Serpiginous choroidopathy is an insidious, relentlessly progressive, idiopathic inflammatory disease affecting the retinal pigment epithelium and inner choroid. Choroidal neovascularisation (CNV) is a well recognised late complication of serpiginous choroidopathy in 10-25% of affected patients. In all previously reported cases CNV was recognised at the time of or after the diagnosis of serpiginous choroidopathy was established. We report a patient presenting with CNV who subsequently developed clinical findings characteristic of serpiginous choroidopathy.

Case report
A 31 year old man presented with decreased vision in his right eye in July 1997. Examination revealed acuities of 20/40 right eye and 20/20 left eye with normal anterior segments. The right fundus showed subretinal fluid and haemorrhage adjacent to the disc (Fig 1A). The left eye showed an irregularity superior to the optic disc (Fig 1B). The vitreous and fundi were otherwise normal bilaterally. Fluorescein angiography (Fig 2A, B) revealed peripapillary choroidal neovascular membranes in both eyes that were treated with argon laser photocoagulation. In April 1998 and February 1999 the left eye required photocoagulation for recurrent peripapillary CNV. Evaluation for floaters in February 2000 revealed 1+ vitreous cells and new lesions in the left eye.

Examination at the National Eye Institute in April 2000 revealed acuities of 20/40 right eye and 20/16 left eye with normal anterior segments. The vitreous contained trace cells without haze bilaterally. The right fundus showed a large peripapillary chorioretinal scar. The left fundus revealed a chorioretinal scar superior to the disc and two yellow, irregularly circumscribed, deep macular lesions (Fig 3A, B). The retinal vessels and discs were normal and no subretinal fluid, haemorrhage, or macular oedema was noted in either eye.

Fluorescein angiography revealed early hypofluorescence and late hyperfluorescence corresponding to the macular lesions in the left eye (Fig 3C, D) with no evidence of CNV in either eye. A diagnosis of serpiginous choroidopathy was made based on the clinical and fluorescein characteristics of the macular lesions in the left eye.

Comment
CNV in serpiginous choroidopathy is associated with a poor visual prognosis. In a small study CNV was reported to develop within 16 months of the serpiginous diagnosis. In a larger retrospective study of 53 serpiginous patients active CNV was found in three patients at the time of initial diagnosis and in three others within 2-17 months. Our patient differs from those previously reported in that he was diagnosed and treated for idiopathic CNV before the recognition of clinical findings.
Optic neuritis in anti-GQ1b positive recurrent Miller Fisher syndrome

Only five cases of optic nerve involvement in Miller Fisher syndrome (MFS) have been documented in the literature. This report further confirms that optic neuritis may be seen in anti-GQ1b positive MFS.

Case report
This 23-year-old woman presented with acute blurring vision, diplopia, and pain with eye movement. Her visual acuity was 20/20 to 20/200 with left visual field loss (VEP). She had left red colour desaturation. Her visual field on tangent screen revealed an enlarged left blind spot and a left upper quadrant temporal peripheral field constriction. She had bilateral sixth nerve palsies, nystagmus in all gazes, and left optic disc oedema. After 1 week her visual acuity improved to 20/20 in both eyes, but her left disc remained oedematous. She then developed left homonymous gait ataxia to such a degree that she was unable to walk. Dysmetria and dysdiadochokiniesia were more marked in her left upper extremity. She had very variable but significant weakness, absent lower extremity deep tendon reflexes, and bilateral Babinski's. She also had tingling in her hands and feet and decreased lower extremity vibratory sensation. Her mental status was normal throughout her illness. She was not taking any drugs. A magnetic resonance image (MRI) of the brain and entire spine and MR venogram were all normal. Her cerebrospinal fluid (CSF) opening pressure was 150 mm H2O. Her CSF protein was elevated at 70 mg/dl, but CSF glucose and cell count were normal; CSF VDRL, Gram stain, routine bacterial, viral, and fungal cultures were negative and the cell type and oligoclonal bands were seen on CSF electrophoresis. Her visual evoked potential (VEP) revealed a delayed left P100 latency at 131 ms and her brainstem auditory evoked potential (BAEP) was normal. Electromyogram/nerve conduction study (EMG/NCV) study revealed mildly prolonged median and peroneal F-waves, normal distal motor latencies in her extremities and a reduced left median sensory nerve action potential (SNAP). Anti-GQ1b antibody (162 EIA U (normal = 100) Athena Diagnostics, Worcester, MA, USA) and anti-GM1 antibody (1035 EIA U (normal = 800) Athena Diagnostics, Worcester, MA, USA) were both positive at high titres. Serum and Borsellino serology was normal. Antibodies for acetylcholine receptor, hepatitis A, B, and C; Mycoplasma, Campylobacter jejuni, Lyme, Hu, MaA, Yo, CV-2, and Ri were all negative. Sphincter of the eye, and c-ANCA were all normal. Serum and urine toxicological screen were both negative. After 5 days of plasmapheresis, her anti-GQ1b and anti-GM1 antibodies were negative. Her optic disc oedema, ocular motor palsies, and nystagmus immediately resolved, but she continued to walk with assistance. Two months later she had fully recovered. Six months after her recovery she developed recurrent episodes of her neurological symptoms and signs with left optic disc oedema. Her visual acuity at that time was 20/20 right eye and 20/100 left eye. She had a dense left Kohnen's field defect and left blind spot again, but no extraocular motility defects. Her VEP showed a delayed left P100 latency at 142 ms and her BAEP was normal. Single fibre EMG of her left frontalis muscle revealed no blocking suggestive of a neuro-muscular transmission defect. HLA-DR2 allele was positive and HLA-Cw5 allele was negative. Her anti-GQ1b antibody (212 EIA U (normal = 100) Athena Diagnostics, Worcester, MA, USA) was elevated again. She underwent plasmapheresis with full recovery in about 6 months.

Comment
In addition to the classic triad of ophthalmoplegia, ataxia, and areflexia, presentation as optic neuritis may be a feature of anti-GQ1b positive recurrent MFS. Only five cases of optic nerve involvement in MFS have been documented in the literature.4,5 In the two previously reported cases of visual impairment in MFS, visual evoked potentials were either absent or suggestive of pre-chiasmal and post-chiasmal visual pathway dysfunction.6 Demyelinating optic neuritis was confirmed by VEP were reported in one patient with possible MFS.4 Two other cases of presumed optic neuritis were associated with anti-GQ1b positive MFS.7 In all patients described here markedly decreased visual acuity, pain with eye movement, dyschromatopsia, and optic disc oedema that resulted in good visual recovery are all indicative of the diagnosis of optic neuritis in MFS. Since high titres of anti-GQ1b gangliosides are known to be present in the human optic nerve and anti-GQ1b antibodies can cross the blood-brain barrier,1 the optic disc oedema in this patient could represent anti-GQ1b immunoglobulin treatment of the visual pathway dysfunction. Furthermore, her ipsilateral delayed P100 latency is consistent with a pre-chiasmal demyelinating optic neuropathy.

In addition to her optic neuritis, this patient concomitantly demonstrated the classic features of MFS which are the acute onset of external ophthalmoplegia, ataxia of the cerebellar type, and the loss of percutaneous reflexes.7 MFS is considered a variant of Guillain-Barré syndrome (GBS) because some patients who present with MFS progress to GBS.8 High titres of anti-GQ1b IgG antibodies are present in 80% to 100% of patients with MFS.9 MFS may be immunologically differentiated from GBS by the presence of anti-GQ1b and anti-GM1 antibodies. Although both anti-GD1a IgG and anti-GM1 IgG are associated with GBS, anti-GM1 IgG is present in patients with typical MFS who have limb weakness,9 as in this patient. As further evidence linking this antibody to MFS,9 the decrease in anti-GQ1b antibody levels after plasmapheresis correlated with the clinical recovery in this patient. Therefore, the elevated titres of anti-GQ1b and anti-GM1 antibodies, along with the clinical triad of ophthalmoplegia, areflexia, and ataxia in this patient all support the diagnosis of MFS, and not GBS.

