The ocular surface toxicity of paraquat

We describe the clinical appearance and progress of bilateral ocular chemical injury caused by paraquat, a herbicide. Paraquat is used more commonly in developing countries and it has been associated with severe and prolonged ocular surface abnormalities due to the nature of the chemical. The current concepts in managing such an injury are reviewed.

Case report

A 69 year old fruit farmer splashed a 20% solution of paraquat into both his eyes. The exposure of the right eye to the solution was more marked. The eyes were irrigated for less than 5 minutes at the time of the injury, and a formal irrigation, using Ringer’s solution for the right and 6/12 on the left. The remaining corneal epithelium was opaque, leathery and oedematous (Fig 1). The left cornea was epithelialised on the right and 6/12 on the left. The patient was commenced on our chemical burns protocol. This comprises topical citrate 10% drops every 2 hours, atropine 1% drops every 3 times a day, fluorescein 2% drops every 2 hours, oral atropine 500 mg four times daily, and 4 g of a urinary alkaliser.

On arrival uncorrected visual acuity was 6/9 on the right and 6/6 on the left. The intraocular pressure was 14 mm Hg on the right and 19 mm Hg on the left. There was a circular 90% epithelial defect centred over the right cornea. The remaining corneal epithelium was opaque, leathery and oedematous (Fig 2). The conjunctiva was hyperaemic and chemotic, particularly on the right. The limbal vasculature initially appeared congested, but there was no evidence of episcleral ischaemia. The corneal stroma was clear. Examination did not reveal any abnormality of the anterior chamber, lens, or posterior pole in either eye.

The patient was commenced on our chemical burns protocol. This comprises topical citrate 10% drops every 2 hours, atropine 1% drops every 2 hours, chloramphenicol ointment four times daily, atropine 1% drops every 3 times a day, haemorrhage acetate 1% drops every 2 hours, oral atropine 500 mg four times daily, and 4 g of a urinary alkaliser.

Figure 1 Right eye at presentation.

Figure 2 Left eye at presentation.

The conjunctiva in the left eye was also oedematous and had thrombosed vessels around the epithelial defect. Over the next few days the epithelial defect in the left eye enlarged to involve the inferonasal quadrant of the cornea although the conjunctival defect only enlarged slightly.

A severe pseudomembranous conjunctivitis developed in the right eye by the third day with fibrinous adhesions developing in the inferior fornix. Periodic glass rodning was commenced to break early symblepharon formation and the steroid was changed to non-preserved dexamethasone 1% hourly by day.

At 6 days post-injury there was evidence of epithelial healing from the margin of the epithelial defect in the inferior fornix of the right eye. Topical citrate and ascorbate were stopped and treatment was altered to non-preserved topical medication only: topical dexamethasone 1% every 2 hours, chloramphenicol four times daily, and hyromellose every 2 hours. Autologous serum tears (diluted to 20% in sterile saline solution) were also commenced 2 hours.

Two weeks after the injury there were persistent epithelial defects in both eyes but the healing edge of conjunctival epithelium had reached the nasal limbus in the right eye. Best corrected visual acuity was 6/24 right and 6/6 left. At this stage there was no pseudomembrane present although the conjunctiva remained inflamed.

By 4 weeks after injury the ocular surface in both eyes had re-epithelialised. The cornea of the right eye at this stage was clear with no vascularisation. Visual acuity remained 6/24 on the right.

Impression cytology of both central corneas was undertaken at this point. The right cornea showed a conjunctival-type epithelium with scattered goblet cells, polymorphonuclear leucocytes, and numerous apoptotic bodies. The left cornea demonstrated a cornal phenotype epithelium.

The last review was at 6 months post-injury. Uncorrected visual acuity was 6/9 in both eyes. The conjunctiva of both eyes remained minimally inflamed with mild erythema, chemosis, and subepithelial fibrosis now evident. These changes were more marked in the right eye (Fig 3). There was superficial pannus encroaching onto the right cornea predominantly superonasally. The affected area in the left eye shows subconjunctival fibrosis with vascular disorganisation and localised sceral translucency (Fig 4). Current treatment was dexamethasone 1% twice daily in both eyes.

Comment

Paraquat is a diipyridyl quaternary ammonium salt that acts as an indiscriminate killer of all plant life. Preparations made commercially commonly contain the related compound diquat as well as surfactants to increase distribution over the leaf and aid penetration. Toxicity in humans is thought to relate to paraquat recycling in the redox reaction. This depletes NADPH and interrupts cell metabolism. The reduced
have a profound effect on reducing the phamide during the inflammatory stages may mon. Pulmonary fibrosis may result in death. The long term. This has been the result of the tial appearance with a poor visual outcome in although few, have noted a relatively mild ini-
ternal injury. Effects lasting up to a year have been reported. Documented cases of paraquat toxicity, although rare, have noted a relatively mild ini-
tial appearance with a poor visual outcome in the long term. This has been the result of the development of a conjunctivalised corneal surface and chronic inflammation. Paraquat ingestion can result in early fatality due to multiorgan failure. In less severe cases acute renal and hepatic toxicity is common. Pulmonary fibrosis may result in death. Pulsed methylprednisolone and cyclophos-
phamide during the inflammatory stages may have a profound effect on reducing the mortality. It is unclear whether a similar regimen would circumvent the long term sequelae of ocular paraquat injury.

The patient in this case had significant exposure to a commercial preparation with minimal first aid measures being imple-
mented at the time of injury. He developed a severe surface injury over the first 48 hours with marked epithelial loss over one eye. This implied there were few, if any, viable limbal stem cells remaining. A severe pseudomen-
branous conjunctivitis then developed. Previous reports of this extensive type of surface injury show that eventually conjuncti-
valisation of the cornea with vascular pannus is to be expected. Severe injury may result in a disordered ocular surface with dryness, sym-
blepharon, akyloblepharon, fornical shortening, entropion, and trichiasis.

Patients with total limbal stem cell loss invariably develop superficial pannus and conjunctivalisation of the cornea. Evidence that previously conjunctival phenotypic epit-
helium can transdifferentiate into corneal type epithelium is derived from animal experiments with a debrided cornea and lim-
bus where corneal epithelium healed the resultant defect. Viable limbal stem cells may thus have remained in the perilimbal crypts of Vogt. The right eye of this patient healed from conjunctival epithelium, confirmed by im-
pression cytology, although most of the cornea remains clear without pannus. It has been reported that transdifferentiation is inhibited once neovascularisation occurs.1 In the left eye, which only had a small zone of limbal stem cell loss if any, the epithelium over the cornea was confirmed as corneal phenotype on impression cytology and there was no vascularisation.

