LETTERS TO THE EDITOR

Surgically removed submacular nematode

EDITOR,—Intraocular filariasis is an uncommon disease in civilised countries. In only a few cases has the worm been surgically removed from the posterior portion of the eye and identified. In this report we describe a patient who had a filaria-like worm in an epimacular and/or submacular lesion, which was successfully removed surgically.

CASE REPORT

A 38 year old woman complained of decreased visual acuity in her left eye of 5 days’ duration. Her medical history was unremarkable. The patient had two pet dogs, and she had not travelled to foreign countries in recent years. On examination, her corrected visual acuity was 20/20 in the right eye and 20/100 in the left. No inflammation was present in the anterior segment or vitreous cavity bilaterally. Ophthalmoscopic examination disclosed a white worm at the macula, a round, slightly rounded at the other (Fig 1). A round, white worm, approximately 3 disc diameters long, was retrieved successfully by pars plana vitrectomy in several reported cases. Preretinal or subretinal parasites were removed and identified in many reports of intraocular filariasis; however, it was lost during transportation to a different laboratory. Parasitological study of the patient’s serum detected an antibody to Dirofilaria. Six months after surgery, the patient’s visual acuity was still 20/50. Ophthalmoscopically the hypopigmented tracks had faded, and mildly irregular pigment was observed in the deep retina in the macular lesion. Cone and rod electroretinograms to full field stimuli were normal bilaterally.

COMMENT

Our patient owned two dogs, and her ocular findings could be differentiated from toxocariasis, in which only larvae of Toxocara canis can infect humans. The length of the Toxocara larva is about 400 μm, and grows no longer. Although no direct microscopical evidence of Dirofilaria infection was obtained in our patient, a positive antibody to Dirofilaria in the serum indicated its infection. There have been many reports of intraocular filariasis; however, the filariae were removed and identified in only six of 56 cases reviewed by Beaver in 1989. Direct parasitological microscopic examination is necessary for accurate diagnosis, but serological study can be helpful, as shown in the present case.

Various types of management for intraocular parasites have been reported. Direct photoagulation to the worm body has been successfully reported in cases with filaria-like worms and in one case with insect parasites. It has been suggested that photoagulation denatures the parasite proteins and mitigates the immune reaction. If the parasite is located in the posterior pole of the retina, however, photoagulation may cause permanent visual impairment, and surgical removal should be selected. Furthermore, photoagulation would make parasitological identification impossible. Preretinal or subretinal parasites were retrieved successfully by pars plana vitrectomy in several reported cases. In the present case, the visual acuity was still 20/50 6 months postoperatively. The migrating worm may have caused considerable damage to macular function, therefore, we believe that intraocular parasites should be removed as soon as possible.

The authors are grateful to Dr Keizo Yamaguchi for parasitological examination and Mr Shingo Yama- zaki for fundus photographs.

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Acanthamoeba keratitis occurring with daily disposable contact lens wear

EDITOR,—Up to 92% of cases of acanthamoeba keratitis occur in contact lens users of all types. Failure to disinfect soft contact lenses and the use of chlorine disinfection systems are major factors accounting for the increase in cases of acanthamoeba keratitis. It is thought that “daily disposable” contact lenses, which require no disinfection, will have a much lower risk for the development of all forms of infectious keratitis. We report a case of acanthamoeba keratitis occurring in a daily disposable contact lens wearer. We believe this is the first such reported case.

CASE REPORT

A healthy 21 year old woman, who had been wearing daily disposable contact lenses for 1 year, wore her lenses for 4 hours on 1 day and then stored the lenses in preserved saline solution overnight in a new contact lens case. She rewore the lenses for a further 3 hours the following day. She reports that this was the first time that she had done this. She then developed a painful left eye. This was initially treated as conjunctivitis by her general practitioner and local accident and emergency department. After 2 weeks her local eye unit suspected acanthamoeba keratitis and performed an epithelial scrape that “revealed amoeba species”. She was then referred to our unit for our opinion.