In rare cases, MFS has been known to recur. This patient presented with a relapse of similar ocular and neurological features 6 months after her initial episode. In the study done by Chida et al.,10 patients with recurrent MFS appeared to have similar HLA typing characteristics as the non-recurrent ones. Both types share HLA-DR2 and Cw3 alleles, but the frequency of HLA-DR2 was slightly higher in the patients with recurrent MFS.10 Therefore, this patient's HLA-DR2-positive status may have been a risk factor for her recurrence of MFS. This case report emphasises that optic neuritis may be a central nervous system feature that should be recognised as part of the Miller Fisher syndrome. The presence of both anti-GQ1b IgG and anti-GM1 IgG in this patient provides immunological evidence supportive

References

of typical MFS. The delayed P100 latency in her VEP also provides electrophysiological evidence that the optic nerve is affected in anti-GQ1b antibody positive MFS. Furthermore, this is the first documented case known to the author of optic neuritis in the recurrent subtype of MFS which is associated with a higher frequency of the HLA-DR2 allele.

J W Chan
Department of Internal Medicine, Division of Neurology, University of Nevada School of Medicine, 1707 W Charleston Blvd, Suite 220, Las Vegas, Nevada 89102, USA; worjun@aol.com

Accepted for publication 6 January 2003

References


Ocular myasthenia gravis and inflammatory bowel disease: a case report and literature review

Myasthenia gravis has been reported to be associated with both ulcerative colitis (UC) and Crohn’s disease (CD). The link between inflammatory bowel disease (IBD) and myasthenia gravis (MG) is thought to be related to the production of autoantibodies. Myasthenia gravis is also associated with other autoimmune diseases including alopecia, lichen planus, vitiligo, and systemic lupus erythematosus.

Similarly, IBD frequently presents with other autoimmune disorders. One study demonstrated a 9.4% prevalence of autoimmune disorders in patients with UC including sclerosing cholangitis, thyroid disorders, vitiligo, insulin dependent diabetes mellitus, thyroid disease, pernicious anaemia, scle- derma, and seropositive rheumatoid arthritis. Despite the association between MG and other autoimmune disorders, there are relatively few reports of ocular findings as the presenting sign of MG in patients with IBD.

Case report

A 21 year old African-American male, with a medical history of biopsy proved ulcerative colitis diagnosed in 1995, focal segmental glomerular sclerosis determined by renal biopsy in 1995, and primary sclerosing cholangitis determined by liver biopsy in 2000 presented to the neuro-ophthalmology service with complaints of binocular diplopia and ptosis of the left upper eyelid. Both the diplo- pia and the ptosis were better in the morning and worsened during the course of the day. His ulcerative colitis had been in remission for the past 5 years without medication.

Best corrected visual acuity was 20/25 in each eye. The external examination revealed ptosis of the left upper eyelid that worsened in sustained upgaze. He had limited extraocular motility in all fields of gaze (Fig 1). The remainder of the neuro-ophthalmic examination was normal and he had no difficulty with speech or swallowing.

Laboratory evaluation revealed a positive acetylcholine receptor antibody and normal thyroid function studies. There was no evi- dence of a thymic mass on magnetic resonance imaging of the chest.

The patient returned to the emergency room 1 week later with difficulty swallowing and shortness of breath. He was hospitalised for plasmapheresis and upon discharge treated with imuran, prednisone, and mesti- none. One month later his ptosis resolved and his extraocular motility was normal.

Comment

Autoimmune disorders, including MG, occur more frequently in UC than in CD. It is not clear how many other cases of IBD manifested with ocular presentations as the initial finding of MG as in our case report. Our literature review revealed only one other purely ocular presentation of myasthenia associated with ulcerative colitis; however, details of the ocular examination were not included. Another report, of a 21 year old woman with a 3 year history of Crohn’s disease, documented diplopia and unilateral ptosis as the initial findings of MG. She was found to have acetylcholine receptor antibodies and her ocular findings improved with pyridostig- mine.

Because of the relatively few reports of ocu- lar myasthenia in patients with IBD we reviewed the English literature and found four additional reports of MG in patients with IBD. Based on these four reports and the three reports reviewed the English literature and found four additional reports of MG in patients with IBD. Based on these four reports and the three (including the present report) with ocular MG in patients with IBD (Table 1), the mean duration of IBD before the diagnosis of MG was 10 years.

Autoimmune dysregulation is the central defect in both MG and IBD. Both IBD and MG may be associated with an elevated carcinoembronic antigen (CEA) and decreased peripheral lymphocyte counts that subsequently normalise following thymectomy. Some studies have shown abnormal thymic involution and the presence of an abnormal ratio of T suppressor to T helper cells in both MG and UC, while others have noted a decline in suppressor T cells and an increase in

Table 1 Previous reports of myasthenia gravis occurring in patients with inflammatory bowel disease

<table>
<thead>
<tr>
<th>Reference</th>
<th>Age (years)</th>
<th>Sex</th>
<th>IBD</th>
<th>Duration of IBD before diagnosis of MG (years)</th>
<th>AchR antibody reactivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miller 1971</td>
<td>35</td>
<td>Male</td>
<td>UC</td>
<td>13</td>
<td>Unknown</td>
</tr>
<tr>
<td>Tan 1974</td>
<td>38</td>
<td>Male</td>
<td>UC</td>
<td>12</td>
<td>Unknown</td>
</tr>
<tr>
<td>Martin et al. 1991</td>
<td>63</td>
<td>Male</td>
<td>CD</td>
<td>15</td>
<td>Positive</td>
</tr>
<tr>
<td>Gooner-Rousseau et al, 1993</td>
<td>27 Female</td>
<td>UC</td>
<td>10</td>
<td>Positive</td>
<td></td>
</tr>
<tr>
<td>Finnie et al, 1994</td>
<td>21</td>
<td>Female</td>
<td>CD</td>
<td>3</td>
<td>Positive</td>
</tr>
<tr>
<td>Lossos et al, 1995</td>
<td>11</td>
<td>Male</td>
<td>CD</td>
<td>9</td>
<td>Unknown</td>
</tr>
<tr>
<td>Present report</td>
<td>21</td>
<td>Male</td>
<td>UC</td>
<td>7</td>
<td>Positive</td>
</tr>
</tbody>
</table>
immature helper T cells suggesting migration without normal maturation.2,3

The immunological link between MG and IBD is highlighted by two reports of patients undergoing surgical treatment. One report of a patient with both MG and CD documented improvement in perineal and perianal disease following thymectomy for severe uncontrolled MG.4 Another patient with both MG and UC demonstrated regression of the myasthenia following proctectomy.5

Although the simultaneous occurrence of these two autoimmune disorders is uncommon, it is important to understand that ocular findings may be the initial manifestation of MG in patients with IBD.

The authors have no proprietary interest in any contents of this manuscript.

R Foroozan, R Sambursky
Neuro-Ophthalmology Service, Baylor College of Medicine, 6565 Fannin, NC-205, Houston, TX 77030, USA

Correspondence to: Dr Rod Foroozan, Neuro-Ophthalmology Service, Baylor College of Medicine, 6565 Fannin, NC-205, Houston, TX 77030, USA

Accepted for publication 10 January 2003

References


Magnetic resonance imaging findings in malignant melanoma of the lacrimal sac

A case of primary malignant melanoma of the lacrimal sac is presented. This is the first report of the preoperative magnetic resonance imaging (MRI) findings of malignant melanoma of the lacrimal sac.

Case report

A 54 year old Chinese woman was referred to an ophthalmologist complaining of a 6 month history of left sided bloody tears and epistaxis. She had a firm, non-tender left medial canthal swelling, and syringing revealed left nasolacrimal duct (NLD) obstruction. Ocular and periorbital examination was otherwise normal. A dacryocystogram (DCG) demonstrated a filling defect in the lacrimal sac with NLD obstruction.

An ENT opinion was sought, and nasal examination revealed left sided septal deviation, with no obvious cause for the epistaxis.

Computed tomography (CT) of the head and orbits demonstrated a left lacrimal sac lesion extending into the NLD with proximal dilatation of the duct and no apparent bone erosion (Fig 1A) MRI confirmed the presence of a lacrimal sac lesion with intermediate signal intensity on T1 and T2 weighted images (Fig 2A, B) The lesion enhanced with intra-venous gadolinium.

An incisional biopsy of the lacrimal sac (Fig 1B) under frozen section control, and paraffin sections, confirmed malignant melanoma.

A full medical review, including MRI of the chest and abdomen, and liver function tests, excluded tumour elsewhere. However, abdominal MRI and ultrasound revealed a co-incident polycystic liver.