A suitable microenvironment for healing should be encouraged through the use of medical therapy. Topical corticosteroids in the first week after injury promote successful healing of epithelial defects by controlling inflammation. Adequate lubrication is also important. Autologous serum tears have been reported to relieve the symptoms of dry eye1 and improve the ocular surface disease more successfully than conventional tear substit-
utes in dry eye states. These drops have also been instrumental in the healing of persistent epithelial defects.1 Essential components of the tear film present in serum tears include epidermal growth factor, vitamin A, and transforming growth factor β, which are important for the proliferation, differentia-
tion, and maturation of the surface epithelium.1 We present a case of severe paraquat chemical injury to both eyes that had a good outcome from treatment. This case demonstrates a very good result from a usually dev-
astating injury.

Preventing conjunctivalisation of the cor-
neal surface after total loss of the limbal stem cell population remains a challenge. Thera-
peutic intervention may help restore a more functional surface visually. The use of inten-
sive early antioxidant therapy followed by autologous serum tears and non-preserved ocular lubricants may have improved the outcome.

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References

Figure 1 Fundus photograph of the right eye demonstrating cherry red spot with severe retinal oedema at macular and peripapillary area, disc oedema, and venous engorgement.

Figure 2 Fundus photograph of the left eye demonstrating cherry red spot with severe retinal oedema at macular and peripapillary area, disc oedema, and venous engorgement.

Henoch-Schonlein purpura with bilateral central retinal artery occlusion
Henoch-Schonlein (H-S) purpura is an acute leukocytoclastic vasculitis that primarily affects children and mainly involves skin, joints, gastrointestinal tract, and kidney.1 Reported ophthalmic manifestations of Henoch-Schonlein purpura include episcleritis, scleri-
tis, keratitis, anterior uveitis, and central reti-

nal vein occlusion.2,3 However, central retinal artery occlusion, to the best of our knowledge, have not been reported. We report a case with H-S purpura complicated with bilateral central retinal artery occlusion.

Case report
A 6 year old girl visited our paediatric depart-
ment with the chief complaint of multiple erythematous rashes over the lower extremi-
ties and buttock for 2 weeks. Under a presumptive diagnosis of H-S purpura, oral prednisolone was prescribed. Nevertheless, arthralgia, haematuria, and moderate hyper-
tension developed 3 weeks later. The his-
opathological findings of renal biopsy were compatible with H-S purpura nephritis. Un-
fortunately, acute renal failure occurred de-
spite aggressive systemic treatment and haemodialysis was started.

Two days before haemodialysis, the patient noticed sudden visual loss. Visual acuity was hand movement in both eyes. Anterior seg-
ment and intraocular pressure were normal. Fundus examination revealed a cherry red 

spot with severe retinal oedema at the macu-
lar and peripapillary area in both eyes. Disc oedema and venous engorgement were also noted in both eyes (Figs 1 and 2). The retinal manifestations were compatible with bilateral central retinal artery occlusion. Fundus fluo-
rescein angiography was not performed be-
cause of her poor general condition.

Three days after haemodialysis, her sys-
temic condition deteriorated due to drowsiness that was proved to be cerebral vasculitis by brain computed tomography.
One month later, her visual acuity was counting finger in both eyes. Fundus examination revealed a pale disc, arterial sheathing, and drusen-like RPE change at foveal area in both eyes. Six months later, her best correction visual acuity was 6/30 in the right eye, and 6/60 in the left.

**Comment**

The dominant clinical manifestations of H-S purpura are cutaneous purpura (100%), abdominal pain (63%), gastrointestinal bleeding (33%), and nephritis (40%). In general, H-S purpura is an acute, self-limiting illness though one third of patients will have one or more recurrences of symptoms. H-S purpura was the cause of renal failure in 2% and 5% of groups of children undergoing haemodialysis in California and France, respectively. Although the aetiology of H-S purpura remains unknown, it is clear that IgA has a critical role in the immunopathogenesis. The clinical features of H-S purpura are a consequence of widespread leukocytoclastic vasculitis due to IgA deposition in vessel walls. Treatment is limited to symptomatic and supportive care. Corticosteroids are often used depending on the severity of the disease.

According to the previous reports, the ocular manifestations of H-S purpura are rare, including episcleritis, scleritis, keratitis, conjunctivitis, and uveitis. The most common manifestation is bilateral central retinal artery occlusion. In this case, H-S purpura vasculitis may have an important role in the pathogenesis of bilateral central retinal artery occlusion. To our knowledge this might be the first case of H-S purpura complicated with bilateral central retinal artery occlusion in the literature.

**Primary iris pigment epithelial hyperplasia and glaucoma**

Primary iris pigment epithelial hyperplasia (PIPH) is a rare condition characterised by the presence of iris pigment epithelium on the anterior surface of the iris stroma. There are few reports that are available in the literature and they generally refer to it as congenital ectropion uveae (CEU). CEU, however, is a misnomer, since the iris pigment layer is known to be separate from the uvea. Yet, the term CEU persists in clinical use.

Primary iris pigment epithelial hyperplasia is a congenital non-progressive condition that is easily differentiated from acquired progressive ectropion uveae, the latter resulting from trabecular erosion of posterior pigment layer and sphericter muscle, secondary to glaucoma and/or uveitis.

The most common association is neurofibromatosis, though other ocular and systemic associations have been described, including a chromosomal abnormality.

This report describes two cases of primary iris pigment epithelial hyperplasia with glaucoma and reviews the available literature on this rare abnormality. In one case the presentation of glaucoma was in adolescence and in infancy in the other. Associated ocular features are described. In these two patients there were no systemic features of diagnostic significance.

**Case 1**

A 15-year-old boy presented with occasional watering in the left eye for 4 years. There was no history of any visual disturbance.

On examination his left eye was apparently normal and Hertel exophthalmometry readings were 19 mm in the left eye and 13 mm in the right with bar reading of 105. He had a ptosis of 2 mm (Fig 1, top right) with good levator function. The appearance of the left upper lid was suggestive of plexiform neurofibroma but no mass was palpable. There was no ptosis of the right upper lid. Proptosis and Hertel exophthalmometry readings were similar in both eyes. The right eye had a fully open Schwalbe’s line, this being very marked in some areas. The right eye had a normal intraocular pressure (IOP) on the first examination. There were no other ocular or systemic abnormalities.

**Case 2**

A 5½ year old girl presented with gradual enlargement of the right eye since the age of 6 months. There was a history of mild photophobia but none of lacrimation or deterioration of vision.