On examination her visual acuity was reduced to 6/18 in the left eye. There was conjunctival injection and a mild scleritis. The

The cornea showing diffuse punctate staining with linear epithelial infiltrates.

Figure 1 Fundus photograph of the left posterior pole demonstrates a white worm and preretinal haemorrhage.

Figure 2 Fundus photograph of the left eye shows a white worm at the macula, a round, preretinal haemorrhage along the superonasal retinal artery, and numerous subretinal hypopigmented tracks in the superior retina.

Figure 3 The cornea showing diffuse punctate staining with linear epithelial infiltrates.
cornea had diffuse punctate staining with linear epithelial and perineural infiltrates (Figs 1 and 2). She had a mild anterior uveitis. Acanthamoeba was strongly suspected. Corneal epithelium was removed for microscopy, culture, and histology. Her contact lens case and solutions were also sent for culure. Acanthamoeba was cultured from both corneal epithelium and lens case, but not the lens solutions. She was treated with topical polyhexamethylene biguanide 0.02% (PHMB) and prednisolone 0.3% as well as oral flurbiprofen (Froben, Knoll Ltd, Nottingham). Six weeks after diagnosis she was asymptomatic with a visual acuity of 6/9. The eye was quiet, though some corneal infiltrates remained.

COMMENT

Acanthamoeba are free living protozoa commonly found in soil and water, including bathroom tap water. Acanthamoeba keratitis is an uncommon but potentially devastating condition. The number of cases diagnosed in the United Kingdom has steadily risen over the past 20 years owing to increased awareness of the condition and the rise in contact lens wear. Radford et al 

found that daily wear disposable contact lenses were associated with greatly increased risk of acanthamoeba keratitis compared with other lens types and wear systems.

Multivariable analysis showed that this was largely attributable to a lack of disinfection, the use of non-sterile saline, and the use of chlorine based disinfection rather than alternative chemical systems. It was concluded that 80% of cases of acanthamoeba keratitis could be prevented by the adequate use of an effective disinfection system. It was felt that the “low care” philosophy of daily wear disposable lenses had become “no care” in practice.

Daily disposable contact lenses, in which the lens is discarded after 1 day’s wear only, were introduced in 1995. When used properly and discarded after a single day’s wear, they do not carry the risks of inadequate lens disinfection, contaminated lens solutions, and storage cases. A case of acanthamoeba keratitis occurring in an extended wear disposable lens wearer has been reported, illustrating that even without the risks of inadequate lens disinfection and contaminated lens cases the infection can occur. However, it is known that contact lens wear increases the susceptibility to keratitis independent of factors relating to disinfection and cleaning.

Our case of acanthamoeba keratitis in a daily disposable lens wearer illustrates that misuse occurs and when it does so inadequate disinfection is almost inevitable leading to greatly increased risk of acanthamoeba infection. Misuse, as in this case, may often be associated with storage in saline or water without disinfection. This has been shown by Radford et al to increase the relative risk of acanthamoeba keratitis to 55.86 (10–302) p<0.001. Our case does not, however, indicate the mechanism of infection. It is possible that the infection is unrelated to the lens misuse and could have been acquired from other unrelated sources, such as exposure to contaminated tap water while wearing lenses. However, we would recommend greater education of daily disposable lens wearers on the importance of strict adherence to wearing their lenses for 1 day only and of the risks of misuse of their lenses.

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Clinical course of acute zonal occult outer retinopathy in visual field and multifocal electroretinogram

EDITOR,—Patients with acute zonal occult outer retinopathy (AZOOR) may present with a normal fundus examination and almost normal fluorescein angiography (FA), despite severe loss of visual field and electroretinogram (ERG) abnormalities.\(^1\) The lesion defined zones of the retinal receptor cells; however, the course of the disease remain unclear.\(^2\) There is also no established conclusion about progression of visual field loss.\(^3\)

With a multifocal ERG (m-ERG), a large number of retinal locations can be stimulated simultaneously and local responses can be extracted independently in a single recording session. High resolution topographic mapping of retinal function also is possible.\(^4\) A previous report indicates its efficiency in the diagnosis of AZOOR.\(^5\) There are no reports about the clinical course. Thus, using m-ERG and static perimeter (Humphrey 30–2), the alteration of retinal function in a clinical course of a patient with AZOOR was investigated.

