Primary nasolacrimal duct malignant mucosal melanoma

Primary nasolacrimal duct malignancy is rare. Only a few tumours have been reported originating from this location including lymphoma, Kaposi’s sarcoma, adenocarcinoma, angiofibroma, and squamous cell carcinoma.

Mucosal melanoma represents 1–2% of all melanomas, with 25–50% in the head and neck—that is, upper respiratory tract, oral cavity, and pharynx. Other sites include urinary, female genital, and ano-rectal tracts. These tumours are uncommon, present in the fifth to eighth decades, have slight male preponderance and are more common in darker skinned individuals. Cutaneous melanoma presents two decades earlier and is more common in white people and is associated with sun exposure.

Case report

A 41 year old Asian male presented to the oculoplastic service with a 3 month history of right sided intermittent bloody tears and epistaxis. He described right simple epiphora for at least 2 years treated with a three snip procedure. Probing the right nasolacrimal system confirmed normal canaliculi and easy entry of the probe into the lacrimal sac. Irrigation demonstrated complete nasolacrimal duct block and reflux of dark bloody tears. Nasal endoscopy (rigid Hopkins nasal endoscope) revealed a greyish mass emerging from the lower end of the nasolacrimal duct into the inferior meatus (fig 1). Magnetic resonance imaging (MRI) and computed tomography (CT) scans (fig 2) demonstrated dilation of the entire length of the nasolacrimal bony canal with a soft tissue mass occupying the lumen of the nasolacrimal duct. The mass was invading the osteometaclial complex, extending into the anterior ethmoidal sinus, causing obstruction to drainage of both maxillary and frontal sinuses.

A transnasal incisional biopsy of the inferior meatus lesion was performed under local anaesthetic. Histopathological analysis of the biopsy showed sheets of epithelioid cells with prominent nucleoli and vesicular cells and pigment. (B) Medium power 200 ×. HMB-45 stain, positive for melanocytes. (C) High power 400 ×. Strongly positive S-100 protein immunohistochemical stain.

Sinonasal melanoma can present with nasal epiphora, bloody tears, and epistaxis. Sinonasal melanoma can present with nasal obstruction and epistaxis. Orbital extension causes proptosis and diplopia. Both lacrimal sac melanoma and sinonasal melanoma are insidious in onset with poor visibility leading to late presentation.

Standard treatment of primary sinonasal melanoma is radical wide local surgical excision. Local recurrence can occur and the very vascular nature of mucosal tissue makes regional and distant metastases common, often accompanying late presentation. Postsurgical radiotherapy may prevent local recurrence, but is unlikely to prevent distant metastases. Other adjunctive treatments are not clinically proved to be beneficial. Chemotherapy has no positive effect, and newer immunological treatments are still under investigation.

Histopathology slides. (A) High power 400 ×. Haematoxylin and eosin stain showing epithelioid cells and vesicular cells and pigment. (B) Medium power 200 ×. HMB-45 stain, positive for melanocytes. (C) High power 400 ×. Strongly positive S-100 protein immunohistochemical stain.

Comment

Nasolacrimal duct primary mucosal melanoma is previously unreported. The closest relations are lacrimal sac melanoma (5% of lacrimal sac tumours) and sinonasal mucosal melanoma (5% of all sinonasal malignancy). The lacrimal sac melanoma can present with epiphora, bloody tears, and epistaxis. Sinonasal melanoma can present with nasal obstruction and epistaxis. Orbital extension causes proptosis and diplopia. Both lacrimal sac melanoma and sinonasal melanoma are insidious in onset with poor visibility leading to late presentation.

Three years after presentation there was no local recurrence of tumour. Unfortunately, the patient developed bone pain and CT scan revealed metastatic spread to the right acetabulum and T8, T9, and T11 vertebrae with localised spinal cord compression. He underwent radiotherapy to the right acetabulum and spine. The patient died approximately 6 months later.
Glycosylation type Ic disorder: idiopathic intracranial hypertension and retinal degeneration

We report a young woman with type Ic congenital disorder of glycosylation (CDG) with new clinical features of idiopathic intracranial hypertension, retinal degeneration, and novel mutations of ALG6. Patients with known or suspected CDG should receive a full ophthalmic examination including dilated fundus examination and electroretinography.

CDG is a rare group of autosomal recessive metabolic disorders. The two major subgroups are type I, caused by dysfunction of glycosylated protein assembly, and type II, caused by abnormal processing of glycosylated protein end products after assembly. Patients with type Ic (OMIM #603147) have mental retardation, axial hypotonia, very low factor XI, and seizures; the gene defect is in the 1,3-glucosyltransferase (human homologue of ALG6; OMIM #604566) that encodes an enzyme that catalyses the transfer of the first glucose residue to the lipid linked oligosaccharide precursor for N-linked glycosylation. The reported ophthalmological manifestations of type I CDG are summarised in table I. We report a case of type Ic congenital disorder of glycosylation with new clinical features of idiopathic intracranial hypertension, retinal degeneration and novel mutations of ALG6.

**Case report**

Our patient, with non-consanguineous parents, was noted at birth to have incomplete digits on her hands and feet. She had episodes of apnoea early in life and the onset of seizures at age 20 months. Delayed physical and developmental milestones were evident. Early. Levels of follicle stimulating hormone and luteinising hormone were low and a diagnosis of poly cystic ovarian disease was made. She underwent esotropia surgery at age 4 years and at 19 years developed thrombosis of the superficial femoral vein. Coagulation factor studies revealed very low factor XI levels. Isoelectric focusing of serum transferrin was suggestive of a congenital disorder of glycosylation. Sequencing of the ALG6 gene showed a novel three base deletion (897–899 delATT) and an intrinsic splice site mutation (IVS7+2T>G). The patient was obese without signs of abnormal fat distribution. She blinked to light and no strabismus was identified by corneal light reflex. Further ocular examination was not feasible. On examination under anaesthesia at age 20 years, the anterior segment was normal. Dilated ophthalmoscopy showed bilateral optic nerve pallor with elevation of each nerve, diffuse retinal pigment epithelial granularity most notable in the macula, and attenuated retinal vessels (fig 1).