Three weeks after biopsy, a wide local excision including the medial upper and lower eyelids, dacryocystectomy and medial maxillectomy was performed. A tumour, confined to the sac, and invasion through the medial wall of the upper NLD, into the lateral wall of the nose, and apposing nasal septal mucosa, was seen peroperatively and confirmed histologically.

She underwent postoperative adjuvant radiotherapy (55 grays) and to date, 4 months later, remains well.

Comment

Malignant melanoma of the lacrimal sac is rare accounting for 5% of lacrimal sac tumours.1 It has an unfavourable prognosis compared with other causes of lacrimal sac tumour, and is considered more aggressive than cutaneous malignant melanoma.2 It is not possible to discern malignant melanoma from the radiographic appearance from other causes of lacrimal tumours.3 Radiological features of lacrimal sac tumours include filling defects on DCG and mass lesions on CT.4 However, to the authors’ knowledge, this is the first report of the MRI findings of malignant melanoma of the lacrimal sac.

Owing to the paramagnetic properties of melanin, malignant melanoma appears hyperintense on T1 weighted imaging, and hypointense on T2 weighted imaging.5 A study of six mucosal melanomas of the head and neck found that on T1, five lesions were hyperintense and one was isointense.6 On T2, five were of mixed intensity and one was iso-intense. They concluded that hyperintensity on T1 of mucosal melanomas was characteristic but not universal.

The majority of malignant lacrimal sac tumours are epithelial in origin.1 Imaging features suggesting malignancy include invasion of bone, rapid growth, and irregular margins with skin fixation. On MRI, the majority of epithelial tumours have intermediate signal intensity on T1 and high T2 signal intensity. High tumour cellularity is associated with intermediate to low T2 signal intensity.5

High signal intensity on T1 is not specific for malignant melanoma. Subacute haemorrhage caused by the presence of methaemoglobin is more likely and although melanoma may undergo intratumoral haemorrhage, other tumours with a tendency to bleed include small cell lung carcinoma, choriocarcinoma, and renal cell carcinoma metastases.7 Less likely causes include fat containing tumours (lipoma, dermoid, and teratoma)
requiring MRI fat suppression methods, 
paramagnetic material (manganese, iron, and 
copper), and very high (non-paramagnetic) 
intratumoral protein concentration.

MRI has been reported as a useful investiga-
tive tool in the assessment of lacrimal 
disease owing to its ability to delineate soft 
tissues. Intravenous and intracanalicular 
gadolinium adds useful information on le-
ssional enhancement and lacrimal apparatus 
structure and function. The predictive value 
of MRI for lacrimal sac melanoma, however, 
appears to be variable. Hyperintensity on T1 
relies on the paramagnetic properties of 
melanin, the presence of which is variable in 
anal melanoma. This is supported by our 
case, where only moderate T1 hyperinten-
sity with contrast enhancement was demon-
strated.

K Billing, R Malhotra, D Selva 
Oculoplastic and Orbital Unit, Department of 
Ophthalmology, Royal Adelaide Hospital, The 
University of Adelaide, Australia 

S Salonikis, J Taylor 
MRI Unit, Department of Radiology, Royal 
Adelaide Hospital, Adelaide, Australia 

S Krishnan 
Department of Otolaryngology, Royal Adelaide 
Hospital, Adelaide, Australia 

Correspondence to: Dr Dinesh Selva, Oculoplastic 
and Orbital Clinic, Department of Ophthalmology, 
Royal Adelaide Hospital, North Terrace, Adelaide, 
South Australia 5000; aselva2000@admhs.sa.gov.au 

Accepted for publication 10 January 2003

References
1 Owens RM, Wax MK, Kostik D, et al. 
Malignant melanoma of the lacrimal sac. 
2 Pe’er JJ, Stefanyszyn M, Hidayat AA. 
Nonpigmented tumors of the lacrimal sac. 
Lacrimal sac tumors. Ophthalmic Plast Reconstr 
4 Kim SH, Han MH, Park SW, et al. 
Radiologic and pathologic correlation of unusual 
lingual masses. Part II: Benign and malignant tumors. 
5 Yoshioka H, Kamao T, Kandatsu S, et al. 
MRI of mucosal malignant melanoma of the 
6 Stark DD, Bradley WD. Magnetic resonance 
7 Atlas SW. Magnetic resonance imaging of 
the brain and spine. 3rd ed. Philadelphia: 
Lippincott Williams and Wilkins, 2002.
8 Goldberg RA, Heinz GW, Chiu L. 
Gadolinium magnetic resonance imaging of 

Photodynamic therapy for recurrent myopic choroidal 
neovascularisation after limited 
macular translocation surgery

Limited macular translocation (LMT) is one of 
the treatment options for subfoveal choroidal 
neovascularisation (CNV) resulting from 
pathological myopia.1 The fundamental surgical 
principle involves the transposition of the 
foveal neurosensory retina to a new site with 
more healthy underlying retinal pigment 
epithelium.2,3 Direct laser photocoagulation 
is usually employed as an adjunct measure in 
enucleating the original CNV after the surgery. 
It has been observed that geometrically 
sizeable translocation is a prerequisite for a 
long term surgical success.4,5 The degree of 
translocation is, however, not often predict-
able and any ineffective displacement may 
render the subsequent laser photocoagulation 
extremely difficult or even impossible to 
perform.4,6 As a result, the recurrent or 
persistent CNV intruding the newly relocated 
fovea may jeopardise the final visual out-
comes.7,8 Photodynamic therapy (PDT) may 
be considered a viable adjunct treatment 
opinion in such circumstance.

Case report
A 41 year old woman with pathological myo-
pia of −11.0 dioptres in both eyes presented 
with a subfoveal CNV and subretinal haemor-
rhage in her right eye in July 2000. The best 
corrected visual acuity (BCVA) was 20/200 
in the right eye and 20/300 in the left eye. LMT 
with superotemporal 6 mm sceral imbrica-
tion was performed in July 2000. The opera-
tion was uneventful and an inferior displace-
ment of the fovea by 600 µm was achieved. 
The CNV however, was still located in the 
vicinity of the juxtafoveal area and therefore 
laser photocoagulation, bearing the potential 
risk of late creaping scar, was not suggested. 
At the 4 months postoperative visit, her left 
BCVA was 20/200 and the original CNV 
became more fibrotic with minimal leakage 
upon fluorescein angiography. Nevertheless, 
she came back at 5 months with a return of 
metamorphopsia and a drop in her right vision 
from 20/200 to 10/200. Dilated fundus exami-
ination showed a tiny patch of submacular 
haemorrhage in direct continuity with the old 
fibrotic scar (Fig 1A). Fluorescein angiogram 
of the early phase demonstrated a fresh 
recurrent CNV budding out from the original 
area (Fig 1B). The vision remained 
stable at 20/200 in the latest visit at 24 months 
after the PDT.

Comment
It has been shown that significant visual 
improvement may be achieved by LMT for 
the treatment of subfoveal CNV associated 
with age related macular degeneration (AMD) or 
pathological myopia.9,10 However, the surgical 
techniques are demanding and the potential 
complications are not unusual. One of the late 
postoperative visually important complica-
tions is recurrence of the CNV and this is par-
tially caused by an ineffective translocation 
of the fovea or a large lesion size of CNV.11 The 
incidence of persistent or recurrent CNV after 
limited LMT has been reported to be 40% and 
35% respectively in age related macular trans-
location and being 21% and 14% respectively in 
pathological myopia.12 Not many treatment 
options are available once the fovea is 
involved. Viable surgical options including 
repeated LMT, full 360 degree retinotomy MT, 
or submacular surgery may be considered but 
the surgical risk may be inadvertently higher 
in the redetachment of the neurosensory 
retina. PDT induces a selective thrombosis of 
the abnormal CNV and has been proved to be 
an effective treatment in preventing a signifi-
cant loss of vision in patients with CNV 
secondary to AMD or pathological myopia.13

Figure 1 Right eye with recurrent myopic CNV after LMT. (A) Fundus photograph of 
the patient showing the recurrent part of CNV budding from the original one with haemorrhage 
involved the subfoveal area. (B) Early phase fluorescein (FA), demonstrating the filling of 
choroidal vascular complex with early hyperfluorescence. (C) Late phase FA showing late 
moderate fluorescence leakage from the CNV. Photodynamic therapy (PDT) with the size of 
the laser spot as marked was delivered. (D) Late phase FA at 12 months revealing a complete 
recession of the recurrent CNV and late scar staining of the original CNV.

www.bjophthalmol.com
Its clinical indications and applications are expanding. Its minimal invasiveness and clinical efficacy make it a safer and visually desirable supplementary treatment in recurrent CNV after LMT. In our patient, the complete closure of CNV was achieved with concomitant vision improvement after a single session of PDT without evidence of recurrence at 24 months.

