LETTERS TO THE EDITOR

Indocyanine green angiography in choroidal tuberculosis

EDITOR,—An 85 year old white woman presented with progressive asthenia, fever, coughing, and dyspnea. Chest roentgenogram showed interstitial pulmonary infiltrates and right pleural effusion. Cultures of the bronchoalveolar lavage fluid subsequently confirmed the presence of Mycobacterium tuberculosis.

On admission, best corrected visual acuity was 20/400 in a right amblyopic eye and 20/50 in the left eye. Biomicroscopic examination revealed no sign of anterior or posterior inflammation. Multiple choroidal lesions (Fig 1) were present in both eyes. The choroidal lesions were deep, white-yellowish, with indistinct borders. Fluorescence angiography (FA) revealed early nodular hypofluorescence, and late moderate hyperfluorescence (Fig 2). Indocyanine green (ICG) angiography revealed prolonged hypofluorescence and in the late stage images, moderate delineation of the lesions by a peripheral hyperfluorescent ring (Fig 3).

COMMENT

Ocular tuberculosis may occur by haematogenous spread from a pulmonary focus. Choroidal tuberculosis is rare ophthalmological findings even in miliary tuberculosis. Previous reports indicate that these lesions have prolonged hypofluorescence in FA, and late mild hyperfluorescence. Only one description of ICG angiography in a case with presumed ocular tuberculosis has been reported previously in the literature. We found similar angiographic characteristics in our case, which represents, to our knowledge, the first ICG angiography description of multiple choroidal tuberculosis in microbiologically confirmed miliary tuberculosis. Hypofluorescence in ICG images may be due to a masking effect of the choroidal vessels by the overlying granulomas.

Ophthalmic examination may be contributive when disseminated tuberculosis is suspected. In this case ICG angiography, which was performed to assess the choroidal involvement, showed prolonged hypofluorescence.

DAN MILEA
CHRISTINE FARDEAU
LIVIA LUMBRUGO
Department of Ophthalmology, Hôpital de la Pitié-Salpêtrière, Paris, France

THOMAS SIMILOWSKI
Department of Respiratory and Intensive Care Medicine, Hôpital de la Pitié-Salpêtrière, Paris, France

PHUC LEHOANG
Department of Ophthalmology, Hôpital de la Pitié-Salpêtrière, Paris, France

Correspondence to: Phuc Le Hoang, MD, Service d'Ophthalmologie, Hôpital de la Pitié-Salpêtrière, 47-83 Boulevard de l'Hôpital, 75651 Paris Cedex 13, France.

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Diagnosis of an atypical case of ocular toxoplasmosis using the demonstration of intraocular antibody production and the polymerase chain reaction

EDITOR,—Ocular toxoplasmosis is the most frequent infectious cause of choriorretinal inflammation in immunocompetent individuals. Diagnosis is usually made by observing the typical fundus lesion, by detecting the presence of anti-Toxoplasma antibodies in the serum, and by excluding other causes of necrotising fundus lesions. In unusual cases, invasive procedures may be required to aid diagnosis.

