Long term survival of patient with invasive aspergillosis involving orbit, paranasal sinus, and central nervous system

Aspergillus infections of the paranasal sinuses are classified as invasive or non-invasive. The vast majority are non-invasive with a good prognosis; however, the invasive type behaves as a malignant neoplasm with bone destruction, orbital and intracranial extensions, and a high mortality rate.

We present one patient with invasive paranasal aspergillosis that extended into the orbit and cranial cavities, and who has survived for 9 years and 1 month.

Case report
Along with headaches and periorbital pain beginning in July 1993, a 64 year old woman noticed a decrease in vision in her right eye and visited us on 7 September 1993. She had poorly controlled diabetes mellitus. Her corrected visual acuity was 20/30 right eye and 20/20 left eye, and her critical flicker fusion frequency was 25 Hz right eye and 32 Hz left eye. A central scotoma with a relative afferent pupillary defect was present in the right eye.

The patient underwent debridement and removal of the frontal bone on 24 December because of the development of an epidural abscess. In February 1994, the abscess subsided but still persisted following antibiotics and antifungal therapy.

The patient was transferred to the department of neurological surgery on 13 October. Antifungal therapy was continued with the addition of oral itraconazole (200 mg/day). Carotid angiography demonstrated that extension of the right ophthalmic artery. A frontal craniotomy was performed on 1 November, and a fibrous granulomatous lesion was found in the right posterior ethmoid sinus, sphenoid sinus, cavernous sinus, and orbit that extended to the right optic nerve. The orbit was necrotic and the sphenoid sinus was severely eroded. Cultures and histopathological examinations were negative for Aspergillus.

The sphenoid sinus mucosa was positive for Aspergillus by methenamine-silver stain, and patient’s immunological status was fairly well controlled, presumably contributing to this long survival. The sphenoid sinus mucosa was positive for Aspergillus but it was not found at the time of the intracranial surgery probably because of the extensive antifungal therapy before surgery and/or the low viability of the mycelium in a fungus ball.

The long term survival of this patient with orbital-paranasal aspergillosis despite intracranial extension is attributed to early diagnosis, optimal antifungal therapy, complete surgical debridement, and the improvement in the patient’s systemic condition.

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The effect of topical glaucoma medications evaluated by perimetry

The emphasis of treatment for glaucoma has been the reduction of intraocular pressure (IOP) to a safer level, which, in turn, theoretically will prevent further visual loss. It has been assumed that lowering IOP by medical means has no adverse effect, which could negate the beneficial effect of IOP reduction. However, several reports have raised the possibility that some may adversely affect visual function. In several studies, levobunolol and timolol were compared with respect to their effect on IOP reduction and perimetric findings. Although timolol lowered IOP more effectively, betaxolol was more effective in preserving the visual field.

These findings suggest that IOP reduction is not the only parameter that demands attention. In this study, we attempted to evaluate various topical antiglaucoma medications in a normal population in terms of their short-term effect on visual function; only minimal effects on IOP reduction were expected since this study population did not have glaucoma.

Methods

Five prospective, randomised, masked studies of levobunolol, dipivefrin, apraclonidine, betaxolol, and dorzolamide, respectively, were conducted over 5 years. In each study, 20 normal volunteers had baseline testing, including measurement of visual acuity (VA), IOP visual field (VF) with the Humphrey computerised perimeter (HCP) program 24-2, and pupil size. One eye was randomly assigned to treatment and given a test dose of either a glaucoma medication or a placebo. VF testing and given a test dose of either a glaucoma medication or a placebo. VF testing was repeated in 1 hour. The same eye was later treated with endoscopic cyclophotocoagulation for treating refractory post-PK penetrative keratoplasty glaucoma.

Endoscopic cyclocryocoagulation (ECP) was introduced as an alternative to trans-scleral cyclocryocoagulation for treating refractory glaucomas in order to minimise complications such as phthisis and hypotony by providing direct visualisation of the ciliary processes. ECP is following penetrating keratoplasty, which has an incidence ranging from 10–52%, often proves refractory to medical treatment. We introduce a case of refractory post-PK penetrative keratoplasty glaucoma and to describe its potential delayed effect in achieving intraocular pressure control.

Case report

A 50 year old African-American man, who had undergone previous cataract surgery, anterior vitrectomy, and anterior chamber intraocular lens placement in his left eye in 1987, presented with pseudophakic bullous keratopathy and hand movement vision in his left eye. In April of 2000, the patient underwent a penetrating keratoplasty in which an 8 mm donor graft was placed in a 7.5 mm host site. Two weeks following the procedure, the patient developed elevated intraocular pressure in the 45–50 mm Hg range which was refractory to conventional medical therapy and discontinuation of topical steroids. An Ahmed valve was placed in June of 2000, yet his intraocular pressure eventually returned to the preoperative range despite the addition of four topical glaucoma medications (timolol 0.5%, brimonidine 0.2%, dorzolamide 2.0%, and lamotrigine 0.05%).

In April of 2001, the patient underwent treatment with endoscopic cyclocryocoagulation via a limbal approach as described by

Table 1

<table>
<thead>
<tr>
<th>Glaucoma Medications</th>
<th>MD (dB)</th>
<th>C/W Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dipivefrin</td>
<td>−0.86</td>
<td>−0.64</td>
</tr>
<tr>
<td>Apraclonidine</td>
<td>−0.44</td>
<td>−0.45</td>
</tr>
<tr>
<td>Levobunolol</td>
<td>−2.90</td>
<td>−1.90*</td>
</tr>
<tr>
<td>Betaxolol</td>
<td>−1.23</td>
<td>−0.79</td>
</tr>
<tr>
<td>Dorzolamide</td>
<td>+0.16</td>
<td>+0.12</td>
</tr>
</tbody>
</table>

* p<0.05

References

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The patient received 300 degrees of treatment at settings ranging from 20–50 mW of energy with laser applied for 0.5–2 seconds, until ciliary process whitening and contraction was observed (Fig 1).

Despite being restarted on all four of his cycloablation.

**Comment**

Previous studies have demonstrated significant pressure lowering within 2–4 weeks of endoscopic cyclophotocoagulation. This represents the first reported case of late success with ECP, with intraocular pressure control achieved more than 3 months following ECP. Though both topical corticosteroids and cycloplegics may lead to a rise in intraocular pressure, the pressure remained elevated for more than 3 months. However, 14 weeks after the cyclodestructive procedure, the intraocular pressure suddenly began to decrease without any further surgical intervention. The patient’s intraocular pressure has remained well controlled in the 10–15 mm Hg range for more than 1 year following ECP, and the total number of glaucoma medications has been systematically reduced from four to two. Furthermore, the patient has not developed any signs of hypotony, phthisis, or graft failure.