Financial interest: Nil.

Financial support: Nil.

W-M Chan, D S C Lam, D T L Liu, T-H Wong, K S C Yuen
Department of Ophthalmology and Visual Sciences, The Chinese University of Hong Kong, Hong Kong.

Correspondence to: Dr Wai-Man Chan, Department of Ophthalmology and Visual Sciences, The Chinese University of Hong Kong, Hong Kong Eye Hospital, 147K Argyle Street, Kowloon, Hong Kong; cwm6373@netvigator.com

Accepted for publication 12 January 2003

References


Acquired Glanzmann’s thrombasthenia causing prolonged bleeding following phacoemulsification

Phacoemulsification under topical anaesthesia using clear corneal incision is not a challenging procedure for the haemostatic system. In patients with known bleeding diathesis, this may be the procedure of choice to remove cataract. We report a patient who bled continuously for 36 hours following phacoemulsification under topical anaesthesia through a clear corneal incision. This was managed by using a topical haemostatic agent that has not been used in ophthalmic surgery before. Extensive haematological evaluation revealed the underlying cause to be an acquired form of Glanzmann’s thrombasthenia, a very rare condition.

Case report

A 79-year-old woman underwent left phacoemulsification with intraocular lens implantation under topical anaesthesia through a clear corneal temporal incision. The procedure was uneventful but she was seen to bleed from the operated eye in the recovery room. The eye was patched but the bleeding continued soaking the pads. When re-examined 2 hours later, as there was continuous bleeding, the eye was patched with gentle pressure. Examination the next day showed that the bleeding was persistent. Pressure bandage was reapplied. Examination in the operating theatre confirmed the conjunctival origin of the bleeding from the site where the left handed surgeon held the conjunctiva during surgery. Cauterisation and an attempt to suture the conjunctiva were unsuccessful. It was decided that the safest option was to use a small piece of oxidised regenerated cellulose (Surgicel, Ethicon) on the bleeding site and patch the eye.

The piece of Surgicel with clotted blood that was lying loose on the conjunctiva was removed at review 24 hours later. The conjunctival site had stopped bleeding with evidence of alternate bleaching and a clear corneal temporal incision. The procedure had been applied (Fig 1A). At her last review 8 weeks later, she was found to have a corrected visual acuity of 6/18 due to pre-existing macular changes secondary to retinal detachment that was reattached in 1976. The conjunctiva had healed well (Fig 1B). The patient had previously undergone an uneventful phacoemulsification and intraocular lens implantation in her right eye under sub-Tenon’s anaesthesia.

The patient’s recent medical history was significant for recurrent admissions elsewhere for investigation of severe anaemia following gastrointestinal bleeding. Platelet count and clotting screen had been normal. Angiodysplasia of stomach and duodenum were treated with laser and angiodysplasia of colon was treated by hemicolectomy. Three episodes of epistaxis and an episode of vaginal bleeding were managed conservatively. She had received 60 units of blood transfusion over a period of 1 year. Interestingly, she had appendicectomy and multiple dental extractions elsewhere many years previously without any significant bleeding. She has not been on any antiplatelet agents or anticoagulants. There was no family history of bleeding disorders.

A defect in the platelet function was suspected, as her coagulation screen including the platelet count was normal. Platelet aggregation tests showed no aggregation against any agonists other than ristocetin, which is dependent on platelet glycoprotein Ib. The patient showed normal normalisation with glycoprotein antigens Ib/IIa and Ib. The patient’s serum showed presence of inhibitory antibody against glycoprotein Ib/IIa. This led to a diagnosis of acquired Glanzmann’s syndrome, an extremely rare condition of haemostasis. No underlying malignant, autoimmune, or lymphoproliferative disorder had been identified as a cause for this patient’s acquired Glanzmann’s thrombasthenia.

Comment

The patient described had uncontrollable bleeding for 36 hours following a procedure, which is generally considered safe in patients with a bleeding disorder. She developed bleeding from the conjunctival site where the surgeon grasped the conjunctiva during certain stages of the procedure. One would usually not expect any significant bleeding from this site; however, in a patient with compromised haemostasis the bleeding may be prolonged. Although the bleeding was no more than a gentle ooze at any point in time it was persistent enough for 36 hours before the topical haemostatic material Surgicel had been put to use. The consequences of an intraocular bleed may have seriously threatened her sight.

We are not aware of any reports of the use of Surgicel in ophthalmic surgery. All reports of its use are in other fields of surgery. This material is supposed to swell up with blood and form a gelatinous mass that aids in the formation of clot. It acts as a haemostatic adjunct. The exact mode of its action in this patient with antiplatelet antibodies is unclear. Our experience shows that oxidised regenerated cellulose (Surgicel) may have a role in ophthalmic surgery especially in lacrimal and orbital surgery, when faced with bleeding that is difficult to stop. Various cautionary tales associated with use of Surgicel have been reported.

Our report suggests that in the presence of a severe bleeding disorder, clear corneal phacoemulsification under topical anaesthesia may not be totally safe. When performing such a procedure in a patient with known bleeding disorder it may be safe to take all the necessary precautions in consultation with a haematologist to avoid a serious bleed that may be sight and life threatening. There may be a role for haemostatic agents like Surgicel.

S Dinakaran, M P Edwards
Department of Ophthalmology, A/Floor, Royal Hallamshire Hospital, Sheffield, UK

K K Hampton
Department of Haematology, Royal Hallamshire Hospital, Sheffield, UK

www.bjophthalmol.com
Propionibacterium acnes endophthalmitis diagnosed by microdissection and PCR

Although Propionibacterium acnes, a Gram positive anaerobic bacillus, is the most commonly identified cause of delayed onset postoperative endophthalmitis, routine vitreous cultures are frequently inadequate for its diagnosis. This case describes the utility of the histopathological technique of microdissection and polymerase chain reaction (PCR) for the diagnosis of delayed postoperative endophthalmitis.

Case report

A 78 year old man with a history of vitreous floaters, a coronary bypass, and aortic valve replacement underwent an uncomplicated cataract extraction with intraocular lens (IOL) implantation in the right eye. Three months later, he developed increasing floaters in the right eye and was diagnosed with vitritis unresponsive to corticosteroid treatment. Examination revealed acuities of 20/25 in the right eye and 20/20 in the left with normal intraocular pressures. The right eye was significant for no anterior chamber cells or flare, dilated iris vessels, an IOL without deposits, 3+ vitreous cells with trace haze, and peripheral pigmentary degeneration. The left eye was normal with the exception of trace vitreous cells and a chorioidal naevus.

Results

The vitreous supernatant and unstained cytology slides were sent to the National Eye Institute for further evaluation. Vitreal analysis for interleukin 2 (IL-2), IL-4, IL-6, IL-10, IFN-γ, and TNF-α using ELISA (Endogen, Woburn, MA, USA) revealed undetectable cytokine levels. The vitreous slides were stained with Giemsa, Gram, and immunohistochemical stains for T cells, B cells, and macrophages. Cytopathological examination showed clusters of macrophages admixed with CD4+ and CD8+ T cells and B cells (Fig 1A). Gram positive bacilli were seen in the cytoplasm of a few macrophages (Fig 1B). The engulfed bacilli were microdissected under a microscope with a 30 gauge needle and submitted for PCR. Nestled PCR with P acnes specific oligodeoxynucleotide primers complementary to regions of 16S rDNA was used. The primers were Pa1, AAG GCC CTT TGT TGG; Pa2, TCC ATC CGC AAC CGC CGA A; and rPa3, ACT CAC GCT TGC TCA CAG. Nested-PCR analysis revealed P acnes (Fig 2). A diagnosis of delayed postoperative endophthalmitis was made.

