LETTERS TO
THE EDITOR

Waardenburg syndrome type 2 in a Turkish family: implications for the importance of the pattern of fundus pigmentation

EDITOR,—Waardenburg syndrome (WS) is a typical auditory pigmentary syndrome with affected individuals showing varying combinations of sensorineural hearing loss, patchy abnormal pigmentation of the eyes, hair and skin, and various defects of neural crest derived tissues.1,2

This syndrome is both clinically and genetically heterogeneous and is clinically classified into four types.3 Mutations of the PAX3 gene have been identified in WS type 1 and 3, while those of either the endothelin B receptor gene, the endothelin-3 gene or the sox10 gene have been identified in WS type 4.4,5 WS type 2 is a heterogeneous group, with about 10% of cases caused by mutations in MITF. But MITF mutations are obviously not the major cause of WS type 2 and for most cases the genetic basis is as yet unknown.

The diagnostic criteria for WS type 2 proposed by Liu et al include, in addition to congenital sensorineural hearing loss and pigmentary disturbances of the hair, pigmentary disturbances of the iris but not of the fundus.

In the two affected boys of the Turkish family presented here, the pattern of fundus pigmentation was one of the most striking clinical features, with dense hyperpigmented areas next to hypopigmented areas. We want to emphasise the importance of a thorough observation of the clinical phenotype and especially of the pattern of fundus pigmentation in WS type 2.

CASE REPORT

A Turkish family presented with two of three sons showing clinical symptoms of WS type 2. Firstly, the 5 year old boy, the youngest of three non-consanguineous children, was referred for ophthalmological examination because of constant esotropia in the left eye. The child has worn hearing aids since the age of 16 months; the first reliable audiogram at age 3 years showed profound sensorineural hearing loss which had not changed over the past years. Best corrected visual acuity was 20/20 right eye and 20/400 left eye. Cycloplegic refraction showed anisohypermetropia (right eye +2.5D and left eye +4.5D). He had bilateral dark brown irides and strabismus (right eye +2.5D and left eye +4.5D). He had bilateral dark brown irides and strabismus (right eye +2.5D and left eye +4.5D). He had a complete iris heterochromia with a dark brown iris right and a brilliant blue iris left (Fig 2, top). Cycloplegic refraction revealed an anisohypermetropia (right eye +0.5D and left eye +5.5D), best corrected visual acuity was 20/20 right eye and 20/200 left eye. Severe fundus pigmentary disturbances were found in the left (blue) eye, with extensive albinoid areas nasally and on the posterior pole, whereas the temporal region showed a homogeneous area of dense hyperpigmentation. In the right (dark brown) eye, the pigmentary disturbances were less extensive with a hyperpigmented peripapillary ring and pigmentary mottling especially in the nasal region (Fig 2, centre). Conventional audiological examinations showed bilateral sensorineural hearing loss with moderate impairment on the right and total deafness on the left side (Fig 2, bottom).

Ophthalmological and audiological evaluations made of the father, the eldest brother, and a son of the father’s first marriage were within normal limits. The mother showed pigmentary mottling in the periphery of the fundus only. No other associated abnormalities (such as hair or skin hypopigmentation, medial eyebrow flare, broad and high nasal root, hypoplasia of alae nasi, or premature greying of hair) were found among the family members. To calculate the W index, a biometric index for dystopia canthusorum, we used dystopia indices for WS as reported by Arias,7

Figure 1 (Top) The 5 year old boy (III-5) with bilateral dark brown irides; corneal reflexes demonstrate left esotropia; there is no evidence of dystopia canthusorum. (Centre) Left: right fundus with an area of hypopigmentation on the posterior pole as well as nasally; pigmentary mottling and spots of hyperpigmentation in the temporal periphery (arrows); (right) left fundus, albinoid in type 1–3

Figure 2 (Bottom) Audiogram: profound bilateral sensorineural hearing loss.
described elsewhere, no abnormally migrating bands in the MITF
observations on the clinical findings in this opportunity to make some interesting obser-
expressed in this Turkish family, we had the
Given the classic symptoms of WS type 2
mutations in the MITF was consistent with the clinical picture of WS
the individuals had dystopia canthorum. This
1.45, indicating that none of
unknown. Because of the fact that most of the other fam-
ly members were living in the Turkey.
other family members were living in the Turkey.
important clinical findings.
lected homogeneous distribution.
In conclusion, we have presented a Turkish
WS type 2 family in which no mutations of the MITF gene could be found. The affected fam-
ily members showed a conspicuous fundus picture with ipsilateral connections between
iris, fundus, and perhaps, inner ear pigmenta-
tion. Therefore, one might suggest, that the clinical signs in WS type 2 could be a conse-
quency of a failure in distribution of pig-
mented melanocytes in their final location.
The genetic basis, as yet unknown for most cases of WS type 2, might be found in a very late step of the pigmentation pathway.