**Simultaneous presentation of choroidal melanoma in mother and daughter**

Despite being the most common primary intraocular malignancy, uveal melanoma is rare, with an incidence of only eight per million per year. Familial cases account for only 0.6% of patients. We report two members of the same family who were both independently found to have choroidal melanoma on the same day.

**Case 1**

A healthy 45 year old woman presented to her general practitioner with a 1 month history of photopsia and visual field defect. She was referred to a general ophthalmologist who referred her to our clinic where she was given an appointment on 22 November 1999. Our assessment showed that the visual acuity was 6/36 with the right eye and 6/12 + with the left eye. Both anterior segments and the left fundus were normal. There was a pigmented choroidal tumour inferonasally extending from the disc to the ciliary body, measuring 19.2 mm in diameter and 6.0 mm in thickness (Fig 2). The patient was treated with proton beam radiotherapy.

**Case 2**

On 7 November 1999, the patient’s 65 year old mother presented to her general practitioner in a different city with a 2 week history of blurred vision in the right eye. She was referred to her primary ophthalmologist who referred her to our clinic where she was given an appointment on 11 November 1999, then to our clinic where she was given an appointment on 22 November 1999. Our assessment showed that both the visual acuity was 6/6 with the right eye and 6/12 + with the left eye. Both anterior segments and the left fundus were normal. There was a pigmented choroidal tumour inferonasally extending from the disc to the ciliary body, measuring 19.2 mm in diameter and 6.0 mm in thickness (Fig 2). The patient was treated with enucleation.

Neither patient had a history of cutaneous melanoma or atypical naevi, nor could they recall any relevant family history of ocular or other disease. The mother’s only sibling and three of four of the daughter’s siblings have had a normal ocular examination elsewhere.

**Comment**

We report on the simultaneous presentation of mother and daughter each with uveal melanoma in the right eye with both individuals being seen by their ophthalmologist and by us on the same day. Uveal melanoma is a rare disease, and instances of both parent and child being affected are even rarer. We report two cases of choroidal melanoma in two siblings with a similar configuration and extending within two disc diameters of the fovea (Fig 1). It measured 12.2 mm in diameter and was 5.1 mm thick. The patient was treated with proton beam radiotherapy.
patients presented within only a few hours of each other. The chance of such simultaneous presentation must be extremely remote, but our report demonstrates that coincidence can occur in any disease.

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References

Relative hypersensitivity in healthy eye by frequency doubling perimetry in patients with severely damaged contralateral eye

Frequency doubling technology (FDT, Humphrey-Zeiss and Welch Allyn, Dublin, CA, USA) has been developed to screen for glaucoma. FDT could detect abnormalities in patients with full visual fields tested by Humphrey field analyser (HFA, Humphrey-Zeiss, Dublin, CA, USA) and nerve fibre layer defects or normal visual fields and large disc cupping. Inversely, FDT did not always detect visual field loss in patients with glaucomatous visual field defects determined by HFA (Fig 1), but it was rare. That was because the ability of FDT to detect glaucomatous visual field loss was limited or for some other reasons. In this study, we presumed that patients with severe damage in one eye had relative hypersensitivity in another eye.

Twenty nine patients (23 men and six women) had one normal healthy eye and one severely damaged eye. Their ages ranged from 18–69 years (mean 51 years). Patients had been examined with threshold c-20 of FDT version 2.6 once. A normal healthy eye meant normal vision (20/20 or better), normal intraocular pressure (less than 21 mm Hg), and normal fundus (normal-tension glaucoma with hemifield test). The chance of such simultaneous presentations must be extremely remote, but such conditions usually involve both eyes. As controls, 26 (20 men and six women) normal healthy volunteers were recruited for this study. Their ages ranged from 23 to 70 years (mean 51 years). Patients had been examined with threshold c-20 of FDT version 2.6 once. They had normal vision (20/20 or better), normal intraocular pressure (less than 21 mm Hg), and normal fundus findings. All subjects were examined with threshold c-20 of FDT version 2.6. Mean sensitivity was calculated from all 17 test areas. Mean sensitivity with one normal healthy eye and one severely damaged eye was compared to that in subjects with two normal healthy eyes with Mann-Whitney U test. All results of less than 20% of fixation loss, 20% of false negative, and 33% of false positive were adopted. The research followed institutional guidelines and the tenets of the World Medical Association Declaration of Helsinki. We obtained written informed consent from all patients before their entry in this study.

Eighty results of 55 patients were studied for analysis. One result in patients with two healthy eyes was excluded because of an unreliable result. Twenty nine eyes with severe damage in one eye had a significantly higher mean sensitivity (30.8 (SE 0.47) dB) in one healthy eye than did both normal healthy eyes (p=0.0065, 28.8 (0.50) dB in 26 better eyes and p=0.0005, 27.9 (0.56) dB in 25 worse healthy eyes).

Figure 2 In 29 patients with one normal healthy eye and one severely damaged eye, the mean sensitivity (30.8 (0.47) dB) in 29 healthy eyes was significantly higher than that in 26 patients with two normal eyes (p=0.0065, 28.8 (0.50) dB in 26 normal better eyes and p=0.0005, 27.9 (0.56) dB in 25 normal worse eyes).

Comment
It was interesting that there were 2 dB differences in sensitivity between patients with a normal healthy eye. The reason for eyes with severe damage in one eye having relative hypersensitivity was unclear. One possible explanation was because the pathway detected by FDT is thought to be a magnocellular pathway and a relatively less, complemental mechanism might work in magnocellular pathway.

In conclusion, patients with one severely damaged eye had relative hypersensitivity in one healthy eye. Estimation of such patients should be considered carefully.