Electroretinography revealed prolonged implicit times on scotopic and photopic functions. Because of the elevated optic nerve heads, head magnetic resonance imaging was performed and was normal; lumbar puncture revealed an elevated opening pressure of 350 mm H₂O (nl 70–180 mm H₂O), a glucose of 50 mg/dl (nl 50–75 mg/dl), and a protein of 44 mg/dl (nl 15–45 mg/dl) without white blood cells. A diagnosis of idiopathic intracranial hypertension was made.

**Comment**

Isoelectric focusing of serum transferrin is the most common screening technique for types I and II CDG. Many congenital disorders of glycosylation have been identified based on mutational and enzyme analyses. Type I congenital disorders of glycosylation are caused by reduced functions of the genes for the assembly and processing pathways of N-glycosylation; a decrease in asialotransferrin and asialolectransferrin are suggestive of the diagnosis.

**Ophthalmological features** of the most common congenital disorder of glycosylation, type Ia (OMIM #210265) include myopia, attenuated retinal vessels, bone spicules, esotropia, and myelopa; this disease subtype is caused by a deficiency of phosphomanomutase (OMIM #210265) encoded by phosphomanomutase2 (PM2; OMIM *601785) gene. In CDG type Ic, much less common, a homozygous amino acid substitution, A33V substitution, in the gene encoding 1,3-glucosyltransferase is the most common mutation. There is no known biochemical link between CDG and idiopathic intracranial hypertension; the association in our patient may be coincidental. Grunwald and colleagues found strabismus to be present in all eight patients with CDG type Ic; neither idiopathic intracranial hypertension nor retinal abnormalities were reported.

The developmental delay evident in our patient was severe. She possessed simple communication skills limiting her ability to complain of visual changes or symptoms of intracranial hypertension. No specific clinical presentation has been identified for the CDG group of diseases. Failure to thrive, unexplained seizures, hypotonia, and developmental delays are all frequently present.

In conclusion, we report an adult patient with CDG type Ic, confirmed by identification of mutations in the ALG6 gene, and describe new systemic and ocular features including idiopathic intracranial hypertension.
Woodhouse Sakati syndrome associated with bilateral keratoconus

Keratoconus is a non-inflammatory degenerative corneal disease characterised by a localised region of stromal thinning spatially associated with a cone-shaped deformation of the surface. It is most commonly an isolated sporadic condition.1 Recent reports demonstrate genetic mapping to chromosomes 16q, 21q, and 18p, as well as association of HLA-A26, B40, and DR 9.4 Keratoconus has been reported in clinical contexts with 36 other multisystem disorders.1,4 We describe the first two cases of keratoconus in association with Woodhouse Sakati syndrome.

Case report
Two sisters (aged 14 years and 18 years) presented with history of bilateral progressive loss of vision over 8 years. Progeny of a first degree consanguineous marriage, they were the only members in the family of six siblings with a diagnosis of Woodhouse Sakati syndrome. Both sisters exhibited variable manifestations of the syndrome including hypogonadism, primary amenorrhoea, hypothyroidism, electrocardiographic abnormalities, and dysmorphic features. The elder sister also had a mild degree of mental retardation. None of their siblings or parents had eye complaints but a maternal aunt’s daughter had bilateral keratoconus.

Ophthalmologic evaluation of the elder sister revealed uncorrected visual acuity (UCVA) of 20/200 in both eyes. Her refraction was −19.0−8.0×120 in the right eye and −9.0−3.75×165 in the left eye. Spectacles improved only left eye vision slightly to 20/160. Slit lamp biomicroscopy showed bilateral central corneal protrusion and stromal thinning at the apex (fig 1A). Keratometry was 71.00/63.00 @ 68 in the right eye and 53.00/49.50 @ 135 in the left eye. Hard contact lens fitting failed and surgical intervention was not conducted.

Ophthalmologic evaluation of the younger sister revealed UCVA of 20/40 in the right eye and 20/160 in the left eye, which improved to 20/80 with spectacles. Slit lamp biomicroscopy showed similar findings to her sister (fig 1B). Keratometry was 36.6 D/54.1 D @ 170 in the right eye and 49.2 D/56.6 D @ 86 in the left eye. She developed corneal hydrops in the left eye and contact lens fitting failed. Because of central corneal scarring and progressive deterioration of her left eye vision, she underwent penetrating keratoplasty (fig 1C). Fourteen months post-operatively, UCVA was 20/50, improving to 20/30 with pin hole.

Comment
Woodhouse Sakati syndrome (MIM 241080) is an extremely rare genetically determined autosomal recessive disorder. It was first described in two Saudi Arabian families,6 and later reported in a single Turkish family.7 Table 1 presents manifestations of the syndrome.1,4

We report a new association in our two cases. Such concurrence of early keratoconus and the syndrome raises the possibility of a genetic linkage, although a chance association cannot be excluded. On one hand, either chromosomal rearrangements such as chromosome 7, 11 translocation or genetically determined syndromes such as this syndrome should be considered in cases where keratoconus is present during childhood.8 That may explain the early presentation of keratoconus in our cases. An additional factor is that keratoconus tends to be more prevalent and diagnosed at a younger age in Asians than in white people.9 On the other hand, familial keratoconus in our cases cannot be excluded because of the presence of keratoconus in a single relative and parental consanguinity. Positive family history has been reported in 6% to 10% of keratoconus cases and is suggested to be caused by autosomal dominant inheritance with incomplete penetrance.10,11

To the best of our knowledge, this is the first report of bilateral keratoconus in association with Woodhouse Sakati syndrome. Ophthalmologists and endocrinologists should be aware that patients with this syndrome who complain of poor vision should be suspected of having keratoconus once other more common conditions are ruled out.