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Figures 2 (Top) The 7 year old boy (III-4) with heterochromia irides (note the brilliant blue iris colour left); there is no evidence of dystopia canthorum. (Centre) Left: right fundus with pigmen-
tary mottling especially nasally (arrow); right: left fundus albinoed in type nasally and between optic disc
and macula: in the temporal region there is a homogeneous dense hyperpigmentation (arrows). (Bottom) Audiogram: bilateral sensorineural hearing loss with moderate impairment in the right ear
and total deafness in the left ear.

1 Liu ZX, Newton VE, Read AP. Waardenburg syndrome type 2: phenotypic features and diag-

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Depression and anxiety frequently accompany or adolescence, and a chronic course is typical. A clinical evaluation was normal. There was no evidence of loss of eyelashes. On either upper eyelid, there were 6/5 point and not cut ends. On either upper eyelid, there were 6/5 point and not cut ends.

CASE REPORT

A 12 year old boy was referred to the eye clinic with complaints of dropping of eyelashes of both upper eyelids. He was seen by his optician before the referral. Lid hygiene, proparpine isethionate ointment 0.15% (Brolene), and sodium cromoglycate eye drops 2% (Opticrom) were tried but with no benefit. The mother reports that his eyelashes grew while they were abroad on a holiday for a benefit. The mother reports that his eyelashes grew while they were abroad on a holiday for a benefit. When seen in the eye clinic his visual acuity was 6/6 in each eye. He was taking no regular medications. His ocular history, was generally fit and well, and there were no significant abnormalities. He had no significant abnormalities. He had no significant abnormalities.

COMMENT

Trichotillomania is characterised by an irresistible urge to pull out hair. This disorder is often accompanied by depression and anxiety. A recent study has shown that the estimated lifetime prevalence of trichotillomania is 1.5% among males and 3.4% among females. The majority of the sufferers see their hair loss as a way to express their emotional and occupational adjustment. The pathophysiology of trichotillomania is not well understood. Treatment options include: medications such as serotonin reuptake inhibitors with or without haloperidol, paroxetine, clomipramine, pimoizide, risperidone, and serotonin reuptake inhibitors refractory trichotillomania. Venlafaxine; Behaviour therapy habit reversal training and hypnotherapy.

Trichotillomania has been infrequently reported in the ophthalmic literature. Management can be difficult. Many of these patients are aware of their behaviour, but are unable to curtail it. Others may, however, curtail it. Others may conceal or deny their habit. Psychiatric counselling may be of benefit if patients are willing to undergo it.

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then occurred, with stromal oedema in the same distribution. This was controlled by reinstitution of topical prednisolone therapy. One year after onset, the patient continues to use topical prednisolone once a day and is asymptomatic. There is no stromal inflammation, but fine golden granules are still evident.

COMMENT

Two variants of gold induced keratopathy (corneal chrysalis) have been described. The more common variant manifests as asymptomatic deposition of fine brown or purple granules in the central posterior corneal stroma, sparing the periphery. Other patterns include peripheral deposition with extension towards the central cornea, superficial and deep stromal deposition. Corneal stromal granule deposition correlates with duration and dosage of therapy and occurs in most, if not all patients after a cumulative dose of 1 g has been reached. Corneal gold deposition by itself is not considered an indication to discontinue gold therapy.

The second variant of keratopathy is rare, presenting with inflammatory symptoms and signs. Examination reveals marginal interstitial keratitis that may ulcerate, with white, subepithelial limbal infiltration and deep, brush-like stromal vascularisation. Crescent-shaped marginal ulcers, 2–3 mm in length may be present. This variant is presumed to be an idiosyncratic reaction. It may be unilateral or bilateral, and is considered an indication to stop gold therapy. The underlying pathogenic mechanism, as well as the possible associations with other systemic gold toxicity, is unknown. However, it is notable that the keratitis in our case was responsive to topical corticosteroids and recurred after their withdrawal. A similar response has been reported in systemic manifestations of gold toxicity.