On examination the patient’s Snellen acuity was 20/240 in the right eye (~1.50 sph, ~4.00 cyl 15°, 45.5 keratometry left eye 105°). The left eye had extensive hyperplasia of the iris pigment epithelium which overlay the stroma of the iris in an irregular manner but did not reach the angle (Fig 1, top left). The normal iris architecture was lost, but no nodules were seen. There was pigment on the anterior surface of the lens but the iris did not transilluminate. There was anisocoria of 1.5 mm, the left pupil being larger but round, regular and reacting to light. Indirect gonioscopy (Fig 1, bottom left) demonstrated an open angle with iridotrabeculodysgenesis in the form of an anterior insertion of the iris into the trabecular meshwork with excessive pigment deposition and a prominent Schwalbe’s line, this being very marked in some areas. The right eye had a fully open angle with all structures clearly seen. Intracocular pressure (IOP) on the first examination was 52 mm Hg in the left eye and 12 mm Hg in the right.

On fundus examination there was an oblique insertion of the disc, with inferonasal crescent and an oval oblique cup involving 0.81 x 0.61 part of the disc (Fig 1, bottom right). A B-scan ultrasound of orbit did not reveal any abnormality and the A-scan biometry confirmed that the apparent proptosis of the left eye was due to a longer axial length (24.36 mm compared with 22.60 mm in the right eye). There were two cafe au lait spots on the trunk but there was no other systemic abnormality. None of the family members had similar ocular findings or any evidence of neurofibromatosis.

The IOP responded poorly to topical medication and a trabeculectomy was performed which controlled the IOP.

![Figure 1](image-url)
cy 90°) and 20/20 in the left eye (0.250 cy 90°). The right eye was buphthalmic with a corneal diameter of 13.0 × 14.0 mm (10.5 × 11.5 mm, left eye). The right eye had extensive hyperplasia of the iris pigment epithelium overlying the stroma of the iris in an irregular manner, but this did not reach the angle. The normal architecture of the iris was lost but there were no iris nodules. The angle was examined with a direct gonioscope and the findings were similar to that of case 1. The right pupil was 6 mm in diameter and did not react to light and was less responsive to miotics and mydriatics.

Intraocular pressure was 27 mm Hg in the right eye, 18 mm Hg in the left. A-cataract and an anterior chamber was seen on fourth postoperative day but intraocular pressure was unrecordably low. The patient’s vision at 4 weeks postoperatively was 20/200.

Comment

In the normal iris the pigment epithelium forms a double layer that includes itself into the pigment lamina as the pigments as the pigments circle is involved in PIPH is variable, but characteristically ends short of the angle. The pupil may be normal in size in some cases and larger than its counterpart in others. It may be round and reactive to light but may be oval and less reactive to light. The iris stroma is generally hypoplastic to a variable degree, with a smooth anterior surface with absence of circular concentric furrows and radial folds. The condition is usually unilateral but a bilateral case has been reported.

Both the cases in this report had extensive PIPPH, loss of normal iris architecture, and pupillary abnormalities.

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References


Unilateral vitreous haemorrhage secondary to caudal epidural injection: a variant of Terson’s syndrome

Terson’s syndrome is characterised by vitreous haemorrhage accompanying subarachnoid or any other form of intracranial haemorrhage. Although Litten reported vitreous haemorrhage in association with intracranial haemorrhage in 1881, it was Terson who described the syndrome in 1900. Haemorrhage in Terson’s syndrome may be contained between the internal limiting membrane and retina or extend into the vitreous cavity. Other findings include multiple preretinal, intraretinal, subretinal haemorrhages, as well as macular rings and epiretinal membranes.

Case report

A 47 year old man with chronic back pain due to epidural adhesions (confirmed in magnetic resonance imaging (MRI)) was referred to the anaesthetic department for caudal epidural injection of steroids and saline to break up the epidural adhesions for pain relief. He received the injection through the sacral hiatus between the spinal dura and spinal canal in the caudal epidural space under general anaesthesia. Following recovery from general anaesthesia, he stated that he had lost the sight in his left eye. Ophthalmic examination at that time confirmed vision of 6/12 over a year period but because of residual severe symptomatic floaters he underwent left pars plana vitrectomy, which allowed his vision to improve to 6/6 unaided.

Comment

Terson proposed that intracranial haemorrhage occurred secondary to intracranial hypertension, which resulted in elevated peri-capillary capillary pressure. The most commonly cited mechanism was that intracranial pressure increased and subarachnoid haemorrhage was transmitted within the optic nerve sheath and obstructs intracranial venous drainage causing distension and rupture of peripapillary and retinal capillaries resulting in significant haemorrhage in the subhyaloid space or vitreous cavity.
In our patient during the caudal epidural injection the fluid wave of injection did not spread uniformly in the epidural space and break the adhesions but, instead, got trapped in tiny compartments formed by the adhesions and caused lateral pressure on the spinal cord, thus increasing subarachnoid space pressure, resulting in vitreous haemorrhage in the left eye (Fig 1).

Therefore, we feel the cases with pathogenesis of intracranial haemorrhage, secondary to a sudden rise of intracranial pressure, should be considered as the variant of Terson’s syndrome.

The clinical course of Terson’s syndrome is typically one of gradual resolution of the vitreous haemorrhage and return of normal vision. Haemorrhages that do not resolve may require vitrectomy, but several studies have proposed that early vitrectomy also may improve visual outcome. Indications for early pars plana vitrectomy in children who develop severe retinal detachment include vitreous haze and wrinkling of retina 12 months postoperatively. During the second surgery, pupilloplasty was performed and we found a tear in the ciliary epithelium of the pars plana resulting from traction of the retropupillary membrane tissue, and also discovered a localised detachment of the retina and ciliary epithelium (Fig 1A). We performed cryopexy with encircling scleral buckle, vitrectomy, and fluid-air exchange, and the retina was reattached. One month later, macular pucker rapidly developed and enfolded the entire posterior retina (Fig 1B). The original tear was completely sealed, and signs of the recurrent rhegmatogenous retinal detachment with proliferative vitreoretinopathy, including vitreous haze and wrinkling of retina in the other location, were not identified.

After additional vitrectomy to remove residual cortex and to perform membrane peeling, the retina was finally reattached with a residue of degeneration near the fovea (Fig 1C). Haematoxylin and eosin and Alberta stains and transmission electron microscopy of the surgically removed membrane showed pigment cells, fibroblast-like cells, vessels, and collagen fibres (Fig 2A). The membrane was immunostained with antibodies for cytokeratin and α-smooth muscle actin (Fig 2B,C), while there was slight immunoreactivity for von Willebrand factor (Fig 2D).

**Severe macular pucker after retinal detachment surgery in an infant**

The appearance and clinical course of rhegmatogenous retinal detachments in children are more complicated than those of adults, because the retinal detachments are generally associated with trauma or congenital anomalies. In an infant, especially, an unexpected course may develop; however, the incidence of these detachments is so low that treatment and complications have scarcely been described in the literature. We report an infant who developed severe macular pucker after retinal detachment surgery.

