LETTERS TO THE EDITOR

Xeroderma pigmentosum in three consecutive siblings of a Nigerian family: observations on oculocutaneous manifestations in black African children

Editor,—Xeroderma pigmentosum (XP), a rare autosomal recessive disorder characterised by defective DNA repair leading to clinical and cellular hypersensitivity to ultraviolet radiation, manifesting mainly as intolerance of skin and eyes to light, has been described in all races, but is exceedingly rare in the negro race, although some cases have been reported in both the American and African black people. We describe three consecutive siblings of a Nigerian, Fulani, family with the typical features of XP. We wish to draw attention to the clinical, phenotypic variations of this syndrome in black children of the same family living together in an area of high sunshine, and the difficulties in the management of XP patients with advanced disease and limited access to facilities in an environment where avoidance of skin exposure to intense ultraviolet rays is problematic. We believe the patients we have described constitute the first series on XP in black children in the west African subregion.

CASE REPORTS

Case 1

The proband, a 9-year-old girl, was first seen at Usmanu Danfodiyo University Teaching Hospital (UDUTH), Sokoto (13.02° N, 8.14° E), Nigeria, in February 1999 with a history of development of photophobia and an erythema of the skin of the limbs, face, and right cheek at the age of 7½ years which had become persistent. The child was a product of a consanguineous marriage; the parents were of low socioeconomic class. The proband was the fifth in birth rank, in a monogamous family consisting of nine children (three of whom were of the same birth sequence, the 6th and 7th, a 7-year-old girl, respectively, were also milder than in the proband. In the right eye the conjunctiva was xerotic, but clear with tendency to dryness. The left eye showed total loss of lashes of the lower lid and hypertrophy of the nasal half of the conjunctiva, with raising of its edge towards the limbus. The VA (6/60 in both eyes) was better than in the proband. The ocular and cutaneous lesions were compatible with xeroderma pigmentosum.

The onset of the disease and its severity took a middle course between that of the index case (case 1) and the second patient. The onset of erythematosus skin lesions and fleshy conjunctival masses followed exposure to sunshine was at age 6 weeks. Hypopigmented and hyperpigmented macules become evident by the age of 2½ years. The actinic keratoses became more obvious by age 3½ years and the upper lip was noticed at age 4½ years. The worsening of vision became obvious from the age of 3 years. Ocular examination revealed marked blepharospasm in the right eye, the conjunctiva was generally fleshy, vascular, with a tendency to bleed and covered the cornea in both its nasal half and inferotemporal quadrant. Other corneal areas were covered by a fibrovascular epithelial membrane (Fig 2). Biopsy of the conjunctival mass revealed moderately differentiated squamous cell carcinoma. In the left eye there was total loss of lashes of the lower lid, and a vascular fleshy overgrowth of the...

Figure 1 Left eye of the proband demonstrating the large pink, friable conjunctival lesion, a biopsy of which showed moderately differentiated squamous cell carcinoma. Note the scaly nature of the surrounding facial skin with actinic keratotic lesions, hypopigmented and hyperpigmented areas, and crusty ulceration of the nasal bridge, all typical cutaneous lesions in xeroderma pigmentosum.

Figure 2 Case 3, right eye showing vascular, fleshy conjunctival tissues, a biopsy of which revealed features consistent with moderately differentiated squamous cell carcinoma. The facial skin demonstrates actinic keratotic lesions typical of xeroderma pigmentosum.
conjunctiva covering the whole of the nasal one third of the cornea, and also a small area of the cornea temporally at about 3 o’clock. The VA in the left eye was limited to hand movement only at 2 metres while in the right eye it was PL only. The severity of actinic keratotic lesions was midway between that of the proband and case 2. Although there were crusty skin ulcers of the upper lip, there were no obvious cutaneous tumours. On the basis of these oculo-cutaneous lesions, associated with sunlight hypersensitivity and the similarity of the symptomatology with that found in the other two siblings, the diagnosis of xeroderma pigmentosum was not in doubt. The disease in this patient had also advanced to the cancerous phase.

COMMENT

XP is generally regarded as a very serious disease. The assertion that the severity of the symptoms was limited to these only. Surgical intervention could not be carried out mainly because the cost was too exorbitant for the poor parents. For these patients with advanced disease, limited access to facilities, in an environment of high sunshine, the prognosis is indeed gloomy.

HAMIDU AHMED
Department of Paediatrics, Usmanu Danfodiyo University, Teaching Hospital, PMB 2370, Sokoto, Nigeria

RAHMATU Y HASSAN
UDUTH, Sokoto, Nigeria

UMAR H PINDIGA
University of Maiduguri Teaching Hospital, Maiduguri, Nigeria

Correspondence to: Dr Ahmed
Accepted for publication 22 May 2000

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Multifocal electroretinographic and
angiographic changes in pre-eclampsia

EYERTON,—Pre-eclampsia is characterised by
hypertension, proteinuria and generalised
oedema developed after 20 weeks’ gestation. We
report serial changes in multifocal elec-
etroretinography (MERG), fluorescein angi-
ography (FA), and indocyanine green angi-
ography (ICGA) in a patient with pre-
eclampsia who developed choroidal ischae-
ma and serous retinal detachment.

CASE REPORT

A 28 year old Chinese woman, gravid a II, para
I, was hospitalised at 31 weeks’ gestation with
blood pressure of 178/98 mm Hg, 4+ pro-
teinuria and pretibial oedema. At 34
weeks’ gestation, emergency caesarean section
was performed because of uncontrolled pre-
eclampsia. Two days post partum, she com-
plained of blurring of vision in the right eye.
On examination, her visual acuity was right eye:
20/30, left eye: 20/15. There was no affer-
tent pupillary defect. Anterior segment and
intraocular pressure was normal. Fundal
examination revealed bilateral greyish-yellow
lesions at the level of retinal pigment epith-
ium (RPE), distributed mainly in peripapil-
lar area and posterior pole. There was
shallow inferior serous retinal detachment in
the right eye. FA and ICGA of both eyes showed early patchy hypofluorescence with
delayed filling of choroid around the discs and
nasal maculae, suggestive of choroidal ischae-
ma. Late phase showed leakage with stippled
staining (Fig 1).

MERG was performed 2 weeks post partum.
Stimulation used was the 103 hexagons at
rate of 75 Hz using pseudorandom binary
m-sequence with visible system (Electro Diag-
nostic Imaging, Inc, San Mateo, CA, USA).

Three dimensional topography and trace
array of the MERG showed decreased re-
sponse amplitudes in both nasal maculae
and the right fovea. There was also delayed N1
and P1 implicit times and diminished re-
sponse density of the nasal macula compared
with the temporal macula in both eyes (Fig 2).
Five weeks post partum, her visual acuity
improved to 20/15 in both eyes. RPE changes
corresponding to areas of delayed filling and
leakage were found. FA and ICGA performed
3 months post partum were unremarkable.
However, MERG showed persistent bilateral
mild decrease in amplitude of the nasal
macula compared with the temporal macula,
despite full recovery of the right foveal peak.
Visual field assessment was not performed.

