which the cyst was mobile within a small cavity in the posterior vitreous overlying the optic nerve and macula, highlighted the controversy over their pathogenesis.\(^1\) Orellana and colleagues reported on the microscopic appearance of a free floating vitreous cyst with its wall made up of a layer of heavily pigmented cuboidal cells, intermingled with non-pigmented cells, forming papillae. Electron microscopy showed the lining cells to contain mature and immature melanosomes, polarized basement membrane, and apical microvilli.\(^1\) These findings support the hypothesis that the cysts originate from the pigmented ciliary epithelium and that trauma may play a role in their development. Awan, however, reported a history of trauma in only 2.7% of cases.\(^9\)

The likelihood is that vitreous cysts originate from different intraocular structures, the vascularised, attached cysts from hyaloid vascular remnants and pigmented, free floating cysts from the ciliary body epithelium. Although the majority are asymptomatic, troublesome symptoms can arise when they float across the visual axis or come within its vicinity. In the case reported, the onset of symptoms may have been associated with increased mobility of the cyst due to liquefaction of the surrounding vitreous gel or partial posterior vitreous detachment.

The severity of symptoms occasionally warrants treatment. Surgical excision through the pars plana has been reported,\(^1\) but there is potential for serious complications from this approach. Argon laser photocystotomy offers an alternative to surgical treatment,\(^2\) but its effectiveness depends on the presence of extensive pigment in the cyst wall and there is a risk of inadvertent retinal photoacoagulation. Neodymium:YAG laser has previously been used for the treatment of persistent subretinal limiting membrane and posterior hyaloid face haemorrhages, vitreous floaters, vitreous adhesions, and for the lysis of vitreous bands.\(^6\) In the case described, Nd:YAG laser was effective in disrupting the wall of a posterior vitreous cyst. Although the cyst did not disappear completely, disruption of the cyst wall caused a reduction in its size. In addition, the cyst wall, being denser than the surrounding liquefied vitreous, gravitated out of the visual axis with relief of symptoms.

In conclusion, vitreous cysts, though rare, can give rise to intractable visual symptoms. Surgical treatment is hazardous and argon laser photocystotomy may not be effective. We report the successful treatment of a posterior vitreous cyst by Nd:YAG laser photocystotomy.

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CASE REPORT
A 42-year-old woman came to the emergency room in an irritated state. Two hours earlier, her vision had become blurred. The patient had been well until she noticed the sudden appearance of floaters and a central red spot. She was referred to Moorfields Eye Hospital where the diagnosis of a posterior vitreous cyst was confirmed using ultrasound. The cyst was treated with Nd:YAG laser photocystotomy.

Figure 1 (A) Pigmented posterior vitreous cyst, free floating in the posterior segment. (B) B scan ultrasound demonstrating the posterior vitreous cyst measuring 5.4 mm in diameter. The posterior hyaloid face was intact.

Figure 2 (A) Posterior vitreous cyst shrank and gravitated immediately after YAG laser photocystotomy. (B) B scan ultrasound following YAG laser photocystotomy, demonstrating a reduction in size to 1.6 x 2.2 mm (borders delineated by the measuring calipers).
Letters

ischaemia

Funduscopic examination showed stimulus, performed about 8 mm dilated. Though revealed and enhanced dyspnoea, became irritable, and fell intermittently after retrobulbar corticosteroid injection,4 but unlike the other cases, it was accompanied by brain infarction due to the fat embolism of the branches of the cerebral artery. It is possible that the injection forces were strong enough to reach into the internal carotid artery, so a fat embolism occurred both at a branch of the ophthalmic artery and at a branch of the cerebral artery.

In the treatment of CRAO, no consensus currently exists regarding therapy.5 Schmidt et al supported the theory that emboli resulting from lipid, cholesterol, and calcific emboli cannot be expected to respond to thrombolytic therapy. The patient did not take the thrombolytic agent, but received ocular massage and carbon dioxide and oxygen therapy intermittently.

This peculiar case should be a warning to all ophthalmologists and plastic surgeons that widely performed simple procedures can cause irreversible misery, and the risk of damage should be explained to the patient. If there is any evidence of a visual problem, prompt consultation with an ophthalmologist is needed.

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