CASE REPORT

A 17 year old white male presented complaining of floaters and reduced visual acuity in the left eye. Visual acuity was 6/9 in the left eye, 6/6 in the right. Examination revealed moderate anterior chamber activity, marked vitritis, and an active retinochoroiditis adjacent to an area of old chorioretinal scarring inferonasal to the optic disc. A diagnosis of ocular toxoplasmosis was suspected, and topical and oral steroids, and oral clindamycin were commenced. Peripheral blood anti-Toxoplasma IgG antibodies, measured using the dye test, were positive (16 IU/ml). Despite treatment, the ocular inflammatory signs increased and 5 weeks following initial presentation he developed a confluent area of retinal necrosis in the peripheral retina leading to a superotemporal retinal detachment. This was distinct from the original area of inflammation. The presence of severe vitreous inflammation and peripheral retinal necrosis suggested a unilateral acute retinal necrosis syndrome. Three port trans pars plana vitrectomy with perfluorocarbon liquid and fluid/silicone exchange was performed. At vitrectomy, vitreous humour was taken for anti-Toxoplasma and antiviral antibody levels and a retinal biopsy was also obtained. Postoperatively, he was commenced on sulfadiazine, pyrimethamine, and folic acid and continued on oral steroid medication. Levels of IgG, IgA, and IgM were measured in serum and vitreous aspirate at the same time. The Goldmann–Witmer coefficient using IgG was greater than 59, using IgA greater than 45, and using IgM greater than 65. This is evidence of intraocular antibody production. Samples were negative for antiviral antibodies. Intraocular Toxoplasma DNA was demonstrated by a polymerase chain reaction (PCR) assay using primers for the P30 gene. PCR testing for viral DNA was negative. Insufficient material was obtained to attempt to isolate the parasite using tissue culture or animal inoculation. Retinal biopsy demonstrated a mixed inflammatory response without a specific infective agent. The patient subsequently responded to treatment and the intraocular inflammatory signs subsided.


COMMENT

Ocular toxoplasmosis is a common cause of retinochoroiditis, and can usually be diagnosed clinically. Rarely is it possible to obtain vitreous and retinal biopsies to aid diagnosis, but in doubtful cases, it may be appropriate to perform anterior or posterior chamber aspirate to confirm the diagnosis. The assessment of Toxoplasma antibodies in serum is of limited use, unless rising titres can be demonstrated, since the incidence of Toxoplasma infection in the general population is high. The demonstration of antibody production within the eye is particularly valuable in the diagnosis of difficult cases. The finding of higher anti-Toxoplasma antibody levels in the aqueous humour than in the serum (the Goldmann–Witner coefficient) indicates intraocular antibody production. A further investigation which is extremely useful is the demonstration of parasite DNA within ocular fluid by PCR. With PCR a sequence of DNA is amplified from minuscule amounts of DNA making it amenable to direct analysis. De Boer et al used a combination of the demonstration of intraocular antibody production and PCR analysis for the diagnosis of a variety of infectious uveitis cases. In this case we initially made a diagnosis of ocular toxoplasmosis, but the disease progressed clinically and did not respond to treatment. The patient was treated with prescribed medication, and had no evidence of immunocompromise. Retinal detachment is unusual in ocular toxoplasmosis, but is typical of acute retinal necrosis syndrome, suggesting an alternative diagnosis in this case. We were, however, able to confirm the diagnosis of toxoplasmosis by evidence of intraocular antibody production and by positive PCR amplification.

M MINIHAN
P E CLEARY
Department of Ophthalmology, Cork University Hospital and University College, Cork

B CRYAN
Department of Medical Microbiology, Cork University Hospital and University College, Cork

R HOLLIMAN
Toxoplasma Reference Unit, Public Health Laboratory, St George’s Hospital, Blackshaw Road, London

Correspondence to: Ms Minihan.

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Protein C and protein S deficiency associated with retinal, optic nerve, and cerebral ischaemia

EDITOR—Deficiencies in the vitamin K dependent factors protein C and protein S can lead to arterial and venous thrombosis. Branch and central retinal arterial and venous occlusions have been associated with deficiencies in these plasma proteins, as have amaurosis fugax and stroke. We report, to the best of our knowledge, the first case of ischaemic optic neuropathy associated with combined protein C and protein S deficiency.

CASE REPORT

A 47 year old woman with non-insulin dependent diabetes mellitus with documented absence of previous retinopathy presented with blurring of vision and bright flashing lights in her right eye for 2 weeks, associated with vague pericentral discomfort and left sided facial and leg numbness. Best corrected visual acuity was 20/30 right eye and 20/25 left eye. The anterior segment examination was unremarkable and the intraocular pressures were normal. Activated protein C and anti-thrombin levels were normal. Activated protein C and anti-thrombin levels were normal, and no lupus anticoagulant activity was detected.