COMMENT

In our patient, the area of decreased response
amplitude and delayed latencies in MERG corre-
sponded with the area of choroidal ischae-
ma detected by FA and ICGA. Addi-
tionally, it detected abnormal area in the right
fovea that did not show up with FA or ICGA.
When repeat FA and ICGA were unremark-
able 3 months later, MERG still showed
persistent abnormality in both nasal maculae.
The partial recovery of MERG in our case
supports the current concept of transient
vasospasm in choroidal circulation in pre-
eclampsia. However, the damage may not be
completely reversible as previously reported.1

Figure 1 Right eye at 2 weeks post partum. (Top) Fluorescein angiogram shows delayed filling of
choriocapillaries in the early phase and leakage with staining in the late phase. (Bottom) Similar
changes in indocyanine green angiogram.
The signals of MERG are thought to be derived from the outer retinal layers of cones and also the inner retinal layer including the bipolar and Muller cells. The retinal response may be impaired secondary to RPE dysfunction and choroidal ischaemia. Similar MERG findings in central serous choriotretnopathy were reported, in which the RPE abnormality is thought to be secondary to the underlying choroidal vascular disease. MERG has the advantage of being non-invasive and risk of breastfeeding after angiography can be avoided. It is more sensitive than FA and ICG in the evaluation of macular choroidal ischaemia. Similar MERG topography shows recovery of the foveal response. However, average MERG response shows persistent mild decrease in response amplitude in the nasal macula (19.2 nV/deg vs 23.4 nV/deg).

Figure 2 Multifocal electroretinogram (MERG) of right eye. (Left) At 2 weeks post partum, trace array and three dimensional MERG topography showing decreased retinal response density in the fovea and nasal part of the macula. Average MERG responses of the temporal and nasal maculae showing prolonged N1 and P1 latencies as well as diminished response amplitude of the nasal macula compared with the temporal macula. Mean N1 and P1 latencies were 16.7 ms and 30.0 ms for the nasal macula, and 14.2 and 27.5 ms for the temporal macula, respectively. Mean P1 response amplitude for the nasal right macula is 70% of the temporal response (18.0 nV/deg vs 26.3 nV/deg). (Right) At 3 months post partum, trace array and three dimensional MERG topography show recovery of the foveal response. However, average MERG response shows persistent mild decrease in response amplitude in the nasal macula, which is 83% of the temporal macula (19.2 nV/deg vs 23.4 nV/deg).

Signet ring cell carcinoma of the eccrine sweat gland in the eyelid, treated by radiotherapy alone

Editor,—The signet ring cell carcinoma of the eccrine sweat gland is a very rare tumour of the eyelid. Only six cases have been published up to now. There is a preponderance of males; only one woman was affected. The patients’ ages ranged from 47 to 78 years. This tumour shares some histological features with breast carcinoma, the metastasis of which represents the most important differential diagnosis—Indian file formations, signet ring cells, and expression of oestrogen, as well as progesterone, receptors. One significant difference is that the positive staining for those hormone receptors is found mainly in the cytoplasm in signet ring cell carcinoma, in contrast with the nuclear staining of breast carcinomas.

Different treatment modalities have been applied in cases of eccrine sweat gland carcinoma. Our case demonstrates that tumour control can be achieved with radiotherapy alone despite extensive orbital involvement.

CASE REPORT
An 87 year old male patient was seen initially in our department in July 1998. He had noticed swelling of his right lower eyelid. We saw a diffuse thickening and induration of the right eyelids at initial presentation in our hospital. An magnetic resonance image (MRI) showed a tumour that had infiltrated the upper (Fig 1) as well as the lower eyelid, the eyebrow, and the perioral muscles. The optic nerve was also surrounded by tumour mass. Two biopsies revealed an infiltrating tumour with Indian file formations; some of the tumour cells had a signet ring appearance with nuclei located peripherally as a result of intracytoplasmic vacuoles. The latter possessed microvilli, as could be demonstrated by electron microscopy. The cytoplasm stained positive with periodic acid Schiff (Fig 2) and with antibodies against oestrogen and progesterone receptors as well as human milk fat globulin. No hormone receptor expression was found in the nuclei. The growth fraction was 5%, determined with MIB1.

Systemic examination did not reveal any other tumour, especially no breast carcinoma and no adenoacarcinoma of the gastrointestinal tract. Two treatment modalities were discussed—orbital exenteration and radiotherapy. Since the patient refused orbital exenteration radiotherapy was started in September and October 1998, and performed over 6 weeks, with a total dosage of 56 Gy. Two months later the cornea showed erosions which were treated with lubricants; the ocular motility was heavily impaired. Fourteen months after radiotherapy the lid skin was soft again without any evidence of tumour recurrence, the cornea only showed irregular epithelium, and the eye motility had returned to almost normal. Unfortunately, because of optic nerve damage by glaucoma and radiotherapy, the right eye went blind.

COMMENT
In most cases of signet ring cell carcinoma described in the literature, upper and lower lids of one eye were involved. Three patients were initially treated by excision alone; all of them had a period of survival of at least 6 years. One of these patients...
developed a recurrence after 10 years, with preauricular lymph node metastasis, as a result of which he was treated with radiotherapy (50 Gy). He had at least 18 months of remission thereafter, but showed subclavicular liver metastasis at necropsy; his death was not tumour related. Another patient was found to have pulmonary metastases from which he finally died.

Radiotherapy alone (35 Gy), as in our case, was applied to another patient. He showed infiltration of the lids and the anterior orbit, and had at least 6 years of remission. The only patient treated by orbital exenteration, radiotherapy, and tamoxifen died as a result of liver and bone metastases within a period of less than 6 years after initial diagnosis. His pretreatment status, showing extensive orbital infiltration, was quite similar to that of the patient we are presenting here.

From the cases reported in the literature, we conclude that this tumour possesses a low to intermediate grade of malignancy. To date, 14 months after radiotherapy, our patient still shows remission. Thus, for elderly patients with extensive infiltration of orbital and adnexal tissue by an eccrine sweat gland carcinoma, we consider this conservative treatment sufficient to achieve local control.

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CLAUDIA AUW-HAEDRICH
Department of Ophthalmology, University of Freiburg,
D-79106 Freiburg, Germany

NORBERT BOEHM
Department of Pathology

CHRISTIAN WEISSENBERGER
Department of Radiology

Correspondence to: Dr Auw-Haedrich
auw@aug.ukl.uni-freiburg.de
Accepted for publication 16 June 2000


Endonasal endoscopic dacryocystorhinostomy for dacryocystocoele in a 4 month old infant

Editor,—Canalisation of the nasolacrimal apparatus usually occurs at the same time throughout its length. However, its distal end has been shown to be occluded by a membrane in 73% of otherwise normal stillborn fetuses at term.