CASE REPORT

A healthy 60 year old woman presented to our outpatient clinic complaining of acute onset of visual disturbance in her left eye. Her corrected visual acuity was 20/20 in her right eye, and 20/100 in her left eye. The pupils were equal and reactive normally. Slit lamp and fundus examination, computed tomography, magnetic resonance imaging scan, and general examination were normal. HVF 30–2 demonstrated blind spot enlargement breaking out to the inferotemporal periphery in the left eye (Fig 1, top). Full field ERG showed grossly reduced A and B waves in the left eye. The FA showed slight leakage from peripapillary capillaries. Indocyanine green (ICG) angiography showed slight hypofluorescence of the macular area at a late phase.

Analysis of the mean deviation in HVF over the clinical course corresponded with the visual acuity (Fig 1, bottom). In addition, m-ERG (Veris III, Tomey, Nagoya, Japan) was analysed during the clinical course. In this examination, the fundus was divided into four foci and the sum of amplitudes in each group was measured (Fig 2, top). In the left eye, the sum of amplitudes was altered individually but all of them were affected during the clinical course. Only in the inferotemporal area did it correspond with HVF. The values in the right eye were about 5000 µV in each focus. This is almost the same as normal volunteers in our clinic (data not shown).

COMMENT

AZOOR may be precipitated by various retinal disorders and is characterised by rapid visual field loss which cannot be explained by the ophthalmoscopic changes resulting from the initiating disease.\(^6\) The ERG is abnormal, indicating that the field loss is due to retinal dysfunction.\(^7\) The cause of the acute damage to sharply defined zones of the retinal receptor cells in the absence of visible fundus changes in patients with AZOOR is unknown.\(^8\) In some previous reports, an apparent response to corticosteroid therapy suggested that an inflammatory and perhaps an immune reaction may play a part in the disease; however, there is no specific evidence for an immune abnormality.\(^9\) An infectious aetiology could also be the cause of AZOOR.\(^10\)

Figure 1 (Top) Raw images of Humphrey 30-2 visual fields in the left eye. (Bottom) The relation between clinical course and mean deviation (MD) of Humphrey 30-2 visual field and visual acuity in the left eye. Asterisks indicate the day in which multifocal ERG was analysed. The roman numerals correspond with raw images in the upper part of the figure.

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The findings of AZOOR that we observed in our patient suggest that the retinal recovery assessed by m-ERG was different for the lesion (main focus was related to the inferotemporal retina) and was delayed compared with visual acuity and HVF. Perhaps this delayed retinal recovery reflects a subtle microrcirculatory disturbance that cannot be clearly detected by FA or ICG. Slight leakage in FA and slight hypofluorescence on the late phase in ICG would suggest such a microrcirculatory disturbance. When better understanding of the aetiology and pathophysiology of AZOOR is available, the clinical response to appropriate therapy may perhaps be better followed by m-ERG.

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Hypotonic maculopathy following pneumatic retinopexy: a UBM study

Editor,—Pneumatic retinopexy is a promising surgical alternative in selected cases of retinal detachment. We report a rare complication, to our knowledge the first ever reported, of this procedure—namely, hypotonic maculopathy, caused by a wound dehiscence on a patient who had previously undergone a standard extracapsular extraction with posterior chamber implant. Ultrasound biomicroscopy (UBM) proved to be a valuable adjunct in both the diagnosis and management of this complicated case.

CASE REPORT

A 63 year old white man, complaining of a shadow in his right visual field, was referred to our department in April 1997 for further management. Ocular history was notable for bilateral extracapsular cataract extraction with posterior chamber lens implantation (PC/ IOL), right eye in January 1997 and left eye in June 1996. Visual acuities were 20/25 in both eyes. IOPs were within normal limits. Anterior segment examination was unremarkable with well positioned IOLs. Fundal examination of his right eye revealed a superotemporal macula on rhegmatogenous retinal detachment, produced by a single horseshoe retinal break around 10 o’clock. After the risks and benefits of pneumatic retinopexy were explained to the patient he chose to have the procedure.