References

Table 1 Variable manifestations in the nine reported patients with Woodhouse Sakati syndrome

| Delayed psychomotor development |
| Variable degree of mental retardation (very frequent sign) |
| Alapoeia (very frequent sign), sparse/absent scalp and eyebrow hair (frequent sign), dystharia |
| Dysmorphic features: high forehead, flat occiput, triangular face, prominent nasal root, hypertelorism, and downs-slaning palpebral fissures |
| Hyper/hypomagnesemia, hyper/hypogonadism and late puberty (very frequent sign) |
| Sensorineural deafness (very frequent sign) |
| Electrocardiographic abnormalities and insulin dependent diabetes mellitus (very frequent signs) |
| No ocular manifestations |

Figure 1 Features of keratoconus are seen. (A) Slit lamp biomicroscopy of the right cornea in the elder patient, showing advanced cone deformation and deep Descemet’s membrane scarring. (B) Slit lamp biomicroscopy of the left cornea in the younger patient, showing dense central scarring following hydrops attack. (C) Histopathological section of left corneal button illustrating the fragmentation of Bowman’s layer (large arrow) and large break in Descemet’s membrane (small arrows) (periodic acid Schiff stain, ×200).

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Retinal ischaemia in type 1 neurofibromatosis

Systemic occlusive arteriopathy associated with type 1 neurofibromatosis (NF-1) has been well described in the aortic and cerebral vasculature; however, it is poorly documented in the retinal vasculature with, to our knowledge, only three reported patients whose retinal vasculopathy was diagnosed at a later sequela stage. Moadel et al, reported cases, our patient presented with acute macular ischaemia combined with diffuse retinal arterial occlusive disease.

Case report

A 26 year old woman with NF-1 presented with a sudden painless loss of vision in her left eye. Visual acuity was counting fingers left eye and 20/20 right eye. NF-1 had previously been diagnosed on the basis of multiple café au lait spots, plexiform neurofibromas, and a paternal history of NF-1. Left fundus examination revealed confluent cottonwool spots in the perifoveal area, focal dilatations and narrowings of retinal veinules, and progressive enlargement of retinal arterioles towards the periphery. The right fundus showed only peripapillary myelinated nerve fibres (fig 1).

Fluorescein angiography (FA) of the left eye showed no delayed perfusion in the choriocapillaris or central retinal artery, but a delayed retinal arteriovenous filling time. It revealed occlusion of macular arterioles, retinal arteriovenous communications in the mid-periphery, and a relatively well perfused retinal periphery (fig 2).

Cerebral and cervical magnetic resonance imaging and colour Doppler ultrasonography showed no vascular flow abnormalities. Internal medical examination and laboratory results excluded other diseases associated with retinal microvasculopathies.

One month after the initial examination, all the cottonwool spots disappeared, and sheathing appeared in a few veins. FA showed worsening of the retinal arteriolar occlusions in the mid-periphery (fig 2). A panretinal photoocoagulation was subsequently performed. At 2 year follow up, left visual acuity remained unchanged, and the patient did not exhibit any preretal fibrinvascular proliferation.

Comment

To our knowledge, only three cases of retinal vascular occlusion in patients with NF-1 have been previously reported. All cases were diagnosed at a later sequela stage. Moadel et al and Kadot et al, respectively, reported the cases of a child who presented with an unilateral amblyopia, and a young woman with a history of unilateral poor vision. They both presented with diffuse sheathing of retinal vessels, retinal arteriovenous communications, and avascular peripheral retina with fibroglial proliferation. Tholen et al described a young man whose routine eye examination showed narrowing of a superotemporal retinal artery with irregular diameter of the corresponding vein, fibroglial proliferation, and arteriovenous communications. These authors suggested the possibility of either a primary occlusion of a retinal arterial or venous branch or alterations of vessel development. In contrast with other reported cases, our patient presented with acute unilateral occlusion of macular arterioles, combined with diffuse retinal arterial occlusive disease, in adulthood. Panretinal photoocoagulation may have prevented fibroglial proliferation which was described in previous reported cases. Recent reports suggest that pathogenesis of NF-1 vasculopathy may result from dysfunction of neurofibromin, the NF-1 gene product, in vessel endothelial and smooth muscle cells.5

Our case shows that NF-1 related occlusive retinal arteriopathy may suddenly appear during adulthood and should be considered in patients with NF-1 or in young adults with retinal vascular occlusive disease and unknown NF-1.
therefore performed to test this hypothesis and determine whether biometric factors may be associated with formation of IFTMH.

Methods

Consecutive patients undergoing surgery for IFTMH had age, sex, axial length in millimetres (mm), and corneal keratometry (K) measurements in dioptres (D) recorded. For each case three age and sex matched controls were randomly identified from a cataract surgery database (Medisoft). Biometric measurements were made in all cases and controls using the IOL-Master (Zeiss, Jena). Mean corneal curvature was calculated by averaging the two K readings. Descriptive statistics and conditional logistic regression method for analysis of matched pair data were used to infer estimates.

Results

Thirty five consecutive cases and 105 controls were identified with a mean age of 67.3 years (35–77 years) and a female to male ratio of 118:1. The mean (SD) axial length in the cases was 22.94 (0.96) mm whereas in controls it was 23.48 (1.44) mm. The axial lengths of the cases also fell within a narrower range than those of the controls (fig 1). Mean K readings in cases was 44.04 D (range 40.56–47.92). The axial lengths (21 mm–23.31 mm in the cases compared to 20.64 mm–29.48 mm in the controls) with the maximum axial length in the cases being 23.31 mm (fig 1). In Japanese literature, high myopia is a prominent, recognised risk factor and in one study the overall mean MSE was −0.66 D. From our study it appears myopic macular holes are encountered much less frequently in a predominantly white population.

We believe the significant corneal dioptric differences found may be a result of the natural process of emmetropisation of a shorter eye, or alternatively be an independent risk factor.

IFTMH are thought to arise from retinal surface traction which in turn arises from an abnormal and incomplete posterior vitreous detachment.1 Our results suggest that eyes with shorter than average axial lengths and therefore lower volume vitreous cavity are either at increased risk of developing such incomplete and abnormal vitreous detachments or, in the presence of such an incomplete vitreous detachment, of developing a macular hole. We are not aware that shorter axial length has previously been shown to be significantly associated with IFTMH.