For typical dacryocystoceles, a regimen of warm compresses and massage, with regular ophthalmological review to check for the first signs of dacryocystitis, seems to be reasonable. Should dacryocystitis supervene, the child should be admitted to hospital for the intravenous administration of antibiotics and probing of the nasolacrimal apparatus. Should the dacryocystocele recur or epithora ensue, and repeated probing does not give the result, it may be necessary to intubate the nasolacrimal apparatus or perform a dacryocystorhinostomy.

In 1893, Caldwell described the first case of an endonasal operative approach to the lacrimal system. This technique was later modified by West and supported by Mosher in 1921.

In spite of these attempts, the external dacryocystorhinostomy (DCR)—the technique inaugurated by Toti in 1904—was, for a long time, the most accepted procedure for lacrimal sac surgery. The reason for this was presumably limited transnasal visualisation caused by bleeding during endonasal dacryocystorhinostomy.

In 1974, Johnson and Kansis revived the endonasal approach. Heermann and Neues used a microscope for a transnasal approach to the lacrimal sac, whereas McDonough and Meiring were the first to advocate endonasal dacryocystorhinostomy (EEDCR), in 1989.

Using new instrumentation and techniques for endonasal sinus surgery in general, many authors have proved that EEDCR can be performed with lower morbidity in adults and with success rates equal to those achieved with the traditional external approach.

Case report

A 4 month old girl presented with huge recurrent abscesses in the left medial canthal region (Fig 1) and a huge epiphora. Initially she was managed by conservative methods (warm compresses and massage over the swollen lacrimal sac), but the clinical appearance did not show any change. She underwent several incisions whenever the abscess severely exacerbated, threatening to perforate spontaneously. Attempts to probe the nasolacrimal canal were performed in the “silent” phases of the disease, but the probe did not pass deeper than the bottom of the lacrimal sac, suggesting the absence of the canal. Attempts to irrigate the lacrimal canals were not successful either. A lacrimal sac massage resulted in a certain amount of mucus bursting out from the inferior lacrimal punctum, indicating a blockage of the lacrimal system underneath the lacrimal sac. Endonasal endoscopic examination showed no signs of intranasal extension.

Because of the clear clinical diagnosis of dacryocystocoele, the patient’s age, and the need for additional anaesthesia, we did not insist on a dacryocystogram or computed tomography scanning.

At the time we decided to try to perform an endonasal endoscopic dacryocystorhinostomy (EEDCR), the girl was in one of her “silent phases”, without any clinical sign of acute exacerbation of the infection. Only moderate hemispheric bulging was seen in the medial canthal region.

We started the procedure by inserting two small, very thin (20×5 mm) gauze flakes, previously soaked in a 5% cocaine solution mixed with adrenaline (5:1 ratio) and then firmly squeezed, into the left nasal cavity. The flake were removed after 5 minutes. A favourable vasoconstriction of the whole nasal mucosa was achieved. Then 0.5 ml of local anaesthetic (1% lignocaine with 1:100 000 adrenaline) was injected submucosally in the area just anterosuperior to the insertion of the middle turbinate. We used a paediatric endoscope of 2.7 mm in diameter and 30 degrees optics. The mucosa of this region was then removed by means of bipolar coagulation, and lacrimal bone was nicely exposed in an oval shape measuring up to 6 mm in longer diameter. The bone was drilled off and thinned out, so that the lacrimal sac became visible (the removal of the underlying lacrimal bone is more easily performed posteriorly, where it is thinner, but it is more safely performed anteriorly to avoid the possibility of orbital disruption). The ophthalmological probe was inserted into the lacrimal canal and the sac itself, tenting it towards the nasal cavity. Then lacrimal sac was marsupialised by performing using otoological microsurgical scissors and punches, and a large amount of turbid tears mixed with mucopurulent discharge was obtained.

A 6 cm long nasal thin gauze ribbon package with antibiotic ointment was placed in the operated region for 3 days. After 5 days, there was no sign of dacryocystocoele or dacryocystitis on the girl’s face (Fig 2). Eight months after the surgery, she is feeling fine.

Comment

Since, after 16 weeks of life, the nasolacrimal duct obstruction and dacryocystocoele did not resolve spontaneously or after conservative treatment, we performed an endonasal endoscopic dacryocystorhinostomy. As far as we know, this was the youngest child ever operated by means of EEDCR. The small anatomical dimensions of the infant nose posed a technical challenge in performing EEDCR: during the use of Richard’s otorological drill for bone removal, there was some difficulty in concomitant endoscopic visualisation and potential damage to the nasal mucosa from rotation of the drill shaft. We also performed a lacrimal opening of 6 mm with angled endoscopic biting forceps (the usual opening is about 3 mm).

In comparison with an external dacryocystorhinostomy, EEDCR avoids an external scar and offers very low morbidity in the immediate postoperative course. In spite of the technical problems, we think that

Figure 1 The appearance of the girl before the surgery.

Figure 2 The appearance on fifth day after the operation.

10 15

Letters
EBDCR, even in such a small infant, can be a good therapeutic choice in cases refractory to conservative treatment (warm compresses, massage, probing) because of its non-invasive performance and a very fast postoperative rehabilitation.

RANKO MLADINA
ORL Department, University Hospital Salata, Zagreb, Croatia

NEDA STIGLMAIYER
Department of Ophthalmology, University Hospital Rebro, Zagreb, Croatia

KRSTO DAWIDOWSKY
ORL Department, University Hospital Salata, Zagreb, Croatia

TOMISLAV JUKIC
Department of Ophthalmology, University Hospital Rebro, Zagreb, Croatia

MARTIN JURLINA
BOZENA TRUPKOVIC-FO TIVEC
ORL Department, University Hospital Salata, Zagreb, Croatia

Correspondence to: Professor Dr R. Mladina, ORL Department, University Hospital Salata, 10000 Zagreb, Croatia

prof_mladina@doctor.com

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CASE REPORT
In 1997 a 32 year old homosexual man presented for the first time to the University Eye Hospital, Tübingen. For 4 weeks he had suffered from an acute retinal necrosis of the left eye. His right eye was not affected. The visual acuity of the left eye was 0.1. The anterior segment of the eye showed corneal precipitates but no cells in the anterior chamber. Owing to massive cell infiltration in the vitreous the lower part of the fundus was not visible. There was a large necrotic area with bleeding and occulsive vasculitis in the upper nasal periphery (Fig 1). The patient claimed to be healthy, apart from an EBV infection with pericarditis which had occurred when he was 17 years old. Tests for HIV and syphilis were repeatedly negative, also for Lyme disease, toxoplasmosis, hepatitis B, HSV, and VZV. There were increased titres for EBV- IgA (1:128), EBV-IgG (1:1512), EBV nuclear antigen, and EBV early antigen (1:64), a constellation typical for an acute EBV infection. After therapy with aciclovir 5 x 400 mg, prednisolone 60 mg, acetylsalicylic acid (200 mg), and topical prednisolone acetate the symptoms decreased.