Cryopexy was applied to the tear and after an anterior chamber paracentesis was performed 0.7 ml of 100% SF6 gas was injected. Initially this visual loss was 20/50. Two weeks postoperatively, the pressure normalised (IOP 12 mm Hg), maculopathy was reversed, and visual acuity improved to 20/50.

Hypotonic maculopathy is an unusual and, to our knowledge, the first reported complication1 of this kind after pneumatic retinopexy. We hypothesise that the original cataract wound did not heal properly and the additional cryoprobe manipulation caused the

Between October 1997 and November 1997 he was presented to our unit on three occasions complaining of further deterioration of vision to 20/200, IOPs between 3–5 mm Hg, and a full blown hypotonic maculopathy. After 3 months of hypotony of “unknown origin”, a diagnosis was made by a glaucoma specialist using indentation gonioscopy revealing a dehiscence of the cataract wound. A preoperative UBM study confirmed the presence of an internal wound gap, behind the limbus, superotemporally, 3 mm in circumference. Ultrasonically the wound dehiscence was depicted as a narrow slit (Fig 1) with a flat inadvertent bleb above which was not apparent clinically. A surgical repair of the wound was decided upon. Intraoperatively no definite dehiscence could be clinically identified. Balanced salt solution through a 30 gauge needle was repeatedly injected under pressure to the anterior chamber but this failed to localise any suspicious area. At this point, based on the ultrasonic study, two 10-0 nylon interrupted sutures were placed through the sclera parallel to the limbus in the suspicious area. These bites were moderately deep in an attempt to engage the internal flap of the cataract wound.

Two weeks postoperatively, the pressure normalised (IOP 12 mm Hg), maculopathy was reversed, and visual acuity improved to 20/50.

wound to leak. The UBM study provided us with an interesting insight into how the scleral suture repair may have worked to correct the wound leak as shown in Figure 2. The fact that hypotony resolved after suturing the wound, indicated that the external part of the wound was secure (no slit is apparent) despite the fact that the internal part of the wound was gaping even more postoperatively. This finding implies, therefore, that only minimal overall alteration of the wound architecture postoperatively, sufficient to rectify the leak.

We believe that UBM is a valuable adjunct in the management of similar cases by clearly identifying both the presence and exact location of leak. Finally, pneumatic retinopexy should be performed with caution, especially in cases of previously operated eyes with large incision wounds.

**CASE REPORT**

A 26 year old man complained of gradual and painless diminution of vision in both eyes, right more than left, for the past 2–3 years. There was a history of an overhead high tension electric transmission cable accidentally falling on the patient’s head 4–5 years earlier. This had resulted in immediate burn to the scalp. The patient was visually asymptomatic till about 1 year after the mishap, when he began to notice the gradual fall in vision that had progressed to its present state.

Corrected visual acuity was 20/200 right eye and 20/60 left eye. A 15 × 2.5 cm linear, sagittal scar extending from the frontal to the occipital region of the head was noticed. The lids, conjunctiva, cornea, and pupils showed no abnormality in either eye. Fundus examination was unremarkable. Slit lamp examination revealed multiple, mid-peripheral snowflake-like anterior subcapsular lens opacities in both eyes, right greater than left. In the right eye some of these opacities were seen encroaching into the visual axis and additionally a few posterior subcapsular opacities were noticed (Fig 1).

In view of the history of electrical injury and classic location and typical appearance of the lens opacities, a diagnosis of bilateral electric cataract was made. Extracapsular cataract extraction (ECCE) with posterior chamber lens implantation was undertaken in both eyes, right eye first followed 3 months later in left eye. The intraoperative and postoperative course were uneventful and the patient has achieved corrected visual acuity of 20/20 in both eyes.