**Case report**

A 2 week old male infant was referred with a diagnosis of bilateral congenital cataracts. The pregnancy and delivery had been uneventful. His mother also had had congenital anomalies. Both eyes of the infant had dense zonular cataracts. The patient had no associated ocular problems on slit lamp biomicroscopy or gonioscopy and no abnormalities on physical examination. He underwent bilateral lensectomy and anterior vitrectomy by limbal approach at 3 weeks of age; both fundus were unremarkable. Although his right eye underwent sufficient anterior vitrectomy, retropapillary membrane developed on the residual vitreous surface and the pupil closed 3 months postoperatively.

**Comment**

Macular pucker in this infant is significantly different from that in adults. The severe posterior retinal folds may be formed by strong contraction of the epiretinal membrane, a firm vitreoretinal juncture, and an extensible retina. A previous histopathological report on recurrent proliferation after vitrectomy in two children with tractional retinal detachments showed that retinal glial cells were the main reactive cells. However, in our case, the major component of the pucker was retinal pigment epithelium (RPE) cells, the same as in adults with rhegmatogenous retinal detachment.**1 4** Cytoplasmic actin within the membrane, rather residual vitreous cortex on the retinal surface, may be involved in forming strong contractile elements, which also may underlie idiopathic cases in children.**2 4** Vessels in the pucker may have originated from the adherent retina, because no residual hyaloid vessels were identified during surgery. Because excessive cryopexy tends to disperse and activate RPE cells, minimal cryopexy is recommended; laser may be preferable.

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**Figure 1** Site of injection is shown by blue arrow, compartments formed by the adhesions shown by red markings.

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References

to treat rhegmatogenous retinal detachment in infants. Enzyme assisted vitrectomy to separate the firm vitreoretinal juncture may prevent the development of subsequent macular pucker. Frequent examinations and careful management are required even after successful reattachment surgery.

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Microbial keratitis associated with extended wear of silicone hydrogel contact lenses

Traditional hydrogel soft contact lenses (SCL) have limited oxygen permeability, allowing near normal oxygen supply to the cornea during extended lid closure, and are hoped by some to address most of the problems related to corneal hypoxia encountered with previous extended wear soft contact lenses. Recently introduced silicone hydrogel SCL have much higher oxygen transmissibility (DK/t O₂), allowing near normal oxygen supply to the cornea during extended lid closure, and are hoped by some to address most of the problems related to corneal hypoxia encountered with previous extended wear soft contact lenses. They have therefore been approved for up to 30 days of continuous wear in both Europe and Australia.

Four cases of microbial keratitis in patients who were using silicone hydrogel SCL (either CibaVision Focus Night and Day lenses (Lotrafilcon A, fluorosiloxane hydrogel) or Bausch & Lomb PureVision lenses (Balafilcon A, silicone hydrogel)) on an extended wear basis are presented. The minimum amount of continuous wear was 24 hours. All cases were treated either in private or at the corneal clinic of the Royal Victorian Eye and Ear Hospital from December 2000 to February 2001. All the patients underwent a complete ophthalmic examination by a corneal specialist. Microbiological specimens were taken from all patients via cornea scrapings and were submitted for Gram and Blankophor staining, and bacterial and fungal cultures via direct inoculation onto sheep blood agar, chocolate agar, and Sabouraud agar. Bacterial sensitivities of cultured organisms were also obtained. Where possible, the contact lenses themselves were also sent for microbial cultures. Each case is described in brief, and a summary presented in Table 1.

Case 1
This 22 year old man presented with a 2 day history of left ocular injection, pain, photophobia, and blurred vision. He was wearing CibaVision Focus Night and Day SCL continuously for 10 days at a time, discarding the lenses after a month of use. He had swum in the sea while wearing the same lenses 2 weeks before, after which he removed the lenses and disinfected them with “Renu” multipurpose solution (boric acid, edetate disodium, polyquaternium-1, sodium chloride, chlorhexidine), manufactured and distributed by Bausch & Lomb, Greenville, SC, USA. Continuous wear was recommenced within a few hours. Examination revealed an uncorrected visual acuity of 6/60 in both eyes, improving to 6/12 in both eyes with pinhole. A paracentral 1 mm epithelial defect with underlying dense infiltrate was noted in the left eye with anterior chamber inflammation of +1 cells and multiple scattered KP (Fig 1). Treatment was commenced with marked symptomatic improvement and resolution of the anterior chamber inflammation after 48 hours. Treatment was tapered and unpressed prednisolone phosphate 0.5% drops were added four times daily. Review 2 weeks later revealed a best corrected visual acuity of 6/6-1 in both eyes, and a central subepithelial scar.

Case 2
A 16 year old boy presented with a 24 hour history of left eye grittiness, marked photophobia, and hazy vision. He was wearing PureVision SCL on a monthly continuous wear basis. He gave a history of swimming in a river in these lenses 1 week earlier, after which he removed the lenses and disinfected them with “Renu” multipurpose solution (boric acid, edetate disodium, polyquaternium-1, sodium chloride, chlorhexidine), manufactured and distributed by Bausch & Lomb, Greenville, SC, USA. Continuous wear was recommenced within a few hours. Examination revealed an uncorrected visual acuity of 3/60 in both eyes, improving to 6/12 in both eyes with pinhole. A paracentral 1 mm epithelial defect with underlying dense infiltrate was noted in the left eye with anterior chamber inflammation of +1 cells and multiple scattered KP (Fig 1).

Corneal scrapings revealed fungal elements on Gram and Blankophor staining. Cultures grew Acinetobacter species in the enrichment broth, sensitive to ciprofloxacin, chloramphenicol, and tobramycin. Penicillium was later grown on the Sabouraud agar slope. A yeast (not Candida albicans) was grown on Sabouraud agar from the left contact lens, with Penicillium species grown from the right.

Topical ciprofloxacin 0.3% was commenced hourly, after which his symptoms and signs markedly improved. The ciprofloxacin was tapered and changed to topical chloramphenicol 0.5% (Chlorsig, Sigma) 8 days after presentation. Two weeks later, the epithelial defect had resolved but significant subepithelial scarring remained. His best corrected visual acuity was 6/6 right eye and 6/7.5 left eye.

Case 3
A 21 year old man was referred to MSL with a 2 day history of right eye injection, pain, photophobia, and decreased vision. He was wearing PureVision lenses on a daily wear basis, but changed to continuous wear 24 hours before the onset of his symptoms.

