Dense Kayser-Fleischer ring in asymptomatic Wilson's disease (hepatolenticular degeneration)

The Kayser-Fleischer ring is the single most important diagnostic sign in Wilson's disease; it is found in 95% of patients. Virtually all patients with Kayser-Fleischer rings have neurological manifestations. The density of a Kayser-Fleischer ring correlates with the severity of Wilson's disease. We describe a rare case of a dense Kayser-Fleischer ring in an asymptomatic patient with an extremely high liver copper content. The recent significant genetic advances, and the clinical implications are discussed.

Case report

At the age of 14 this 23 year old white woman had an eversion of her left eye for painful subacute glaucoma following chronic retinal detachment, resulting from ANA positive iridocyclitis. Her optician referred her because over the past few years, her left prostatic eye had repeatedly needed an increasingly dense brown ring painted onto it, to match her remaining eye. On examination the visual acuity in the right eye was 6/6 with a heavily pigmented red brown Kayser-Fleischer ring (Fig 1). Her systemic and neurological examination were normal.

Baseline biochemistry, liver function, haematology, and cerebral magnetic resonance imaging (MRI) were normal. She was ANA positive 1 in 20, serum copper 11.6 µmol/l (normal 11–22), and ceruloplasmin 0.15 g/l (normal 0.15–0.45). Twenty four hour urinary copper 9.2 µmol/24 h (normal 0.9 µmol/24 h). Haematoxylin and eosin stained liver biopsy showed normal architecture. Orein and rhodanine stains showed patchy excessive copper binding protein, and copper within the hepatocytes. The quantified copper content of the sample was hugely elevated at 3000 µg/g (normal 20–50 µg/g). She was treated with trientine dihydrochloride. The Kayser-Fleischer ring initially became denser but has faded considerably over the past 5 years; a thin rim still persists (Fig 2).

The patient remains well with no hepatic or neurological manifestations.

Comment

This patient had an extremely elevated liver copper level, 60 times the normal level. She had to our knowledge the highest ever published liver copper content level over twice the highest level recorded in other publications. She had a very dense Kayser-Fleischer ring, but no neurological or hepatic abnormalities. Despite the severity of her condition she remained neurologically asymptomatic with normal liver architecture.

Wilson's disease is inherited as an autosomal recessive trait. The defect has been mapped and sequenced to the long arm of chromosome 13 (13q14.3). The Wilson's gene is responsible for a defective membranous bound P-type ATPase copper transport molecule, ATP7B. This is located in the trans golgi network; the ATPase delivers copper to copper binding ceruloplasmin. During elevated copper levels vesicles containing the ATPase and copper are released by exocytosis into bile. In patients with a defective gene there is an abnormal accumulation and, in comparison, low excretion of stored liver copper. These findings contrast with previous theories that Wilson's disease was caused by a defect of apo-ceruloplasmin post-translational modification, and abnormal binding to ceruloplasmin.

There are a large number of copper binding ATP7B mutations. The clinical heterogeneity and overlap of clinical manifestations suggest that locus heterogeneity alone is unlikely to be responsible: It has been hypothesised that there is a subset of pedigrees in which an additional gene is affected other than that for ATP7B. Genes encode proteins for detoxification of stored copper—for example, metallothionein, and neutralisation of free radicals such as super oxide dismutase. This could be a plausible explanation as to why such an extraordinarily high level of copper was bound safely in this patient's liver.

Untreated Wilson's disease has progressive, irreversible consequences, and ultimately causes death. The identification of a Kayser-Fleischer ring remains the most important clinical sign for the diagnosis of Wilson's disease.

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References


Rapidly developing intimal fibrosis mimicking giant cell arteritis

Temporal headache associated with a tender superficial temporal artery and decreased pulse on palpation are characteristics of giant cell arteritis. We report the clinical and biopsy findings in a patient in whom these symptoms were caused by a rapid developing intimal fibrosis.