Figure 1 Initial large cotton wool spot inferotemporal to right optic disc.

Figure 2 Initial cotton wool spot along the inferotemporal vessel resolving 2 weeks later with appearance of new cotton wool spots superiorly.

painless loss of vision to the level of hand movements in the right eye. Fundus examination 6 weeks later revealed a pale optic disc with both generalised and focal narrowing of the retinal arterioles, and an overall reduction in venous calibre and tortuosity (Fig 3). Three months later, at which time the visual acuity remained hand movements, electroretinography (ERG) was performed to distinguish retinal vascular pathology from optic nerve embarrassment. The right eye exhibited modest reductions in scotopic b-wave amplitudes in response to dim white flash (33%) and to bright white flash (20%) compared with the left eye. Cone b-wave implicit time on 30 Hz flicker testing was only slightly longer in the right eye compared with the left eye (30.5 ms versus 29.5 ms). Oscillatory potential amplitudes were normal in both eyes. These results were interpreted as showing insufficient evidence for ischaemic retinal damage as an explanation for her profound loss of vision. The patient was diagnosed with ischaemic optic neuropathy in the right eye based on clinical findings and the ERG results. Laboratory testing revealed that protein C antigen was 47% and protein S antigen 46% of normal levels. Activated protein C and anti-thrombin levels were normal, and no lupus anticoagulant activity was detected.

COMMENT

This patient, with combined protein C and protein S deficiency, suffered ipsilateral retinal, optic nerve, and cerebral ischaemia within a period of 6 weeks. The rapid changes in the appearance of cotton wool spots over a period of several days, which is not consistent with their natural course in diabetic retinopathy, combined with neurological symptoms prompted us to search for systemic causes of ischaemia, including evaluation for hypercoagulable states. We suggest that new cotton wool spots in a patient free of other signs of vascular retinopathy such as microaneurysms or retinal haemorrhages should raise the spectre of a systemic basis for the ischaemia. As the ERG was not compatible with occlusion of the ophthalmic or central retinal arteries, demonstrating only mild retinal ischaemia, we ascribed the sudden visual loss in the face of diffuse disc pallor to optic nerve ischaemia, perhaps from occlusion of multiple ciliary vessels. Ischaemic optic neuropathy has, to our knowledge, not previously been associated with protein C or protein S deficiency, and expands the spectrum of ophthalmic manifestations of the hypercoagulable state.

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JAYAKRISHNA AMBATI

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4 Holland GN and the Executive Committee of the Toxoplasma Reference Unit, Public Health Laboratory, Department of Medical Microbiology, Cork University Hospital and University College, Cork


Macular hole following YAG capsulotomy

EDITOR.—Since the initial identification of macular holes as pathological entities in the middle of the 19th century, there has been an evolution in the understanding of their aetiology. Temporal macular traction by perifoveal vitreous cortex is now accepted as the causative factor in the development of idiopathic macular holes.1,2 The widespread use of extracapsular cataract extraction procedures, posterior capsulotomy, and lensectomy has been associated with a number of complications, including retinal detachment, cystoid macular oedema, and raised intraocular pressure (IOP).3 A much rarer complication of YAG capsulotomy herein reported is the formation of a macular hole after YAG capsulotomy.4