References

Microbial keratitis associated with extended wear of silicone hydrogel contact lenses

Figure 2 (A) Light micrograph shows pigmented cells, fibroblast-like cells, and collagen (Azan, original magnification ×100). Positive immunostaining for cytokeratin (B) and smooth muscle actin (C) is seen prominently in the membrane. (D) Positive staining for von Willebrand factor shows the vessels (peroxidase-antiperoxidase, original magnification ×100).
Examination revealed a visual acuity of 6/6 right eye and 6/5 left eye with his spectacle correction. Marked right eye ciliary injection and anterior chamber activity were noted with cells, flare, multiple scattered KP's, and a small paracentral epithelial defect with underlying infiltrate.

Corneal scrapings revealed polymorphs on Gram stain (no organisms seen), and a heavy growth of Corynebacterium species on the sheep blood agar plate, sensitive to penicillin, ciprofloxacin, and chloramphenicol. Culture of the contact lenses was impossible as they had been discarded.

Treatment consisted of hourly topical ciprofloxacin 0.3%. Topical fluoromethalone acetate 0.1% (Flarex, Alcon, Fort Worth, TX, USA) was added four times daily after clinical improvement 24 hours later. All treatment was tapered and ceased after 2 weeks.

The patient failed to attend for any further follow up appointments but on contact by telephone stated his vision had returned to normal.

Case 4
A 17 year old presented with a 5 day history of left eye redness, irritation, photophobia, and blurred vision. He was wearing CibaVision Focus Night and Day SCL on a monthly continuous wear basis and gave a history of swimming in a river with a previous pair of continuous wear basis and gave a history of Focus Night and Day SCL on a monthly blurred vision. He was wearing CibaVision left eye redness, irritation, photophobia, and

Table 1  Summary of case details

<table>
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<th>Patient details</th>
<th>Case 1</th>
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<td>Acinetobacter (enrichment broth)</td>
<td>Penicillium (Sauravard agar)</td>
<td>Haemolytic streptococcus, α Haemolytic streptococcus, in enrichment broth</td>
</tr>
<tr>
<td>Contact lent culture</td>
<td>Serratia marcescens</td>
<td>Yeast from left lens; Penicillium from right lens</td>
<td>Not available</td>
<td>No growth</td>
</tr>
<tr>
<td>Other risk factors</td>
<td>Swam in lenses 2 weeks earlier</td>
<td>Swam in lenses 1 week earlier</td>
<td>Swam in a different pair of lenses 3 days earlier</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Last corrected VA (time)</td>
<td>VAR=6/6−1 (2 weeks)</td>
<td>VAL=6/7.5 (8 days)</td>
<td>Unavailable</td>
<td>VAL=6/7.5 (1 week)</td>
</tr>
</tbody>
</table>

These lenses were discarded and replaced with his current lenses the next day.

Initial treatment by the general practitioner consisted of topical chloramphenicol (0.5%) drops 2 hourly by day and chloramphenicol (1%) ointment (Chlorisig, Sigma) at night. Examination revealed a visual acuity of 6/6 right eye (with SCL) and 3/6 left eye unaidied, improving to 6/18 with pinhole. Conjunctival injection was noted in the left eye, with a 3 × 4 mm paracentral area of stromal haze and an associated area of subepithelial infiltrate. The overlying epithelium was intact.

Corneal scrapings revealed no polymorphs or organisms on Gram stain, but grew α haemolytic streptococcus from the enrichment broth sensitive to penicillin, chloramphenicol, ciprofloxacin, and neomycin.

Treatment was with hourly topical ciprofloxacin 0.3%, with tapering after 48 hours. Review 1 week later revealed a persisting subepithelial scar and a best corrected spectacle acuity of 6/7.5.

Comment
Extended wear of soft contact lenses for up to 6 days has been advocated in various forms since the 1980s with traditional hydrogel lenses. However, owing to the relatively high rates of associated microbial keratitis, extended wear of soft contact lenses has not had widespread use.

The advent of high oxygen permeability silicone hydrogel soft contact lenses has again made extended wear a viable option, as the increased oxygen permeability is thought to reduce the risk of development of a hypoxic epithelial defect, which can serve as a portal of infection. Pre-release extended wear studies did not reveal any cases of microbial keratitis but these studies were relatively small. Lenses with a Dk/t O2 greater than 50 × 10−9 have also been shown to have a lesser affinity for P aeruginosa binding during extended wear, further decreasing the risk of microbial keratitis.

Our experience suggests that extended wear with even these newer SCL is still a risk factor in the development of microbial keratitis. All four patients had central or paracentral infiltrates, with three patients presenting with an associated epithelial defect. All four patients also had a positive culture or Gram/Blankophor stain from the corneal scrapes and had residual scarring after resolution of the acute episode. Although Corynebacterium species are considered by some to be a non-pathogenic organism, it has been described as the causative organism in several cases of microbial keratitis.7 We therefore feel that it is very unlikely that any of these cases represent a more benign non-infectious contact lens complication such as CLPU (contact lens-induced perilimbal ulcer), CLARE (contact lens induced acute red eye), or IK (infiltrative keratitis), which are all described as being conditions that resolve after cessation of contact lens wear alone, without the development of residual corneal scarring.8

Previous studies have shown that the most important risk factor for the development of microbial keratitis in soft contact lens wearers is the duration of contact lens wear, where overnight wear in particular aggravates the relative hypoxia of the cornea.9 However, there are other risk factors such as hypercapnia, trauma, biofilm alterations/contamination, altered corneal sensation, altered tear volume, and composition.3,10 Only hypoxia and hypercapnia should be improved by increased contact lens gas permeability.

Three of the four patients described had sworn in their lenses within weeks of their presentation. This might be an important risk factor in the development of their microbial keratitis in association with their silicone hydrogel SCL (as it is with other SCL), although the organisms involved were not those typically associated with microbial keratitis from contaminated water exposure. All four of the patients were also males between the ages of 16 and 22 years. These two demographic factors have been linked to an increased risk of microbial keratitis in contact lens wearers.

Recent studies have shown that bacterial populations grown from silicone hydrogel SCL in asymptomatic wear were not statistically different in comparison with those grown from standard HEMA based SCL.11 This
suggests that a silicone hydrogel SCL can still be a means of contamination in the pathogenesis of SCL microbial keratitis. Certainly, some of the lenses in this small series did grow the same organisms as the corneal lesions themselves.

Our experience supports a multifactorial causality for the development of microbial keratitis in extended SCL wearers, rather than just corneal epithelial hypoxia, particularly in high risk groups such as the four patients described where high risk behaviour is also undertaken. Further investigation needs to be done on the effects these lenses have in extended wear with regard to the development of microbial keratitis before their long term safety can be assured.

