termed leucocidin because of its cytopathic effects on polymorphonuclear leucocytes, and the production of elastase and an alkaline protease, which inhibit neutrophil chemotaxis in vitro.⁷ These characteristic factors of *Pseudomonas* along with the neutropenia may explain this unusual case. We did not use rG-CSF in this patient because of his prompt response to antibiotic therapy. However, we consider that the use of rG-CSF in combination with antibiotic therapy in severe neutropenic patients with life threatening infection is mandatory because it minimises the risk of infection and decreases the mortality rates. We therefore conclude that an early diagnosis is necessary, as well as aggressive treatment, because a *Pseudomonas* infection in a neutropenic patient manifests a truly fulminating progression.

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Ocular melanocytosis and cavernous haemangioma of the optic disc

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Cavernous haemangioma of the optic disc is a rare vascular tumour that may occasionally produce a vitreous haemorrhage.^{1,2} Ocular melanocytosis, on the other hand, is a more common condition but one that is associated with an increased incidence of uveal melanoma.³⁻⁵ We encountered an unusual case in which ocular melanocytosis was associated with a cavernous haemangioma of the optic disc that had been masked behind a dense vitreous haemorrhage.

Case report

A 38-year-old man was referred with a diagnosis of vitreous haemorrhage of the right eye due to a tumour of the optic disc. Over the past 7 years,

he had been seen on several occasions with vitreous haemorrhages, each of which had resorbed spontaneously.

When first examined by us, visual acuity in the right eye was finger counting. The diagnosis of ocular melanocytosis was based upon the presence of several dark scleral flecks (Fig 1) and iris hyperchromia. Visualisation of the fundus was obscured by a vitreous haemorrhage, and B scan ultrasonography disclosed a 4.5 mm thick mass covering the optic disc (Fig 2). The anterior two thirds of the mass were moderately reflective,

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Figure 1 Right eye of the patient demonstrating a diffuse perilimbal episcleral pigmentation.

Figure 2 B scan ultrasonography. A 4.5 mm thick tumour mass covers the optic nerve. Internal reflectivity of the base of the tumour is high.

Figure 3 Arteriovenous phase fluorescein angiography. Typical angiographic pattern of a cavernous haemangioma of the optic disc is seen, with numerous small aneurysms showing plasma/erythrocyte sedimentation.

while the posterior third was highly reflective and without spontaneous movement. Axial tomography did not reveal evidence of tumour infiltration of the optic nerve, and a thorough general examination did not disclose any distant metastases. Because of these negative findings it was decided to observe the spontaneous evolution of the tumour and to wait for resorption of the vitreous haemorrhage.

One month later the size of the tumour had decreased and its height measured 4.2 mm; tumour thickness decreased to 1.5 mm 4 months later. This apparent decrease in the tumour size was attributed to possible dissolution of a blood clot located at the top of the tumour. Because the vitreous haemorrhage did not resorb, a pars plana vitrectomy was performed; this restored visual acuity to 20/20. At this point, cavernous haemangioma which had been suspected clinically, was confirmed by fluorescein angiography (Fig 3).

Comment

When ocular melanocytosis is present, the risk of the eye harbouring a uveal melanoma is multiplied by a factor of 30–60.^{3–5} For that reason, in a patient with melanocytosis, it is justifiable to consider any intraocular tumour as a possible malignant melanoma, especially if the media are opaque. In our case, the echographically documented decrease in the size of the tumour made the diagnosis of malignant melanoma unlikely. Moreover, the 7-year evolution of the tumour suggested a stationary or very slowly growing tumour. Diagnosis was made only after a vitrectomy was performed.

The occurrence of a cavernous haemangioma of the optic disc in an eye with ocular melanocytosis may be considered as an extremely rare, albeit fortuitous association. This case illustrates the diagnostic problems presented by intraocular tumours in eyes with opaque media, and also emphasises the need for a long period of observation of any non-progressive intraocular tumour when the diagnosis is not clear.

The known association of melanocytosis with malignant melanoma must not rule out the possibility of a less common intraocular tumour in a patient with melanocytosis.

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Atypical cytomegalovirus retinitis: a clinicopathological correlation

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Cytomegalovirus (CMV) retinitis occurs in 15%–20% of patients with AIDS¹ and untreated is a progressive and potentially blinding disease.² Treatment of CMV retinitis with intravenous ganciclovir or foscarnet is well established³ but both of these drugs are only virostatic³ and therefore once CMV retinitis is in remission a maintenance dose is required for the rest of the patient's life to prevent reactivation. We present a case of CMV retinitis which remained in

remission for 20 months without ganciclovir or foscarnet treatment.

Case report

A 26-year-old homosexual man was diagnosed HIV antibody positive in 1988. In February 1990, routine ophthalmic screening revealed HIV retinopathy of the right eye while the appearance of the left eye was of an uncertain