CASE REPORT
A 71 year old woman underwent an uncomplicated extracapsular cataract extraction with posterior capsulotomy and lensectomy in her left eye. Her ocular history was significant for chronic open angle glaucoma. In the immediate postoperative period, there was an acute rise in IOP to 40 mm Hg that responded to Diamox (acetazolamide) orally. Three months postoperatively, best corrected visual acuity was 20/20 in both eyes with IOPs of 17 mm Hg in the right eye and 13 mm Hg in the left. Vision was 20/20 in both eyes with IOPs of 17 mm Hg in the right eye and 13 mm Hg in the left eye. The purpose of this study was to determine whether such malformations are associated with a complex malformation syndrome.1 Historically, it is a well demarcated, excavated, infrapatellar area of absent retina, pigment epithelium, Bruch's membrane, and choriocapillaris, with variable attenuation of the chorioid.3 Some retinochoroidal colobomas incorporate the optic disc and cause the inferior aspect of the optic disc to appear retracted or absent within the excavation.4 The purpose of this study was to determine whether such malformations are associated with hypoplasia of the intracranial optic nerve.5 Five patients with unilateral retinochoroidal colobomas involving the optic disc underwent magnetic resonance imaging (MRI) of the head to rule out associated intracranial malformations. Patients consisted of two males and three females, with ages at MRI ranging from 2 weeks to 4 years. All patients had large unilateral retinochoroidal colobomas that incorporated the optic disc (Fig 1).

MRI consisted of sagittal T1 weighted images, axial T2 weighted images, and coronal T1 weighted thin section images (with 3 mm slice thickness and 0.5 mm gaps) through the chiasm, intracranial optic nerves, and orbits. T1 weighted coronal MR images of the
intracranial optic nerves were examined to compare the size of the intracranial optic nerve corresponding to the colobomatous eye with that corresponding to the normal eye. Cases 1–3 had no associated systemic or intracranial malformations. Case 4 had Gold-nen syndrome with hemifacial microsomia, cerebral hemispheric asymmetry without disorganisation, and colobomatous microphthalmos on the involved side. Case 5 had Aicardi syndrome with agenesis of the corpus callosum and bilateral grey matter heterotopia.

In all patients, coronal MRI showed a smaller intracranial optic nerve on the side corresponding to the retinochoroidal coloboma (Fig 1). The degree of intracranial optic nerve hypoplasia varied according to the ophthalmoscopic configuration of the optic disc. In the present study, MRI demonstrated hypoplasia of the right optic nerve (small arrow). The area of the right optic nerve is approximately half the size of the normal left optic nerve (large arrow).

Orbital haemangiopericytoma simulating an intraocular mass

Editor—Most patients with orbital tumours present with proptosis. It is uncommon for an orbital mass to cause symptoms and signs simulating intraocular disease. We report the case of a patient with an orbital tumour that was initially suspected to be an intraocular tumour.

CASE REPORT

A 71 year old woman noted a photopsia, diplopia, and peripheral scotoma in her left eye. She was evaluated and underwent laser treatment for suspected retinal hole at the margin of a presumed retinal detachment. After non-resolution of the “detachment”, a second ophthalmologist raised the possibility that the fundus lesion was a choroidal melanoma. The patient was then referred to the oncology service for further management. Ocular examination revealed corrected visual acuity of 6/7.5 in both eyes. Proposito of 3 mm with minimal limitation of supraretinal and intraretinal was noted. Fundus examination showed an elevated choroidal mass with normal appearing retinal and choroidal vessels overlying the mass. The mass did not shift with eye position. Fluorescein angiography demonstrated retinal and choroidal isofluorescence.

COMMENT

Haemangiopericytoma is a rare vascular tumour derived from an abnormal proliferation of pericytes. It rarely occurs in the orbit, accounting for only 1% of all orbital biopsies. Orbital haemangiopericytoma occurs as a painless, unifocal tumour often in the muscle cone. The majority of cases are recognised between the ages of 20–70 years. In most cases there is progressive proptosis. However, in our case mild proptosis but marked compression of the globe was seen. Orbital haemangiopericytoma poses a risk for recurrence and metastasis, especially when the pseudocapsule invades beyond the pseudocapsule.