Acknowledgements
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References

Figure 1 A 34 year old man had high intraocular pressure (29 mm Hg) and abnormal points in the right nasal field with Humphrey field analyser (HFA, right), but not with frequency doubling technology (FDT, left). His left eye was blind as a result of glaucoma.
Solitary choroidal tuberculoma in a patient with chest wall tuberculosis

Tuberculosis has re-emerged as a serious public health problem in industrialised countries.1 There are several explanations for the increased incidence but it is mainly due to an increase in immunocompromised hosts such as those who are older or with malignancies, those with AIDS, those who are immunosuppressed after transplantation, and the malnourished. However, a choroidal tuberculoma is rare except in cases with human immunodeficiency virus (HIV) infection.1-3 We present a case of choroidal tuberculoma in an immunocompetent patient with an extra-pulmonary tuberculoma in the chest wall, which is also rare.1,4

Case report

A 34 year old Filipina woman, who was in good health, complained of a pain in her right lateral chest. Computed tomography scan showed a well defined mass measuring 4 × 4 cm (Fig 1). Cultures of fluid aspirated from the mass showed acid fast bacteria. Polymerase chain reaction demonstrated Mycobacterium tuberculosis DNA in the aspirated fluid. Her sputum had never been positive for tuberculosis. Although the patient had no fever, cough, or anorexia, the mass was diagnosed as extrapulmonary tuberculoma with minimal pulmonary involvement. Antituberculous treatment was started with isoniazid, rifampicin, pyrazinamide, and streptomycin after five months of treatment. HIV infection was also ruled out.

On initial examination, the best corrected visual acuities were 30/20 in the right eye and 80/200 in the left eye. Anterior segment examination was unremarkable, and no evidence of anterior or posterior inflammation was present.

Fundus examination showed an elevated yellow-white mass in the left eye that measured approximately 2 × 2 disc diameters just inferior and temporal to the optic disc (Fig 2A). The mass had a slightly irregular and fuzzy outline, and the disc had irregular margins and was reddish. There was a flat retinal detachment in the macula area, and fluorescein angiography (FA) demonstrated minimal early fluorescence with late moderate hyperfluorescence and peripapillary leakage in the lesion (Fig 2B). Indocyanine green angiography (IA) demonstrated persistent blockage of fluorescein (Fig 2C). Optic coherence tomography (OCT) showed a highly elevated mass associated with a serous retinal detachment. We excluded sarcoidosis, toxoplasmosis, or fungus infection by laboratory examinations; the levels of angiotensin converting enzyme, β-D-glucan, titre of antibody for toxoplasmosis, and metastatic tumour from a breast cancer. HIV infection was also ruled out.

The visual acuity in the left eye decreased to 12/200 because of the retinal detachment, and vitreous cells and opacities, and retinal vascularity were observed. Four to 6 weeks after beginning the anti-tuberculosis therapy, the mass became smaller and visual acuity improved. Although retinal folds were present in the macular lesion after 16 weeks of therapy, the best visual acuity was 20/20 (Fig 3). The cold abscess in the chest wall disappeared within 2 months, with drainage of the fluid and injection of streptomycin.

Figure 1 An enhanced chest computed tomography scan showing a capsulated mass (arrow) with destruction of the 12th cartilage (arrowhead).

Figure 2 (A) Fundus photograph showing an elevated choroidal lesion just inferior and temporal to the optic disc. (B) Late fluorescein angiogram demonstrating minimal hyperfluorescence. (C) Indocyanine green angiography showing blockage of fluorescein.

Comment

There are only a few reported cases of solitary choroidal tuberculoma,1,6 and it may present with or without active pulmonary tuberculosis. Ocular tuberculosis commonly presents in the choroid, and reaches the choroid by direct haematogenous spread from a primary infection. The chest wall is also a rare site for tuberculosis,7 and the co-occurrence of chest wall tuberculosis and choroidal tuberculoma has never been reported with or without HIV infection.1-3 Rib tuberculosis was observed in 5% of all cases of bone and joint tuberculosis, and only in 0.1% of all hospital admission for tuberculosis.4 It is usually secondary to haematogenous spread or, more rarely, due to direct extension of underlying pleural or pulmonary parenchymal disease.1 In our patient, minimal pulmonary involvement was suspected in the apical lesion, not in chest wall mass lesion. Taken together, the tuberculomas in this patient may be caused by direct haematogenous dissemination. Anti-tuberculosis therapy was effective for both tuberculomas.

In conclusion, we report a rare case of choroidal tuberculoma with chest wall tuberculosis. With the re-emergence of tuberculosis, ophthalmologists should be aware that solitary choroidal tuberculoma as well as extrapulmonary tuberculosis can occur in immunocompetent individuals.

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References


Giant neurosensory detachments associated with disciform lesions in neovascular age related macular degeneration

Age related macular degeneration (AMD) is the leading cause of blindness among the population over 65 years of age in Europe and North America.4,5 Neovascular AMD, which is characterised by choroidal neovascularisation, often leads to severe central vision loss.6 Choroidal neovascularisation may lead to
Figure 1  (A, B) Transverse (cross sectional) B scans of both eyes showing bullous retinal detachments (arrows) overlying a localised scar scans of both eyes showing bullous detachments development of fibrous tissue which replaces the normal retina and may be associated with serous or haemorrhagic detachment of the retinal pigment epithelium (RPE) and overlying retina.1, 2 We describe a case of neovascular AMD associated with large, bullous neurosensory detachments overlying bilateral macular disciform lesions.

Case report
A 69 year old white man presented to the Vitreoretinal Division at the Wilmer Ophthalmological Institute for evaluation of his macular degeneration. He was diagnosed with macular degeneration by an outside ophthalmologist in 1992. He reported slowly worsening vision in both eyes over many years. He denied any recent changes in his vision. Family history was significant for AMD affecting his father, sister and brother. He denied history of ocular trauma, surgery, or laser.

On ophthalmological examination, the best corrected visual acuity was “hand movement at 6 feet” in the right eye and 6/200 in the left eye. There was no relative afferent pupillary defect. Extraocular movements were full in each eye. Intraocular pressures were 15 mm Hg in the right eye and 17 mm Hg in the left eye. Anterior segment examination was remarkable for moderate nuclear sclerotic and cortical cataractous changes in each eye. Extended ophthalmoscopy showed cup to disc ratios of 0.5 without evidence of optic nerve head oedema or pallor. The maculae showed disciform lesions in both eyes with overlying large and bullous neurosensory detachments. Shifting subretinal fluid was not identified. Given the extent of the neurosensory elevation, B scan echography was performed in order to quantify these lesions. B scan images showed bullous elevation of the retina in the posterior pole in each eye corresponding to the neurosensory detachments and the localised areas of scar tissue beneath the detachments (Fig 1). The maximum elevation of the neurosensory detachment measured 2.5 mm in the right eye and 5.0 mm in the left eye at the centre of the lesion. The retinal periphery was unremarkable in both eyes.