**COMMENT**

Involvement of the lens exclusively, sparing other ocular structures is rare. This case documents such a possibility and also highlights the salient features involving electric trauma to the lens. The scalp burn in this case represents the entrance wound for the electrical energy but the lack of an exit wound makes this case particularly peculiar. Both entry and exit sites for the electric current have been reported by all previous authors.

The excellent surgical results noted in both eyes of this patient are in keeping with the similar result reported by Portellos et al. This observation should encourage the ophthalmologist to undertake surgery for electric cataract, where necessary, without any undue concern.

**Figure 1** The characteristic anterior subcapsular lens opacities. (A) Right eye, (B) left eye.
Comment
Juxtafoveal telangiectasis is difficult to detect ophthalmoscopically and therefore can be neglected by routine eye fundus examinations made before the first visual symptoms appear. Unilateral renal agenesis occurs in approximately 1 per 1000 births and can be associated with vascular anomalies.

The aetiology of juxtafoveal telangiectasis is unknown. The patient we examined had retinal vascular malformations that may have originated in the early stages of life. Indeed, the deformed capillaries may function for many years before endothelial decompensation causes retinal swelling. While the exact pathogenesis of Poland's syndrome is not well known, it has been postulated that the original cause may be a vascular abnormality at the embryonic stages.

The vascular abnormalities, mostly of the dashed hemithorax, may be affected by this syndrome and our finding of retinal vascular abnormalities in this patient support this hypothesis.

To our knowledge, this is the first reported case of coexistent juxtafoveal telangiectasis, renal agenesis, and Poland's syndrome. Although we are not aware of direct evidence reported in the literature indicating any retinal involvement linked to this syndrome, it is plausible that the three anomalies found in this patient may have had common original vascular causative factors. Therefore, we recommend a careful eye fundus examination of patients presenting with this syndrome.

Bilateral optic disc oedema associated with latanoprost

Editor,—Latanoprost is a recent addition to the medical management of raised intraocular pressure in chronic open angle glaucoma and ocular hypertension. It is a potent ocular hypotensive agent with few ocular or systemic side effects.

We report a case of bilateral optic disc oedema developing soon after commencing treatment with latanoprost which resolved once therapy was stopped.

Case Report
An asymptomatic 64 year old woman presented with raised intraocular pressure. She maintained good general health, had no significant past medical or family history, and was not on any medication. Snellen visual acuities were 6/5 in both eyes. The intraocular pressures were 28 mm Hg right eye and 26 mm Hg left eye. Ocular examination was otherwise unremarkable with open angles, normal optic nerves, and full Humphrey 24-2 visual fields. She was thus diagnosed as having ocular hypertension and consented to enter a prospective double masked trial comparing some of the intraocular pressure lowering drops. Therapy was commenced with one of the drugs involved in the study and at a 1 month review she reported no problems with the drops. The intraocular pressures had lowered to 16 mm Hg in both eyes and the examination was otherwise unchanged. At her third visit 2 months later, she was again asymptomatic with visual acuities of 6/5 in both eyes and intraocular pressures of 15 mm Hg. However, examination of the optic nerves revealed bilateral oedema which was more prominent in the left eye. There were no signs of uveitis in either eye, papillary reflexes were normal, colour vision and Amsler testing were not affected, and the visual fields were full. At this point the code for the trial drug was broken and it was seen that she had been using latanoprost 0.005% eye drops at night to both eyes over the 3 month period. A neurological consultation failed to find any neurological abnormality and all haematological and biochemical analyses were normal. A computed tomography scan with contrast showed no abnormality and she was discharged from neurological review. Follow up in the eye clinic revealed no change after 72 hours. The latanoprost was stopped and the disc swelling had largely resolved at 1 week. By 10 weeks
both optic nerves looked normal. Visual acuities were still 6/5 in both eyes and there was no loss of colour vision or visual field. The intraocular pressures had increased to 22 mm Hg in both eyes.