The diagnosis of gold keratopathy should be considered in patients with rheumatoid arthritis who present with marginal keratitis. Assessment of possible systemic toxicity is warranted and cessation of therapy should be considered in such cases. Patients should be continuously followed, since stromal inflammation may recur even after cessation of gold therapy.

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Osteosarcoma with metastasis to orbit

EDITOR,—Osteosarcoma is the most common primary malignant tumour of the bone. More than 90% of patients with this disease die with pulmonary metastases. Metastatic disease to the orbit from sarcomas is rare. An English language computer Medline search (from January 1966 to December 2000) for osteosarcoma metastatic to the orbit did not reveal any previous report. We describe perhaps the first case of osteosarcoma metastasising to the orbit.

CASE REPORT

An 8 year old boy was referred from a district hospital for a swelling over the proximal right leg of 5 months' duration. Lower extremity ultrasound showed a metaphyseal lesion in the proximal tibia with bone destruction and new bone formation. A clinical and radiological diagnosis of osteosarcoma was made. A plain chest radiograph did not reveal any abnormality. Histopathological examination of the tumour confirmed the diagnosis of osteosarcoma. An above knee amputation of the right leg was performed.

One month later, the child developed proptosis of the right eye (Fig 1). An ophthalmic examination confirmed proptosis of the right eye. Vision, fundus, and eye movements were normal in both eyes. Ultrasound examination of the eye revealed a 12 mm × 18 mm lobulated, nodular, hypodense retrobulbar mass on the temporal side, displacing the optic nerve medially. An area of necrosis was seen in the mass, but no calcification was present (Fig 2). Computed tomography of the orbit confirmed the findings of ultrasonography, demonstrating a soft tissue density mass in the right orbit displacing the eyeball. Fine needle aspiration cytology from the mass showed malignant spindle cells. A diagnosis of osteosarcoma with metastasis to right orbit was made. The patient was offered palliative chemotherapy but refused further treatment and was discharged from the hospital.

COMMENT

Osteosarcoma is the most common primary malignant tumour of bone. Most cases occur in children, adolescents, and young adults with a male predominance. The classic site of occurrence is the medulla of the long bones, particularly the distal femur, proximal tibia, and proximal humerus. Metastases of osteosarcoma typically occur in the lungs. Recent studies indicate, however, that the incidence of non-pulmonary metastases is increasing.

Orbital metastases from malignant neoplasms are rare and can originate from anywhere in the body. In adults, the primary tumour is almost always a carcinoma, with breast and lung accounting for the vast majority of orbital metastases, followed in frequency by genitourinary and gastrointestinal primaries. In children with orbital metastases the primary tumours in descending order of frequency are neuroblastoma, Ewing's sarcoma, and Wilm's tumour.5,6 Lymphoma and neuroblastoma as the commonest tumours producing orbital metastases. The two populations studied in these reports differed geographically (United States and India respectively). These tumours tend to involve the orbits and spare the globes in contradistinction to metastatic disease in adults. Metastatic osteosarcoma to the eye is very rare. Newman and DiLoreto7 reported a single case metastatic to the synovial fold. Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfin and Woodfi
An unusual cause of oscillopsia

EDITOR,—Chronic maxillary atelectasis (SSS)1 also known as silent sinus syndrome (SSS)2 describes the same condition. Typically, the patient presents with acute enophthalmos and hypoglobus in the absence of previous trauma or surgery. Past sinus disease may be present and computed tomograph (CT) scans demonstrate ipsilateral sinus contraction, orbital floor resorption, and thinning with inferior prolapase into the maxillary sinus. We present a patient who noted oscillopsia while jogging 1 year after being diagnosed with SSS.

CASE REPORT

A 26 year old woman was referred with a 6 month history of painless gradual sinking of the left eye (Fig 1). She had suffered two episodes of mild sinusitis, one at the age of 12 and one at a year before presentation. Visual acuity was 6/6 in each eye and there was no evidence of optic neuropathy. There was 4 mm of left relative enophthalmos, no manifest deviation, and full extraocular movements. The height of the palpebral aperture was 1 mm less on the left. Orbital CT scans showed a unilaterally opaque maxillary antrum and ethmoid sinus, a collapsed inferior bowing of the orbital floor.