Comment
Previous studies have measured neurosensory detachments in AMD.3 4 In a study of 16 eyes with neurosensory detachments secondary to neovascular AMD, the authors found that the average maximal height of the lesions at baseline measured 272 µm by confocal microscopy.5 The measurements ranged from 146 µm to 584 µm. Using confocal techniques, Bartsch et al described a case with a neurosensory detachment secondary to AMD which measured 1300 µm.6 The use of ultrasound in ophthalmology has increased significantly over the past three decades to encompass a variety of indications.7 Quantification of lesion dimensions is one aspect that has proved to be a significant tool for documenting findings noted on clinical examination. B scan echography provides two dimensional images to document the topographic features such as shape, location, and extent. Various probe positions (transverse and longitudinal) facilitate accurate delineation of the lateral and radial borders of intraocular lesions.8 The case illustrated in this report clearly demonstrates that neurosensory detachments associated with neovascular AMD can be significantly larger than previously described. This may contribute to significant loss of central vision. Understanding the pathophysiological mechanisms which determine the maximal elevation of the neurosensory detachments in neovascular AMD may help in designing treatment strategies targeted towards preventing or restricting this process.

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References

Successful photodynamic therapy for subretinal neovascularisation due to Sorsby’s fundus dystrophy: 1 year follow up

Sorsby’s fundus dystrophy (SFD) is a rare but severe autosomal dominant disease. Clinically it is characterised by severe central visual loss, mainly due to submacular choroidal neovascularisation (CNV) during the second decade of life.1, 2 Blindness therefore occurs during the patient’s most productive years of employment. We report a case of successful treatment of CNV in SFD with photodynamic therapy (PDT) and verteporfin.

Case report
A 40 year old white man (occupation photographer) presented in 1999 with sudden blurring and distortion of vision in the right eye. Visual acuity was 6/6 in the right eye, and 6/4 in the left. Funduscopy and fundus fluorescein angiogram (FFA) demonstrated a large subfoveal CNV. This was deemed unsuitable for laser photocoagulation owing to its location and size. Subsequently, acuity in the right eye deteriorated to 3/60 with the formation of a disciform macular scar. Standard flash electroretinogram (ERG) was normal, while dark adapted ERG was abnormal. Family history revealed that his mother and maternal grandmother went “blind” in their 30s. The patient’s cousin had also suffered from recent vision loss. A clinical diagnosis of SFD was made based on the patient’s age, family history, and retinal appearance. This was confirmed by molecular genetic assessment. Restriction digest analysis (using XhoI) showed that both the patient and his affected cousin were heterozygous for the Ser181Cys mutation in the TIMP3 gene.

In 2001 the patient reported visual disturbance in his left eye. Visual acuity in the left eye had decreased to 6/36. FFA revealed a left extrafoveal, predominantly classic, CNV (Fig 1). It was known that submacular CNV in SFD responded poorly to conventional argon laser treatment, so we elected to undertake photodynamic therapy (PDT) with verteporfin.9 The protocol used for treatment was as previously described.10 Further PDT treatments were applied to the left macula at 3, 6, and 12 months. These supplemental treatments were prompted by fresh leakage seen on FFA. At 1 year, a small subretinal scar was seen at the site of the original CNV and some leakage was noted at
the inferonasal edge of this scar (Fig 2). Further PDT treatment is planned for this. Visual acuity in his left eye improved from 6/36 to 6/12 and this has been maintained for the 1 year of follow up.

Comment
SFD was first described by Sorsby in 1949. Mildly affected patients suffer colour vision defects and night blindness. In such patients, mid-peripheral drusen are often seen. Histologically, a confluent, lipid containing layer is seen deposited within the inner layer of Bruch’s membrane. Consistently, in the fourth to fifth decade of life affected patients suffer sudden, severe vision loss due to CNV. A few experience more gradual vision loss due to macular atrophy. All patients invariably progress to vision loss sufficient for blind registration.

Despite some evidence to suggest improvement in night blindness with vitamin A supplements by far the most significant variable final visual acuity. It is the first report suggesting that treatment may limit severe visual deficit in an SFD patient and for an extended period. Photodynamic therapy with verteporfin should therefore be considered in other SFD patients when they suffer CNV.

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References

Association of HLA type and Mooren’s Ulcer in Chinese in Taiwan

We read with interest the article by Taylor et al., suggesting a possible association between HLA-DR17(3) and/or DQ2 and susceptibility to Mooren’s ulcer on the basis of cases collected globally, though none were Chinese. We have collected HLA data on cases of peripheral ulcerative keratopathy and investigated the genetic relation between Mooren’s ulcer and HLA type in Chinese people.

In total, eight patients with non-infectious peripheral destructive corneal ulcer were treated in our referral clinic. Full systemic and ocular examinations were performed to diagnose Mooren’s ulcer. A laboratory examination to rule out the possible rheumatological and infectious causes, included complete blood count with platelet count, serum immunoglobulin, antinuclear antibodies, C reactive protein, rapid plasma reagent/fluorescent treponemal antibody absorption test, antibodies of herpes simplex, hepatitis B and C tests, liver function tests, blood urea nitrogen and creatinine, fasting blood sugar, urinalysis, chest x ray, sinus x ray, and kidney, ureter, and bladder x ray (KUB) study. Complete ocular evaluations included slit lamp microscopy, conjunctival and corneal swabs for cultures of possible infective agents, and tear function tests such as Schirmer’s test and tear break up time (TBUT). All of our patients were Chinese and two were given the diagnosis of Mooren’s ulcer. Both patients had a normal other eye, and were otherwise healthy except for previous hepatitis B infection, which is very common (up to 90% in those more than 40 years old) in Taiwan.

Case report
Patient 1
A 67 year old woman presented with a 3 week history of a painful, tearing and a photophobic right eye in June 2002. Slit lamp biomicroscopy revealed an inferior peripheral corneal ulcer and adjacent conjunctival injection of her right eye. This crescent shaped ulcer caused thinning to 30% of the corneal thickness, thereby weakening the central edge of the inferior peripheral cornea. In addition,
overlying epithelial defect was noted by fluorescence staining.