After 8 weeks his visual acuity increased up to 0.5 but dropped to 0.2 after 5 months as a result of vitreous haemorrhages because of neovascularisation. After clearance of the bleeding and peripheral laser coagulation the neovascularisations resolved. The fundus showed scars but no holes in the area of the necrotic retina (Fig 2). After 25 months the visual acuity was 0.2. The anterior parts showed mild cataracta complicata. Vitreous cell infiltration still persisted and the central part of the fundus was not clearly seen. The patient showed an absolute central scotoma and atrophy of the optic nerve, without treatment.

COMMENT
The role of EBV in ocular diseases is still not clear, because approximately 95% of adults are positive for EBV antigen and only a few suffer from ocular disease. Previously described cases of “EBV retinitis” only described inflammation of the posterior pole without scarring, which is not typical for viral retinitis. Proving an acute EBV infection usually is done with increased EBV titres. Such a constellation was found in our patient. The titre decreased during the following 12 weeks suggesting that EBV may play a part in this man’s retinitis. The reported patient showed all criteria of the American Uveitis Society for ARN.

However, it is not possible to rule out that other herpesviruses have caused the retinitis. This probably could only have been proved with a diagnostic vitrectomy or anterior chamber tap which was refused because of improvement with treatment. Serological findings showed no signs of other herpes infections.

SUSANNE KRAMER
Katharinenhospital Stuttgart, Kriegerstrasse 60, D-70174 Stuttgart, Germany

CHRISTOF BRUMMER
MANFRED ZIEHRUT
University Eye Hospital, Department I, Schleichstrasse 12, D-72076 Tübingen, Germany

Correspondence to: Dr Manfred Zierhut, University Eye Hospital, Schleichstrasse 12, D-72076 Tübingen, Germany

manfred.zierhut@med.uni-tuebingen.de

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Intrascleral recurrence of uveal melanoma after transretinal “endorsection”

EDITOR.—Conservation of the eye and vision in patients with juxtapapillary choroidal melanoma is still a challenge. Both plaque radiotherapy and proton beam radiotherapy tend to cause optic neuropathy, which is associated with disc and iris neovascularisation, vitreous haemorrhage, and neovascular glaucoma. These complications can also occur after photocoagulation, which is less effective than radiotherapy at destroying the deeper parts of the tumour. Transcleral local resection of posterior tumours is especially difficult because of the acute retinal necrosis syndrome. In this report, eight out of 52 cases received secondary photocoagulation for possible tumour recurrence at the margins of the surgical coloboma and one enucleated eye was found to have microscopic tumour deposits.
its within the coloboma. We report a case of intrascleral tumour recurrence.

CASE REPORT
A 40 year old man presented with a 6 month history of photopsia. He was found to have a choroidal melanoma in the right eye and referred for conservative treatment. On examination, the vision was 0/4 with each eye. The tumour was pigmented and located inferiorly, extending to within two disc diameters of the fovea and optic disc margin (Fig 1). Approximately 40% of the retina was detached. On ultrasonography, the tumour had basal dimensions of 12.0 mm by 11.7 mm and a thickness of 4.8 mm (Fig 2). The left eye was healthy. Full systemic assessment revealed no other disease.

Figure 1 Fundus photographs (A) preoperatively, showing an inferior choroidal melanoma extending close to optic disc and fovea, and (B) 2 months postoperatively, showing surgical coloboma.

Figure 2 Light micrographs of the enucleated eye. (A) Low power view showing intrascleral tumour recurrence close to optic disc and (B) high power view showing a ciliary nerve within the tumour.

Transretinal “endoresection” was performed in July 1994. The procedure involved three port vitrectomy, retinectomy over the tumour, endodiathermy to bleeding points, endolaser photocoagulation applied to the margins and the bed of surgical coloboma and fluid-gas-silicone exchange. Histological examination showed the melanoma to be of mixed, spindle, and epithelioid cell type. In September 1994, the eye was settling well, except for an amelanotic choroidal swelling, which was noted adjacent to the inferonasal margin of the coloboma. This was believed to consist of a bubble of silicone oil in the suprachoroidal space although the possibility of recurrent melanoma could not be excluded clinically. There was also a localised trachial retinal detachment caused by vitreous bands.

Vitreoretinal surgery was performed, with release of the vitreous traction and excision of the retina and choroid over the swelling. This procedure confirmed that the tumour consisted of a bubble of silicone oil beneath the choroid. The procedure also included endolaser photocoagulation and silicone-gas exchange. The eye nevertheless developed retinal detachment with proliferative vitreoretinopathy and cataract. In December 1994, further surgery was performed, which consisted of phacoemulsification, removal of epiretinal membrane, 180 degree retinectomy, endolaser photocoagulation, and silicone oil fill.

In April 1995, the retina was flat with an epiretinal membrane covering the inferior margin of the coloboma and a fibrovascular scar partially obscuring the optic disc. It was decided that the silicone oil should be left in place because of the high risk of retinal detachment. When reviewed in February 1999, the vision was hand movements and there was band keratopathy, which precluded ophthalmoscopy. Enucleation was performed because it was not possible to screen the eye adequately for local tumour recurrence. At the time of surgery, an extrascleral tumour nodule was noted medial to the optic nerve. The tumour nodule measured approximately 8 mm by 6 mm.

Pathological examination showed the recurrent tumour to be of mixed, spindle, and epithelioid cell type. The tumour appeared to arise within the sclera because of the way in which it was encapsulated by the scleral lamellae. The presence of nerve tissue within the tumour suggested that the melanoma had entered the sclera along a channel for a ciliary nerve. Posteriorly, the tumour had broken through the sclera into the orbit.

COMMENT
To our knowledge, this is the first report of intrascleral recurrence of choroidal melanoma after transretinal endoresection. The tumour probably survived the surgery and photocoagulation because it had invaded a scleral canal adjacent to the optic nerve.

It is known that intrascleral tumour deposits can survive after photocoagulation or transscleral local resection of choroidal melanoma. In the present case, the adjunctive photocoagulation after completion of the tumour resection was either of insufficient power or was not applied to the area where the scleral invasion had taken place. A more effective method of eliminating residual intrascleral tumour would have been to administer adjunctive plaque radiotherapy, which is routine after transscleral local resection in some centres. In the present case, however, this would probably have caused optic neuropathy.