Case report

A 51 year old woman presented with a 2 month history of a tender and painful left superficial temporal artery (STA). First she noticed a "thickened cord" on the left temple which felt pulsatile on palpation. Within 6 weeks the throbbing pulse disappeared and was followed by tenderness and pain. She also reported arthritic pain in the limbs and a morning cough over a 2 year period. She had smoked 40 cigarettes per day for 30 years. On examination the left STA felt hardened, knotted, non-pulsatile, and was slightly tender over a 2 cm distance (Fig 1, cross). There were no bruises on auscultation of major arteries. The facial and maxillary arteries were soft and
follow up period and subsequent ESR and CRP were normal. She continued having diffuse body pain.

Comment
GCA is a neurological emergency which, when left unrecognised and untreated frequently leads to permanent blindness. 1 ESR can be normal in 5–30% of patients, 2 but this is an exceptionally rare diagnosis in middle aged patients.

In summary, our patient presented with a clinical picture suspicious of vasculitic occlusion of the superficial temporal artery, polymyalgia, and cough. We present this case as an illustration that this clinical picture can result from rapidly developing intimal fibrosis without any evidence of inflammation.

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References

Fixed dilated pupil following deep lamellar keratoplasty (Urrets-Zavalia syndrome)

A fixed dilated pupil following penetrating keratoplasty is a well recognised if rare postoperative complication. We report a case of Urrets-Zavalia syndrome following a deep lamellar keratoplasty (DLK). To our knowledge this association has not been previously described.

The mydriasis following penetrating keratoplasty was first described by Castroviejo (Castroviejo R, personal communication) but it was Urrets-Zavalia who first published his observations on a series of six cases and suggested an association of fixed dilated pupil, iris atrophy, and secondary glaucoma.

The incidence of this syndrome is estimated at 5.8%, from pooled data on 445 eyes undergoing penetrating keratoplasty for keratoconus, of which 24 eyes developed a fixed dilated pupil. Davies and Ruben also found a similar incidence. However, other more recent studies find no cases, 5,6 and some even question its continued existence. This may in part reflect improved surgical technique and differing diagnostic criteria.

The pupil can become abnormally dilated following penetrating keratoplasty for keratoconus, particularly if dilating drops are used. There are three main groups of pupillary dilatation:

(1) A pupil with normal light and near reaction which is at least 1.5 mm larger than its fellow unoperated eye. It fully constricts with topical miotics. An incidence of approximately 90% has been reported for this type of abnormality.

(2) An unreactive paretic pupil that returns slowly to normal.

(3) Irreversible pupil dilatation with iris atrophy.

This syndrome has also been reported when no dilating drops were used. 7

In addition to the pupil and iris abnormalities, Urrets-Zavalia also described other features—iris ectropion, pigment dispersion, anterior subcapsular cataract and posterior synechiae. No early postoperative pressure rises were documented, although some had peripheral anterior synechiae and secondary glaucoma. Gasset also describes the glaucoma as a secondary phenomenon, commenting that it is not integral to the syndrome. 8 In the series presented by Pouliquen et al, severe anterior uveitis, fibrinous exudate, and birefringent posterior synechiae are described. 9 An early postoperative intraocular pressure rise is documented in two of the three cases presented by Tuft and Buckley. 10

We describe the case of a patient undergoing deep lamellar keratoplasty for keratoconus who developed a permanently dilated pupil with iris atrophy. In addition she had marked anterior uveitis and posterior synechiae similar to the cases presented by Pouliquen et al. 1

Dilating drops were not used.

In her medical history of note was atopic eczema and hay fever.

The eye became painful during the first postoperative evening. At the first dressing the next morning she was unresponsive with a 7.75 mm diameter recipient DLK was performed with parabulbar anaesthesia with sedation. Disposable Beaver Haggard suction trephines were used and the deep lamellar dissection performed after an indentation of the limbus as described by Tuft and Buckley. 11 A paracentesis was performed and no viscoelastic or air was injected into the anterior chamber. The procedure was uncomplicated.

The visual acuity at 1 month postoperatively was 6/9+ with −1.75/−1.50 × 125. Unfortunately 11 weeks postoperatively she developed an inferior retinal detachment. No breaks were identified but she underwent a cryobuckle procedure with an encircling band. Six months after her initial surgery she sees 6/12 wearing a contact lens correction of −2.25/−3.50 × 65. She is still troubled by glare and is somewhat unhappy with the cosmetic appearance of the eye.

