AN UNUSUAL CASE OF RETINAL DETACHMENT*

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THIS is an account of an instructive case of retinal detachment.

Case history

B. N., a man aged 48 (packer and despatcher), was sent to one of us (J. G. M.) at hospital on November 2, 1949, by Dr. G. F. Ensor of Bishop's Stortford. The story was that one week previously the patient noticed a shadow in the upper field of vision of the right eye. The following day he saw Dr. Ensor, who diagnosed a detached retina. The patient came to hospital six days later. He said that two days after seeing Dr. Ensor the shadow had increased considerably in size.

Examination.—There was only a grey reflex in the right eye, the pupil was semi-dilated, and gave a very sluggish reaction to light, and there was no perception of light. The retina appeared to be almost completely detached, there was a suspicion of a faint reflex at the extreme periphery at 12 o'clock. Nothing else could be made out. The eye was moderately myopic (5D).

—4.5 sph.

In the left eye vision was 6/18 $\bar{c}$ — 0.5 cyl. $\times$ 140°.

Fundus normal. The left had always been the weaker eye. It seemed probable that this was a simple detachment unlikely to be improved by operation, but we decided to admit him for a few days' rest to see if there was any change in the fundus appearance. After six days there was hardly any change, the faint reflex above, noted at the first examination was, perhaps, slightly more obvious, and there was faint perception of light. It was decided to evacuate the sub-retinal fluid. This was done on November 9, 1949, by cautery puncture in the 7-30 meridian 12 mm. from the limbus. A quantity of brown fluid escaped, much darker than the usual straw-coloured sub-retinal fluid. Some of this was collected for microscopical examination. It subsequently revealed red cells, a few white cells, but no malignant cells.

Ophthalmoscopic examination immediately after the operation showed the retina in place above, there were considerable folds of detachment elsewhere. Transillumination was quite clear all over the globe. Two days later the upper half of the retina was in place, and there was a fairly large field of vision; below at 5 o'clock was a large solid growth with some small haemorrhages on its surface. The eye was excised.

Pathological Report.—"Situated in the lower nasal quadrant of the choroid and extending over the equatorial region there is a spindle-celled malignant melanoma of the choroid. Pigmentation is moderate to heavy in places, there are numerous blood sinuses and the reticulin development is heavy. Invasion of the sclera has taken place, but there is no evidence of extra-ocular extension."

(N. Ashton, Institute of Ophthalmology).

Comment

From the patient's history (he seemed to be an intelligent observer) and the fact that he was myopic, our first impression was that here was a simple detachment with sudden increase in extent

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involving the whole globe. Transillumination was perfect. There was no reason to suspect a neoplasm, and the sudden rapid deterioration described by the patient was against a detachment secondary to neoplasm, and in favour of a simple detachment; particularly as the cause of the rapid loss of field was not a vitreous haemorrhage but a greatly enlarged area of retinal separation.

It would have been easy to explain the situation to the patient and to have sent him away.

The lesson to be learned, therefore, is that in all cases where a view of the fundus cannot be obtained it is advisable to withdraw sub-retinal fluid if by so doing there is a chance of obtaining information. This should be done by aspiration if a neoplasm is suspected.