Mean spherical equivalence (MSE) was measured by the Eye Disease Case Control Study Group2 and although their findings were statistically insignificant, their regression analysis found an increased likelihood of hypermetropia in the IFTMH cases. Our cases clustered in a relatively narrow range of axial lengths (21 mm–23.31 mm in the cases compared to 20.64 mm–29.48 mm in the controls) with the maximum axial length in the cases being 23.31 mm (fig 1). In Japanese literature, high myopia is a prominent, recognised risk factor and in one study the overall mean MSE was −0.66 D. From our study it appears myopic macular holes are encountered much less frequently in a predominantly white population.

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Comment

As in previous studies our population sample demonstrates an increased risk of IFTMH in females with most cases clustering in the 60–70 year age group. The mean axial length in controls was also found to be similar to results in the published literature. Mean spherical equivalence (MSE) was measured by the Eye Disease Case Control Study Group and although their findings were statistically insignificant, their regression analysis found an increased likelihood of hypermetropia in the IFTMH cases. Our cases clustered in a relatively narrow range of axial lengths.

![Figure 1](http://bjo.bmj.com/content/118/6/368/F1.large.jpg)

**Figure 1** Axial lengths (mm) of patients with macular holes compared with age and sex matched controls.

References


Choroiditis and exudative macular detachments in a post transplant leukaemic patient: an unusual presentation of *Pneumocystis jiroveci* infection

*Pneumocystis jiroveci* is a commensal found in the respiratory tract of healthy individuals. It can cause infections of almost any organ in immunocompromised hosts. *P jiroveci* choroiditis, featuring multifocal choroidal lesions, has been reported in immunocompromised patients despite prophylactic use of inhaled pentamidine. We report a post-transplant leukaemic patient whose posterior segment findings demonstrate an atypical picture of recurrent *P jiroveci* choroiditis.

Case report

A 20 year old woman presented with a 1 week history of bilateral blurred vision, dyspnoea, and dry cough. Visual acuity was reduced to 6/66 bilaterally with posterior subcapsular cataracts. Funduscopy disclosed multifocal, creamy-yellow choroidal lesions at both posterior poles with exudative retinal detachments at the maculae (fig 1). Optic discs and retinal vessels were normal. Fluorescein angiography showed early patchy hypofluorescence (corresponding to the choroidal lesions) and late hyperfluorescence with pooling beneath the detachments.

Three years earlier she had undergone a successful allogeneic bone marrow transplant for chronic myeloid leukaemia. Her maintenance therapy included inhaled pentamidine as prophylaxis against *P jiroveci* infection. However, she admitted to not taking her inhaled pentamidine. Molecular genetic and radiological investigations excluded leukaemic recurrence. Chest x ray showed left lung shadowing and bronchoalveolar lavage isolated *P jiroveci*. *P jiroveci* pneumonia with *P jiroveci* choroiditis was diagnosed and high dose oral co-trimoxazole 7.2 g/day (120 mg/kg/day) and prednisolone 60 mg/day commenced. Within 2 weeks her respiratory and ocular symptoms improved. Visual acuities returned to 6/9 and the fundal appearances resolved. She was discharged on daily oral co-trimoxazole 960 mg, prednisolone 20 mg, and inhaled pentamidine.
Three weeks later she was readmitted with increasing dyspnoea and blurred vision. Chest x-ray and computed tomography findings were compatible with diffuse interstitial fibrosis in both lungs. Funduscopy revealed peripapillary choroidal lesions with disc swelling bilaterally (fig 2). This time the choroidal lesions were peripapillary only rather than throughout the posterior pole, with exudative detachments inferiorly. Recurrent P jiroveci pneumonia and choroiditis was diagnosed and oral atovaquone and high dose prednisolone were commenced. Within 3 weeks her fundal appearance resolved leaving only some pigmentary changes. Her discharge medication included daily oral prednisolone 40 mg, cotrimoxazole 960 mg, and inhaled pentamidine. There have been no further intraocular recurrences.

Comment

Pneumocystis jiroveci is a commensal, found in the respiratory tract of healthy individuals. It can cause infections of almost any organ in immunocompromised hosts.4-6 P jiroveci choroiditis has been reported in immunocompromised patients despite prophylactic use of inhaled pentamidine.7 The diagnosis is based on the clinical findings of multifocal yellowish circular choroidal lesions at the posterior pole. P jiroveci has been found in these lesions on histological sections and the lesions resolve on systemic anti-pneumocystis treatment.4 However, most cases of P jiroveci choroiditis are diagnosed histologically post mortem.4,5 Thus, the acute clinical findings may be more varied than previously described. In our patient, massive exudative retinal detachments were associated with the previously described choroidal lesions. The clinical picture varied on the second presentation, but there was complete and rapid resolution of the signs with anti-pneumocystis therapy. To the best of our knowledge, this is the first report of P jiroveci choroiditis causing exudative retinal detachments. P jiroveci should be considered in the differential diagnosis of susceptible patients, even if the ophthalmological findings are “atypical.”

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References


Prothrombotic and atherosclerotic risk factors lack significance in NAION patients harbouring mitochondrial DNA mutations

We recently reported that a group of patients with non-arteritic anterior ischaemic optic neuropathy (NAION) had an increased prevalence of potentially pathological mitochondrial DNA (mtDNA) mutations, implying a link between mitochondrial disease and this optic neuropathy.4 We decided to investigate the association of other risk factors for NAION in these same patients.

Case reports

NAION patients were genotyped for the presence of prothrombotic polymorphisms that have been reported in association with NAION, including factor H2 G20210A prothrombin variant, factor V Leiden G1691A variant, MTHFR C677T and A1298C variants, platelet glycoprotein receptor IIa (PII(a)) allele, and apolipoprotein E (4) allele, as described previously.4 These reports included large control groups that were ethnically matched to our NAION patients and that had been queried regarding the presence of atherothrombotic risk factors. Controls older than 50 years were selected for comparison with NAION patients.