Recurrent tumour after transscleral local resection is associated with an adverse prognosis for survival. It is not known, however, whether the recurrence is the source of metastasis or merely an indicator of tumour aggression.

Further follow up studies are required to determine the incidence of intrascleral tumour recurrence after endoresection of choroidal melanoma.

B DAMATO
D WONG
Department of Ophthalmology, Royal Liverpool University Hospital
F D GREEN
Department of Pathology, Aberdeen Royal Hospitals
J M MACKENZIE
Department of Pathology, Aberdeen Royal Hospitals

Correspondence to: Professor B Damato, St Paul’s Eye Unit, Royal Liverpool University Hospital, Prescot St, Liverpool L7 8XP, UK. Accepted for publication 23 June 2000

References

Leucocoria as the presenting sign of a ciliary body melanoma in a child

EDITOR,—Uveal melanoma is generally a disease of adulthood.1 It has been reported that 0.6% to 1.6% of all uveal melanomas occur in patients under 20 years of age.2 In a review of 3706 consecutive patients with uveal melanoma, Shields and associates found that 1.1% were children and teenagers younger than 20 years of age, of whom only 0.3% had ciliary body melanoma.3

Patients with ciliary body melanoma usually are asymptomatic until the tumour impinges on the lens and causes visual distortion.4 Children with intraocular tumours generally have few visual symptoms and adapt to visual distortion without complaints.5 Leucocoria in childhood is the most frequent presenting sign of retinoblastoma, but it is generally not associated with uveal melanoma.6 We report an unusual case of a 9 year old child with a ciliary body melanoma who presented with leucocoria.

CASE REPORT
A 9 year old white girl was referred to Oncology Service at Wilms Eye Hospital with a 1 month history of leucocoria and strabismus in...
and B-scan] showed an acoustically hollow, pedunculated mass in the ciliary body region measuring 10 mm in thickness. Ciliary body melanoma was diagnosed and the eye was enucleated.

Histopathological examination revealed a heavily pigmented multilobulated tumour arising from the pars plana (Fig 1B). The highly cellular tumour was composed of a mixture of spindle and epithelioid cells with a predominance of epithelioid cells. About 15–20% of the tumour was composed of melanophages within extensive areas of necrosis (Fig 2). No mitotic figures were identified. The cataractous lens was partially encased and dislocated by tumour. Parts of the iris, ciliary body, and choroid, were heavily pigmented and dendritic melanocytes were observed within the sclera and on the episceral surface, especially near the optic nerve. These findings were consistent with sector ocular melanocytosis. The histopathological diagnosis was ciliary body melanoma and sector ocular melanocytosis.

The patient has been followed for 10 years and has no evidence of local or systemic metastases.

COMMENT

Uveal melanoma is very rare in children and adolescents. Shields and associates reported that approximately 1% of all uveal melanoma patients are 20 years of age or younger at diagnosis.1 In no case has any of these young patients presented with leucocoria.2,3

Ciliary body melanomas in both children and adults is usually asymptomatic and can remain undetected before it is recognised clinically.4 The most common presenting manifestations of ciliary body melanoma include dilated episcleral vessels in the quadrant of tumour, secondary hypopyon or glaucoma, and subluxation of lens with visual aberration. The presence of a large tumour size was an important predictive factor of metastatic disease in children with uveal melanoma.5 Despite the large size of the tumour in our patient, no mitotic activity was found on histopathological examination. This may explain the continued survival of our patient.

In conclusion, we report a case of ciliary body melanoma in a 9 year old child who presented initially with a tumour induced cataract. A unilateral cataract in a child deserves an evaluation for common and rare conditions such as ciliary body melanoma.

CASE REPORT

HAKAN DEMIRCI
CAROL L SHIELDS
JERRY A SHIELDS
SANTOSH G HONAVAR

Oncology Service, Wills Eye Hospital, Thomas Jefferson University, Philadelphia, PA, USA

RALPH C EAGLE, JR
Pathology Department

Correspondence to: Dr Carol L. Shields, Oncology Service, Wills Eye Hospital, 900 Walnut Street, Philadelphia, PA 19107, USA
Accepted for publication 17 June 2000


Spontaneous extrusion of subconjunctival cysticercus cellulosae

EDITOR,—Cysticercus cellulosae, the larval form of Taenia solium (tape-worm), often affects the human eye. Human infection occurs on eating raw or inadequately cooked infected pork, consuming food or water contaminated with faecal material containing the ova, or as a result of autoinfection.1 Sommering first reported a case of ocular cysticercosis.2 The parasite’s most favoured site in the eye is vitreous and subretinal space followed by the subconjunctival tissue.3 Spontaneous expulsion of cysticercosis from the subconjunctival space and orbit is uncommon.4 We report a case of subconjunctival cysticercus cellulosae in which there occurred spontaneous extrusion.

CASE REPORT

A young 7 year boy presented with redness and swelling in the right eye. General physical and systemic examination revealed no abnormality. The right eye had a smooth, pinkish, hemispherical, subconjunctival, cystic swelling of approximately 8 x 10 mm size near the inner canthus (Fig 1). It was loosely adherent to the eyeball, non-reducible, and was wildly tender. The conjunctival vessels over and around it were markedly congested. The left eye was normal. An ultrasound of the right eye done with a waterbath revealed a subconjunctival mass of 5 mm size near the inner canthus of the right eye. A sector cataract of the right eye with a waterbath revealed a subconjunctival mass of 5 mm size near the inner canthus of the right eye. A sector cataract of the right eye with prominent episcleral vessels in the quadrant of tumour. These findings were consistent with sector ocular melanocytosis. The histopathological diagnosis was ciliary body melanoma and sector ocular melanocytosis.

The patient has been followed for 10 years and has no evidence of local or systemic metastases.

COMMENT

Uveal melanoma is very rare in children and adolescents. Shields and associates reported that approximately 1% of all uveal melanoma patients are 20 years of age or younger at diagnosis.1 In no case has any of these young patients presented with leucocoria.2,3

Ciliary body melanomas in both children and adults is usually asymptomatic and can remain undetected before it is recognised clinically.4 The most common presenting manifestations of ciliary body melanoma include dilated episcleral vessels in the quadrant of tumour, secondary hypopyon or glaucoma, and subluxation of lens with visual aberration. The presence of a large tumour size was an important predictive factor of metastatic disease in children with uveal melanoma.5 Despite the large size of the tumour in our patient, no mitotic activity was found on histopathological examination. This may explain the continued survival of our patient.

In conclusion, we report a case of ciliary body melanoma in a 9 year old child who presented initially with a tumour induced cataract. A unilateral cataract in a child deserves an evaluation for common and rare conditions such as ciliary body melanoma.