Comment

The most common causes of vitritis in elderly patients are acquired or postoperative infections, sarcoidosis, and intraocular malignancies masquerading as uveitis. An early diagnostic procedure is indicated if postoperative endophthalmitis is suspected. In this case, although the chronic inflammation and intracytoplasmic Gram positive bacilli in a few macrophages suggested an infectious process, the negative cultures precluded the diagnosis of an infectious endophthalmitis. To further investigate the possibility of a bacterial infection nested PCR was performed on the microdissected bacilli. Molecular analysis verified the presence of P acnes and a diagnosis of delayed postoperative endophthalmitis was confirmed.

Vitreous cultures are positive in less than 50% of postoperative endophthalmitis cases. In a study of 25 patients with delayed onset endophthalmitis aqueous culture and microscopy were diagnostic in 0% of cases, vitreous culture was positive in 24% and PCR from the aqueous and vitreous yielded a positive diagnosis in 84% and 92%, respectively. Treatment of P acnes endophthalmitis includes intravitreal vancomycin plus consideration of pars plana vitrectomy with or without capsulotomy with or without IOL removal. Although aggressive surgical intervention eradicates the infection similar visual outcomes are reported with more limited surgical treatment.

In our case the intracytoplasmic bacteria in the macrophages were the only evidence of a bacterial infection. To detect the presence of P acnes we referenced the PCR method described by Hykin that used 150 µl of the vitreous for culture and 100 µl for PCR. Using the technique of microdissection and PCR with a similar volume of vitreous we additionally performed cytology and cytokine analysis which are helpful in the diagnosis of other causes of vitritis.

This case further illustrates the benefits of molecular analysis for the diagnosis of culture...
negative delayed onset endophthalmitis. It also describes for the first time microdissection and PCR for the evaluation of endophthalmitis. Advantages of this technique are that it allows for a more comprehensive pathological examination on a limited specimen and provides the option of having the molecular studies being performed elsewhere.

R R Buggage, D F Shen, C-C Chan
Laboratory of Immunology, National Eye Institute, National Institutes of Health, Bethesda, MD, USA

D G Callanan
Texas Retina Associates, Arlington, TX, USA

Correspondence to: Ronald R Buggage, MD, NIH/NEI, Building 10, Room 10N112, Bethesda, MD 20892-1857, USA; buggage@nei.nih.gov

Accepted for publication 21 January 2003

References


Interferon treatment of childhood conjunctival lymphoma

Mucosa associated lymphoid tissue (MALT) lymphoma is the most common ocular adnexal tumour of childhood. The neoplastic lesions have a more indolent course than non-MALT lymphomas, are usually found in the older age groups (50–70 years), are usually limited to localised, stage I disease at presentation, and radiotherapy and chemotherapy have been the mainstay of treatment.

Case report

A 15 year old male was referred by an ophthalmologist after an 8 month history of unilateral painless follicles at both nasal surfaces (Fig 1A). There were no visual symptoms and, based on a working diagnosis of an atypical vernal reaction, topical steroid treatment had resulted in mild size reduction of the lesions. Incisional biopsy was performed after the lesions remained static for 3–4 months.

The patient’s visual acuity was 6/4 in both eyes and intraocular pressures measured 15 mm Hg in each eye. Slit lamp examination demonstrated small follicular deposits in both nasal follicles and nasal palpebral conjunctiva. The rest of the ocular examination was unremarkable. Review of systems was negative and the patient’s past medical history and family medical history did not reveal the presence of lymphoproliferative or autoimmune diseases. There were no findings suggestive of Sjögren’s syndrome and physical examination was normal.

The limited amount of biopsy tissue was divided for routine processing and flow cytometry; frozen tissue was therefore unavailable. Histologically a dense lymphoid infiltrate including benign appearing lymphoid follicles was identified (Fig 1B). Lymphoid follicles were surrounded by centrocytic-like cells and small lymphocytes, some of which infiltrated the conjunctival epithelium. Flow cytometry identified a monoclonal B cell population with a CD5–, CD20–, CD10 equivocal phenotype. The histopathological findings in isolation may have represented either an early marginal zone lymphoma or a benign B cell follicular hyperplasia. Absolute distinction on the small amount of tissue was not possible. However, in conjunction with the flow cytometric finding of a monoclonal B cell population, a diagnosis of low grade B cell lymphoma (probably of MALT type) could be made.

Comment

Conjunctival lymphoma is mostly a disease of the elderly, with Shields et al reporting a mean age of diagnosis of 61 years. While not a common disease, Akpek et al suggest that its prevalence is higher than previously recognised, and that vigilance is required in patients with chronic ocular irritation and conjunctivitis who do not respond to conventional therapy. This is the youngest case of conjunctival lymphoma that we know of in the literature; hence conjunctival lymphoma should be considered in the differential diagnosis of atypical conjunctival lesions in younger patients.

Treatments outlined by Shields et al included radiotherapy (44%), complete excisional biopsy (36%), observation (9%), chemotherapy (6%), and cryotherapy (4%). Radiotherapy has been widely used with successful results but occurs morbidity in the form of corneal ulcer, radiation induced cataract and ocular lubrication disorders have been reported. Intranasal IFN-α is a relatively new therapy which has been shown to be both effective and safe in a small number of cases. Non-sight threatening ocular complications such as subconjunctival haemorrhage and local chemoablation have been reported, as well as minor transient systemic effects including headaches, nausea, fever, chills, and myalgia. Administration of intranasal IFN-α is also a relatively simple and quick procedure. It shows great promise as a first line agent to treat conjunctival lymphoma, but long term follow up is needed.
Unilateral corneal anaesthesia and ulceration following squint surgery in a child with Pendred syndrome and bilateral sixth nerve palsy

We present a 4 year old child with Pendred syndrome and bilateral sixth nerve palsy. To our knowledge this association has not been previously reported. In addition, this patient developed unilateral corneal ulceration with associated corneal anaesthesia following squint surgery. We will discuss the pathophysiology of this unusual complication following squint surgery.

Case report

This patient presented when he was 6 months old with right convergent squint. He was diagnosed with Pendred syndrome (sensorineural hearing loss and thyroid dysfunction) by the paediatricians and the otolaryngologists following abnormal thyroid function tests and a computed tomography (CT) scan of the temporal bones showing Mondini malformations of both cochleas. At presentation his visual acuities were 6/60 right eye and 6/60 left eye using the Cardiff acuity cards. He had bilateral alternating esotropia with an inability to abduct either eye. There was no globe retraction or abnormal lid movements and a magnetic resonance imaging (MRI) scan had shown congenital absence of the auditory nerves but no other abnormality. A diagnosis of bilateral sixth nerve palsy was made. The squint was cosmetically poor and measured at 45 prism diptres in the distance and near. He had low hypermetropia with no significant anisometropia. Funduscopy was normal. He was reviewed regularly in the paediatric eye clinic over the next 3 years during which time his visual acuities were within normal limits, the best recorded acuity being 6/9 right eye and 6/9 left eye using singles.

When he was 4 years old, he underwent bilateral superior rectus and inferior rectus lateral transpositions under general anaesthesia, which was uneventful with no immediate postoperative complications, and a cosmetic improvement. Alternating convergent squint of 15 prism diptres for distance and near.

Two months later he developed a left inferior corneal ulcer (Fig 1) with surrounding punctate epitheliopathy which surprisingly did not seem to cause him as much distress as expected. The left corneal sensation was definitely reduced compared to the right which appeared normal. Sensation was assessed clinically (an anaesthesiometer was not available), and was consistently reproducible by different ophthalmologists. There was no exophthalmos or any other sign of thyroid orbitopathy. The right eye remained asymptomatic. Empirical therapy with topical ofloxacin and lubricants was unhelpful. He proceeded to have glue tarsorrhaphy which transiently aided the healing of the corneal ulcer. However, the ulcer quickly recurred when the tarsorrhaphy reversed. He subsequently had left inferior lid shortening with a canthal sling to elevate the lower lid to protect the corneal epithelium. The ulcer resolved leaving an area of corneal scarring. He is being reviewed regularly in the eye clinic.

Comment

Pendred syndrome is an autosomal recessive disorder characterised by congenital deafness and thyroid goitre. The hearing loss is usually severe and is present at birth, and the goitre generally appears at puberty or later but may be present in early childhood with an associated euthyroid or hypothyroid state.1–3 Affected individuals are reported to be otherwise normal.

