The biter bit

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It was about the end of my afternoon clinic, while I was examining a patient's fundus, that I became aware of some indistinctness of the view. When I failed to find the source of this opacity in the patient's ocular media, it was gradually borne in on me that the beam was in my own eye and not a mote in the patient's! At first the opacity was rather vague, but gradually over half an hour or so it resolved itself into two narrow dark brown jet streams (like high altitude vapour trails) moving steadily forwards in parallel. They appeared to be about 2 mm apart, slightly to the nasal side, and gradually rising until they curled round directly in front of my line of vision. Then they started to hook round to the temporal side, still in parallel, but in sharper curves, as if they were deflected by the posterior surface of the lens. Then they began to curl back on themselves, forming a woolly skein, more and more tangled in loose formation, with fine frayed-out ends, and with occasional snags or knots along the threads, usually where they appeared to cross.

By the time these 'jet streams' reached their most forward position, it was possible to see a myriad of minute circles faintly silver in appearance scattered over the remaining pupillary space, with a clearer centre, as well as solid cylinders of similar size. Presumably these were red blood cells, some seen edge-on and some on the flat. The cause of the condition was thus clearly evident: not one, but two haemorrhages must have occurred simultaneously from retinal vessels, probably of capillary size, from the slow rate of progress. Since I am aware that my blood pressure is consistently low (*ca* 120/90 at age 60)

and that my blood count is normal—I gave a blood donation only 6 weeks earlier—both hypertension and blood dyscrasia can be eliminated. On the other hand, I have a moderate degree of myopia (-4 D sph., -4.25 D cyl.) with moderate circumpapillary stretching, so that even without any family history of detachment, the almost certain occurrence of retinal breaks was clear.

The absence of my senior colleagues on holiday was unfortunate, but one of the junior members was able to reassure me that at least there was no immediate evidence of detachment. I was therefore fortunate, when a senior colleague arrived back from London a few days later, to have my retina sealed round both breaks with Xenon arc coagulation. In one of the breaks the operculum had pulled right out and lay in the vitreous a little away from the retina, but the second was of horse-shoe shape with the tongue still attached (Davis 1974).

The shifting wool-like skein remained for some weeks, gradually thinning and occasionally floating completely out of the way, and the visual acuity was found to be still 6/5.

Three weeks after the operation, while demonstrating methods of detecting the 'master eye', I discovered my master eye had switched over to the left side, but now, 3 months later, the master is once more the right eye and the corrected vision at 6/4 pt is nearly as good as that of the left eye. The floater, which is far forward, has mainly a 'nuisance value' and is only troublesome when trying to examine a right fundus unilocularly with an undilated pupil.

I find myself tending to use binocular methods for this reason, and am unaware of any other disability at all.

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Reference

DAVIS, M. D. (1974) *Arch. Ophthalmol.* (Chicago), **92**, 183