Comment
The precise aetiology of this syndrome is unknown; it has been suggested that iris ischaemia can develop if it is compressed between the lens and cornea during surgery. 8

This cannot be the explanation for the patients undergoing deep lamellar keratoplasty. Urrets-Zavalia syndrome has also been described after penetrating keratoplasty for other indications and after cataract surgery.

Urrets-Zavalia suggested that the strong mydriasis produced by atropine at the time of publication was useful to exclude an inflammatory cause of the pupil dilatation. 3

Figure 1 Thickened, tender, and painful superficial temporal artery in a 51 year old woman. At the site of biopsy the artery was pulseless (cross). A knotted appearance is also present distally and rostrally (arrow).

Figure 2 Photomicrograph showing a segment of the superficial temporal artery with severely narrowed lumen (asterisk). The internal elastic lamina (a) is well preserved (elastica stain). The intima is considerably thickened (b) and shows tissue proliferation. There are no signs of necrosis, inflammation, or thrombus.
surgery brought the iris into contact with the peripheral cornea to produce peripheral anterior synchia and glaucoma.1–3 Davis and Ruben noted the condition was more common in the absence of a peripheral iridotomy and proposed a mechanism of relative pupil block.4 Nunnall comments that in over 1000 cases of penetrating keratoplasty he has never seen this condition and suggests that performing a peripheral iridotomy in phakic patients is protective.5 Interestingly he always uses dilating drops.

It has been suggested that the iris is in some way abnormal in keratoconus, supported by the observation that these pupils remain dilated for longer periods following mydriasis than in normal eyes.6 Keratoconic eyes seem to hyperreact to application of mydriatics as far as speed of dilatation and duration of effect, this observation is also seen the eyes of patients with Down’s syndrome.7

An abnormality of the sympathetic nervous system in the keratoconic eye remains unproven.8

Davies and Ruben also suggest that direct iris trauma during surgery could result in strangulation of iris vessels in the mid-periphery and ischaemic paralysis of the sphincter pupillae.9

Tuft and Buckley suggest in the presence of raised intraocular pressure, the low ocular rigidity of the keratoconic eye permits occlusion of the vessels at the root of iris within the sclera, which results in iris ischaemia while preserving ciliary body function.10

This case, the first to our knowledge, describes the Urrets-Zavalia syndrome following a lamellar keratoplasty. The compressive theory cannot play a part in this instance and it may lend support to the theory of an intrinsic iris abnormality in keratoconus. Equally, the pain she experienced on the first post-operative evening may have been secondary to raised intraocular pressure and perhaps supports the ischaemic theory.11 In either case, this syndrome is still poorly understood.

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and exudative retinopathy was first described  

The association between retinitis pigmentosa  

slightly less extensive and the visual acuity  

treatment. One year later the retinal telangiectasia were treated with retinal cryo-  

made and the areas of most severe tel-  

ative retinopathy, and retinitis pigmentosa was  

constriction in both eyes.  

(Fig 2B). Visual field testing revealed marked  

under both scotopic and photopic conditions  

gram (ERG) showed an isoelectric response  

macular oedema (Fig 2A). An electroretinogram showing isoelectric  

adjacent telangiectasia. (B) Scotopic  

Figure 2  

both eyes showed extensive subretinal exuda-  

tion, serous retinal detachment, and overlying  

retinal telangiectasia (Fig 1A). There was  

cystoid macular oedema with a lamellar  

macular hole in the left eye. The optic discs  

were normal. Additionally, mottled  

macular ischaemia and disc neovascularisation in  

the right eye, and minimal retinal ischaemia in  

the left eye (Fig 1). Her visual acuities were  

6/12 in the right eye and 6/9 on the left. There  

was no anterior segment neovascularisation in  

either eye. Carotid Doppler and carotid  

angiography showed critical stenosis at the  

origin of the right internal carotid artery. The  

right middle cerebral artery branches were  

visualised as a result of retrograde flow  

through the ophthalmic artery. The left inter-  

nal carotid was narrowed by 50% and  

there were no collaterals to the right hemi-  

sphere (Fig 2). Fluorescein angiography re-  

vealed a prolonged transit time with slow fill-  

ing of choroidal and retinal vasculature,  

everal retinal capillary closure, and leak-  

age from the disc neovascularisation.  