COMMENT

Oscillopsia is an illusion that the world is in motion; we believe that this is the first report

in a patient with SSS. It occurs most frequently with disorders of the vestibular system, cerebellum, or brainstem. Our patient had no associated neurological signs or symptoms, and a normal head CT scan. A mechanical cause of oscillopsia caused by an instability of fixation is a rare but well documented finding.3

In our patient we postulate that the oscillopsia during jogging arises from inadequate globe support caused by demineralisation and downward displacement of the orbital floor and Lockwood’s ligament, while the levator palpebrae superioris and Whitnall’s ligament remain in their normal positions. Patients with SSS may also develop vertical diplopia, lid retraction, lagophthalmos, or blurred vision.4

Spontaneous enophthalmos unrelated to trauma, surgery, local malignancy, or systemic disease is uncommon. The presence of diplopia may suggest an underlying neuro-ophthalmic disorder; however, hypoglobus and enophthalmos point to the orbital/maxillary area as the primary site of pathology.

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Cytogenetic analysis in ocular lymphoma

EDITOR,—A 56 year old man was referred to the ocular oncology service with complaints of pain, redness, and blurring of vision in his left eye for the previous 2 months. He had no significant past ocular history. He was a known hypertensive with no known allergies.

On examination his visual acuity was 6/6 in each eye and 6/6 in the left eye. There was 2 mm of relative exophthalmos on the right side. A pink subconjunctival patch was noticed in the superior quadrant (Fig 1). He had a shallow anterior chamber. Gonioscopy showed that anterior bowing of the iris closed 270 degrees of the angle. A YAG iridotomy was performed and pupils dilated for fundus evaluation. Funduscopy showed extensive peripheral elevation of the ciliary body and pars plana, which appeared to extend subretinally to the disc with an overlying retinal detachment in places (Fig 2) Ultrasound biomicroscopy along with B scan of the globe confirmed diffuse infiltration of the ciliary body and choroid (Fig 3A). Diffuse extension of this abnormal tissue behind the globe was also evident. The left eye was normal. A working diagnosis of benign reactive lymphoid hyperplasia was made and an incisional biopsy planned. The patient was subsequently admitted for an incisional biopsy and investigations to rule out systemic disease. No systemic evidence of lymphoma was found, however. Histopathology confirmed the diagnosis of well differentiated B cell lymphoma (diffuse large cell lymphoma (REAL classification))(5) (Fig 4).

A cytogenetic analysis was also performed as detailed previously.6 Only a partial analysis was possible, but from analysis of 12 divisions the karyotype was determined to be: 2 cells, 46 XY; 10 cells, 46–46 X-Y, add (1)(q?)[10], add (6)(q?)[10], −10[10], −14[10], +mar[5].

The patient was subsequently started on 30 mg of prednisolone and was referred to the radiotherapy department where he received 30 Gy in 15 sessions over a 3 week period. Follow up at 4 months and further 3 months following the radiotherapy showed resolution

Figure 1 Photograph showing the conjunctival lesion at presentation.

Figure 2 (A) Colour fundus photograph showing the posterior extension of the lesion. (B) Fundus fluorescein angiography showing multiple areas of hyperfluorescence.
general, suggesting that similarities exist between development of ocular and other lymphomas.

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Figure 1 The patient presented with bilateral lower eyelid swelling.

Figure 2 Histology of the upper lids showed densely packed empty spaces.

Figure 3 At high magnification the empty spaces reveal a lining of macrophages.

Grotegus bilateral eyelid swelling as a symptom of Munchausen’s syndrome

Editor,—Eyelid swelling can be diffuse or solid, acute or chronic, isolated or part of a syndrome. The differential diagnosis of solid, chronic, and isolated eyelid swelling comprises tumours of multiple origin. We report a case of eyelid swelling which was caused by automutilation as part of Munchausen’s syndrome.