Table 1 shows that the prevalence rates for prothrombotic variants among NAION patients did not differ from controls. Reported prevalence of diabetes, hypertension, and hyperlipidaemia was relatively high in NAION patients but was also not significantly different from controls.

Comment

The lack of a significant association between NAION patients and controls in relation to thrombophilic genetics markers has been reported before, and the role of these factors remains uncertain. More surprising is the lack of a statistical association with atherosclerotic risk factors. For example, in our group of NAION patients, 68% were diabetic, but this figure did not differ significantly from the prevalence of more than 50% in well matched controls. This observation reflects the high, and rising, frequency of diabetes and other atherosclerotic risk factors in the developing world.

A few qualifications are appropriate. NAION patients were a relatively small group of Middle Eastern Arabs, and it is possible that a larger group would have yielded statistically significant results or that the observations reported here are specific to this genetically homogeneous population. Atherosclerotic risk factors were assessed by individual report from patients and controls, and the actual prevalence of these disorders may be different from that recognised. Finally, other risk factors, such as homocysteine levels, nocturnal hypotension, or environmental factors were not consistently investigated.

Nevertheless, the fact that the occurrence of NAION cannot be easily explained by the presence of prothrombotic or atherosclerotic risk factors shifts focus to the possibility that mitochondrial abnormalities may be important in the development of NAION. Based on these observations, testing for mitochondrial abnormalities may be warranted in NAION patients, especially the ones without a

Figure 1 Multifocal, creamy-yellow choroidal lesions at both posterior poles with massive exudative retinal detachments at the maculae.

Figure 2 Peripapillary choroidal lesions with disc swelling.
Table 1  Comparison of risk factors in NAION patients and controls

<table>
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NAION, non-arteritic ischaemic optic neuropathy; CAD, coronary artery disease; NS mtDNA changes, non-synonymous (changing an amino acid in the resultant protein) mitochondrial DNA nucleotide change; Homo, homozygous; Hetero, heterozygous.

References


Inflammatory cytokine of basal and reflex tears analysed by multicytokine assay

Tear cytokine has a major role in various pathophysiological conditions of the ocular surface. So far, studies on tear cytokines have shown significant progress in providing an understanding of corneal disease. Information that could be acquired from each subject, however, until recently has been severely hampered by limited sample volume and assay sensitivity. More importantly, it has become apparent that the relative balance between various cytokines and combinations of cytokines could be more important than absolute concentrations. Previous studies showed that the composition of basic and reflex tears was different, which made it more difficult to understand the ocular surface disorder correctly or to treat the patients suitably.18,19 Cytometric bead array (CBA) is a microparticle based flow cytometric assay that allows us to quantify multiple molecules from a very small sample.20,21 Using this method, we evaluated the inflammatory cytokines of basal and reflex tears from a single sample of individual eyes.

Methods

Twenty three normal volunteers (11 males and 12 females, 22–44 years of age, average 28 years) were recruited for this study. None of the subjects had signs of ocular diseases. The study was performed with the approval of the institutional review board. The basal tear samples of 10–15 µl were obtained from each eye by capillary flow, with no nasal stimulation or previous instillation of drugs or vital dyestuffs. Each sample was collected at 5 pm. No anaesthetic drops were instilled. The samples were collected non-traumatically from the inferior meniscus. Successively, reflex tear samples were collected by inserting application sticks into a nostril near the patient’s nose. The amounts of six inflammatory molecules interleukin (IL)-1β, IL-6, IL-8, IL-10, IL-12p70, and tumour necrosis factor α (TNF-α) were measured by CBA (BD Biosciences, San Diego, CA, USA) according to the manufacturer’s instructions. Briefly, for the tear sample and cytokine standard mixture, 10 µl of sample or standard were added to 40 µl sterile purified water, a mixture of 50 µl each of capture Ab-bead reagent and detector Ab-phycocerythrin (PE) reagent. The mixture was subsequently incubated for 5 hours at room temperature, and washed to remove any unbound detector Ab-PE reagent before data acquisition using flow cytometry. A two colour flow cytometric analysis was performed using a FACScan flow cytometer (Beckton Dickinson ImmunoCytometry Systems). Data were acquired and analysed using BD cyometric bead array software.

Results

The concentrations of IL-1β, IL-6, IL-10, IL-12p70, and TNF-α were not significantly different between basal and reflex tears. In contrast, the concentration of IL-8 was significantly decreased in reflex tears compared with basal tears in each eye (paired t test, p<0.01, fig 1). In order to illuminate the inter-relation of each cytokine, the ratio of two different cytokines is shown in table 1.

Comment

Previously published studies have demonstrated that CBA correlates well with enzyme linked immunosorbent assay (ELISA), but the absolute concentrations obtained from each assay were differed for kits of different manufacturers.6 Indeed, the concentrations of tear cytokines in the present results were almost equal to the previous report using the same kit.23 Nakamura et al performed ELISA for multiple cytokines measuring pooled tears.7 The pooled tears enable measurement of multiple cytokines; however the results
can be strongly influenced by samples with high concentrations. Because the absolute concentrations of tear cytokines varied widely, this can have a strong bias. In this study, to our knowledge, we measured the multiple cytokines of basal and reflex tears from a single sample for the first time, which can provide concentration ranges for these cytokines in normal subjects that may prove important for studies of ocular inflammation. Of note, only the concentration of IL-8 was decreased more significantly in reflex tears than in basal tears. Maitchouk et al showed that there is no distinctive role of major and accessory glands in secreting basal or reflex tears, thus these tears might be produced primarily by the same tissue and differences might be only the result of the secretory rate of reflex tears. It was reported that a neuropeptide released from corneal sensory nerves stimulated conjunctival epithelium to secrete IL-8. Because sensory nerves are present in the cornea so abundantly, IL-8 can be produced constantly on the ocular surface. IL-8 is a potent pro-inflammatory cytokine, and has a pivotal role in the host defense system. But excessive IL-8 might be so harmful that constant washout might be helpful for homeostasis of the ocular surface. Indeed, a large amount of IL-8 was found in the tears of dry eyes. Thus, basal tears might be composed of products of the ocular surface including IL-8 and small amounts of reflex tears that are induced by mild stimulation such as blinks.