COMMENT

Latanoprost is a prostaglandin F1α analogue which acts by increasing uveoscleral outflow. Side effects include increased iris pigmentation,7 hypertrichosis and increased eyelash pigmentation,8 anterior uveitis in patients with complicated glaucoma or in those having had previous incisional surgery,9 and cystoid macular oedema occurring soon after beginning latanoprost in pseudophakic or aphakic eyes.10 Ocular hypotony with choroidal effusions and facial rash have also been attributed to latanoprost.11 To the best of our knowledge, optic disc oedema associated with latanoprost has not previously been described. The mechanism behind this association is unclear. One may not be surprised to see optic nerve swelling in association with signs of posterior uveitis or hypotony but in this case it occurred without any sign of ocular inflammation and the lowest recorded intraocular pressure was 15 mm Hg. It may be feasible that the perfusion to the optic nerve heads via the short posterior ciliary arteries was compromised by a prostaglandin-like action manifesting as disc oedema and that latanoprost acid and prostaglandin F1α at high concentrations could cause vasoconstriction of bovine ciliary arteries12 and a similar action cannot be discounted in this case. The rapid resolution of the swelling with seemingly no long term sequelae once latanoprost was stopped would perhaps support this hypothesis.

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Retinal neovascularisation in Goltz syndrome (focal dermal hypoplasia)

EDITOR,—This is the first reported case of Goltz syndrome with documented peripheral retinal non-perfusion and subsequent retinal neovascularisation and vitreous haemorrhage. In the eye this represents solely a mesodermal disturbance compared with the more common cases which present with both mesodermal and neuroectodermal disturbances, such as coloboma or microphthalmia.

CASE REPORT
Goltz syndrome was diagnosed shortly after birth in a girl with linear lesions of atrophic skin following Blaschko’s lines on the trunk and symmetrical syndactyly of the third to fourth fingers and second to third toes. Initial ophthalmic screening revealed no ocular anomalies. Dental screening revealed the congenital absence of one deciduous incisor. Screening of the parents, brother, and sister was negative for skin, skeletal, and ocular anomalies. When she was aged 5 years, routine ophthalmic review showed a vision of right eye 6/9 and left eye 6/5, with a minor right myopia.

At age 7 years, she complained of a brief episode of photopsia and floaters in the right eye. Vision was right eye 6/20 and left eye 6/6. Examination revealed a right vitreous haemorrhage, telangiectatic vessels temporal to the macula, and temporal equatorial fibrovascular vessels and haemorrhage. Fluorescein angiography showed bilateral peripheral retinal non-perfusion and right temporal neovascularisation (see Figs 1 and 2). This was treated conservatively for 2 years; however, after six bleeds within 3 months indirect retinal photoocoagulation to the areas of non-perfusion was performed with subsequent new vessel regression within weeks.

COMMENT
Focal dermal hypoplasia is a rare disorder of ectodermal and mesodermal dysplasia originally described by Goltz et al.1 It is characterised by congenital atrophic skin changes often associated with herniation of the subcutaneous fat; skeletal anomalies, in particular syndactyly, polydactyly, or adactyly as well as skeletal anomalies, especially hypodontia. Ocular anomalies occur in 40% of cases.2 Colobomata have been reported in one third of cases, then less frequently microphthalmia, strabismus, nystagmus, and ectopia lentis.3 Other reported ocular anomalies include anophthalmia, corneal clouding, aniridia, heterochromia, and optic atrophy. Rarely ectropion and ptosis may occur as well as lid margin or conjunctival papillomatous lesions (histologically angiofibromas).1,4,5 Only one case of cloudy vitreous has been reported. This was in association with microphthalmia, aniridia, and lens subluxation. Retinal scarring or hypopigmentation was reported in Goltz’s original case report.6 No attempt was made to explain these findings. In our case, there was peripheral retinal non-perfusion and temporal retinal telangiectasia with subsequent neovascularisation and vitreous haemorrhage.