One year later the optic disc neovascularisa-  

tion and retinal ischaemia were unchanged  

with no iris neovascularisation. In April 1997  

she underwent an uneventful right carotid  

endarterectomy. Two months later she de-  

veloped clinically significant macular oedema in  

the right eye that was treated with focal argon  

laser photoagulation.  

Six months later the maculopathy had  

resolved and 14 months after surgery there  

was complete resolution of the optic disc neo-  

vascularisation. Three years after surgery the  

right eye had a visual acuity of 6/9, a near  

normal fluorescein angiogram transit time,  

minimal peripheral retinal ischaemia, and no  

posterior segment neovascularisation.

Resolution of proliferative venous stasis retinopathy after carotid endarterectomy  

Ocular ischaemic syndrome (OIS) may present as an asymmetric retinopathy in  

diabetic patients. We report a case of asymmetric diabetic retinopathy with posterior  

segment neovascularisation due to OIS associated with critical ipsilateral carotid stenosis  

where the neovascularisation resolved after carotid endarterectomy.

Case report  

A 50 year old woman presented in May 1996 with left sided weakness. She had hypercho-  

lesterolaemia, hypertension, a family history of vascular disease, and was a smoker. She  

was found to be diabetic with peripheral reti-  

nal ischaemia and disc neovascularisation in  

the right eye, and minimal retinal ischaemia in  

the left eye (Fig 1). Her visual acuities were  

6/12 in the right eye and 6/9 on the left. There  

was no anterior segment neovascularisation in  

either eye. Carotid Doppler and carotid  

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origin of the right internal carotid artery. The  

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right eye had a visual acuity of 6/9, a near  

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minimal peripheral retinal ischaemia, and no  

posterior segment neovascularisation.

References


Comment

The association between retinitis pigmentosa and exudative retinopathy was first described  

in 1956 and has been termed a “Coats’-like RP.” Various studies have suggested that 1–4%  

of RP cases will show such a response. The entity differs from true Coats’ disease in that  

Coats’-like RP often occurs bilaterally, has no sex predisposition, and shows diffuse pig-  

mented alterations in both fundi. The cause is unknown but it may represent a vasodila-  

tory response to toxic products of photoreceptor/RPE degeneration. Our case is  

unusual in that almost all previous reported  

cases have occurred in the setting of long-  

standing RP. Our patient had never con-  

sulted an ophthalmologist despite being night  

blind and having markedly constricted visual  

fields. We recommend that ophthalmologists  

consider an underlying diagnosis of retinitis pigmentosa in any patient presenting a  

picture of bilateral exudative retinopathy.

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Comment

Ocular ischaemic syndrome (OIS) is characterised in the anterior segment by flare and initial hypopyon, with later iris neovascularisation. Retinopathy with neovascular proliferation occurs in the fundus because of chronic hypoperfusion. The development of neovascular glaucoma can lead to permanent blindness.\(^5\) In the diabetic patient OIS is superimposed on any pre-existing diabetic retinopathy, and markedly asymmetric retinopathy should prompt a search for underlying ischaemia from carotid occlusive disease. Diabetic patients with marked proliferative changes require treatment with panretinal photocoagulation (PRP), which has been shown to reduce the risk of severe visual loss and neovascular glaucoma. However, there is no clear evidence for the benefit of PRP in patients with OIS. In one study only 36% of OIS patients with iris neovascularisation responded to PRP which may be due to unclear rather than retinal ischaemia.\(^6\)

Angiography showing narrowing of the right internal carotid artery (A, arrow) and angiography of the left side (B) revealing lack of crossflow to the right cerebral hemisphere, allowing the development of collateral circulation via the ophthalmic artery.

Ocular Carotid Surgery Trial showed that the risk of ischaemic stroke in symptomatic patients with 70–99% carotid stenosis with medical treatment was only 20% over 3 years and CEA lowered this by 50%. Based on the results of this a risk factor score suggested that a cerebral rather than an ocular event had a greater risk for stroke on medical treatment and would therefore derive greater benefit from surgery.\(^7\)

In the absence of iris neovascularisation and severe peripheral retinal ischaemia the ocular changes in patients with OIS can be monitored closely for the development of iris neovascularisation but the retinal vascularisation may not require early treatment with PRP.