Patient 2
A 60 year old woman was referred for a painful, red right eye with incipient peripheral corneal perforation of 3 months' duration. She reported a history of extracapsular cataract extraction of her right eye 8 months before, in November 2001. On examination, there was marked thinning of the right superior cornea from 10 to 2:30 o'clock with pannus and an infiltrated leading edge. Within the marginal ulcer, around 90% of the areas was thinned to 10% of the corneal thickness. Rheumatological evaluation was normal. This ulcer perforated 4 days after admission and emergency repair with multilayered amniotic membrane covered with a conjunctival graft was performed smoothly. Afterwards the destruction of peripheral corneal stroma ceased to progress and the anterior chamber was reformed 3 days after surgery. Blood samples of these patients were obtained and tested for HLA-A, B, C, DR, and DQ typing by the polymerase chain reaction (PCR). Specific sequence primer (PCR-SSP) low resolution method. HLA-A, B, C, DR, and DQ typing was used due to the polymorphism of HLA class I and II typing trays. HLA-DQ typing was tested by using Dynal all set typing trays. (Dynal Biotech Ltd, Wirral, UK) The HLA types of these two Mooren’s ulcer patients are listed in Table 1. HLA phenotype frequency data of the Chinese population in Taiwan were obtained from recently published data.1

Comment
According to Craig's report, 10 of 12 Mooren’s ulcer patients (83%) were HLA-DR17(3) and/or HLA-DQ2 positive. According to published population studies, the HLA-DR17(3) antigen frequency are 4–19% in India, 10–20% in black South Africans, and 23% in white northern Europeans. The HLA-DQ2 antigen frequencies are 36–45% in India, 17–19% in black South Africans, and 33% in white northern Europeans.2 These findings suggest predisposition of HLA-DR17(3) and HLA-DQ2 might have some significant association with susceptibility to Mooren’s ulcer. The HLA-DR17(3) and DQ2 antigen frequencies for Chinese people are 1–8% and 7–15%, respectively. If we combine the data of our two female Chinese Mooren’s ulcer patients with those of patients in Craig’s study, we find that 11 of 14 (78.5%) patients with Mooren’s ulcer are HLA-DR17(3) and DQ2 positive, which is still higher than in ethnically matched control populations. In Craig’s article, 100% of non-white Mooren’s ulcer patients are HLA-DR17(3) and DQ2 positive, but if our patients are included in this assessment, the frequency decreases to 90% of non-white patients.

Another interesting finding was the increased frequencies of HLA-DQ5. In the Mooren’s ulcer group, HLA-DQ5 was found in 50% patients, whether or not our data and Craig’s are considered as a whole. The HLA-DQ5 antigen frequencies are 21–25% in Indian people, 13–22% in black South Africans, 10–32% in white northern Europeans,1 and 10–21% in Chinese. Therefore, our data support the possible linkage of HLA-DR17(3), HLA-DQ2 gene with Mooren’s ulcer proposed by Craig’s article, and suggest HLA-DQ5 might be another candidate gene of HLA associated with Mooren’s ulcer.

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Corneal endothelial deposits secondary to rifabutin prophylaxis for Mycobacterium avium complex bacteraemia
We report a case of corneal endothelial deposits in a patient positive for human immunodeficiency virus (HIV) who had received rifabutin prophylaxis for Mycobacterium avium complex bacteraemia.

Case report
A 50 year old man was referred to the corneal clinic with bilateral scattered endothelial deposits. He was asymptomatic at the time of presentation.

His history indicated that he had been HIV positive since 1992 and had been commenced on treatment in 1999. Since then he had suffered from tuberculosis and pneumonia but there was no history of any eye problems.

His systemic health was currently good and his CD4 count was 540 cells × 103. His ophthalmic history revealed loss of vision in the right eye in 1986 following an episode of herpes zoster in this eye.

On examination his right visual acuity was no perception of light and his left visual acuity was 6/9. Both eyes were white. Corneal examination revealed bilateral endothelial deposits, scattered throughout the cornea, stellate in the middle but more confluent in the periphery (Fig 1).

There was no associated uveitis. The intraocular pressures were within normal limits. There were posterior synchiae and a white cataract in the right eye, which precluded any fundal view. The left eye had a clear lens and fundal examination was entirely normal.

A detailed history of his medications indicated that he had received rifabutin for 2 years but had been off this treatment for 18 months before his referral to the eye clinic.

References

Table 1 HLA class I and II types of two Mooren’s ulcer patients

<table>
<thead>
<tr>
<th>Antigen frequencies (%)</th>
<th>Patient 1</th>
<th>Patient 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HLA-A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2</td>
<td>28.82–32.81</td>
<td></td>
</tr>
<tr>
<td>A11</td>
<td>18.00–36.06</td>
<td></td>
</tr>
<tr>
<td>HLA-B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B46</td>
<td>8.55–17.23</td>
<td></td>
</tr>
<tr>
<td>B54</td>
<td>1.61–4.32</td>
<td></td>
</tr>
<tr>
<td>B61</td>
<td>2.71–3.77</td>
<td></td>
</tr>
<tr>
<td>B75</td>
<td>1.64–5.40</td>
<td></td>
</tr>
<tr>
<td>BW6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BW6*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HLA-DR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR4</td>
<td>11.69–15.41</td>
<td></td>
</tr>
<tr>
<td>DR8</td>
<td>13.56–16.36</td>
<td></td>
</tr>
<tr>
<td>DR9</td>
<td>3.31–5.44</td>
<td></td>
</tr>
<tr>
<td>DR16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DR17(3)</td>
<td>0.98–8.37</td>
<td></td>
</tr>
<tr>
<td>DR53</td>
<td></td>
<td></td>
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<tr>
<td>HLA-DQ</td>
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<td></td>
</tr>
<tr>
<td>DQ2</td>
<td>7.51–15.66</td>
<td></td>
</tr>
<tr>
<td>DQ4</td>
<td>5.03–9.88</td>
<td></td>
</tr>
<tr>
<td>DQ5</td>
<td>10.60–21.50</td>
<td></td>
</tr>
<tr>
<td>DQ9</td>
<td>4.31–13.06</td>
<td></td>
</tr>
</tbody>
</table>

*BW6 associations: B46, B54, B61, B75; †DR5 associations: DR15, DR16, DR1; ‡DR53 associations: DR4, DR7, DR9.

Figure 1 Example of bilateral endothelial deposits.
Serial photography over the past 9 months has not shown any change in the appearance of these deposits.

**Comment**

Rifabutin is used to prevent *Mycobacterium avium* complex (MAC) disease in patients with HIV and CD4 counts of less than 100 cells × 10³.² Rifabutin causes inhibition of DNA dependent RNA polymerase in sensitive strains of *Escherichia coli* and *Bacillus subtilis*. However, its mode of action against *M avium* is unclear.³

It has been associated with uveitis, which may be difficult to differentiate from other causes of uveitis in patients with AIDS.⁴ ⁵ Uveitis is unusual at the recommended oral dosage of 300 mg/day, but becomes common as the total daily dose approaches 1 g.⁶

Corneal endothelial deposits secondary to treatment with rifabutin have been reported in children positive for HIV.⁷ The deposits are usually bilateral and initially peripheral and stellate. Of interest is the fact that these deposits occur without any associated uveitis. They increase in number with continued administration of rifabutin but appear not to be sight threatening.⁸

This case demonstrates that these endothelial deposits do not appear to resolve upon termination of rifabutin therapy in the short to medium term. A longer period of observation is required to determine if these deposits alter in the long term.