CASE REPORT
A 44 year old white woman presented with bilateral lower eyelid swelling that had been present for 6 months, which made reading impossible (Fig 1). In the past she had undergone several parasal sinus operations and 3 years earlier she had been treated for a presellar orbital cellulitis and pansinusitis. For the past 4 years she had been bedridden because of fibromyalgia. The swellings measured 7 × 5 × 2 cm and felt solid on palpation. Complete ocular, internal, otolaryngological, dermatological, parasitological, and psychological examination revealed no clues for the diagnosis. The swellings were surgically removed to the level of the orbital septum, the defects being covered with full thickness skin grafts. Histological examination showed chronic lymphoedema with lymphangiectasia, inflammation, and striking eosinophilia, but no conclusive diagnosis could be made at this time. During uneventful healing of the lower lids, the patient developed bilateral upper eyelid swelling. These swellings were removed as well and replaced by split skin grafts. Histologically the upper lids showed densely packed empty spaces, which almost obscured pre-existent structures such as the orbicularis muscle (Fig 2). In between a patchy infiltrate of lymphocytes, neutrophils, eosinophils, and many macrophages was seen. At high magnification (Fig 3), the empty spaces revealed a lining of macrophages as was demonstrated by positivity for the CD 68 antibody, a reaction pattern highly suggestive of a factitial process. The diagnosis of Munchausen’s syndrome was made.

COMMENT
The patient was confronted with these results and admitted having pin-pricked herself after putting fatty ointments on her eyelids. She thought this would help the “blisters” to disappear more rapidly. After an emotional conversation, she was able to get up and walk for the first time in 4 years. The repeated psychiatric evaluation resulted in a diagnosis of a factitious disorder with physical signs superimposed on a somatisation disorder. The complaints seemed to have a function in the maintenance of the balance of power in the matrimonial relationship. The patient refused psychiatric treatment.

Factitious disorders, such as the Munchausen’s syndrome, are under the patient’s voluntary control and are intended to get or maintain the role of patient. Self inflicted enucleation and corneal perforation are described ophthalmological representatives of these disorders and easy to recognise. The above described swellings are a less common symptom of Munchausen’s syndrome, are under the patient’s voluntary control and are intended to get or maintain the role of patient. The patient was confronted with these results and admitted having pin-pricked herself after putting fatty ointments on her eyelids. She thought this would help the “blisters” to disappear more rapidly. After an emotional conversation, she was able to get up and walk for the first time in 4 years. The repeated psychiatric evaluation resulted in a diagnosis of a factitious disorder with physical signs superimposed on a somatisation disorder. The complaints seemed to have a function in the maintenance of the balance of power in the matrimonial relationship. The patient refused psychiatric treatment.

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and more difficult to prove example of an ocular factitious disorder, although the patient's medical history might make the doctor suspicious. In summary, self-inflicted disorders must be considered as a cause of cyslswelling.

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Angle closure glaucoma secondary to hemiretinal vein occlusion

EDITOR.—Central retinal vein occlusion (CRVO) has been reported to cause shallow- ing of the anterior chamber with acute angle closure glaucoma.1,2 This is due to anterior displacement of the lens-iris diaphragm caused by the transudation of fluid from retinal vessels into the vitreous cavity or swelling of the ciliary body due to spasms, oedema, or detachment which may cause relaxation of lens zonules with subsequent crowding and closure of the angle.3 We describe a patient who developed angle closure glaucoma without neovascularisation of the angle secondary to hemiretinal vein occlusion which responded to miotics and iridotomies suggesting a “pupillary block” mechanism. This is the first report of angle closure glaucoma follow- ing a hemiretinal vein occlusion.

CASE REPORT
A 63 year old African American man with controlled systemic hypertension noted reduced vision in his right eye for 1 month. Best corrected visual acuity was 20/200 right eye with +1.75 –0.75 × 85, and 20/25 left eye with +2.25 –1.00 × 95. Slit lamp examination was unremarkable, pupils were equally reactive without an afferent pupillary defect. Intraocular pressure (IOP) was 26 mm Hg right eye and 25 mm Hg left eye. Gonioscopy revealed grade 3 angles in both eyes. The superior half of the retina right eye had dilated tortuous veins and multiple superficial haemorrhages. The right optic nerve was oedematous and hyperaemic. Retinal examination was unremarkable left eye with a cup to disc ratio of 0.4 horizontally and 0.5 vertically. The patient was diagnosed with a hemiretinal vein occlusion right eye, elevated IOP in both eyes, and treated with betaxolol 0.25% twice daily in both eyes.