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References

Identifying the proportion of age related macular degeneration patients who would benefit from photodynamic therapy with verteporfin (Visudyne)

Verteporfin has recently been licensed for the treatment of subfoveal exudative cases of age related macular degeneration (AMD); however, it is not clear how many patients would actually benefit from this treatment.\(^1,2\) This question has far reaching implications in terms of verteporfin’s introduction into the National Health Service in the United Kingdom.

Case report

We have recently looked at a cohort of 1418 new referrals (out of a possible 1481 (95.7%)) seen at the 166 consultant outpatient clinic at Southampton Eye Unit, between 1 December 2000 and 31 January 2001. Diagnoses were obtained from the consultant’s letter to the referring doctor following the clinic visit to obtain the spectrum of diagnoses made. When two eyes were similarly affected this was recorded as a single diagnostic event.

Cataract related diagnoses\(^3\) were found to be most frequent, accounting for 28.8% (397) of the total. This was followed by retinal disease\(^4\) at 23.4% (485).

Within the retinal disease group AMD was the single most frequent diagnosis even though it may not have been the primary reason for referral, accounting for 22.3% (108) of the 485 retinal disease cases recorded. Of the 108 AMD patients identified, 62% (67) were female and 38% (41) male, the majority being above the age of 75 (90.7%). Approximately 78% (84) of the total number of patients had AMD affecting both eyes with unilateral involvement in the remaining 22% (24).

Of the 108, most were not felt to need further investigation, having either established and untreatable disease or mild changes. Only 13% (14) underwent further investigation with fluorescein angiography. Of these, four were thought to be possibly suitable for verteporfin treatment with only one fully meeting the criteria for treatment, having a predominantly classical subfoveal membrane.\(^2,4\)

Co-existing ocular diseases such as cataract and glaucoma were treated in 49% (53) of the 108 patients, cataract extraction predominating (70% (37)).

The majority of the 107 patients (77) who did not receive verteporfin therapy did not require or were not suitable for any further assistance for their AMD. The remainder (30) were assessed for low vision aids and/or registered as partially sighted/blind.

Comment

Photodynamic therapy with verteporfin has caused much excitement, as it is heralded as a breakthrough in the treatment of exudative AMD.\(^6\) A recent editorial in the BJO suggested
that 20–30% of the 200,000 cases of exudative AMD that present to ophthalmologists each year in the United States would benefit from such photodynamic therapy.1 Southampton Eye Unit serves approximately 570,000 people as part of its main catchment area, corresponding to approximately 1% of the UK population, and produced only one person over the 2 month study period suitable for treatment with verteporfin by the strict criteria for its use.1,3 The period studied was before the awareness of photodynamic therapy was fully developed and represents an unselected group of patients having some degree of AMD. Subsequent studies might show a higher proportion of suitable patients. However the referral is with a view for verteporfin treatment. Between August 2000 and April 2001 a total of 24 patients were assessed for verteporfin therapy resulting in seven receiving treatment, in keeping with the 4:1 ratio of those assessed and treated in the 2 month study. While it is difficult to extrapolate from such a small number it would seem that the number likely to benefit from verteporfin treatment may well be smaller than suggested even if the treatment criteria was extended to include occult, myopic, and idiopathic lesions.3,4 Even with the addition of verteporfin therapy to the ranks of the treatment modalities available, the vast majority of AMD patients are still considered untreatable if the treatment criteria are observed.1,3 Rehabilitation in the form of low vision aids, registration as partially sighted or blind, and the treatment of co-existing ocular disease remains the mainstay of help that the ophthalmologist can offer.4 However, the interest created and accepted value of verteporfin should not be underestimated. It represents a new and non-destructive approach to the problem (in contrast with laser photocoagulation) and the first of a novel treatment option likely to be joined by others in the not too distant future.