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Serious corneoscleral complications after pterygium excision with mitomycin C

The use of topical mitomycin C (MMC) to prevent recurrence after pterygium surgery is increasing since its introduction by Kunitomo and Mori in Japan, and its subsequent popularisation in the United States by Singh and associates. Low dose MMC (0.02%) twice daily for 5 days after the operation has been prospectively studied with long term follow up, and few serious side effects have been noted.1 2 Intraoperative MMC appeared to be an effective and safe adjunctive treatment of primary pterygium excision.9

Case reports

We retrospectively analysed three patients who presented at the Haemek Medical Central, Afula, Israel with scleral melting which developed after pterygium excision between October and November 2000, with intraoperative application of MMC (0.02%) for 3 minutes. The MMC was washed out immediately with an abundant amount of balanced salt solution for at least 3 minutes. During the past 10 years we performed over 300 pterygium excisions with intraoperative use of MMC in Haemek Medical Center with three cases having serious complications.

Case 1 (Fig 1)

A previously healthy 50 year old man underwent recurrent pterygium excision of the right eye using a bare sclera technique with intraoperative application of MMC 0.02% for 3 minutes, having undergone pterygium excision with MMC 10 months earlier in his right eye. Visual acuity was 6/9 + SC. Preoperative ophthalmological examination revealed a nasal flashy wide lesion 4.5 mm over the limbus and inferior symblepharon, with the remainder of the examination being normal. He was released on the same day, following surgery at which time there were no complications. On the first (postoperative day 1) and second (postoperative day 7) follow ups no complaints or complications were noted. However, on postoperative day 30, corneal limbal perforation and iris incarceration in the wound was noted. Immediately, he underwent right eye corneal tectonic graft surgery. At his last follow up (12 weeks after the pterygium excision with MMC), the best corrected visual acuity was 6/24 CPH, the graft has good adaptation, no gap and no rejection signs.

Case 2 (Fig 2)

A previously healthy 37 year old man underwent pterygium excision of the left eye using a bare sclera technique with intraoperative application of MMC 0.02% for 3 minutes. His presenting symptoms were cosmetic only. Visual acuity was 6/6 partial SC. Preoperative ophthalmological examination revealed nasal flashy wide lesion 2.8 mm over the limbus with the remainder of the examination being normal. Two years previously he had undergone pterygium excision of the right eye using a bare sclera technique with intraoperative application of MMC 0.02% for 3 minutes. The right eye procedure had been successful and was performed in the same institute. Three weeks after the surgery, on routine follow up scleral melting and necrosis were noted. The scleral defect was unresponsive to ocular lubricants, topical antibiotics, topical steroids, and patching. Ten weeks after the left eye pterygium excision and MMC application, he underwent autologous conjunctival graft surgery to repair the defect. Follow up 2 weeks later showed that the graft has good adaptation and re-epithelialisation was noted.

Case 3

A previously healthy 70 year old man underwent pterygium excision of the right eye using a bare sclera technique with intraoperative application of MMC 0.02% for 3 minutes. On preoperative examination visual acuity was 6/24 partial SC in the right eye and 6/60 SC in the left, anterior segment was quiet except flashy temporal pterygium 7 mm over the limbus partially covering the pupil axis in the right eye. The procedure of the right eye pterygium excision with MMC was successful and performed in the same institute. No complaints or complications were noted at the first two follow ups; however, 3 weeks postoperatively right eye temporal scleral melting and ectasia was seen (3 mm × 3 mm in size). Conservative topical treatment with antibiotics, topical anti-inflammatory agents, and steroids failed to resolve the situation. Consequently, 8 weeks after the initial right eye surgery he underwent right eye conjunctival flap grafting over the area of scleral melting. At his last examination best corrected visual acuity was 6/36 partial; blood vessel growth was noted towards the bare sclera and re-epithelialisation with minimal staining. He is still being treated with topical antibiotics with some improvement.

www.bjophthalmol.com
It also inhibits DNA, RNA, and protein to alkylating agents; it alkylates and 

References
shorter time (30 seconds).

These combined effects may result in a long term influence on cellular proliferation.

Scleral melting occurring after pterygium surgery with adjunctive treatment has been well reported. However, no serious complications were noted in the study by Frucht-Pery and Ilsar with postoperative use of 0.1 mg/ml MMC twice daily for 5 days (with a mean follow up period of 15.3 months) or in intraoperative MMC treated eyes. A common element in toxicity with MMC is a relatively large cumulative dose. Therefore, most ophthalmologists believe that a single intraoperative exposure to MMC would reduce the complication rate of MMC eye drop regimen.

In the current series, all patients underwent pterygium excision in the bare sclera technique with the low concentration of 0.02% of MMC and a short application of 3 minutes. Among our patients one had corneal perforation that was treated by tectonic keratoplasty and other two had severe deep scleral melting that required conjunctival flaps or autologous grafts. Our patients were all healthy, without conditions predisposing to ulceration or poor wound healing such as Sjögren syndrome, severe keratoconjunctivitis sicca, acna rosacea, atopic keratoconjunctivitis, or herpes keratitis (Table 1). We suspected that the MMC concentration was not appropriate during that period. We checked the concentration and it was difficult to obtain precise results after a waiting period, owing to the degradation of the material.

This report raises serious questions regarding routine use of MMC. Recently, some investigators have evaluated the safety and efficacy of low dose MMC (0.02%) for an even shorter time (30 seconds). All ophthalmologists should be aware of the possibility of vision threatening complications and avoid routine and broad use of mitomycin in all fields.

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References

Extracocular extension of a choroidal melanoma after argon photocoagulation and transpupillary thermotherapy

The optimal management of small posterior choroidal melanomas remains controversial, especially for tumours located near the optic disc and fovea. Although with increasing rarity, argon laser photocoagulation continues to be used in the primary treatment of small tumours, despite data suggesting that other therapeutic methods may be more successful. More recently, transpupillary thermotherapy (TTT) has emerged as a therapeutic option for the primary treatment of small choroidal melanomas. Initial results are promising, but like any new treatments, more widespread use and longer follow up are needed for a thorough assessment of its efficacy. As a cautionary reminder that additional study is required to define the potential complications of these treatments, we present a case of choroidal melanoma in which treatment with primary argon photocoagulation followed by TTT was associated with extracocular extension of the tumour.

Case report
A 38 year old woman presented with decreased visual acuity in her right eye. An ophthalmologist noted a pigmented choroidal lesion with associated subretinal fluid. The lesion was initially treated with argon laser photocoagulation, but within a month the decision was made to re-treat the lesion with TTT. Over the next 7 months, visual acuity deteriorated to 20/200. The lesion exhibited persistent elevation and subretinal fluid. By ultrasound, a change in the retrolental echogenicity was observed, precipitating referral to an ophthalmic oncologist whereupon a diagnosis of choroidal melanoma with extracocular extension was made. The patient was then referred to UCSF for consideration of proton beam therapy.