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HAKAN DEMIRCI
CAROL L SHIELDS
JERRY A SHIELDS
SANTOSH G HONAVAR

Oncology Service, Wills Eye Hospital, Thomas Jefferson University, Philadelphia, PA, USA

RALPH C EAGLE, JR
Pathology Department

Correspondence to: Dr Carol L. Shields, Oncology Service, Wills Eye Hospital, 900 Walnut Street, Philadelphia, PA 19107, USA
Accepted for publication 17 June 2000


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CASE REPORT

A young 7 year boy presented with redness and swelling in the right eye. General physical and systemic examination revealed no abnormality. The right eye had a smooth, pinkish, hemispherical, subconjunctival, cystic swelling of approximately 8 x 10 mm size near the inner canthus (Fig 1). It was loosely adherent to the eyeball, non-reducible, and was wildly tender. The conjunctival vessels over and around it were markedly congested. The left eye was normal. An ultrasound of the right eye done with a waterbath revealed a subconjunctival mass.
A subconjunctival cyst at the inner canthus of the right eye.

Figure 1

A subconjunctival cyst with a central echogenic nodule suggestive of a cysticercus cellulosae (Fig. 2). Excision of the cyst was planned, but the patient reported a week later with history of spontaneous expulsion of a small balloon-like translucent structure from the eye after which the swelling subsided. Repeat slit lamp examination did not show any swelling in the eye though there was redness and a conjunctival rent close to the inner canthus. An ultrasound examination was normal and the cyst seen earlier was not present.

COMMENT

Cystercosis has a global distribution particularly in countries where there is increased incidence of pork eating. Ocular dissemination of cystercus cellulosae is well known and is evident from several reports in the literature. The most favoured site is the vitreous and subretinal space followed by subconjunctival tissue and extraocular muscles. The cystercus in the present case was subconjunctival and there was spontaneous expulsion. Since 1970 only six cases of spontaneous extrusion of cystercus from subconjunctival space have been reported. 1–4

In the three cases reported by Bansal et al. 1, 2 the cyst was located within the medial rectus muscle in the first case, in the subconjunctival space in the second case, and in the superior orbit in the third case from where they were extruded. In the present case the cystic swelling was present near the inner canthus of the eye with attachment to the underlying muscle sheath.

In orbital and subconjunctival cystercosis the cyst is usually attached to the muscle sheath, where it induces an inflammatory reaction and because of its constant motility it erodes through the conjunctiva and comes out leaving a rent in the conjunctiva which ultimately heals within a short period. 2 This case report highlights the importance of ultrasound in such lesions and should be the primary mode of investigation. On ultrasound the cyst is seen as a sonolucent area with well defined anterior and posterior margin with the presence of a central echodense, curvilinear highly reflective structure within the cyst, that of a scolex. 2

SARITA MAGU

Department of Radiology, Pt BDL Sharma PGIMS, Rohtak, India

MANISHA NADA

A K KHRURANA

JP CHUGH

Department of Ophthalmology

Correspondence to: Dr Manisha Nada, Lecturer 2/11 J, University Type, Medical Enclave, PGIMS Rohtak-124001, Haryana, India

Accepted for publication 22 June 2000

Massive basal cell carcinoma in a schizophrenic patient: treatment options and constraints

EDITOR,—Basal cell carcinoma (BCC) is the most common malignant tumour of the eyelids and face. Factors which increase the chance of orbital invasion include a medial canthal location, slow indolent growth, morpheiform growth pattern, surgical recurrence, advanced presentation, and neglect. Orbital invasion predisposes to intracranial involvement by direct or perineural spread. Management of orbital invasion is difficult and requires a multidisciplinary team approach for radical surgery and/or radiotherapy. 1

We present a 76 year old Ukrainian man with a neglected tumour on his forehead which had spread over several years to involve the upper eyelids, anterior orbits, and ethmoid sinuses.

CASE REPORT

A 76 year old man with a long history of untreated forehead BCC complained of deteriorating vision in his right eye and ocular discharge. He had been admitted by the care of the elderly unit, for social reasons. He was a known paranoid schizophrenic treated with psychotropic drugs. Four years previously his physician had measured the lesion as being 2 cm × 4 cm and recommended plastic surgery, which was declined.

There was a massive, fungating lesion of the forehead, superior orbits, and nasal bridge, at least 15 cm × 17 cm (Fig 1). The right uncorrected visual acuity was 6/24 and left only light perception (unable to use a pin hole). There was fixed ptosis and right lower eyelid involuntary ectropion. There was an opaque left cornea. The right fundus was normal. He did not permit intracocular pressure measurement.

Investigations included a computed tomograph (CT) scan to evaluate the extent of tumour invasion and an incisonal biopsy for histopathological diagnosis. The CT scan showed extensive soft tissue destruction, loss of the nasal bone, frontal sinuses, and bilateral anterior ethmoid, and extraconal orbital invasion (Fig 2). Histopathology confirmed extensive solid basal cell carcinoma.

He received symptomatic care with lid cleansing and topical chloramphenicol. A low visual aid assessment was arranged. Palliative treatment with radiotherapy was recommended but he refused all treatment including the low vision assessment.

The patient underwent a thorough mental status examination, which confirmed well controlled schizophrenia. We were not empowered to detain him for treatment against his will. He discharged himself from hospital with an untreated fungating BCC.

COMMENT

This patient had a neglected BCC which had caused destruction of soft tissue and bone, with orbital invasion and was threatening the vision in his remaining eye.

Where advanced scalp cancer displays deep invasion, radical excision and reconstruction are indicated. 3, 4 Some authors suggest that aggressive surgical management of advanced skin neoplasia is the only treatment to produce long term survival. 3 In malignant cutaneous tumours involving the anterior skull base, invasion of the dura mater significantly affects survival. 4 In particular, spread along the medial orbital wall can lead to meningial infiltration by direct invasion. As with squamous cell carcinoma, large basal cell carcinomas can invade the central nervous system by

Figure 2

Ultrasound showing a cystic mass in the subconjunctival region in the lateral aspect of the eyeball with a central echogenic scleral and turbid contents within the cyst.

Figure 1

Oblique view of massive basal cell carcinoma of the forehead, nasal bridge, and upper eyelids showing right upper eyelid involvement, subperiosteal ulceration, and lower eyelid ectropion.
perineural spread. Our patient risks spread of the tumour along the supraorbital and supratrochlear nerves.

When local surgical therapy fails to prevent recurrence or definitive surgical resection is not possible, as in this case, alternative therapies must be considered. Opinions vary on the roles and efficacy of radiation therapy and chemotherapy for extensive lesions. Cisplatin and doxorubicin have been reported to achieve complete remission of recurrent invasive BCC of the medial canthus and orbit at 5 years.1 Using adjunctive radiotherapy, large BCCs of the head showed partial to complete response but no cures achieved. A complete response was defined as disappearance of all measurable lesions (but cancer cells are still present microscopically) and a partial response was 50% reduction in all lesions.

