Fuchs' heterochromic uveitis and sarcoidosis

EDITOR—Richard Gobe and Philip Murray proposed 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 may be for this purpose. We therefore rely on indirect methods of diagnosis.

Weinreb measured ACE levels in normal controls and found that 4.2% had significantly raised levels. By comparison, 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, though unproven, 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 speculations.

Fuch's heterochromic uveitis (FHU) resemble their appearance (small, dome-shaped, multiple, and translucent) and position (anterior iris surface, mostly peripupillary, scattered symmetrically) differentiate them from nodules seen in granulomatosus 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 granulomatosus disease, however, though unproven, 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 are a recognised feature of FHU, yet their appearance (small, dome-shaped, multiple, and translucent) and position (anterior iris surface, mostly peripupillary, scattered symmetrically) differ from those 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 granulomatosus disease, however, though unproven, 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 larger 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 of five patients with Fuchs' disease forming 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.

Determining the importance of eye diseases in Africa

EDITOR.—In Africa the public health importance of trachoma and xerophthalmia is often underestimated when based on routine surveillance data and even data from population based surveys of low vision and blindness. Surveillance data may under-represent occurrence because both diseases are prevalent in children who rarely complain of it and health personnel seldom report it. However, they do not have an eye complaint. Population based surveys may under-represent occurrence if cluster sampling is used as this is a weak technique for detecting diseases with focal distribution. These problems are highlighted below using experiences on estimating the importance of these diseases in Ethiopia.

In 1978–80 the Ethiopian Nutrition Institute and the WHO conducted a countrywide assessment on the reporting of xerophthalmia in health centres and hospitals. The study concluded that the condition was rarely recorded. In the early 1980s two foci of vitamin A deficiencies were detected in famine-free areas. In the late 1980s, four districts of Ethiopia showed a high prevalence of xerophthalmia. Trachoma was also heavily underestimated. In a study of eye conditions at three health centres, where all children under 10 years of age attending the centres for any reason were examined for eye diseases, prevalence of trachoma was 10-fold higher than previously suggested by hospital records.

In 1981 a population based survey of blindness was undertaken. The survey found a blindness prevalence of between 1.35% and 1.9% and trachoma was found to be the major cause. However, the survey failed to detect a high prevalence of xerophthalmia in the country. By chance the xerophthalmia foci were not selected when the random sample of clusters were drawn.

Because of the limitation of the methods discussed above health authorities should identify areas where the population is likely to be at high risk, because of the presence of known risk factors for that condition, and then undertake a sample survey of the children within the high risk areas. This should provide a more realistic insight into the magnitude of the problem in specific high risk areas and direct planning for targeted intervention.