The pathophysiology of the corneal anaesthesia and ulceration in this patient is uncertain. There are several possible reasons for the corneal anaesthesia. They include herps simplex keratitis, postoperative anterior segment ischaemia, surgical trauma to the long posterior ciliary nerves or ciliary ganglion, congenital absence of sensation, and surgery reducing Bell’s phenomenon.

The clinical course was not typical of herps simplex and there was no previous history of corneal pathology. Postoperative anterior ischaemic syndrome was unlikely, the two recti muscles were operated on and there was no anterior uveitis was observed. To our knowledge there are no reported cases of corneal anaesthesia after squint surgery. There was no evidence of pre-operative involvement, which one may expect with trauma to the long posterior ciliary nerves or ciliary ganglion.

Congenital absence of corneal sensation was the most likely cause, especially in view of his unusual cranial nerve anomalies, and we believe he had pre-existing corneal anaesthesia before squint surgery despite the absence of any other fifth cranial nerve signs. Following the lateral transposition of the superior rectus bell’s phenomenon was noted to be absent thereby compromising his corneal protection. In addition, he was observed to have significant lagophthalmos while asleep. We believe that the combination of corneal anaesthesia, abolished bell’s phenomenon, and lagophthalmos compromised his corneal integrity resulting in corneal ulceration.

This case highlights the importance of determining corneal sensation before transposition surgery on the superior rectus as Bell’s phenomenon may be abolished therefore compromising corneal protection. This is especially relevant in patients with unusual cranial neuropathy and lagophthalmos.

Figure 1 Inferior corneal ulcer before treatment.

References

1 Pendred V. Deaf mutism and goitre. Lancet 1896;11:539


Gemella haemolymsans acute postoperative endophthalmitis

Endophthalmitis is perhaps the most feared complication of cataract surgery, with a reported incidence between 0.07 and 0.13%.4–5 The most common organisms reported in previous studies are Gram positive staphylococci and streptococci.4–5 We report a case of severe endophthalmitis with an unusual Gram positive organism, after uncomplicated phacoemulsification, with foldable intraocular lens implantation.

Case report

A 66 year old white man underwent routine phacoemulsification cataract extraction with posterior chamber lens implantation (Acrylic, Model H60M, Bausch & Lomb) to the right eye in January 2002. The left eye had previously undergone similar surgery in September 2001. He was generally in good health, and on no medication. There was a past medical history of sarcoidosis treated with oral prednisolone in 1970, which has since been in remission, and an episode of staphylococcal septicemia in 1987, without sequelae.

On the first postoperative day, visual acuity measured 6/9 unaided and ocular examination was unremarkable. That same afternoon the patient developed ocular pain, initially relieved by paracetamol (acetaminophen), which however, worsened during the night with progressive deterioration of vision. He presented to the ophthalmic emergency department the following morning with the aforementioned symptoms. Visual acuity was reduced to hand movements right eye and 6/9 left eye. Slit lamp examination revealed an oedematous cornea with Descemet’s folds. The anterior chamber was hazy, with 1 mm hyperopic shift and the intraocular pressure measured 38 mm Hg.

There was no red reflex. B-scan ultrasound examination showed extensive vitreous debris with attached retina. The left eye was pseudophakic with no abnormalities of note. A diagnosis of acute postoperative endophthalmitis was made. Anterior chamber and vitreous samples were obtained for aerobic and anaerobic culture/sensitivity and Gram staining. Intravitreal vancomycin 2 mg and amikacin 300 μg, each in 0.1 ml of balanced salt solution and subconjunctival cefuroxime 125 mg were administered. Oral ciprofloxacin 500 mg twice daily, prednisolone 60 mg once a day, topical gentamicin hourly, ofloxacin hourly, and atropine 1% twice a day were commenced.

Preliminary Gram staining suggested a Gram positive coccus, sensitive to ciprofloxacin—oral and topical antibiotics were therefore continued. Owing to difficulty in identifying the nature of the organism, the samples were sent to a regional reference laboratory, which identified Gemella haemolymsans from both anterior chamber and vitreous aspirates. The organism was reported to be sensitive to gentamicin, ciprofloxacin, latamoxef, amoxicillin/clavulanate, chloramphenicol, and resistant to trimethoprim.

R V Wintle
Eye Unit, Southampton General Hospital, Tremona Road, Southampton SO22 5DS, UK

Y F Choong
Eye Unit, University Hospital of Wales, Cardiff, UK

D E Laws
Department of Ophthalmology, Singleton Hospital, Swansea, UK

Correspondence to: Mr Richard V Wintle, Eye Unit, Southampton General Hospital, Tremona Road, Southampton SO22 5DS, UK; richardwintle67@yahoo.com

Accepted for publication 16 February 2003
The patient continued to make steady progress; 2 months later vision had improved to 6/9 unaided. The patient at that time was troubled by floaters secondary to considerable vitreous debris. At last review in September 2002, visual acuity had further improved to 6/4 with −0.75 DS ph correction.

Comment
Gemella haemolytica is an aerobic or facultative anaerobic, Gram positive coccus, a normal commensal of the oral cavity and upper respiratory tract of low virulence. Gemella haemolysans is an aerobic or facultative anaerobic, Gram positive, catalase negative organism that is frequently isolated from the upper respiratory tract. It can also cause infectious endophthalmitis. Streptococcus Streptococci have been reported to have active sarcoidosis on systemic steroid therapy, whereas our patient was reported to have active sarcoidosis on at least history of sarcoidosis. This possible association between sarcoidosis and infection by Gemella may be purely coincidental, as no such association has been reported with systemic infection.

Gemella haemolytica is difficult to identify, because of its close resemblance to viridans streptococci and Neisseria. As diagnostic technology improves, Gemella haemolytica endophthalmitis may be described more often in the future. This report highlights the importance of infection with rare commensal organisms in healthy, immune competent individuals after uneventful phacoemulsification cataract surgery.

S V Raman, N Evans, T J Freeggard
Royal Eye Infirmary, Aspley Road, Plymouth, UK

R Cunningham
Department of Microbiology, Derriford Hospital, Plymouth, UK

Correspondence to: S V Raman, West of England Eye Unit, Royal Devon and Exeter Hospital, Exeter, UK; vason317@yahoo.com

Accepted for publication 25 February 2003

References

Does topical brimonidine tartrate help NAION?

There is no proved treatment for non-arterior anterior ischaemic optic neuropathy (NAION). Topical brimonidine tartrate has been reported to have a neuroprotective effect for retinal diseases following experimental elevation of intraocular pressure and optic nerve injury in the rat, which is blocked with coadministration of the α2 antagonist, raubasine. Increased retinal ganglion cell survival has also been shown to occur following oral administration of brimonidine in monkeys with experimental glaucoma. These results were the basis of the recently aborted clinical trial of topical brimonidine for acute NAION and our retrospective study of 31 patients with NAION, who were evaluated within 3 weeks of the onset of visual loss and followed up for a minimum of 8 weeks. During 2001–2, we treated all (14) patients with brimonidine tartrate within 14 days (mean 5.3, SD 5.52) of the onset of visual loss. Five patients were treated after 1 day of symptoms. Brimonidine was taken four times a day in 11, three times a day in 13, twice a day in two patients. All (17) untreated patients were evaluated the year after and were matched to the treated group for age, sex, cardiovascular risk factors, previous aspirin use, and previous first eye NAION.

Snellen visual acuity and colour vision, using the Ishihara colour plates, were documented and expressed as a decimal equivalent (for acuity: 20/60 = 0.33 and light perception = 0.001; for colour vision: the number of correctly identified plates/the total number of visual fields). The visual fields (Humphrey or tangent perimetry) were analysed and defects were graded according to the following scale: 0 = normal, 1 = arcuate nerve fibre bundle defects, 2 = retinal nerve fibre layer (6 degrees), 3 = centro- or altitudinal defects, 3 = altitudinal defect plus additional loss, 4 = no light perception. A third examiner, who was unaware of the dates of the visual fields and the patients’ treatment status, had evaluated all visual fields and determined, in each patient, whether the field was better or worse than or equivalent to the other field. The intraocular pressure was normal in all except two patients. The pressure was 25 mm Hg in one patient in the treated group and 24 mm Hg in one patient in the untreated group.