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References
In the recent paper by Feltgen and colleagues, the intraocular pressure (IOP) was measured by Goldmann applanation tonometry and by using a cannula inserted into the anterior chamber connected with a pressure transducer. Thus, the measurement took place omitting a possible influence of the cornea on the result. Marx et al believed that by intracameral measurement the “true” intraocular pressure may be measured. Feltgen et al share his opinion. They believe, thereby, that they have compared the intraocular pressure measured with and without the possible influence of the cornea.

Feltgen et al write in their conclusion: “There is no systematic error of applanation tonometry with increasing central corneal thickness (CCT). Therefore it is inadequate to recalculate IOP based on regression formula of applanatory IOP versus CCT.” They base their conclusion on their results. In our opinion their paper shows the following methodological deficits: (1) Both methods used for measuring IOP are not up to the demands of the scientific technique of measurement; (2) their intracameral measured IOP values do not reflect the IOP because of bias; (3) a non-significant regression coefficient does not prove that the slope is actually 0 and, therefore, by a non-significant regression coefficient it is not proved that applanatory readings are not influenced by CCT; (4) the goodness of fit of the linear regression model is insufficient; and (5) an important covariate (true IOP value) was omitted in the linear regression. We would like to discuss these points in detail.

In the study of Feltgen et al the only criterion for the quality of measurement is the stability of the readings on the monitor. However, it is not sufficient to conclude from the presence of stability that the scale readings represent the “true” pressure value that is at the tip of the cannula. If there were a barrier inside the cannula the reading on the monitor would also be stable but would not represent the pressure at the tip. There are many pitfalls in pressure measurements by thin tubes that we know from the literature. "Minute air bubbles or tiny particles influence the result a great deal. If we want to know that a display reading represents the quantity in question then we have to estimate how the measurement system has the opportunity to react freely to changes in the quantity. This guarantee can be obtained by feeding a known signal to the input of the system and by observing the output. If the output reacts in the expected way then the guarantee is given. Ehlers et al realised this in their rabbit experiments and in electrophysiology.” As long as this demand is not met the results are not definitive, giving cause for criticism and leading to misinterpretations.

Feltgen et al write in their paper (p 86): “...however, we believe intracameral measured IOP values reflect the ‘true’ IOP more accurately.” Scientific facts should not be a matter of belief. The belief of the authors in the values they measured is not justified. In the study under discussion their figure 2 shows the scatter plot of the pressure differences versus central corneal thickness. From this diagram and from their statistical calculations the authors draw their conclusions. Their results are quite different from those of Ehlers et al of the same article. From this diagram we must compare these two data sets. To facilitate this task, we have digitised the data presented in the figures of Feltgen et al and of Ehlers et al. They are shown here in Figures 1 and 2 on the same scale. The difference is striking.

Let’s first consider a possible reason from the physical point of view. Ehlers et al reduced the pressure measurement to a basic physical quantity, here to the length of a water column. We can, therefore, trust the results of Ehlers et al more than the results of Feltgen et al who used a pressure transducer which has a zero point fluctuation of up to 4.5 mm Hg (Abbott GmbH, data file). It is recommended also by the manufacturer that the zero point of the measurement system has to be determined for each patient by comparison with a water column (Dr Beer, Abbott GmbH, Wiesbaden, personal communication). This procedure is not described by Feltgen et al.

Therefore, none of the methods used in the article by Feltgen et al may be called a reference method and all methods may be prone to error and bias. Hence, analysis of differences in IOP between these models is inappropriate in order to decide on the necessity of a conversion formula.

Further, the variability of differences is large, which is probably the result of errors in the intracameral measurement of IOP. Regression lines with a small non-significant slope (0.38 mm Hg IOP difference per 0.1 mm cornea thickness in the article by Feltgen et al may occur in both situations where variability is both high and low. Only, in the latter case, whereas as a consequence of the small variability—the confidence interval for the slope is narrow, may this be interpreted in the way that the covariate included in the model (that is, CCT) has no effect. If the variability is higher and the slope is approximately 0, this may lead to the conclusion that IOP measurement is inappropriate because of too large an error. This conclusion is allowed if no other essential covariates were overlooked. If variability is high and the slope of the regression line is near 0, a large p value may not be interpreted as a proof of no effect of the covariate considered in the regression model. For better interpretation of the results a confidence interval for the estimated slope should be evaluated first. If measurements by applanatory IOP are highly correlated with measurements by the reference method a conversion formula may be derived from linear regression. Under the assumption of small variability of residuals (difference between observed value and regression line)—that is, a satisfactory goodness of fit (for example, r²>50%), results may lead to the recommendation of the use of a conversion formula. In contrast, Feltgen et al report an r² of 0.2%. Only for small residuals, a slope approximately 0, and a confidence interval with limits near 0, may the recommendation that a conversion formula is not necessary be given.