Orbital haemangiopericytoma generally is a slow growing tumour that has an ocular and systemic prognosis. There is a risk for recurrence and metastasis when the pseudocapsule is breached. In one series, a 30% recurrence rate was noted with recurrences generally occurring 1 month to 7 years after surgery. Our patient may be at risk of developing orbital recurrence in the future because there was invasion of the pseudocapsule.

Orbital tumours should be included in the differential diagnosis of a solid intraocular mass. Those orbital tumours that arise in the muscle cone adjacent to the sclera may produce these confusing clinical features.

Dr Ralph C Eagle Jr performed the interpretation of the histopathology. Supported by the Eye Tumor Research Foundation, Philadelphia, PA and the Paul Kayser International Retina Research Fund, Houston, Texas, (Dr C Shields), and the Macular Foundation, New York (Dr C Shields).
Delayed suprachoroidal haemorrhage following trabeculectomy bleb needling

EDITOR,—Transconjunctival needling of trabeculectomy blebs is a relatively safe, simple outpatient procedure that can successfully reduce intraocular pressure. However, severe complications may arise and these need to be taken into consideration, especially when managing high risk patients.

CASE REPORT

Fifteen years previously a 75 year old myopic man underwent bilateral intracapsular cataract extractions. He developed secondary open angle glaucoma but was intolerant of topical beta blockers because of bradycardia. He was managed on pilocarpine drops 4% four times daily but control of intraocular pressure (IOP) was inadequate with deterioration in visual fields. Twelve years after the cataract extractions he underwent bilateral trabeculectomies with postoperative 5-fluorouracil. Three years later the left visual acuity was 6/18 with no light perception and the right eye had a total hyphaema. The patient was managed conservatively with topical steroids and antibiotics. When he bent over 7 hours later he experienced sudden pain in his left eye with immediate reduction of vision. He presented for examination the following day when the visual acuity was noted to be finger counting movements with a left relative afferent pupillary defect (RAPD). There was a large subconjunctival haemorrhage, a total hyphaema, and IOP of 7 mm Hg. There was no fundal view but B scan ultrasound showed vitreous haemorrhage and a shallow anterior chamber. The anterior chamber was well maintained with a persistent RAPD and a soft eye. B scan ultrasound 4 months after needling showed an open funnel retinal detachment (Fig 2 which, in view of the poor visual prognosis, was not felt to be amenable to vitreoretinal surgery.

COMMENT

Delayed suprachoroidal haemorrhage is a well recognised but fortunately rare complication of all forms of intraocular surgery, especially filtering procedures. Pathological study of eyes enucleated within hours of the haemorrhage occurring have suggested the cause to be rupture of necrotic posterior ciliary arteries. A number of risk factors for delayed suprachoroidal haemorrhage have been reported, including aphakia, high myopia, a large peripapillary choroidal haemorrhage, intraocular pressure, and systemic vascular disease. The patient reported here was myopic, aphakic, had ischaemic heart disease and additionally was on aspirin. Two cases of haemorrhagic choroidal detachments have been reported after bleb needling with adjunctive mitomycin C. Precise details of the individual cases were not supplied, however, so it is not clear if these patients had predisposing risk factors or the result of their final visual outcome. A large choroidal effusion occurring after bleb needling has been reported in a pseudophakic patient, the effusion resolving after surgical reformation of the anterior chamber. Our patient was managed conservatively owing to early subjective improvement in his visual acuity. It is possible, however, that the outcome may have been improved with surgical drainage of the suprachoroidal haemorrhage at an early stage, as has been advocated by some authors. The contribution that aspirin played in the development or exacerbation of the haemorrhage is unknown but has not been previously reported as a risk factor. This report emphasises that, while needling of trabeculectomy blebs is usually a safe procedure, severe complications may arise and these need to be taken into consideration, especially when managing high risk patients.