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**References**


**Corneal ectasia following deep lamellar keratoplasty**

Keratoconus is a bilateral non-inflammatory corneal ectasia with an incidence of approximately one per 2000 in the general population. Contact lenses are the most common treatment. When contact lenses fail, a surgical approach is necessary for visual rehabilitation. Penetrating keratoplasty has been the traditional and most common mode of treatment and has excellent results.² However, more recently, deep lamellar keratoplasty (DLK) is gaining popularity as an alternative option for the surgical management of keratoconus.³ It has obvious advantages in that endothelial rejection is rare and it is essentially an extracocular procedure.⁴

Recurrent keratoconus following penetrating keratoplasty is rare but has been described.⁵ We report on the first case of recurrent ectasia following deep lamellar keratoplasty supported by clinical and histological evidence.

**Case report**

A 38 year old chronic schizophrenic male was referred to the anterior segment clinic with advanced bilateral keratoconus. He had previously been treated with hard contact lenses. His condition had deteriorated over the years and he was now keen on surgical intervention. On examination, visual acuity was counting fingers in both eyes with no improvement with +4.00 correction and 6/9 left eye with +3.25–8.00×140 correction. The patient underwent uneventful right lamellar keratoplasty with a 112/116 vertical meridian following deep lamellar keratoplasty while reducing the rate of rejection.⁶

The procedure was uneventful but the graft keratoplasty was marked apical thinning with subepithelial scarring and nuclear sclerotic cataract in the right eye (Fig 1). A repeat DLK was performed on the left eye and histology from the second grafted corneal button showed degenerative thinning consistent with ectasia. The original host tissue in comparison revealed breaks in Bowman’s membrane which is typical of keratoconus (Fig 3). At his last clinic visit 1 month later, having undergone bilateral cataract extraction and femtosecond laser in situ keratomileusis (FSLK), his visual acuity was 6/9–2 right eye with +3.25−8.00×140 correction and 6/9 left eye with +4.00−4.50×180.

**Comment**

Lamellar keratoplasty (LK) has been an established procedure for corneal pathology for over a 100 years. Advances in surgical techniques such as deep lamellar anterior keratoplasty have expanded the application of lamellar surgery and have achieved visual results approaching those of penetrating keratoplasty while reducing the rate of rejection and improving the long term graft stability.⁷ The procedure can be defined as the excision of superficial stromal layers. A number of techniques have been used for dissection of the stroma such as air, viscoelastic, and fluid injection.⁸ The entire stroma can be completely excised so that only Descemet’s membrane and endothelial cells remain.

Studies have shown that in deep lamellar keratoplasty, endothelial rejection reaction is rare with cell counts being maintained for a longer period.⁹ This confers obvious advantages over penetrating keratoplasty in the treatment of keratoconus. However, it is still a relatively new procedure and is technically more challenging. There have been a few cases in the literature of recurrent keratoconus following penetrating keratoplasty successfully treated with regrafting.¹⁰ In all these cases, the pathogenesis of this complication was unclear. In our patient, ectasia recurred in the left eye 3 years after deep lamellar keratoplasty and this was confirmed both clinically and histologically.

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nise such late complications which may increasingly popular it is important to recog-

etry are vital in monitoring progression of potential. Preoperative and postoperative data important in order to obtain the best visual treatment option—deep lamellar keratoplasty tribute to ectasia.

ing abnormal corneal architecture, may con-

which may be metabolically prone to produc-

invasion of the graft by host keratocytes,

activity of stromal collagenase (matrix

of the metalloproteinase system (gelatinolytic

first DLK failure due to infection, in particular

therefore necessary before surgery. The in-

olathed corneal lenticule used at the time of

corneas if routinely employed.

Another consideration is that the cry-

thinning and subepithelial scarring in the low magnification (A) High magnification with Jones stain shows disruption of Bowman’s membrane [B]. In comparison, the deep lamellar keratoplasty corneal button shows apical thinning [C] but no disruption of Bowman’s membrane [D]. Low power (haematoxylin and eosin stain) high power (Jones stain).

Figure 3  Histopathology slides of the original host keratoconic cornea showing apical prevent potential problems with using ectatic corneas if routinely employed.9

Another consideration is that the cryo-

lated corneal lenticule used at the time of repeat surgery may have been inherently thin as the procedure was done as an emergency. Adequate preparation of the donor tissue is therefore necessary before surgery. The inflam-

atory pathways activated following the first DLK failure due to infection, in particular the metalloproteinase system (gelatinolytic activity of stromal collagenase (matrix metalloproteinase-1 (MMP-1)), may play an important part through thinning of the stromal tissue.4

These lenticules are devoid of keratocytes; invasion of the graft by host keratocytes, which may be metabolically prone to produc-

ing abnormal corneal architecture, may con-

tribute to ectasia.

In summary, we have reported the first case of recurrent ectasia in a relatively new treatment option—deep lamellar keratoplasty for keratoconus. Protection of the lamellar graft from infection and inflammation is important in order to obtain the best visual potential. Preoperative and postoperative data such as refraction, topography, and pachymetry are vital in monitoring progression of these patients. As lamellar surgery becomes increasingly popular it is important to recogn-

ise such late complications which may require further surgical intervention in the future.

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References


Opatification of SC60B-OUV lens implant following routine phacoemulsification surgery: case report and EM study

In 1949, Sir Harold Ridley implanted the first artificial intraocular lens (IOL) to reduce refractive error following cataract extraction.

Numerous designs of IOL implants have been followed and a variety of materials have been used in their manufacture, including poly(methyl methacrylate) (PMMA), silicone, acrylic, and hydrogel based materials. Important requirements of IOL implant material are to not excite an inflammatory response and the ability to remain transparent within the eye for an extended period of time. In recent years, there have been reports of opacification of IOL implants such as calcification on the optical surface of the Hydroview lens; “glis-

tenings” of fluid filled vacuoles in the optic of the AcrySof IOL;8 and “snowflake” crystal-

line opacification of three piece rigid PMMA lenses.10

In particular, late postoperative opacifica-

tion of a particular hydrophilic acrylic IOL, the SC60B-OUV, has been reported and analysis of these explanted IOLs have shown the presence of granular deposits within the optic. We report examination, using electron microscopy, of a similar explanted IOL removed following late postoperative opacifica-

tion, which appears to have different surface morphology from those reported previously.