Patients with large or aggressive skin cancer are fortunately uncommon and management should be individualised following discussion with both the patient and his/her family. The options include a combination of surgery, radiotherapy, and chemotherapy with every effort made to preserve vision.

Our elderly, schizophrenic patient declined treatment and in these circumstances informed consent that can be offered. Legal issues prevent forced treatment.

Informed consent includes providing adequate information about the treatment to make a reasoned decision. Obtaining consent must be free of coercion or threats, which would affect the patient’s decision. The patient must be presumed competent unless shown otherwise. Psychiatric assessment confirmed that this patient was competent to make his own decisions. Exceptions include if immediate need is apparent and the patient is unable to provide it (in coma or insufficient time to obtain it), the patient is legally incompetent to make a treatment decision, or decides to waive the right to be fully informed.

Untreated, the outlook for this patient is grim.

MOHAMMED MHUTTASEB
JANE M OLVER
Eye Department, Charing Cross Hospital, Fulham Palace Road, London W6 8RF, UK

SHARON CONSTANTINE
Pathology Department
Correspondence to: Jane M Olver
Accepted for publication 28 June 2000

Spontaneous resolution of eyeball displacement caused by maxillary sinusitis

EDITORS,—Spontaneous displacement of the eyeball caused by maxillary sinusitis is rare but is well documented.1,2 Different treatments have been suggested but all are surgical. Spontaneous enophthalmos due to maxillary sinusitis was first described by Montgomery;3 there have since been a series of reports describing this condition. The mechanism appears to arise from obstruction of the osteomeatal complex which impairs sinus ventilation. The resorption of retained secretions within the sinus produces a negative pressure which results in erosion of the thin orbital floor.4 In the absence of trauma the triad of obstructive sinus disease, diminished antral volume, and enophthalmos has been thought to be caused by inflammatory resorption and inferior displacement of the orbital floor.5 The globe is also displaced downwards and backwards such that the patient will have a narrow palpebral fissure and a deep superior sulcus above the eye.6

CASE REPORT

A 29 year old white male presented to the ophthalmology clinic having noticed that his right eye had been at a lower level than left one for the previous 2 years. There was no history of trauma. There were no nasal complaints or history of sinusitis. On examination, the right globe was displaced inferiorly by 5–6 mm. Ophthalmic examination, including a visual acuity cover test and ocular movements were otherwise normal. A computed tomograph (CT) scan showed an opaque right maxillary antrum which was hypoplastic. The floor of the orbit was eroded and the right eyeball had sunk into the antrum (Fig 1). He was seen in the ENT clinic and listed for an endoscopic middle meatal antrostomy and repair of the orbital floor. The patient changed his address and we were unable to contact him. Three years later, he contacted the ENT department to inquire about his appointment. We advised him that a further review might be beneficial. When reviewed the right eye was noted to be in a normal position. A repeat scan was undertaken which showed a well aerated right maxillary sinus which was larger than on the previous CT scan. The right orbital floor appeared well ossified and at a higher level than before (Fig 2). In view of these findings, it was decided that no further management was required.

COMMENT

In this case report the support of the orbital floor was presumably lost secondary to blockage of osteomeatal complex and subsequent inflammatory changes and/or pressure changes within the antrum. Previous reports have advocated surgical reconstruction of the orbital floor at an early stage.4,6 Maxillary sinusitis is frequently a self resolving disease, as occurred in this case. Resolution of maxillary sinusitis, inflammatory and pressure components that produced the displacement of eyeball appears to have taken place. In the absence of negative pressure in the maxillary antrum and with orbital floor periosteum intact, new bone was laid down to reform the orbital floor with subsequent repositioning of the globe.

This case raises the question as to whether surgical intervention is required in these cases if the maxillary sinus disease can be treated or resolves of its own accord. Should medical or conservative management be inadequate then it can be hypothesised that a simple middle meatal antrostomy may be enough, following which the orbital floor might reform without need for reconstruction. The authors suggest this as a hypothesis extrapolating from the events that occurred in this patient.

U RAGHAVAN
Department of Otorhinolaryngology, Queen’s Medical Centre, University Hospital, Nottingham NG7 2UH, UK

R DOWNES
Department of Ophthalmology

N S JONES
Department of Otorhinolaryngology

Correspondence to: Professor N S Jones
nick.jones@nottingham.ac.uk
Accepted for publication 28 June 2000


Familial thombophilia and normal tension glaucoma

EDITORS,—The aetiology of normal tension glaucoma (NTG) is still debatable. Abnormal blood flow, systemic hypertension, abnormal blood coagulability, and other factors associated with cerebrovascular disease may have a causative role in NTG.7 A study was designed to look at the prevalence of familial thrombophilia in cases of NTG.

CASE REPORT

Seventy-two patients were identified from an ophthalmological database records with the diagnosis of NTG (defined as intraocular pressure <21 mm Hg, open drainage angle on gonioscopy, absence of any secondary cause for a glaucomatous optic neuropathy, and typical optic disc cupping which correlates with the visual field loss). Strict criteria were used for entry into the study. Patients with NTG had to be under the age of 70 years with normal computerised tomography and normal day intraocular pressure phasing. Forty-five patients did not fulfill these criteria and so were excluded. Twenty-seven patients formed the study group. None of these patients were on any medication which would be expected to alter the values of the prothrombotic factors measured. The control group comprised 90 blood donors used by the regional thrombophilia laboratory as their control values of thrombophilic markers. The control group had an equal male:female ratio, an age range of 18–60 years, and no donor was on any medication or suffering from a medical illness. This gave a good control prevalence of the prothrombotic factors tested for in the study which are not altered by age variation. If any abnormality was found a repeat screen was performed to control for the thrombophilic state. Blood for rheological factors (full blood count, plasma viscosity, lipid levels, glucose and liver function tests) and thrombophilic markers (protein S, protein C, factor V Leiden mutation, prothrombin G20210A allele, antiphospholipid antibodies, and hyperhomocysteinaemia) was taken for investigation. Informed consent was obtained and ethical approval had been given.

The study group was made up of 16 females and 11 males (ratio 1.5:1). The mean age of diagnosis was 60 years (range 43–69). Table 1 shows the patient details. Twenty-three patients had a normal thrombophilia screen. Two patients had moderate hyperhomocysteinaemia (7%, controls 8% p>0.5), one was heterozygous for the factor V Leiden mutation (4%, controls 4.5% p>0.5) and another had a low titre of antiphospholipid antibodies (4%, controls 3% p>0.5). No patient had the prothrombin G20210A variant.