JERRY A SHIELDS
KAAN GUNDUZ
Ocular Oncology Service of the Wills Eye Hospital,
Thomas Jefferson University, Philadelphia, USA

ALAN BRACKUP
Saint Mary’s Hospital, Langhorne, PA, USA

Correspondence to: Jerry A Shields, MD, Ocular Oncology Service, Wills Eye Hospital, 900 Walnut Street, Philadelphia, PA 19107, USA.

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Figure 2 B scan ultrasound examination of the same eye 4 months later showing a fixed funnel retinal detachment.
warfarin until 2 months before the original presentation. The clinical findings were left eye visual acuity −6/60 (Sn) improving to 6/12p with a pinhole; circumscribed congestion and an area of reddish-brown discoloration (6.0–6.5 mm) inferotemporally on the cornea, clinically resembling corneal blood staining. The intraocular pressure was within normal limits and no other ocular abnormality was detected. The other eye had a visual acuity of 6/6p with pinhole and appeared to be normal. On review, 2 months after initial presentation, he was noted to have shrinkage of the area of discoloration revealing underlying prominent superficial and deep stromal corneal vessels adjacent to the area of discoloration, and some lipid deposition close to the deeply vascularised limbus. On further follow up 5 months later, the patient had retained the same visual acuity of 6/6p with pinhole and appeared to be normal. Though the ciliary congestion persisted, the patient was not in any discomfort. The area of discoloration had a greenish-yellow tinge now and measured 5.7–4.2 mm.

COMMENT
Deep intracorneal haemorrhage is most often seen after intraocular surgery, after direct, blunt ocular trauma, and in a vascularised cornea. The contribution of systemic factors such as diabetes or hypertension is unclear. Acne rosacea is known to cause peripheral vascularisation especially involving the inferonasal and inferotemporal quadrant. These vessels are known to progress in the absence of acute symptoms. In our patient, the corneal blood staining was a result of direct bleeding into the corneal stroma from the deep stromal vessels. The deep stromal vascularisation appears to have developed insidiously as in similar cases reported subsequent to contact lens wear. Corneal blood staining either from persisting hyphaema or deep intraocular haemorrhage represents deposition of haemoglobin and its breakdown products within the cornea. A histopathological analysis of blood stained corneas, most of which were associated with raised intraocular pressures, indicated a gradient of haemoglobin degradation from the posterior to the anterior corneal stroma, extracellular haemoglobin particles being concentrated more posteriorly while haemosiderin laden keratocytes predominated anteriorly. Animal model experiments in rabbits utilising total persistent hyphaema with sustained increased intraocular pressures have also revealed similar results. Endothelial degeneration accompanies corneal blood staining and keratocytes appear to be actively involved in haemoglobin degradation. Porphyrin induced photosensitivity producing cytotoxic oxygen species within the blood stained cornea have also been considered as contributing to endothelial and keratocyte degeneration. Clearing of blood staining is thought to be a result of the phagocytic action of the kerocytes and from a diffusion of haemoglobin into the conjunctival circulation and the anterior chamber. The pattern of peripheral, posterior, and anterior stromal clearing observed seems consistent with diffusion of haemoglobin breakdown products out of the cornea as the primary mechanism of clearing. In the absence of a hyphaema, therapeutic efforts are directed towards prevention of corneal blood staining—for example, treating the corneal ulcer vigorously, correction of entropion or treatment of systemic hypertension. The presence of deep stromal vascularisation secondary to any cause must be watched carefully and managed as a potentially vision threatening complication especially in contact lens wearers. Once intracorneal bleeding has occurred, Giessler et al advise waiting for a spontaneous clearing, although it may take 2 or 3 years or more. In the absence of severe associated pathology, corneal blood staining has been noted to clear without permanent corneal opacity changes. Penetrating keratoplasty may be considered.

V Sudha

Department of Ophthalmology, Princess Margaret Hospital, Swindon, Wiltshire SN1 4JU.

Correspondence to: Miss S E P Burgess, Princess Margaret Hospital, Okeu Road, Swindon, Wilts SN1 4JU.

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