On examination, all abnormal findings were confined to the right eye. The patient’s visual acuity was counting fingers at 2 feet. Funduscopy revealed a raised pigmented tumour centred on the fovea, measuring 7 mm vertically by 10 mm horizontally, extending to within 2.3 mm of the disc. Subretinal fluid was present and extended over the nasal aspect of the tumour (Fig 1A). A flat choroidal vessels within the tumour that are irregular angiography demonstrates irregular choroidal vessels within the tumour that are bright in the early arterial phase and show late leakage with punctate hot spots.
naevus 2 mm in diameter was also noted ineffectually (not shown). Fluorescein angiography was remarkable for an irregular plexus of choroidal vessels within the tumour noted in the early arterial phase, mid-phase leakage from retinal veins overlying the tumour, and late leakage with punctate hot spots at the tumour margin (Fig 1B). B-scan ultrasound revealed choroidal excavation, an acoustic quiet zone, and orbital shadowing (Fig 2A). A-scan demonstrated spontaneous pulsation, low to medium internal reflectivity, and a sharp posterior spike (Fig 2B). The intraocular thickness was 3.0 mm, with 7.7 mm of extraocular extension. These findings are consistent with choroidal melanoma with posterior extraocular extension. Systematic evaluation revealed no signs of metastasis. The potential for orbital contamination by tumour made focal therapy by proton beam a less desirable alternative. Therefore, enucleation with en bloc resection of the extracocular tumour was recommended and subsequently performed. Pathological examination confirmed the diagnosis of malignant choroidal melanoma, mixed cell type, with extensive extraocular extension and focal vascular invasion. The patient elected to undergo adjuvant post-surgical external beam irradiation to reduce the risk of orbital recurrence, with the understanding that this treatment, while not definitively harmful, is of unproved benefit. She was also referred to the medical oncology service for systemic therapy and has begun an experimental treatment protocol using interferon alfa. Systemic chemotherapy is currently under consideration.

Comment

Options for the management of choroidal melanoma include observation, laser photocoagulation, transpupillary thermotherapy, charged particle radiotherapy, brachytherapy, local resection, and enucleation. Argon laser photocoagulation is typically used as an adjunct to other treatments, but in select cases has been used as primary therapy for choroidal melanoma. Typically, photocoagulation is reserved for small tumours (less than 3–4 mm in thickness and less than 10 mm in diameter) that are close to the fovea and/or the optic disc in eyes with good vision. Because the level of tumour necrosis with laser photocoagulation is shallow (0.2–0.8 mm), multiple sessions are often necessary. Therefore, the greatest challenge to successful photocoagulative therapy in choroidal melanomas is determining when the tumour has been fully ablated. TTT shares the advantage that photocoagulation has over radiotherapy, including the more rapid visible reduction of tumour size, the relative sparing of adjacent normal tissue, and the convenience and economy of an outpatient procedure. In contrast with the shallow penetration of the argon laser, however, TTT employs near infrared light to produce up to 3.9 mm depth of tumour necrosis. The potential for orbital extension is the promise of this therapy. Therefore, the experience of the current case serves as a reminder that this modality is rarely used as a primary treatment for choroidal melanomas with posterior extension. (B) A-scan ultrasonography shows the choroidal melanoma. Arrows surround areas of tumour and exhibits the choroidal thickness was 3.0 mm with 7.7 mm of extraocular extension.

Figure 2  [A] B-scan ultrasonography demonstrates extraocular extension of the tumour and exhibits the choroidal excavation, acoustic quiet zone, and orbital shadowing characteristic of a uveal melanoma. Arrows surround areas of tumour extension. [B] A-scan ultrasonography shows spontaneous pulsation, low to medium internal reflectivity, and a sharp posterior spike. The measured intraocular tumour thickness was 3.0 mm with 7.7 mm of extraocular extension.


Macular infarction after intravitreal amikacin: mounting evidence against amikacin

Retinal toxicity attributable to intravitreal use of aminoglycosides for endophthalmitis has been reported. Campochiaro and Conway reported 101 cases of retinal damage due to intravitreal aminoglycosides. Amikacin, an aminoglycoside, is in widespread use in the United Kingdom for the treatment of Gram negative organisms in endophthalmitis. We report a case of macular toxicity following the use of intravitreal amikacin for postoperative endophthalmitis, outlining the mechanisms of retinal toxicity, and offer alternatives to amikacin. We believe that enough evidence now exists to support a change in the current Royal College of Ophthalmologists’ endophthalmitis treatment guidelines that are based on the Endophthalmitis Vitrectomy Study.

Case report

A 69 year old white woman presented 1 day after uneventful right phacoemulsification and intraocular lens implantation with a vision of counting fingers (CF), a relative afferent pupil defect, hypopyon with anterior chamber fibrin, and normal intraocular pressure. We were unable to visualise the fundus although a red reflex was noted. Ultrasound examination showed patchy increased vitreous reflectivity with a flat retina and choroid. Pars plana vitreous tap of 0.2 ml was performed followed by injection of 1 mg/0.1 ml of vancomycin and 0.4 mg/0.1 ml of amikacin. Sterile dilution was conducted with typewritten instructions. The globe never became tense. The ocular inflammation resolved on a daily regimen of oral prednisolone 60 mg, oral ciprofloxacin 750 mg four times daily, topical diclofenac 0.3% hourly, topical dexamethasone 0.1% 2 hourly, and topical atropine 1% once daily. Vision however remained CF because of angiographically proved macular ischaemia and vascular occlusion (Figs 1 and 2). There was no microbiological growth from the vitreous sample.
we support a change in current UK treatment guidelines. Choices will remain controversial until the incidence of toxicity for both amikacin and ceftazidime is determined by a prospective randomised controlled study; however, on the evidence currently available we suggest that ceftazidime should replace amikacin as the first line agent of choice against Gram negative organisms in postoperative endophthalmitis.

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References

Spontaneous invovlement of retinal and intracranial arteriovenous malformation in Bonnet-Dechaume-Blanc syndrome

Intracranial arteriovenous malformations are capable of spontaneous regression. There are also numerous recorded events of vascular remodelling, thrombosis, and autoinvolution in retinal arteriovenous malformations. This report documents a self obliterated retinal arteriovenous malformation in a patient with Bonnet-Dechaume-Blanc syndrome who developed neurological symptoms due to spontaneous regression of the intracranial component of the anastomotic malformation.

Case report
A 32 year old man from Guam was evaluated for a history of right parietal headaches for several months and acquired temporal hemianopia in the left eye. He had a history of blindness in the right eye from early childhood, and had recently become aware of a temporal hemianopia in the left eye.