In summary, the present study showed that pro-inflammatory and anti-inflammatory cytokines/chemokines are present in the ocular surface even in the absence of inflammation and this was detectable from a small sample of single eyes. Stimulating tears, with the exception of IL-8, has minimal effect on cytokine concentration. We believe the CBA technique can make a valuable contribution in understanding the specific immunopathological mechanisms underlying cytokine interaction with the ocular surface.

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doi: 10.1136/bjo.2005.076737

Accepted for publication 12 August 2005

References

Table 1 Ratios of cytokine concentration

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>IL-1b</th>
<th>IL-6</th>
<th>TNF-α</th>
<th>IL-12p70</th>
<th>IL-10</th>
<th>IL-8</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Basal tear</td>
<td>IL-1b</td>
<td>3.022 (0.246)</td>
<td>54.162 (6.549)</td>
<td>3.222 (0.316)</td>
<td>12.556 (0.889)</td>
<td>0.716 (0.086)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IL-6</td>
<td>0.386 (0.037)</td>
<td>1</td>
<td>23.568 (5.952)</td>
<td>1.238 (0.184)</td>
<td>4.707 (0.553)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TNF-α</td>
<td>0.022 (0.002)</td>
<td>0.07 (0.008)</td>
<td>1</td>
<td>0.074 (0.011)</td>
<td>0.275 (0.028)</td>
<td></td>
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<tr>
<td></td>
<td>IL-12p70</td>
<td>0.349 (0.026)</td>
<td>0.989 (0.071)</td>
<td>15.269 (2.086)</td>
<td>1</td>
<td>3.981 (0.166)</td>
<td></td>
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<tr>
<td></td>
<td>IL-10</td>
<td>0.087 (0.005)</td>
<td>0.253 (0.02)</td>
<td>4.518 (0.47)</td>
<td>0.261 (0.012)</td>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>IL-8</td>
<td>2.14 (0.34)</td>
<td>5.576 (0.694)</td>
<td>15.913 (4.971)</td>
<td>7.447 (1.546)</td>
<td>28.257 (5.078)</td>
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<tr>
<th></th>
<th>B</th>
<th>IL-1b</th>
<th>IL-6</th>
<th>TNF-α</th>
<th>IL-12p70</th>
<th>IL-10</th>
<th>IL-8</th>
</tr>
</thead>
<tbody>
<tr>
<td>(B) Reflex tear</td>
<td>IL-1b</td>
<td>3.71 (0.252)</td>
<td>53.061 (5.46)</td>
<td>2.918 (0.331)</td>
<td>12.012 (1.123)</td>
<td>0.972 (0.094)</td>
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<tr>
<td></td>
<td>IL-6</td>
<td>0.304 (0.027)</td>
<td>1.078 (0.007)</td>
<td>15.807 (1.976)</td>
<td>0.808 (0.061)</td>
<td>3.381 (0.274)</td>
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<tr>
<td></td>
<td>TNF-α</td>
<td>0.021 (0.001)</td>
<td>1.361 (0.082)</td>
<td>21.357 (3.427)</td>
<td>1</td>
<td>0.062 (0.007)</td>
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<tr>
<td></td>
<td>IL-12p70</td>
<td>0.390 (0.023)</td>
<td>1.361 (0.082)</td>
<td>21.357 (3.427)</td>
<td>1</td>
<td>0.062 (0.007)</td>
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<tr>
<td></td>
<td>IL-10</td>
<td>0.093 (0.005)</td>
<td>0.324 (0.018)</td>
<td>4.837 (0.524)</td>
<td>0.241 (0.007)</td>
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<tr>
<td></td>
<td>IL-8</td>
<td>1.043 (0.231)</td>
<td>4.779 (0.665)</td>
<td>73.465 (13.897)</td>
<td>4.02 (0.727)</td>
<td>17.235 (3.251)</td>
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</table>

Ratio of cytokine concentration was calculated as A/B. Each cell shows the mean (SEM).
Outcome of implementing the national services framework guidelines for diabetic retinopathy screening: results of an audit in a primary care trust

Systematic screening for diabetic retinopathy is the key to achieving the targets set out in the recently published national service framework (NSF) guidelines. One of the two priorities and planning framework (PPF) targets is that by March 2006 a minimum of 80% of people with diabetes are to be offered screening, rising to 100% by December 2007. Digital photography is the modality for screening. The British Diabetic Association has established standards for any diabetic retinopathy screening programme of at least 80% sensitivity and 95% specificity.

Screening programme

Our screening programme was set up to evaluate the existing nationally recommended diabetic retinopathy screening service.

In all, 2165 patients were invited over a period of 12 months; 909 participated. At the screening mydriatic drops (1% tropicamide and 2.5% phenylephrine) were instilled. The patients were photographed with a Topcon fundus camera and each photograph was screened and graded by consultant ophthalmologists (table 1).

Of the total 909, there were 198 patients with retinopathy (grades R1, M, R2, and R3), 644 patients without retinopathy (grade 0), 63 patients with OL (other lesions), and one was (grade U) ungradeable (tables 2 and 3). The sensitivity was 98% and specificity 97%. The retinopathy present was 21% and the referral rate for retinopathy (STDR) was 7%; 59% did not take up the offer to be screened. Some of the reasons cited: 956 (44%) declined or did not respond, 251 (11%) are being screened elsewhere, 11 (0.5%) are not diabetic, five (0.18%) are dead, six (0.27%) are registered blind, and 21 (1%) have moved.

Comment

Our screening methods surpassed the standards set by the NICE guidelines. However 59% of patients did not take up the offer. The achievable standard to which strategic health authorities and primary care trusts are working is 90% uptake of those offered screening with the minimum standards of 70%–80%, but even though quality assurance systems are in place uptake is still very poor.