Table 1  Patient details

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<td>M</td>
<td>Mild raised homocysteine</td>
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<td>65</td>
<td>F</td>
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<td>MI increased cholesterol</td>
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COMMENT

In trying to discover the aetiology of NTG, some studies have suggested that these patients may have altered rheology producing a greater tendency to thrombosis.1 4 There is also evidence of activation of the coagulation cascade and fibrinolytic pathway but there is no conclusive evidence of a general vascular aetiology in the causation of NTG.1 7 8

The factor V Leiden mutation is a common hereditary abnormality with a 1–8% prevalence of heterozygous carriers depending on geographic location and accounts for the majority of activated protein C resistance. It is known that thrombophilia greatly increases the risk of venous thrombosis but it must be stressed that the most people with the Leiden mutation will not experience a thrombotic event. The prothrombin G20210A variant is another common abnormality with a carrier prevalence of 1–4% being more common in southern Europe and, like the Leiden mutation, rare in people from Asian or African descent. An association of the prothrombin variant and the factor V Leiden mutation with arterial disease has not been demonstrated convincingly9 and this therefore questions the role of these prothrombotic factors in the causation of ocular anomalies suggested, in part, to be due to poor arterial supply. With this in mind, and the non-significant prevalence of factor V Leiden between the patient and control groups, it is unlikely that familial thrombophilia plays a significant aetiological part in NTG. Atheroma plaques develop following from a medical cascade and fibrinolytic pathway9 which are not altered by age variation. If any abnormality was found a repeat screen was performed to control for the thrombophilic state. Blood for rheological factors (full blood count, plasma viscosity, lipid levels, glucose and liver function tests) and thrombophilic markers (protein S, protein C, factor V Leiden mutation, prothrombin G20210A allele, antiphospholipid antibodies, and hyperhomocysteinaemia) was taken for investigation. Informed consent was obtained and ethical approval had been given.

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Other hereditary thrombophilic conditions, such as protein C and protein S deficiency, and antiphospholipid antibodies have been reported in association with ocular vascular pathology and a combination of these factors may further increase the risk of hypercoagulability. The low levels of antiphospholipid antibodies, as seen in patient 20, are thought not to be prothrombotic.

It is unlikely that familial thrombophilia plays a significant aetiological part in NTG. A larger study is needed to confirm our findings. On the available evidence, thrombophilia screening in patients with NTG is not justified.

Previous poster presentation at the Royal College of Ophthalmologists’ annual congress, Harrogate 2000.

O C BACKHOUSE
M J MENAGE
B A M CERRY

Leds Teaching Hospitals NHS Trust, Leeds, UK

Correspondence to: O Backhouse, Department of Ophthalmology, Leeds General Infirmary, Leeds LS1 3EX, UK

obackhouse@hotmail.com

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The wide field multilocal ERG reveals a retinal defect caused by vigabatrin toxicity?

EDITOR,—Vigabatrin is an effective drug for controlling chronic epilepsy and is taken more commonly in conjunction with additional anticonvulsant drugs. There has been increasing subjective evidence that this drug may be associated with visual field defects.1 2 We report here the interesting results we found from wide field multilocal ERGs performed on a patient taking vigabatrin.

CASE REPORT

A 52 year old white man was referred to the eye clinic with a 6 month history of bumping into objects. His optician reported a bilateral inferonasal and nasal field defect. On examination his visual acuity was 6/6, N5 with correction, Ishihara 17/17 in each eye and intraocular pressures were 19 mm Hg. He had a full range of ocular movements and pupil reactions were normal. There was a mild pallor to both optic discs. www.bjophthalmol.com

DVT = deep vein thrombosis; MI = myocardial infarction; CVA = cerebrovascular accident.
discs and a spontaneous venous pulsation was present. Both maculae were healthy. Humphrey central 30-2 threshold visual fields recorded peripheral constriction within 10° of fixation. Blood pressure was 162/88 and urinalysis was negative. There was no significant family history nor did he have any history of night blindness. His medical history included epilepsy, for which he commenced anticonvulsant treatment in 1966. Despite a variety of drug regimens he never had adequate control of his symptoms until February 1990, when 1000 mg twice daily of vigabatrin was added to a regimen of carbamazepine 300 mg three times daily and sodium valproate 500 mg three times daily. Attempts were made to replace vigabatrin with gabapentin and then lamotrigine but neither proved to be successful; therefore, he returned to using vigabatrin. At the time of examination treatment included vigabatrin, carbamazepine, sodium valproate, and propranolol. Although the patient has been informed of the associated risk of visual field loss; he has elected to remain on vigabatrin treatment.

In November 1999 he was referred for conventional electrophysiological investigations, including electro-oculogram (EOG), visual evoked cortical potentials (VECP), and electroretinograms (ERG). All tests were performed in accordance with current ISCEV international standards. Findings were similar to other reports in that VEPs were normal, his Arden index was >1.7 but <1.9. There was a small reduction in cone and maximal responses of the left eye in the ERG and a significant reduction of oscillatory potentials in both eyes (Table 1).

COMMENT

Advances in electrophysiological techniques have enabled topographical maps of retinal function to be constructed.1 Wide field (90 degree) multifocal stimulation of the retina was performed using a custom built system with a 61 hexagonal display digitally back projected onto a polysilicon screen.2 Multifocal electroretinograms were performed in June 2000, results showed good correlation with visual fields in determining the area of visual loss. Normal retinal function was recorded in the central 40° of both eyes. However, a delay in implicit timings occurred with eccentricity; more importantly there were marked reductions in peripheral b-wave amplitudes which may be suggestive of retinal toxicity. These results were consistent in both eyes. Figure 1 depicts MFERG responses of the patients left eye in comparison with the right eye of a normal subject.3 The wide field multifocal ERG technique is the only objective tool for assessing the effect of vigabatrin toxicity on the peripheral retina. Currently, a larger clinical study utilising this technique is under way. We are confident that this technique will help to answer many of the unresolved issues associated with this form of treatment.

Table 1 Conventional electrophysiology findings

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<td>30 Hz flicker</td>
<td>25–150</td>
<td>57 68</td>
</tr>
</tbody>
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Figure 1 Left eye wide field multifocal ERG results from patient taking vigabatrin shown against results from a normal patient with no ocular pathology. (A) Multifocal waveforms show reduction in peripheral field retinal function, note areas of reduced b-wave amplitudes. (B) Normal multifocal waveforms. (C, D) Topographical maps of retinal function. (E, F) Plan view topographical maps.


J MCDONAGH
ElectroDiagnostic Imaging Unit, Tennent Institute of Ophthalmology, Gartnavel General Hospital, Glasgow, UK

D KEATING
Department of Ophthalmology, Glasgow Royal Infirmary, Glasgow, UK