Statistical analysis of the data involving comparisons of the treated and untreated groups at baseline and 8–12 weeks was performed using the two tailed Student’s t test. The Wilcoxon signed rank test was used to compare the individual vision performance from baseline to the 8–12 week examination. For visual acuity and colour vision, a positive rank indicated improvement and a negative rank indicated a worse visual outcome. For the visual field grade, a positive rank indicated that the visual field was worse in six patients (50%), and unchanged in eight patients.

The outcome visual field grade was significantly worse in the treated group. The masked examiner’s evaluation demonstrated that more treated patients worsened in those treated with topical brimonidine. Although there was no significant difference for the colour vision outcome, this might reflect that the baseline colour vision value was better for the treated group. The outcome visual field grade was significantly worse in the treated group. The masked examiner’s visual field evaluations demonstrated that more treated patients worsened in those treated with topical brimonidine. When the baseline and outcome of all visual parameters for each individual were compared, the treated group had a significantly worse outcome at 8–12 weeks.

Our results are not the first description of worse outcome in patients treated with α2 agonists for central nervous system ischaemic disease. Studies in animal models and clinical studies in humans suggest the potential efficacy of drugs, including α2 receptor agonists, may impede recovery following stroke. Clonidine administration caused recurrence of the neurological deficit in animals who had partially recovered. In a retrospective study, the level of motor recovery of stroke patients was worse in those treated with α2 agonists than in patients not receiving these agents. Although in experimental optic nerve injury in animal models, brimonidine appears to offer neuroprotection, our results demonstrate that brimonidine, applied topically up to four times daily, does not appear to be a beneficial treatment for acute NAION.
is possible earlier treatment might have been more effective, although patients who worsened received treatment sooner than those who did not worsen. Increased dosing frequency or using a different preparation of brimonidine might be more effective. Additionally, the number of subjects in the study was small and a negative trend could appear more profound.

### References


### Chronic eye movement induced pain and a possible role for its treatment with botulinum toxin

Chronic ocular pain may have many causes and can be a frustrating problem for both patient and doctor alike. We describe two patients who had similar symptoms and eye findings who had been unable to relieve their pain with conventional analgesia. We postulate a cause for their pain and describe our experience of a treatment strategy using a standard dose of botulinum toxin injection into an extraocular muscle.

### Case 1

A 56 year old white woman presented with what was initially thought to be a right orbital cellulitis but investigations and clinical course subsequently suggested a non-infectious idiopathic inflammatory aetiology. Her history suggested orbital myositis and she described right sided facial weakness, nausea, and right sided ptosis. She had a 9 month course of oral steroids and despite this needed tramadol, paracetamol, and flurbiprofen to control her pain. Her symptoms and examination findings slowly stabilised until she was left with marked limitation of upgaze in her right eye. Her symptoms did not change over the next 3 years, at which point she was referred to our care. When she attempted to look up she described a juddering sensation and severe pain just above the right eye. She found it impossible to raise her right eye at night but was still using regular oral buprenforfen for pain relief. Her pain was exacerbated by reading or looking at the computer and she complained of vertical diplopia.

On examination she had limitation of abduction and elevation of her right eye and prisms did not improve her symptoms. A tentative diagnosis of inflammatory spasm was made. She was treated with botulinum toxin injection to her right inferior rectus. Two weeks later there was much less tightness and discomfort in the orbit but she had diplopia in all positions of gaze and was forced to occlude one eye. Three months later the pain was much improved but she still found the diplopia intolerable and declined further treatment.

### Case 2

A 46 year old white man presented complaining of chronic constant ocular discomfort which followed strabismus surgery 8 years earlier for an A-pattern exotropia with diplopia on downgaze. The pain was worsened by prolonged television watching and prisms in his glasses did not help. Pain was much worse on upgaze and right gaze, which were limited. Oral non-steroidal anti-inflammatory agents (NSAIDs) reduced the pain a little but only when taken in high doses (100 mg three times daily flurbiprofen).

On examination he had a right hyperphoria, with an A-pattern exotropia and an abnormal head posture for distance. He still had diplopia. Botulinum toxin was injected into his left medial rectus muscle, which resulted in a profound reduction in his symptoms, leaving him with a small esotropia. His diplopia resolved completely after 10 weeks. The “pressure sensation” and pain in the right eye recur after about 6 months, this time with no diplopia. He had a further injection of toxin 8 months after his first injection which again significantly improved his pain but gave him diplopia for 3 weeks. He continues to take flurbiprofen 50 mg three times daily orally.

### Comment

The pain demonstrated by these two patients with the use of botulinum toxin A: a randomized, placebo-controlled clinical trial. *Dev Med Child Neonat* 2000;42:116–21.

### References


Intrastromal lamellar femtosecond laser keratoplasty with superficial flap

Lamellar keratoplasty has usually been performed taking a trephine to delineate the extent of the tissue to be excised, and a knife or similar instrument to remove the lamellar corneal tissue from the underlying deep corneal bed. In a similar way, the lamellar donor tissue was prepared and inserted into the recipient bed. The depth of the lamellar excision of the corneal stroma was created in five postmortem eyes of slaughterhouse pigs. The diameter of the deep stromal incision was 7 mm. In a second step, a circular sagittal incision was performed starting from the peripheral edge of the already existing incision in the pre-desecmental level to the superficial layer of the corneal stroma. In continuation of the latter sagittal incision the corneal flap was prepared with a diameter of 7 mm, a thickness of about 100 µm, a hinge, and three positional pikes. 6 The pikes in the flap with the corresponding notches in the bed of the flap were formed to increase the rotational stability of the flap after repositioning. The height of the peaks was about 0.40 mm. After opening of the flap the lamellar segment situated between the pre-desecmental incision and the incision in the superficial stromal level was removed and exchanged against a similar formed segment obtained from another (donor) pig eye. The flap was repositioned.

For all eyes included in the study, the intrastromal corneal button and the superficial flap with the three positional pikes could be prepared without major difficulties. The corneal buttons could easily be repositioned into their original beds as well as into the recipient beds of other eyes in which the reciprocals were created with the same diameter as the donor button. The time taken for preparation of the intrastromal corneal button and the flap, and for the exchange of the corneal buttons was less than 10 minutes in all cases.

Comment

Femtosecond laser technology allows a new type of intrastromal lamellar keratoplasty with removal of a mid-stromal segment and preservation of an intact Bowman’s membrane. Considering the decreased amount of alloegenic corneal tissue transplanted, and regarding the preservation of the original corneal surface, lamellar intrastromal femtosecond laser keratoplasty may be associated with a smaller rate of immunological graft reaction and with a lower postoperative corneal astigmatism in some eyes. Future clinical studies may show whether positional edges in the superficial flap increase its postoperative rotational stability.

Proprietary interest: none

J B Jonas
Universitäts-Augenklinik, Theodor-Kutzer-Ufer 1–3, 68167 Mannheim, Germany; jost.jonas@ma.augen.uni-heidelberg.de

Accepted for publication 17 March 2003

References


Demographic study of paediatric allergic conjunctivitis within a multiethnic patient population

From October 1999, all patients referred to the paediatric ophthalmology service in Bradford have been added to a computerised database. This is the only paediatric ophthalmology service within the city of Bradford and receives all GP referrals of this type. Patients with a clinical diagnosis of chronic allergic conjunctivitis were identified from October 1999 to July 2000. We compared the relative prevalence of chronic allergic eye disease between white and Asian patients in the paediatric population of the city of Bradford.

Confirmation of the diagnosis of chronic allergic conjunctivitis was based on reviewing case records. All patients were seen at the first visit by a consultant paediatric ophthalmologist (JAB). A diagnosis of chronic allergic conjunctivitis was made if the patient had characteristic symptoms and signs based on criteria set out by Buckley in 1998. 7 This was done to ensure accurate and consistent diagnosis of chronic allergic conjunctivitis so as not to include other forms of ocular allergy—for example, drug allergy or preservative toxicity. Inclusion criteria required a history of at least three of the following: a history of recurring symptoms over a period of at least 1 year; itching as a symptom; personal or family history of non-allergic conjunctivitis; and exacerbation during the pollen season and/or exposure to household pets. Presence of the following clinical signs was also necessary: conjunctival hyperaemia and subnasal papillae.