In the intercollegiate audit, led by the Royal College of Ophthalmologists, data were analysed from 9827 patients with diabetes from 129 general practices in 25 health authorities. The lowest level of coverage in a district was 38% and the highest 85%. In general practice the coverage ranged from 14% to 97%. The likelihood of having an eye examination was marginally higher in districts with a systematic examination rather than opportunistic or without recognised schemes at all.

In the Hounslow Primary Care Trust our hospital episode statistics (HES) are the only existing screening programme. Patients registered with a GP are referred to the HES for the screening. The reasons for the 44% who did not respond were that some did not have the time, some were elderly living on their own with nobody to take them, some did not understand the screening leaflet, and some just forgot.

Problems about coverage could be tackled if we had a central electronic database linked to all screening programmes. Although software providers have been agreed for such a data collection exercise, primary care trusts have yet to implement this. People unable to attend during the week could be accommodated in weekend or evening clinics. These clinics could also be reserved, with bilingual support workers to explain the importance of screening for the ethnic patients. Community networks like the rotary, patient groups, ethnic resource centres, and senior citizens groups can be used. The National Service Framework targets will be achieved only if the diabetic population is convinced of the importance of screening.

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doi: 10.1136/bjo.2005.076760

Competing interests: none.

References


Table 1 Referred patients

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<th>Appointment made</th>
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<tr>
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<td>93</td>
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<tr>
<td>Diabetic patients type 2</td>
<td>Invited</td>
<td>Appointment made</td>
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<td></td>
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<td>609</td>
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<tr>
<td>Diabetic patients type not stated</td>
<td>Invited</td>
<td>Appointment made</td>
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Table 2 Outcome by grade

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<td>363</td>
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<tr>
<td>F</td>
<td>261</td>
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<tr>
<td>R1</td>
<td>T</td>
<td>624</td>
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<td>R2</td>
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<td>R3</td>
<td>M</td>
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<td></td>
<td>T</td>
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</table>

Table 3 Final data

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<th>Total patients screened</th>
<th>Sample size</th>
<th>Ungradable</th>
<th>True positives</th>
<th>False negatives</th>
<th>True negatives</th>
<th>False positive</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>Retinopathy present</th>
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</thead>
<tbody>
<tr>
<td>909</td>
<td>909</td>
<td>1</td>
<td>198</td>
<td>4</td>
<td>644</td>
<td>8</td>
<td>98%</td>
<td>97%</td>
<td>21.78%</td>
</tr>
</tbody>
</table>
Late improvement in upward gaze in a patient with hydrocephalus related Parinaud dorsal midbrain syndrome

Acute hydrocephalus is a common cause of the Parinaud dorsal midbrain syndrome.1 The patient stated by García-Arumí et al that some patients retain the potential to improve even after several years have passed. However, our patient’s spontaneous improvement about 4½ years after onset and treatment of the underlying condition indicates that some patients retain the potential to improve even after several years have passed. This information may be of value in counselling patients with the dorsal midbrain syndrome who ask if there is any chance of improvement when none has occurred after months to a few years.

References


MAILBOX

Purification of triamcinolone acetonide suspension for intravitreal injection

In the article by García-Arumí and associates, the authors reported the results of several techniques used for purification of triamcinolone acetonide suspension for intravitreal injection (two filter and centrifugation). I very much appreciate that they finally recommended our method (centrifugation for 5 minutes at 3000 rpm with extraction of 0.9 ml of the supernatant and pellet resuspension with 0.9 ml of balanced salt solution, BSS) among those compared.

This could have been an interesting report but I want to raise some important issues mentioned in their paper. The source of the purified techniques was not clearly specified by the authors. Are they previously published techniques? Are they techniques developed entirely by García-Arumí et al? As far as I know, the centrifugation technique described by García-Arumí et al. was first reported by Hernaez-Ortega in 2003 and it was first published by Hernaez-Ortega and myself in the 2004 July/August issue of the British Journal of Ophthalmology (BJO). In fact, the term “purification” was first applied to removal of most of the vehicle from a commercially available triamcinolone acetonide suspension by us.

Parametric tests tend to be more powerful than non-parametric tests if their distributional assumptions are met. However, non-parametric methods require fewer...
assumptions, and they are generally robust against problems like outliers and non-con-
stant variances. The authors tested statistical significance by the Kruskal-Wallis test, a non-
parametric procedure that is a K-sample generalisation of the two sample rank sum test
(also called the Mann-Whitney U test). It tests the null hypothesis of identical group medians,
rather than means. With the data available in this report, the authors should have noticed that
figures 1 and 2 show means and standard deviations; they should instead have shown group medians. Moreover, their results should have been expressed as medians. It also remains unclear how many
assays were performed. By looking at figures 1 and 2, it seems that three assays were done
each time but somehow they were done in duplicate. This is important to show the real
sample size that was used to compute the estimates.

The pellet resuspension with 0.9 ml of BSS in the centrifugation technique appeared in
their final recommendation at the end of the paper. However, the authors stated in the
methods section that the pellet was resus-
pended with 1 ml of BSS. This point needs to be
explained.

1 recommend that the authors clarify the
above mentioned issues. I also suggest that
they learn the golden rule of fair use of another author’s protected material: take from
someone else only what you wouldn’t mind someone taking from you.

Correspondence to: Dr Enrique Soto-Pedro, European Innovative Biomedicine Institute, C/Jardines #2, Apt 1-G, 39700 Castro-Urdiales, Cantabria, Spain; eblb@eurolabs.com

The author does not have commercial interest in any product mentioned in the manuscript. doi: 10.1136/bjo.2005.083501

Accepted for publication 26 September 2005

References


PHEMA as a keratoprosthesis material

An aim to provide an optimised keratoprosth-
essis, with excellent biointegration, and all other
properties meeting ideal requirements, is one we share with Mehta et al. However, their
report, though includes some points that require clarification.