Moreover, the large variability in IOP differences may occur because Feltgen et al do not adjust for “true” intraocular hydrostatic pressure as Ehlers et al did. Since Ehlers et al calculated separate linear regression models for 10 mm Hg and 30 mm Hg which resulted in different intercepts and slope parameters, this might be another source of variation in the IOP differences from Feltgen et al which were unadjusted.

We hope our arguments are convincing and ask that you bring them to the attention of your readers.

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Authors' reply
In reply to the comments of Stödtmeister and colleagues on our recent paper, we won't argue about the correlation between central corneal thickness (CCT) and intraocular pressure (IOP), but we mistrust the clinical application of correcting factors. Stödtmeister et al compare our study to that of Ehlers et al which is often cited to prove an influence of corneal thickness in an applanatory measurement.

In our paper simultaneous IOP measurement by application and intracameral tonometry was performed. Assuming a normal CCT of 520 μm, an IOP correction for every 10 μm change in corneal thickness is recommended. But in the Ehlers paper, there are some confusing arguments. Ehlers et al describe a very good correlation between direct and intracameral IOP measurement (correlation coefficient approximated 1). Unfortunately, they didn't give the measured IOP values. In figure 2, the slopes of correlation lines at different CCT are approximately 1. Unfortunately, they didn't give a hint on the influence of CCT on IOP alterations. In summary, the above mentioned study gives a hint on the influence of CCT on IOP measurement, but does not prove this assumption. It is amazing that within the last 25 years nearly 50 published papers refer to the Ehlers study without checking the results by intracameral measurement. Author's reply

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NOTICES
Onchocerciasis
The latest issue of Community Eye Health (No 38) discusses onchocerciasis and the impact of interventions, with an editorial by Bjorn Thylefors, former director of the Programme for the Prevention of Blindness and Deafness, WHO. For further information please contact Community Eye Health, International Centre for Eye Health, Institute of Ophthalmology, 11–43 Bath Street, London EC1V 9EL. (tel: +44 (0) 20 7608 6990/6910/6923; fax: +44 (0) 7250 3207; email: eyeresource@ucl.ac.uk).

Annual subscription £25. Free to workers in developing countries.

International Centre for Eye Health
The International Centre for Eye Health has published a new edition of the Standard List of Medical Equipment, Instruments, Supplies (2001) for eye care services in developing countries. It is compiled by the Task Force of the International Agency for the Prevention of Blindness. Further details: Sue Strevel, International Centre for Eye Health, 11–43 Bath Street, London EC1V 9EL, UK (tel: +44 (0) 20 7608 6910; email: eyeresource@ucl.ac.uk).

Leonhard Klein Award 2002
To promote ophthalmic surgery the Leonhard Klein Foundation bestows the Leonhard Klein Award 2002 for innovative, scientific works in the field of development and application of microsurgical instruments, as well as for microsurgical operating techniques.

The award is endowed with 15,000€ and can be conferred to an individual person as well as to a group of researchers. The prize sum must be spent for research in the field of ophthalmic surgery. Individual and third party applications are accepted. Five copies of the works must be submitted in either English or German. The deadline for applications is 31 March 2002. Applications should be sent to: Stifterverband für die Deutsche Wissenschaft e.V., Frau Dr Marilen Macher, Postfach 164460, D-45224 Essen, Germany.

Second Sight
Second Sight, a UK based charity whose aims are to eliminate the backlog of cataract blind in India by the year 2020 and to establish strong links between Indian and British ophthalmologists, is regularly sending volunteer surgeons to India. Details can be found at the charity website (www.secondsight.org.uk) or by contacting Dr Lucy Mathen (lucymathen@yahoo.com).

