataract that needed surgery, a dacryocystectomy was done in January 1999. During surgery, when the lacrimal sac was being dissected, a localised small area of black pigmentation was seen on the sac. The excised sac was sent for histopathological examination to rule out melanoma. There were no associated pigmentation on the skin overlying the sac or any fistulas in the region.

Histopathological examination of the lacrimal sac showed focal and diffuse collections of cells containing blackish-brown pigments in the stroma and the epithelial cells of the sac. Inflammatory cell collections consisting of lymphocytes, histiocytes, and plasma cells were also seen in the stroma (Fig 1). The intracellular pigment gave negative results when stained with Perl’s stain for haemosiderin but gave a positive result when stained with Fontana-Masson stain for melanin (Fig 2).1 The pigment was completely bleached and removed,1 thus confirming that the pigment present was melanin.

COMMENT
The pigmentation in the lacrimal sac was a chance finding. The cells containing the pigment were confirmed to be melanocytes by the Fontana-Masson staining. The origin of malignant melanoma of the sac is uncertain.1 Presumably, it can arise from nests of melanocytes located either within the epithelium of the lacrimal sac or in the underlying stroma.1 This histopathological finding establishes that melanocytes can be found in isolation in the lacrimal sac. A morphologically similar histopathology can be seen in blue naevus and in the naevoid of Ota but clinically the patient did not exhibit any ocular melanosis nor was the skin of the face pigmented.

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Pupillary distortion after contact transscleral diode laser cyclophotocoagulation

EDITOR,—In recent years, transscleral contact diode laser cyclophotocoagulation (TCDLC) has been shown to be efficient in successfully lowering the intraocular pressure in different types of glaucoma.2,3 Reported success rates by various criteria ranged from 38% to 85%. Mostly, a fixed distance from the corneoscleral limbus with a specially designed contact probe without visualisation of the ciliary body is used.

Complications reported so far include phthisis, chronic hypotony, corneal graft decompensation, macular pucker, cystoid macular oedema, hyphaema, vitreous haemorrhage, loss of visual acuity, retinal detachment, conjunctival burns, uveitis, and ocular pain.4 However, with the increasing use of TCDLC, more complications may be observed. This report describes pupillary distortion, a previously unreported complication.

CASE REPORT
A 32 year old man with bilateral juvenile glaucoma since 1987 was referred to our hospital. Trabeculotomy and cyclocryotherapy had been performed in both eyes. In June 1997 visual acuity of the right eye was 20/20 and of the left eye 20/400. Intraocular pressure (IOP) of the right eye was between 12 and 45 mm Hg under maximal medical treatment. IOP of the left eye was normal. Examination of both eyes revealed focal scleral thinning due to cyclocryotherapy. Gonioscopy revealed a wide

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COMMENT
It appears likely that pupillary distortion in this patient was the result of a peripheral iris injury, caused by an anterior displacement of the laser spot. The “pop” effect was caused by the distorsion of the iris pigment epithelium.

TCDLC using the G-probe is applied at the distance of 1.2 mm posterior to the surgical limbus, parallel to the visual axis, without visualisation of the ciliary body. At least three aspects should be taken into account in the discussion of causes for the displacement of laser spots during TCDLC. (1) Even in normal or emmetropic eyes, the anterior margin of the ciliary body varies between 1.5 and 2.2 mm depending on the meridian. (2) Individual variations in the anatomical location of the pars plicata of the ciliary body may exist in normal and, especially, in eyes affected by juvenile glaucoma. (3) Bloom and Weber have demonstrated, in human necropsy eyes, that relatively small changes in probe orientation may result in peripheral iris involvement.

Our observation supports the need for online control of the induced tissue reaction and visualisation of the ciliary body itself. In our opinion this may become an important online control of the induced tissue reaction depending on the meridian.

Unrrets-Zavalia syndrome following trabeculectomy

CASE 1
A 38 year old woman with bilateral advanced glaucoma was referred for further management of her condition. Her ophthalmic history included surgery to her left squint as a child and a pupillary distortion was observed toward the 2 o’clock position, where the “pop” effect had occurred (Fig 1). A pigment defect of the peripheral iris was seen in transillumination (Fig 2).

Unrrets-Zavalia syndrome following trabeculectomy

CASE 2
A 60 year old Turkish woman was referred with a high IOP in her right eye. She had no ophthalmic history of note. Her medical history was unremarkable and she took no medication.

On examination her best corrected visual acuities were 6/9 in the right eye and 6/6 in the left. Her anterior segments were normal and her IOPs were 40 mm Hg in the right eye and 15 in the left. Initial medical treatment failed to control her IOP and a right trabeculectomy was carried out 2 months after presentation. Since the operation her right IOP has been well controlled and took no systemic medication.