Patients were excluded if they had any signs of staphylococcal blepharoconjunctivitis such as eyelid and eyelash crusting; matting of the eyelids; purulent, sticky discharge; eyelid notching and scarring. Patients with mixed disease were also excluded from this study. The presence of corneal complications that required topical steroid for resolution was used to define severe disease.

Clinical data

Forty-three patients were identified from the database; 39 patients fulfilled entry criteria for this study and records were retrieved for 35. There were 24 Asians and 11 white children.

For Asian patients, the mean age was 9.58 (SD 2.82) years. For the white patients, the mean age was 7.82 (SD 3.19) years. Follow-up ranged from 3–14 months, mean 6 months. The prevalence of allergic conjunctivitis in Asians was 59 per 100 000 (24 in 40 524) and in white children, 12 per 100 000 (11 in 93 988); a relative prevalence of 5 to 1 (χ² test p <0.001).

There was a predominance of males in both ethnic groups, 2.4:1 in Asians and 1.8:1 in white children. This difference in sex was not significant between both groups (Fisher’s test, p =0.71).

The overall age distribution for all males was 4.54 years and for all females was 10.01 years. For Asians, the mean age for males was 9.18 years and for females was 10.57 years. For white children, the mean age for males was 9.00 years and for females was 9.23 years.

Corneal complications

There were 14 with punctate epithelial erosions (10 Asians and four white children). Comparing patients from both groups with severe disease, there was a relative prevalence of Asians by 6.75 to 1 (Fisher’s test, p =0.001).

In two cases, visual loss occurred after the onset of chronic allergic conjunctivitis from epithelial plaque and corneal pannus. Both were Asian.

Comment

Various studies have reported allergic eye disease to be more common among Asian and black patients. 8,9 This may be due to genetic and environmental factors.

We found allergic eye disease to be more common in Asians than white children. It is possible that ocular allergy is multifactorial but perhaps with a greater genetic predisposition in certain ethnic communities. 10 We could not comment on the prevalence of chronic allergic conjunctivitis in the community because of referral bias since we only see patients referred by GPs. The extent to which milder cases are treated in the community is not known but we feel that the more severe cases are the ones referred to our department. Our findings highlight that allergic eye disease appears to be more common and complicated in Asian patients in the Bradford population. This potential risk of sight threatening disease means that they are more likely to require topical steroid treatment. This has led us to consider that appropriately aggressive treatment is essential in these patients.

A J Singh, R K Loh, J A Bradbury
St James’s University Hospital, Beckett Street, Leeds LS9 7TF, UK

Correspondence to: Mr Anil J Singh, St James’s University Hospital, Beckett Street, Leeds LS9 7TF, UK; mraniljsingh@yahoo.co.uk

Accepted for publication 20 March 2003

References


**NOTICES**

**Helping the blind and visually impaired**

The latest issue of Community Eye Health (No 45) discusses help for the blind, with an editorial by Sir John Wall of the Royal National Institute for the Blind on the rights of blind people. For further information please contact: Journal of Community Eye Health, International Resource Centre, International Centre for Eye Health, Department of Infectious and Tropical Diseases, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK (tel: +44 (0)20 7612 7964; email: Anita.Shah@lshtm.ac.uk; website: www.jche.ac.uk). Annual subscription (4 issues) UK£28/US$45. Free developing country applicants.

**Second Sight**

Second Sight, a UK based charity whose aims are to eliminate the backlog of cataract blind in the UK by 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 (lucymathen@yahoo.com).

**Surgical Eye Examinations 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 Examinations International, 27 East De La Guerra, C-2, Santa Barbara, CA 93101–9858, USA (tel: +805 963 3303; fax: +805 965 3564; email: hsbrown.md@cox.net or seeinl@seeintl.org; website: www.seeintl.org).

**Surgical Eye Examinations 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 Examinations International, 27 East De La Guerra, C-2, Santa Barbara, CA 93101–9858, USA (tel: +805 963 3303; fax: +805 965 3564; email: hsbrown.md@cox.net or seeinl@seeintl.org; website: www.seeintl.org).

**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 50 different organisations related to eye disorders ranging from conditions that are relatively common to very rare syndromes. The website acts as a portal giving direct access to support groups own sites. The SPECS website 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 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 retinitis pigmentosa and the care 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 860 363), 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: hynda@brps.demon.co.uk; website: www.brps.demon.co.uk).

**Rise in organ transplant numbers**

According to UK Transplant, the UK has seen the highest number of organ transplants in six years. Between 8.30am on 31 March 2003 and 31 March 2003) 2777 patients had their lives saved or dramatically improved through the generosity of 1064 donors. This equated to a 6% increase compared to the previous 12 months (1 April 2002 to 31 March 2002). Furthermore during 2002–3, the highest number of people benefited from a cornea transplant for five years (1997–98) and 240 more people had their sight restored than the previous year. For further information see UK Transplant’s website (www.uktransplant.org.uk).

**Elimination of avoidable blindness**

The 56th World Health Assembly (WHA) considered the report on the elimination of avoidable blindness (doc A56/26) and urged Member States to: (1) Commit themselves to supporting the Global Initiative for the Elimination of Avoidable Blindness by setting up a national Vision 2020 plan by 2005; (2) Establish a national coordinating committee for Vision 2020, or a national blindness prevention committee to help implement the plan; (3) Implement the plan by 2007; (4) Include effective monitoring and evaluation of the plan with the aim of showing a reduction in the magnitude of avoidable blindness by 2010; (5) To support the mobilisation of resources for eliminating avoidable blindness. The WHA also urged the Director-General to maintain and strengthen WHO’s collaboration with Member States and the partners of the Global Initiative for the Elimination of Avoidable Blindness as well as in the coordination and support of national capability.

**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 £3993 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: Adrienne.Burrough@lshtm.ac.uk; website: www.lshtm.ac.uk).

**Ophthalmic Anesthesia Society (OAS)—17th Scientific Meeting**

The 17th Scientific Meeting of the Ophthalmic Anesthesia Society (OAS) will be held 3–5 October 2003 at the Westin Michigan Avenue Chicago, Chicago, USA. Programme co-chairs: Marc Allen Feldman MD MHs and Steven T Charles MD. The CME joint sponsor is the Cleveland Clinic Foundation; CME hours are pending. Fees for OAS members are $300; non-members $475; students $50.

Further details: OAS, 793-A Foothill Blvd, PMB 19, San Luis Obispo, CA 93405 USA (tel: +1 805 534 0300; fax: +1 805 534 9030; email: info@eyeanesthesia.org; website: www.eyeanesthesia.org).

**Glaucomea Society 24th Annual Meeting and Dinner**

The Glaucomea Society 24th Annual Meeting and Dinner will take place on 20 November 2003 from 7.30 to 9.30pm at the Royal College of Physicians, London, UK. Further details: Ms Janet Flowers (email: glaucom@ukiere.freerve.co.uk).

**Detachment Course with international faculty on: Retinal and Vitreous Surgery with Case Presentations preceding the Annual Meeting of Iranian Society of Ophthalmology**

The detachment course with international faculty on: Retinal and Vitreous Surgery with Case Presentations preceding Annual Meeting of Iranian Society of Ophthalmology will be held
5th International Symposium on Ocular Pharmacology and Therapeutics (ISOPT)

The 5th International Symposium on Ocular Pharmacology and Therapeutics (ISOPT) will take place 11–14 March 2004, in Monte Carlo, Monaco. Please visit our website for details of the scientific programme, registration, and accommodation. To receive a copy of the Call for Abstracts and registration brochure please submit your full mailing details to http://www.kenes.com/isopt/interest.htm.


XVth Meeting of the International Neuro-Ophthalmology Society

The XVth Meeting of the International Neuro-Ophthalmology Society will take place 18–22 July 2004, in Geneva, Switzerland.

Further details: Prof. A Safran, University Hospital Geneva, c/o SYMPORG SA, Geneva (fax: +41 22 839 8484; email: info@symporg.ch; website: www.symporg.ch).
Gemella haemolysans acute postoperative endophthalmitis

S V Raman, N Evans, T J Freegard and R Cunningham

Br J Ophthalmol 2003 87: 1192-1193
doi: 10.1136/bjo.87.9.1192-a

Updated information and services can be found at:
http://bjo.bmj.com/content/87/9/1192.2

These include:

References
This article cites 7 articles, 1 of which you can access for free at:
http://bjo.bmj.com/content/87/9/1192.2#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/