Visual acuity was no light perception in the right eye and 20/20 in the left eye. The right pupil was unresponsive to light. The left pupil was sluggishly reactive and there was a right afferent pupillary defect. Slt lamp examination showed conjunctival venous engorgement in the right eye. Retinal examination disclosed white, sclerotic major retinal vessels, with no evidence of retinal vascular perfusion in the right eye (Fig 2). The major retinal vessels were surrounded by non-perfused clusters of white, racemose, telangiectatic, vessels (Fig 1). The left optic nerve showed band atrophy with corresponding nerve fibre layer dropout but no other retinal abnormality.

Magnetic resonance imaging showed numerous vascular channels permeating the right basal ganglia, anterior portion of the midbrain, prefrontal gyri, optic chiasm, and the right orbit. The deep hemispheric portion of the lesion showed surrounding oedema. CT scanning showed punctate and conglomerate calcifications in the malformation, as well as enlargement of the right optic canal. Cerebral angiography demonstrated an angiomatosus vascular malformation that permeated the basal ganglia as well as the optic chiasm region and extended into the right orbit (Fig 2). There was a relative lack of deep venous drainage in the chiasmatic region of the malformation, with diversion to the Sylvian vein system and over the convexities to the sagittal sinus. The lack of hypertrophy in these draining venous channels, together with the...
region oedema on magnetic resonance imaging, suggested a recent obstruction of vascular flow within the angiomatous malformation.

Comment

The syndrome of unilateral retinocephalic arteriovenous malformation was first described in 1937 by Bonnet et al. Six years later, Wyburn-Mason published his report in the English language. These congenital unilateral arteriovenous malformations may involve the visual pathways from the retina to the optic nerve to the ipsilateral occipital cortex, and may include the chiasm, hypothalamus, basal ganglia, midbrain, and cerebellum. Since these arteriovenous malformations are high flow systems in which veins are exposed to arterial blood pressures, they are susceptible to turbulent blood flow and to vessel wall damage which can lead to thrombosis and occlusion. Over time, components of an angiomatous malformation may grow, haemorrhage, scleros, thrombose, and involute.

Our patient had longstanding involution of his retinal arteriovenous malformation, with new neurological symptoms resulting from thrombosis of the intracranial component of the tumour. Spontaneous occlusion of the major venous drainage within the deep cerebral hemisphere and optic chiasm may have caused headaches by producing regional oedema or by diverting flow to other venous structures. Since the major venous drainage within the malformation was already occluded at the time of presentation, no treatment was advised. The complex evolution of clinical signs in our patient underscores the need to distinguish disease progression from spontaneous involution in symptomatic patients with Bonnet-Dechaume-Blanc syndrome.

Acknowledgement

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NOTICES

Glaucma

The latest issue of Community Eye Health (No 39) discusses the glaucomas, with an editorial by Professor Gordon J Johnson, director of the International Centre for Eye Health. For further information please contact: Journal of Community Eye Health, International Centre for Eye Health, Institute of Ophthalmology, 11–43 Bath Street, London EC1V 9EL, UK (tel: +44 (0)20 7608 6910; email: eyeresource@ucl.ac.uk; website: www.jech.co.uk). Annual subscription (4 issues) UK£25/$US40. Free to workers in developing countries.

International Centre for Eye Health

The International Centre for Eye Health has published a new edition of the Standard List of Medicines, Equipment, Instruments and Optical Supplies (2001) for eye care services in developing countries. It is compiled by the Task Force of the International Agency for the Prevention of Blindness. Further details: Sue Stevens, International Centre for Eye Health, 11–43 Bath Street, London EC1V 9EL, UK (tel: +44 (0)20 7608 6910; email: eyeresource@ucl.ac.uk).

Second Sight

Second Sight, a UK based charity whose aims are to eliminate the backlog of cataract blind in India by the year 2020 and to establish strong links between Indian and British ophthalmologists, is regularly sending volunteer surgeons to India. They can be found at the charity website (www.secondsight.org.uk) or by contacting Dr Lucy Mathen (lucymathen@yahoo.com).

Specific Eye ConditionS (SPECS)

Specific Eye Conditions (SPECS) is a not for profit organisation which acts as an umbrella organisation for support groups of any conditions or syndrome with an integral eye disorder. SPECS represents over fifty different organisations related to eye disorders ranging from conditions that are relatively common to very rare syndromes. We also include groups who offer support of a more general nature to visually impaired and blind people. Support groups meet regularly in the Boardroom at Moorfields Eye Hospital to offer support to each other, share experiences and explore new ways of working together. The web site (www.eyecareconditions.org.uk) is a portal giving direct access to support groups own sites. The SPECS web page is a valuable resource for professionals and may also be of interest to people with a visual impairment or who are blind. For further details about SPECS contact: Kay Parkinson, SPECS Development Officer (tel: +44 (0)1803 524238; email: kparkinson@eyeconditions.org.uk; www.eyecareconditions.org.uk).

Joachim Kuhlmann Fellowship for Ophthalmologists 2002

In honour of its founder’s memory, the Joachim Kuhlmann AIDS-Stiftung, Essen, Germany, is sponsoring two fellowships for ophthalmologists at a well known institute, who want to train in CMV retinitis and other HIV related ophthalmologic diseases. The fellowships each include $US 5000. Deadline for application is 31 March 2002.

Detailed applications including a CV and publication list should be sent to: Joachim Kuhlmann AIDS-Foundation, Bismarckstr. 55, 45128 Essen, Germany. Further information is available at www.jkj-AIDS-stiftung.de.

12th Meeting of the European Association for the Study of Diabetic Eye Complications (EASDEC)

The 12th meeting of the EASDEC will be held on 24–26 May 2002 in Udine, Italy. The deadline for abstracts is 15 February 2002. Three travel grants for young members (less than 35 years of age at the time of the meeting) are available. For information on the travel grants, please contact Pr CD Agardh, President of EASDEC, Malmö University Hospital, SE-205 02 Malmö, Sweden (tel +46 40 33 10 16; fax: +46 40 33 73 66; email: carl-david.agardh@endo.mas.lu.se). Further details: NORD EST CONGRESSI, Via Aquilea 2, 31-33100 Udine, Italy (tel: +39 343 21391; fax: +39 0432 50687; email: nord.est.congressi@ud.nettuno.it).

International Society for Behçet’s Disease

The 10th International Congress on Behçet’s Disease will be held in Berlin 27–29 June 2002. Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de). The 11th International Congress on Behçet’s Disease will be held in Singapore 168751 (tel: (65) 322 8374; fax: (65) 322 8377; email: cchoh@nus.edu.sg).

BEAVRS Meeting

The next BEAVRS meeting will be held in the Dalmahoy Hotel near Edinburgh on 31 October to 1 November 2002. Further details: Susan Campbell, Medical Secretary, Gartnavel General Hospital (email: susan.j.campbell.west@northglasgow.scot.nhs.uk).