Two weeks later visual acuity was counting fingers right eye and unchanged left eye. IOP was 42 mm Hg right eye and 20 mm Hg left eye, on betaxolol. The patient was referred to our office.

On examination the anterior chambers were shallow right eye and deep left eye. IOP was 45 mm Hg right eye and 21 mm Hg left eye. The angles remained open to scleral spur. Intraocular pressure (IOP) was 26 mm Hg right eye and 21 mm Hg left eye. A scan ultrasonography revealed an unremarkable posterior segment without choroidal detach- ments right eye. The Brimondine 0.2% and Cosopt were administered to the right eye. Thirty minutes later the IOP was 36 mm Hg right eye. Three hours later IOP right eye was 28 mm Hg. Mydriacyl 1%, neosynephrine 2.5%, and Cyclogyl 2% were administered and the IOP increased to 37 mm Hg. The patient was discharged on acetazolamide 250 mg by mouth four times daily, brimonidine 0.2% three times daily right eye, Cosopt twice daily right eye, and pilocarpine 2% four times daily right eye.

The following day, the anterior chamber had deepened and the IOP was 24 mm Hg right eye. Gonioscopy revealed a closed angle (Fig 1). Pilocarpine 2% was instilled and a laser iridotomy performed right eye. The following day the IOP was 16 mm Hg right eye. Gonioscopy revealed a grade 2 angle. Acetazolamide was discontinued, pilocarpine 4% four times daily, and Cosopt twice daily right eye were continued.

Two months later, the anterior chambers were deep and the angles were grade 3 in both eyes. IOP was 14 mm Hg right eye on pilocarpine 4% four times daily and Timoptic XE four times daily. 0.5% IOP on subsequent visits remained below 20 mm Hg, and the angle remained open (Fig 2). Visual acuity did not improve.

COMMENT
Transient angle closure glaucoma, an infre- quent sequela of CRVO, has not been reported following hemiretinal vein occlusion (HRVO). Angle closure may occur days to months following a CRVO. Neovascular glau- coma may develop weeks or months following a retinal vascular occlusion. Elevated IOP during an acute attack of primary pupillary block angle closure glaucoma can lead to a retinal vascular occlusion. Risk factors for CRVO and HRVO include systemic hyper- tension and diabetes mellitus. A history of glaucoma has been associated with CRVO, HRVO, and branch retinal vein occlusion (BRVO).4 The patient in this report developed angle closure glaucoma within a few weeks of the HRVO. He had a history of systemic hypertension. Elevated IOP was noted in both eyes on initial examination. Cyclogyl agents increased the IOP, suggesting the angle closure was not due to a ciliary block mechanism. Pilocarpine and a laser iridotomy reduced the IOP and opened the angle in this patient, suggesting a secondary pupillary block mechanism. At the time of diagnosis of angle closure glaucoma the contralateral eye had a deep anterior chamber and a wide open angle, making a diagnosis of primary pupillary block angle closure glaucoma unlikely.

Previous reports of angle closure glaucoma secondary to central retinal vein occlusion suggest that treatment with miotic or miotic therapy and acute agents is beneficial in some patients.5 Miotic agents have been reported to be of benefit in cases of angle closure glaucoma following a CRVO.6 Determining the mechanism of angle closure in an individual patient following a retinal vascular occlusion will guide the ophthal- mologist to the appropriate treatment options, miydriatic or miotic therapy. Ultrasound bi- omicroscopy may be of benefit in differentiat- ing between a ciliary block mechanism and a pupillary block mechanism.7

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Varicella zoster virus immune recovery stromal keratitis in a patient with AIDS

EDITOR.—The advent of potent antiretroviral therapy has resulted in the recognition of the syndrome of immune recovery uveitis in patients with AIDS and a history of cytomegalo- lovirus (CMV) retinitis.8 Although the patho- genesis of this disease is poorly understood, it is hypothesised to be a consequence of an improved immune response to viral antigen
already present in the eye, with or without active viral replication. We describe a case of immune recovery varicella zoster virus (VZV) stromal keratitis in a patient with AIDS.

CASE REPORT
A 37 year old man with AIDS (CD4 = 180 cells x 10⁹/l) developed right sided ophthalmic zoster and was treated with aciclovir (800 mg by mouth five times a day). Twelve days after onset of the rash, topical prednisolone acetate (one drop every 2 hours) was prescribed to treat multiple anterior stromal corneal infiltrates. The keratitis promptly resolved, and the corticosteroid drops were discontinued 3 weeks after the rash cleared.