PHHEMA (poly(2-hydroxyethyl methacryl-
te) is a non-toxic polymer of the toxic
monomer HEMA, though cytotoxicity is still present, but is significantly reduced when
methacrylate” the authors obtained for their
study was not fully described, and may have
been contact lens blanks, unlikely to have
been processed for “implantable quality.” Whether the samples had been fully
extracted was not stated, nor was the hydration of the samples when used for the
study. Contact lens blanks are not designed for cell adhesion and the results of this study,
with regard to PHEMA, are entirely predict-
able and have been previously reported.

The commercially available keratoprosth-
thesis AlphaCor is made from a form of
PHEMA, specifically modified for its intended
purpose within the cornea. In particular, the
AlphaCor OPTIC is made from a relatively
low water-content, but hydrated, microspon-
iform form, similar to the samples evaluated by
the authors, specifically because it does not encourage cellular adhesion (epithelial cover-
age is not desired for this model, nor would
adherent posterior cells and membranes be desirable).

In contradistinction, the biointegratable
SKIRT region of AlphaCor is made from a
macroporous form of PHEMA with a very
high water content; this material, with its
interconnecting channels, has been optimised to promote viable biocolonisation, which has
been extensively described in the literature. Mehta et al do concede that cells “may behave
differently in colonising a 3-D porous kerato-
prosthesis skirt”, indeed they do. Further,
very subtle modifications of the sponge
structure significantly affect all aspects of
biointegration.

Both early trial results, such as the preliminary cases cited by Mehta et al, and
current results for over 250 AlphaCor devices,
have been extensively presented and made
available to all device users. Histology now
available from AlphaCor devices explanted
from human recipients confirms that the
biointegration process in humans is similar to
that previously shown in the animal model,
and maintained in the long term. As
expected, specific inflammatory processes
can cause localised reversal of biointe-
gration in areas of stromal melting. Certainly, porosity itself does not prevent
melting processes, as is also seen in relation to hydroxyapatite keratoprostheses and orbi-

tal implants.

There is no argument that keratoprosthesis materials and designs require ongoing
review and improvement. The authors’ findings in relation to hydroxyapatite are interesting
although, as they note, this rigid material has its own limitations. Novel approaches are
undergoing early evaluation and may offer benefits. However, at present, in our
view, AlphaCor is a device worthy of con-

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doi: 10.1136/bjo.2005.08455

Accepted for publication 11 October 2005

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1 Mehta JS, Futter CE, Sandeman SR, et al. Hydroxyapatite promotes superior keratocyte
adhesion and proliferation in comparison with current keratoprosthesis skirt materials.

Expression of TSH-R in normal human extraocular muscles

We read with interest the paper published by Boschi et al, in which immunohistochemistry
was performed on orbital tissue from patients with thyroid associated ophthalmopa-
thy (TAO) and compared with non-dis-
cased orbital tissue.

Our laboratory recently reported positive TSH receptor staining within normal human
muscle fibres, using one of the same anti-
bodies (3G4) as Boschi et al (supplied by
Costagliola) and a commercial antibody
(3B12).

Our findings differ from Boschi et al’s as no
staining of the muscle fibres was visible in
their experience.

Assessing the techniques used suggested
some possibilities as to why our findings
differ. Our paraffin embedded tissues were
subjected to a proteolytic antigen retrieval
step, as commonly used in avidin-biotin
staining. The reason for this is that formalin
used in fixation is notorious for altering
proteins immunoreactivity, and hence masking
protein expression.1 2

Moreover, the amplification immunohisto-
chemistry kit used in our experiments is
possibly more sensitive than conventional
immunohistochemistry used in the experi-
ments of Boschi et al.1

We do not dispute the finding that TSH-R
expression is elevated in orbital connective
tissue of diseased patients. Combined with
our findings, Boschi et al’s paper also suggests
that expression of TSH-R on normal muscle
fibres is lower than in the connective tissue
of diseased patients. Boschi et al have

s s kloprogge@pgrad.unimelb.edu.au

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1 Boschi A, Daumerie C, Spiritus M, et al. Quantification of cells expressing the thyroid
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associated orbitopathy. Br J Ophthalmol

2 Kloprogge SJ, Busuttil BE, Frauman AG. TSH
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human extraocular muscle. Muscle Nerve
Trabeculotomy versus trabeculotomy-trabeculectomy for congenital glaucoma

The article by Al-Hazmi et al. states that combined trabeculotomy-trabeculectomy with mitomycin C (CTTM) gave better results than trabeculotomy alone for primary congenital glaucoma (PCG) at King Khalid Eye Specialist Hospital (KKESH) in Riyadh, Saudi Arabia, between 1982 and 2002. For moderate PCG the success rate was stated as 40% and 80% for trabeculotomy and CTTM, respectively. For severe PCG the stated success rate is 10% and 70% for trabeculotomy and CTTM, respectively. However, without more specific information regarding when the trabeculotomies were performed at KKESH, the authors cannot advocate CTTM over trabeculotomy for moderate and severe PCG.

As the article states, over the years at KKESH the success rate for trabeculotomy for PCG dramatically improved (29% from 1982–90; 47% from 1991–4; 82% from 1995–2002). The authors attribute these improved results over the years to improved primary health-care facilities within the kingdom, earlier referrals, better equipment availability, and surgeons becoming more adept at surgical intervention. In contrast, CTTM for PCG was first performed at KKESH in 1994 with less of a “learning curve”; the success rate from 1994–2002 was 72%. The complication rate, however, was higher for CTTM than for trabeculotomy.

Because initial trabeculotomy success for PCG at KKESH has dramatically increased with time, it is important to know how many of the reported trabeculotomy failures for moderate and severe PCG were from the earlier periods in the hospital. This information was not in the paper. It may be that trabeculotomy as currently performed at KKESH for moderate and severe PCG has a success rate similar to that of CTTM for the same patient population with fewer surgical complications.
Outcome of implementing the national services framework guidelines for diabetic retinopathy screening: results of an audit in a primary care trust
M J Saldanha and U Meyer-Bothling

*Br J Ophthalmol* 2006 90: 122
doi: 10.1136/bjo.2005.076760

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