Case report

An 82 year old female patient with Fuchs’ endothelial dystrophy underwent uneventful phacoemulsification and foldable lens implantation into the capsular bag of the left eye. Two weeks later, the best corrected visual acuity was 6/9. Fifteen months later, she underwent a similar procedure with a different foldable lens in the right eye leading to a visual outcome of 6/9. At that time, the left visual acuity had dropped to 6/18 and red reflex assessment of the dilated eye with a direct ophthalmoscope was very similar to that of a senile nuclear cataract. On slit lamp examination, the intraocular lens optic was found to have become uniformly cloudy (Fig 1). The patient was offered a lens exchange procedure and this was carried out 6 months later. Extensive capsular fibrosis and capsular dehiscence meant that the lens could not be explanted in one piece. The

Figure 1  Slit lamp examination of opacified IOL.

Figure 3  Histopathology slides of the original host keratoconic cornea showing apical thinning and subepithelial scarring in the low magnification (A) High magnification with Jones stain shows disruption of Bowman’s membrane [B]. In comparison, the deep lamellar keratoplasty corneal button shows apical thinning [C] but no disruption of Bowman’s membrane [D]. Low power (haematoxylin and eosin stain) high power (Jones stain).
haptics were left in situ and the optic was transacted before explantation. Anterior vitrectomy and peripheral iridectomy were carried out and an anterior chamber implant was inserted. Five months postoperatively, her vision had recovered to 6/9.

The explanted lens underwent detailed examination at the School of Pharmacy and Biomolecular Sciences, University of Brighton. The surface and the interior portion of the explanted (test) lens were examined and compared to an identical unused SC60B-OUV (control) lens. Fourier Transformed infrared (FT-IR) spectroscopy was performed using a diamond attenuated reflectance unit on a Perkin-Elmer 1620 spectrophotometer under control pressure. For analysis by scanning electron microscopy (SEM), both the control and test lens were cut to produce cross sections to enable the visualisation of the interior and exterior surfaces. All sections were then sputter coated with palladium and photographed at \( \times 2000 \), \( \times 2000 \), and \( \times 7000 \) magnification using a Joel JSM 6310 scanning electron microscope.

**Comment**

The opaque lens was a 12.5 mm SC60B-OUV (manufactured and distributed by Medical Developmental Research Inc, USA). The lens is hydrophilic in nature and is a composite of polyoxyethylene (HEMA) polymerised in 80% water. Such damage may therefore have been caused by slow degradation of the polymer matrix or dissolution of unpolymerised monomer/oligomers and swelling of incompletely polymerised material in the core of the optic.

These findings are different to those previously reported by Werner et al. who found granular deposits in a region beneath the anterior and posterior surfaces with intact surface structure. The time frame for the appearance of the opacification and clinical description appears to be equivalent in both studies. The reason for the difference in SEM findings is unclear. If our findings represent an earlier phase of the same degenerative process then one would expect some residual surface degradation in their study. Conversely, if ours is a later phase then one might expect the presence of granular deposits in the substance of the optic.

Although our lens showed the same clinical appearance of postoperative opacification before explantation as other studies, the EM results suggest that our findings may represent a different degenerative process. The nine explanted lenses examined by Werner et al came from the same surgeon in Turkey, and the type of opacification may be due to a “batch” effect as well as a polymer effect. In conclusion our findings may represent a different degeneration in IOL structure to that previously described.

The manufacturer has withdrawn all SC60B-OUV IOLs made from materials obtained from Vista Optics, UK and these IOLs are now being manufactured by polymer from a new source (Benz Research, USA). Out of 12 patients who received this IOL at our institution, seven experienced significant clouding, three had corrected vision of 6/12 or better, and two have died. Of the seven patients with significant clouding, two have undergone exchange, two awaiting exchange, two are considering exchange, and one declined exchange. Figures from the Medical Devices Agency (MDA) state that of 3200 lenses distributed in the United Kingdom, only 27 reports of clouding have been received. There may be under-reporting of cases and we encourage reporting of all cases to the MDA. Vigilance is clearly necessary with this IOL to ensure that the change in polymer manufacture has resolved the problem.

**Isolated foveal retinoschisis as a cause of visual loss in young females**

Foveal or macular retinoschisis is an uncommon retinal disorder, usually seen in patients affected with generalised retinal disease such as X linked retinoschisis, \(^\text{1}\) Goldmann-Favre syndrome, \(^\text{2}\) and enhanced S-cone syndrome. \(^\text{3}\)

There have been a handful of previous reports of patients exhibiting foveal retinoschisis in whom there appeared to be limited concomitant peripheral retinal disease, \(^\text{4–6}\) suggesting the existence of a distinct disorder. We report the clinical findings in four female patients presenting with a reduction in central acuity and exhibiting isolated bilateral foveal retinoschisis, and investigations including scanning laser ophthalmoscopy (SLO) autofluorescence imaging, optical coherence tomography (OCT), and electrophysiology.

**Case reports**

**Case 1**

A 17 year old girl presented with bilateral reduction in central vision. With refraction \( \pm 0.50 \text{DS right}, +0.25 \text{DS left} \) her visual acuity was 6/18. On examination the only abnormal finding was thickening of the neurosensory retina at the fovea with a radial pattern of striae bilaterally. There was no leakage suggestive of macular oedema on fluorescein angiography.

**Cases 2 and 3**

Female dizygotic twins 19 years of age both reported a mild non-progressive reduction in

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**References**

1. Ridley NHL. Artificial intraocular lenses after cataract extraction. St Thomas Hospital Reports 1951; 7: 12–14.


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**Figure 2** SEM examination of explanted IOL showing 5 µm thick degraded layer of outer surface. (A) \( \times 2000 \), (B) \( \times 7000 \).
their central vision. Best corrected visual acuities ranged from 6/12 to 6/18. On examination the only abnormal finding was thickening of the neurosensory retina at the foveal retina in all four eyes. Fluorescein angiography showed no evidence of macular oedema.

**Case 4**

A 22 year old girl presented with difficulties for near vision over the previous 4 years. Best corrected visual acuity was 6/12 with each eye with a small hyperopic correction. The only abnormal findings on ophthalmoscopy were a short wavelength cut off at 521 nm. Single line bilaminar scans of the macular retina were performed using the OCT 2000 scanner (Zeiss Humphrey Instruments, San Leandro, CA, USA).

**Figure 1** A prototype Zeiss confocal scanning laser ophthalmoscope (SLO) recorded autofluorescence images using argon laser blue light and a broadband pass barrier filter with a short wavelength cut off at 521 nm. Single line bilaminar scans of the macular retina were performed using the OCT 2000 scanner (Zeiss Humphrey Instruments, San Leandro, CA, USA).