The differential diagnosis of retinal vascular anomalies includes incontinentia pigmenti (IP) and Cockayne’s syndrome. Although focal skin atrophy may occur in IP, the initial skin lesions are vesicles and bullae which may later become pigmented macules. The skin lesions in Cockayne’s syndrome are pigmented scars due to light sensitivity and trauma. Neither syndrome is associated with digital anomalies. The genetic anomaly in Goltz syndrome remains to be determined. Most cases are sporadic. It is generally thought to be X linked with lethality in males, like IP; however, 9% of cases are male. These are proposed to be the result of half chromatid mutations.7 Deletions in the region of the chromosome Xp22 are a suggested site, though these must be differentiated from the deletions seen in microphthalmia with linear skin defects (MSL) and that of microphthalmia, dermal aplasia, and sclerocornea (MIDAS), which are now considered to be distinct entities.8 The wide variation in severity of expression is thought to be due to mosaicism.

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Retinitis sclopetaria associated with airbag inflation

EDITOR,—Chorioretinitis sclopetaria is a severe form of blunt trauma, caused by a high velocity object grazing the globe but not penetrating it. It is a concussion injury, which usually manifests as severe choroidal and retinal rupture associated with haemorrhage but an intact sclera.1 We report a case of chorioretinitis sclopetaria resulting from deployment of an airbag in a stationary motor vehicle.

CASE REPORT
A 32 year old pregnant woman was the driver in a car accident in which the airbag failed to deploy at the time of impact but inflated when she returned to sit in the driver’s seat approximately 5 minutes after the accident occurred. The patient was not wearing spectacles and there was no evidence of injury from other sources.

At presentation the visual acuity was hand movements in the left eye and 6/6 in the right eye. Examination revealed evidence of swollen eyelids and marked chemosis and subconjunctival haemorrhages on the left, with no bony injury and a full range of eye movements. Anterior segment examination revealed a clear left cornea and a quiet anterior chamber with a microhyphaema. The lens was clear and there was no evidence of injury. There was no angle recession and the intraocular tension was normal.

pressure was recorded at less than 4 mm Hg. Fundal examination revealed evidence of a retinal tear although details were obscured by a diffuse vitreous haemorrhage. An ultrasound examination showed a vitreous haemorrhage and large retinal tear but no evidence of a scleral perforation.

An examination under anaesthesia performed the following day confirmed that there was no scleral rupture and indirect ophthalmoscopy confirmed the findings of diffuse vitreous haemorrhage and a retinal tear.

At the 2 week postoperative clinic visit, visual acuity had improved to 6/18. There was 2+ cells in the anterior chamber and the intraocular pressure was 24 mm Hg. Posterior segment findings were an intragel haemorrhage, and retinitis sclopeteria with no evidence of retinal detachment.

Four months later, the best corrected visual acuity was 6/36. The anterior chamber activity had settled; the intraocular pressure was 10 mm Hg, and fundal examination was unchanged. In view of the persistent vitreous haemorrhage the patient was listed for routine pars plana vitrectomy in the postpartum period.

COMMENT

Airbags are designed to protect the driver from direct impact from the steering wheel, dashboard, and windshield. They are designed to inflate in 10 ms in response to sudden deceleration and during deployment, the airbag is propelled out of its storage compartment at speeds of more than 100 mph.4 Following inflation the airbag deflates slowly within seconds.

Facial and ocular injuries associated with airbags have been reported in the literature. Skin abrasions, burns, and eyelid ecchymoses are the most common injuries. Reported ocular injuries include orbital fractures, keratitis, corneal abrasions, hyphaemmas, angle recession, and lens subluxation. In the posterior segment, vitreous and retinal haemorrhages, commotio retinae, retinal tears and dialyses, and choroidal ruptures have been reported.1 To our knowledge, this is the first reported case of retinitis sclopeteria secondary to airbag inflation.

Although airbags have clearly been shown to reduce serious morbidity and mortality associated with road traffic accidents, they are associated with a number of injuries directly attributable to their inflation. Some of these are serious ocular injuries and it is important for ophthalmologists and others involved with trauma cases to be aware of these complications. A full ophthalmic assessment is mandatory in all cases and this should include indentification of retinitis. A variety of posterior segment injuries have been reported in the literature but this is the first report of retinitis sclopeteria resulting from airbag deployment.

COMMENT

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