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Other examples of immune recovery disease in patients with AIDS include subepithelial stromal keratitis due to immune recognition of adenovirus. In that case, subepithelial opacities associated with a previous adenoviral follicular keratoconjunctivitis recurred 9 months following the original infection in association with a severe upper respiratory infection. In this report, a patient with AIDS and a history of ophthalmic zoster had a recurrence of anterior corneal stromal infiltrates almost 3 years after the initial skin eruption. Recurrence of the keratitis was not associated with skin or corneal epithelial disease and occurred despite aciclovir prophylaxis.

Although the recurrence of the keratitis with this patient’s immune recovery may be coincidental, the significant delay between his initial zosteriform eruption and the recurrence of his stromal disease, as well as the close temporal relation between the recurrence and the patient’s immune recovery, suggest that this is a case of immune recovery zoster keratitis in a patient with ophthalmic zoster.

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COMMENT
VZV-associated anterior stromal keratitis is thought to be due to immune recognition of residual viral antigen in the corneal stroma. The incidence of recurrent VZV stromal keratitis has not been well characterised, nor have factors which might precipitate recurrences. Recurrent keratitis related to immune system activation has been recognised following immune recovery inflammation has been seen in association with previously clinically silent systemic Mycobacterium avium complex infection and in patients with cryptococcal meningitis. In at least one of the cases of meningitis, immune recovery inflammation was thought to be directed against residual cryptococcal antigen, as opposed to a delayed immune response to viable organisms. As advances in AIDS therapy continue to improve the immune status of patients, immune recovery inflammation may become increasingly recognised.

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Dipetalonema reconditum in the human eye

EDITOR—Human ocular invasion by non-human filarial parasites has been reported for more than 200 years. However, only just over a handful have actually been removed, described and identified in detail. Furthermore, the Dipetalonema species that have been described in these cases were thought to be from the body cavity of the natural hosts—the porcupine and the beaver.

Figure 1. Slit lamp photograph of the temporal aspect of the patient’s right eye shows stromal infiltrates with an intact corneal epithelium.

This report describes a case of Dipetalonema reconditum (usually associated with canine filariasis) in the human eye. It is noteworthy that this worm has morphological similarities to the canine heartworm Dirofilaria immitis, which in the past has been described in the human eye but not satisfactorily identified.

CASE REPORT
A 62 year old white resident of suburban Victoria, Australia, presented with a red and irritated right eye of 2 weeks’ duration. This was exacerbated after a rural walking trip and did not improve with topical lubrication. He also noted mild diplopia on extreme gaze. On examination, the visual acuity was 6/6 in the right eye and 6/4 in the left. There was mild limitation of right eye abduction. Localised bulbar conjunctival erythema and chemosis were noted inferotemporally in the right eye near the insertion of the lateral rectus. Slit lamp biomicroscopy revealed a slithering, clear, thread-like mobile mass in the subconjunctival space of the inflamed area (Fig 1 and video report (see BJ Ophthalmology website)). Intracocular pressure and the rest of the ocular examination, including anterior and posterior segments, were unremarkable. Previous history included pyrexia of unknown origin (PUO) and lancing headaches 5 months previously. Investigation results then of note included erythrocyte sedimentation rate (ESR) 96 mm in the first hour, C reactive protein (CRP) 411 mg/l, and trace proteinuria. He improved on intravenous ceftriaxone, metronidazole, and oral roxithromycin. He had also had another period of PUO and suffered with chronic Guardia infection.

The worm was removed following localised peritomy under topical local anaesthesia using lignocaine 2%, phenylephrine 10%, and phospholine iodide 12.5% (in an attempt to paralyse the worm). The specimen was removed alive and intact and sent in normal saline for identification. Laboratory examination revealed a worm measuring 32 mm in length with morphological features consistent with an unfertilised adult female D reconditum. Patient investigations including thick and thin blood film, full blood count, ESR, CRP electrolytes, liver function tests, and chest x ray were all within normal limits. His pet dogs were found to be serologically negative for Dipetalonema.

He was treated with oral mebendazole, topical prednisolone acetate 1%, and chlorphenicol prior to the worm’s identification. Two weeks following removal of the worm the diplopia had resolved and residual fibrosis of the conjunctiva at the site of removal was noted.