Specific Eye Conditions (SPECS)
Specific Eye Conditions (SPECS) is a not for profit organisation which acts as an umbrella organisation for support groups of any conditions or syndrome with an integral eye disorder. SPECS represents over fifty different organisations related to eye disorders ranging from conditions that are relatively common to very rare syndromes. We also include groups who offer support of a more general nature to visually impaired and blind people. Support groups meet regularly in the Boardroom at Moorfields Eye Hospital to offer support to each other, share experiences and explore new ways of working together. The web site www.eyeconditions.org.uk acts as a portal giving direct access to support groups own sites. The SPECS web page is a valuable resource for professionals and may also be of interest to people with a visual impairment or who are blind. For further details about SPECS contact: Kay Parkinson, SPECS Development Officer (tel: +44 (0)1803 524236; email: k@eyeconditions.org.uk; www.eyeconditions.org.uk).

4th International Conference on the Adjuvant Therapy of Malignant Melanoma
The 4th International Conference on the adjuvant therapy of malignant melanoma will
be held at The Royal College of Physicians, London on 15–16 March 2002. Further details: Conference Secretariat, CCI Ltd, 2 Palm erston Court, Palmerston Way, London SW8 4AJ, UK (tel: +44 (0) 20 7720 0600; fax: +44 (0) 20 7720 7177; email: melanoma@confcomm.co.uk; website: www.confcomm.co.uk/Melanoma).

EUPO 2002 Course Retina
A course on retina will be held on 15–17 March 2002 at Erlangen, Germany, where European professors will teach European residents. Further details: Priv Doz Dr Ulrich Schonherr, Friedrich-Alexander-University of Erlangen-Nuemberg, Department of Ophthalmology, Schwabachanlage 6 (Kopfklinikum), D-91054 Erlangen, Germany (tel: +49 9131 853 4379; fax: +49 9131 853 4332; email: ulrich-schoenherr@augen.imed.uni-erlangen.de).

XXIXth International Congress of Ophthalmology
The XXIXth International Congress of Ophthalmology will be held on 21–25 April 2002 in Sydney, Australia. Further details: Congress Secretariat, C/- ICMS Australia Pty Ltd, GPO Box 2609, Sydney, NSW 2001, Australia (tel: +61 2 9241 1478; fax: +61 2 9251 3552; email: ophthal@icmsaust.com.au; website: www.ophthalmology.aust.com).

12th Meeting of the European Association for the Study of Diabetic Eye Complications (EASDEC)
The 12th meeting of the EASDEC will be held on 24–26 May 2002 in Udine, Italy. The deadline for abstracts is 15 February 2002. Three travel grants for young members (less than 35 years of age at the time of the meeting) are available. For information on the travel grants, please contact Pr CD Agardh, President of EASDEC, Malmö University Hospital, SE-205 02 Malmö, Sweden (tel +46 40 33 10 16; fax: +46 40 33 73 66; email: carl-david.agardh@endo.mas.lu.se). Further details: NORD EST CONGRESSI, Via Aquilea, 21–33100 Udine, Italy (tel: +30 0432 21391; fax: +39 0432 50687; email: nordest.congressi@ud.nettuno.it).

International Society for Behçet’s Disease
The 10th International Congress on Behçet’s Disease will be held in Berlin 27–29 June 2002. Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).

Singapore National Eye Centre 5th International Meeting
The Singapore National Eye Centre 5th International Meeting will be held on 3–5 August 2002 in Singapore. Further details: Ms Amy Lim, Organising Secretariat, Singapore National Eye Centre, 11 Third Hospital Avenue, Singapore 168751 (tel: (65) 322 8374; fax: (65) 227 7290; email: Amy_Lim@snec.com.sg).

CORRECTION
We regret that an error occurred in the mailbox letter published by Kenawy et al in the November 2001 issue of BJO (2001;85:1394–5). The name of one of the authors was incorrect and should have been Omar M Ayoub.
Resolution of proliferative venous stasis retinopathy after carotid endarterectomy

Christina A Rennie and Declan W Flanagan

doi: 10.1136/bjo.86.1.117

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