test has significant problems with both specificity and sensitivity, and raised levels are reported in as many as 17% in a population of non-sarcoid uveitis. The significance of raised ACE levels in four patients with possible FHU should therefore be statistically justified in the context of the authors' FHU group of patients. Even should this reach statistical significance, the assumption that this represents a form of sarcoidosis is speculative.

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Fuchs' heterochromic uveitis and sarcoidosis

EDITOR.—Richard Goble and Philip Murray provided further interest in the possible cause(s) of Fuchs' heterochromic uveitis (FHU), in reporting five patients with suggested sarcoidosis, including four with raised serum angiotensin converting enzyme (ACE).

In patients with sarcoidosis, increased production of ACE is attributed to activated cells within granuloma. In 'granulomatous' uveitis it is reasonable, even in the absence of systemic symptoms, to investigate for the possibility of sarcoidosis. However, it is rarely appreciated that sarcoidosis can arise for this purpose. We therefore rely on indirect methods of diagnosis.

Weirb5 measured ACE levels in normal controls and found that 4.2% had significantly raised levels. By comparison, of those with 'granulomatous' uveitis but without evidence of systemic sarcoidosis, 44% had raised levels. His conclusion, that 'ocular sarcoidosis' may be diagnosed in the absence of systemic evidence, is of course theoretical, unproved, and would explain a large subset of idiopathic uveitis. However, to extend this group to include forms of uveitis which are untypical of sarcoid related uveitis is mere speculation.

The as a recognised feature of FHU,5 yet their appearance (small, dome-shaped, multiple, and translucent) and position (on the anterior iris surface, mostly peripupillary, scattered symmetrically) differentiate them from nodules seen in granulomatous disease (usually larger, fewer, often irregular in shape, sometimes buried within the stroma). Their presence in FHU cannot be made a convincing case for a granulomatous uveitis, however unproved, and would explain a large subset of idiopathic uveitis. However, to extend this group to include forms of uveitis which are untypical of sarcoid related uveitis is mere speculation.

We agree that a large series of patients would be required in order to demonstrate any statistically significant association between raised ACE levels and FHU. Nevertheless, the finding of a raised ACE in four patients with this condition that forms only 3% of all uveitis entities would appear to be more than just coincidental.

Ocular sarcoidosis may not always present with the typical textbook findings, an example of this would be those patients who have a fundal appearance similar to birdshot retinochoroidopathy but are HLA-A29 negative. The features of FHU seen in our patients may be another atypical presentation.

Although FHU has been reported in combination with numerous conditions, a possible association with sarcoidosis has not been previously described. We felt that this was an interesting new finding which would support the theory that FHU may be a secondary phenomenon or a clinical end stage of a number of conditions.