COMMENT
Dipetalonema reconditum is a nematode that is commonly found to be endemic in dogs’ subcutaneous tissues. Worldwide distribution

www.bjophthalmol.com
includes the United States, Italy, and Africa. Its infestation in dogs, the only definitive host, is not clinically significant, although they may manifest an elevated eosinophil and leukocyte count. This manifestation may result in false positives in test for circulating *Dirofilaria immitis* microfilariae, also known as the dog heartworm. The differentiation of these two worms is important as *Dirofilaria* is pathogenic to canines. Knott’s test is used to detect these microfilariae serologically. Identification of these two adult worms is by their staining patterns with acid phosphatase: *Dipetalonema* stains evenly while *Dirofilaria* concentrates the acid phosphatase in two regions. *Dipetalonema reconditum* microfilaremia averages about 250–270 µm in length and 4–4.5 µm in width with a round curved body, a distinguishing cephalic hook, and a blunt anterior end. Adult males average 13 mm in length and females 17–32 mm.1

*Dipetalonema* has an indirect life cycle with development of infective larvae that are carried by fleas (genus *Ctenocephalides, Pulex*), ticks (*Rhipicephalus sanguineus*), and lice (louse)2. Dogs are infected when bitten by the fleas. The microfilaremia circulates in the blood as a first stage larva. The larval life cycle lasts 61–68 days. The adult worm tends to be found in the anterior chamber. *Dipetalonema* is a cause of canine anterior uveitis.3

The adult worm is 3.5 cm long and up to 1 mm wide. Eggs are passed in the feces and passed into the environment in the fleas. Upon ingestion by the definitive host, the microfilaria travels to the anterior chamber of the eye. It matures into a filaria. An ovoid eosinophilic capsule is present on the anterior end. Adult males average 13 mm in length and 4–4.5 µm in width with a round curved body, a distinguishing cephalic hook, and a blunt anterior end. Adult males average 13 mm in length and females 17–32 mm.1

In the literature, *Dipetalonema reconditum* is a cause of canine intraocular infection. This is confirmed by several studies.3 However, no differences in clinical presentation were observed between pterygium and *Dipetalonema reconditum* in this report. The authors thank Dr Harsha Sheorey, microbiologist, for his help in identifying the organism.

**Table 1** Immunohistochemical staining of epithelial cells for *Hsp27* and *Ki-67* in pterygia and normal conjunctiva

<table>
<thead>
<tr>
<th>Epithelium</th>
<th><em>Hsp27</em> (mean ± SD)</th>
<th><em>Ki-67</em> (mean ± SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pterygia</td>
<td>0.12 ± 0.05</td>
<td>0.10 ± 0.05</td>
</tr>
<tr>
<td>Normal</td>
<td>0.10 ± 0.05</td>
<td>0.10 ± 0.05</td>
</tr>
</tbody>
</table>

Mean: 0.12, SD: 0.05

**Figure 1** Immunohistochemical staining of epithelial cells for *Hsp27* and *Ki-67* in pterygia and normal conjunctiva. I: *Hsp27* immunoreactivity (positive cells) in normal conjunctiva. Mean: 0.10, SD: 0.05. II: *Ki-67* immunoreactivity (positive cells) in normal conjunctiva. Mean: 0.10, SD: 0.05.
pterygia is interesting because this protein is known to be related to differentiation when expressed in other epithelial tissues—for example, skin. In view of the recent report that Hsp27 transient expression seems essential for preventing embryonic stem cells from undergoing apoptosis, Tan et al. recently proposed that pterygium may be related to faulty apoptosis. The role of Hsp27 in pterygium remains to be elucidated since Hsp27 is expressed in basal epithelial cells of normal conjunctiva, where the cells are mainly differentiating stem cells and in all layers of epithelium in pterygia. Further studies would provide valuable information regarding the possible role of Hsp27, and the involvement of heat shock proteins generally in the pathogenesis of pterygium.

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Figure 1 (A) Normal conjunctiva: Hsp27 cytoplasmic immunoreactivity in basal and subbasal layers of epithelium (×400). (B) Pterygium: Hsp27 positive cells in all layers of epithelium. Cells of subepithelial connective tissue are Hsp27 negative while vessels are Hsp27 positive (arrows) (×400).