On examination her best corrected visual acuities were 6/6 in the right eye and 6/36 in the left with a left relative afferent pupillary defect. Her anterior segments were normal and her intraocular pressure (IOP) was 19 mm Hg bilaterally on timolol twice daily.

Figure 1 Case 1. Fluorescein angiogram shows delayed filling of the iris capillary plexus with large areas of non-perfusion on the right (A). The left iris is normal (B).

Figure 2 Case 2. Fixed and dilated right pupil (A). The left pupil is normal (B).
Correspondence to: Mr I E Murdoch

To our knowledge these are the first cases of Urrets-Zavalia syndrome to be reported after penetrating keratoplasty. The clinical features of this syndrome following penetrating keratoplasty for keratoconus.

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than altitude alone had contributed to the retinal haemorrhages seen.

Two prospective studies have shown that the incidence of retinal haemorrhage is greater in subjects exercising heavily at altitude, but is not related to the number of altitude related symptoms. Similar retinal changes are seen after Valsalva manoeuvres at sea level and pathological evidence suggests that haemorrhages at altitude are similar and originate from ruptured capillaries that become grossly dilated in response to chronic hypoxia.

This case reports retinal haemorrhages occurring without disc oedema or venous stasis in an otherwise healthy subject exercising at altitude. It seems that the most likely mechanism is that of Valsalva retinopathy.

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Panuveitis as a presenting feature of giant cell arteritis

EDITOR.—It is unusual for bilateral panuveitis to be a presenting feature of giant cell arteritis. We present a patient diagnosed as having giant cell arteritis who had developed panuveitis some months previously for which the arteritis was probably responsible.

CASE REPORT
A 79 year old woman presented with gradual blurring and photophobia of 6 weeks’ duration. There was no significant ocular history. She had had a recent history of weight loss and anorexia for which she underwent endoscopy which revealed a duodenal ulcer. Ophthalmological examination revealed a visual acuity of 6/12 in both eyes. There was no relative afferent pupillary defect. There were bilateral keratic precipitates and cells in anterior chamber and vitreous. The fundus examination revealed bilateral disc oedema, left disc haemorrhages, and multiple raised creamy subretinal peripapillary lesions (Fig 1). The general physical examination was essentially normal. Investigations revealed a hypochromic microcytic anaemia, an erythrocyte sedimentation rate of 98 mm in the first hour, normal angiotensin converting enzyme level, chest x ray, computed tomograph scan of head, orbits, abdomen, and pelvis, abdominal ultrasonography, and autoantibody profile. With the diagnosis of bilateral panuveitis she was started on systemic and topical steroids. The patient improved symptomatically on treatment with the visual acuity improving to 6/9 in both eyes. Ophthalmological examination revealed quiet anterior segments, slightly pale discs with flat subretinal peripapillary lesions, and there were no cells in the vitreous. Systemic steroids were gradually tapered over next few months. A year later she complained of further blurring, continuing weight loss, myalgia, and arthralgia. On examination she had visual acuities of 6/12 in the right eye and 6/18 in the left eye with quiet anterior segments, no relative afferent pupillary defect, and fundus changes similar to the previous episode with bilateral disc oedema, raised peripapillary creamy subretinal lesions with cells in the vitreous. She was also found to have non-pulsatile, non-tender temporal arteries. A temporal artery biopsy was performed which showed evidence of giant cell arteritis.

COMMENT
Partial or complete visual loss is the most common and the most serious ophthalmic complication of giant cell arteritis. Because giant cell arteritis is a potentially blinding disease and its early diagnosis is the key to preventing blindness, it is important to recognise its various ocular manifestations. Panuveitis as a presenting feature is uncommon and to the best of our knowledge this is the first report of a subacute panuveitis as a presenting feature of giant cell arteritis. There is one another case reported where the presenting feature was acute anterior and posterior uveitis. The fluorescein angiogram showed leakage from the subretinal peripapillary lesions and the optic discs (Fig 2) and there was no wedge shaped alteration suggestive of choroidal ischaemia. Although this patient had a history of weight loss and high erythrocyte sedimentation rate at presentation the diagnosis of giant cell arteritis was not considered because of this unusual presentation. Serum angiotensin converting enzyme levels, chest x ray, computed tomograph scans of abdomen and pelvis were done to exclude sarcoidosis and lymphoma. In conclusion we describe a case in which giant cell arteritis offers a possible explanation for the clinical picture of subacute panuveitis in the absence of an exhaustive search for an underlying cause.

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Panuveitis as a presenting feature of giant cell arteritis

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