This girl’s visual acuity was 6/12 with each eye; there was no leakage suggestive of macular oedema. Fluorescein angiography showed no evidence of macular oedema.

In none of the three families was there any family history of eye disease. Moreover, the six parents were examined and all found to have normal acuities and retinal macula appearance. The results of SLO autofluorescence imaging and OCT imaging are shown in Figure 1. In all cases, there was a radial hyper-autofluorescence at the central macula, within an otherwise uniform normal retinal signal. The splitting of the neurosensory layer at the central macula was confirmed on OCT imaging. The gangfzd ERGs were normal and the pattern electroretinogram (PERG) sub-normal in amplitude in all four patients (Fig 2).

**Comment**

All four patients have localised central retinal disease as confirmed by electrophysiology, and are therefore distinct from those cases with generalised retinal disorders listed above, as well as the reported families with inherited macular oedema. Similarly, they are unlikely to be manifesting homozygotes, or X0 cases of X linked retinoschisis. The morphology of the central retina in each of the cases does seem to be identical to the findings in hemizygotes affected by X linked retinoschisis.

Instead, these cases closely resemble clinically the patients described by Lewis et al and Lorenz et al. When viewed collectively it is likely that this disorder is autosomal recessive in inheritance. It is of interest that all eight cases are female. This might represent a chance finding (this is unlikely: p = 0.016, considering the identical twins in the report by Lewis et al as one case), a real underlying sex difference in the prevalence of this rare condition, or the under-reporting of similar male cases as a result of their assignment to a diagnosis of XLRS.

There are a few other cases in the literature demonstrating a similar foveal appearance with minimal peripheral changes which may be manifesting a different disorder. It is very difficult to predict the long term prognosis for our patients, as such cases are rare and longitudinal data are unavailable. Future genetic analysis, such as screening for novel mutations in NR2E3, the gene responsible for enhanced S-cone syndrome, may shed light on the aetiology of this rare disorder.

**References**

NOTICES

Monitoring cataract surgical outcomes
The latest issue of Community Eye Health (No 44) discusses the monitoring of cataract surgical outcomes in the Third World. For further information please contact: Journal of Community Eye Health, International Centre for Eye Health, Institute of Ophthalmology, 11–43 Bath Street, London EC1V 9EL, UK (tel: +44 (0)20 7608 6910; fax: +44 (0)20 7250 3207; email: eyeresource@ucl.ac.uk; website: www.jceh.co.uk). Annual subscription (4 issues) UK£25/ US$40. 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 Medicines, Equipment, Instruments and Optical 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 Stevens, International Centre for Eye Health, 11–43 Bath Street, London EC1V 9EL, UK (tel: +44 (0)20 7608 6910; email: eyeresource@ucl.ac.uk).

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’s website (www.secondsight.org.uk) or by contacting Dr Lucy Mathen (lucynathen@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 condition or syndrome with an integral eye disorder. SPECS represents over 50 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 people with a visual impairment or blindness. For further details about SPECS contact: Kay Parkinson, SPECS Development Officer (tel: +44 (0)1803 524238; email: k@eyeconditions.org.uk; website: www.eyeconditions.org.uk).

The British Retinitis Pigmentosa Society
The British Retinitis Pigmentosa Society (BRPS) was formed in 1975 to bring together people with retinitis pigmentosa and their families. The principle aims of BRPS are to raise funds to support the programme of medical research into an eventual cure for this hereditary disease, and through the BRPS welfare service, help members and their families cope with the everyday concerns caused by retinitis pigmentosa. Part of the welfare service is the telephone help line (+44 (0)1280 860 361), which is a useful resource for any queries or worries relating to the problems retinitis pigmentosa can bring. This service is especially valuable for those recently diagnosed with retinitis pigmentosa, and all calls are taken in the strictest confidence. Many people with retinitis pigmentosa have found the Society helpful, providing encouragement, and support through the Help line, the welfare network and the BRPS branches throughout the UK (tel: +44 (0)1280 821 334; email: lynda@brps.demon.co.uk; website: www.brps.demon.co.uk).

Surgical Eye Expeditions International
Volunteer ophthalmologists in active surgical practice are needed to participate in short term, sight restoring eye surgery clinics around the world. Contact: Harry S Brown, Surgical Eye Expeditions International, 27 East De La Guerra, C-2, Santa Barbara, CA 93101-9858, USA (tel: +805 963 3303; fax: +805 963 3564; email: hsbrown.md@cox.net or seeintl@seeintl.org; website: www.seeintl.org).

MSc course in Community Eye Health
The International Centre for Eye Health is offering a full time MSc course in Community Eye Health from 29 September 2003 to 19 September 2004. The course is not clinical and is specifically for eye health professionals wanting to work in the field of community eye health. The course is designed in keeping with the aims, priorities, and strategies of Vision 2020—the Right to Sight. The course costs £3939 for home students and £14 110 for overseas students. Further information: The Registry, 50 Bedford Square, London WC1B 3DP, UK (tel: +44 (0)20 7927 2239; fax: +44 (0)20 7323 0638; email: Adriennec.Burrough@lshtm.ac.uk; website: www.lshtm.ac.uk).

Institute of Ophthalmology: Professor Alan Bird’s 65th Birthday Meeting
The Institute of Ophthalmology is holding a meeting to celebrate Professor Alan Bird’s 65th Birthday on 10–11 July 2003, at The Beveridge Hall, Senate House, University of London, Malet Street, London. Session one on Retinal Dystrophies will be chaired by Professor Tony Moore and session two on The Ageing Macula will be chaired by Professor Steve Ryan. It is expected that CME credit will be awarded. Admission is free. Places for the meeting are limited and booking is essential. There will also be a dinner held on Thursday evening for guests and partners, the cost is £40 (US$62). Further details: Miss Laura Short, Institute of Ophthalmology, 11–43 Bath Street, London EC1V 9EL, UK (register on the website: www.ucl.ac.uk/ioo).

Glaucoma Society 24th Annual Meeting and Dinner
The Glaucoma Society 24th Annual Meeting and Dinner will take place on 20 November 2003, from 8:30 am to 5:00 pm at The Royal College of Physicians, London, UK. Further details: Ms Janet Flowers (email: glauoc@ukeire.freeserve.co.uk).
Isolated foveal retinoschisis as a cause of visual loss in young females

S A Kabanarou, G E Holder, A C Bird, A R Webster, P E Stanga, S Vickers and B A Harney

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