LETTERS

Unusual case of residual cortical lens matter in anterior chamber

Modern cataract surgery does not allow for any residual cortical matter in the anterior or posterior chamber, not even in the capsular bag. But for a beginner, a residual cortex in the eye is preferable to a ruptured posterior capsule and its associated complications. Therefore, the surgeon can stop and allow a minor complication (retained cortical material) to prevent posterior capsular rupture.

Case report

A 52 year old female patient was operated for posterior subcapsular cataract in her right eye. Her left eye had previously gone into phthisis bulbi 5 years earlier; she underwent a 360° buckling with vitreoretinal surgery in her left eye for traumatic total retinal detachment 6 years earlier.

The surgery was performed by a resident eye surgeon who was in the learning stage of phacoemulsification. During cortical aspiration, the matter at the 12 o’clock position was proving difficult to handle for the surgeon. The surgeon therefore thought, in the best interest of the patient, that the amount of sub-incisional cortical matter (approximately 2 clock hours, extending up to the capsulorhexis margin towards the centre) would abate and its residual matter would not pose any risk of further manipulations and getting a posterior capsular tear.

The surgeon increased the size of the corneal incision and implanted all-PMMA (Single-piece, Biconvex, Mod C Step Vault, from AI Optics Ltd, India) intraocular lens. The patient could not afford any other lens and the above lens is available free of cost for deserving patients in our centre.) The wound was closed with 10/0 monofilament Nylon sutures.

The first postoperative day did not reveal any unusual inflammation. The eye was quiet on third postoperative day (first follow up). At second follow up (10th postoperative day), the operated eye revealed a white, fluffy mass (Fig 1) in the anterior chamber. This cotton-wool ball-like mass was diagnosed to be retained sub-incisional cortical lens matter based on normal anterior segment and fundus findings. The IOP was 28 mm Hg in her right eye. Because of the raised IOP and the one eyed status of the patient, immediate removal of cortical lens matter was planned. The side port was used to aspirate cortical matter with topical 0.5% oxybuprocaine (proparacaine) eye drops, using a 23 gauge canula. Postoperatively there was normalisation (off oral medications) of raised IOP within 48 hours. All sutures were removed after 6 weeks (Fig 2). The final best corrected visual acuity was 6/6.

Comment

The case is reported to highlight the importance of complete removal of cortical matter. The reason for difficulty in aspirating sub-incisional cortex in our case was inferiorly decentralised capsulorhexis and corneal oedema at the incision site. Other reasons that can hamper the removal of such cortex could be positive vitreous pressure, long tunnel, fluid leakage due to disorganisation of incision lips, small capsulorhexis, probable miosis and corneal folds. The raised IOP in our case could be due to obstruction of trabecular meshwork by lens debris and inflammatory components in the form of foamy macrophages and lens particles and reduction of outflow facility of the anterior chamber angle. The lens debris was seen as a fluffy pseudohyphophypon layer in the inferior anterior chamber; this can cause a mistaken diagnosis of postoperative endophthalmitis if associated with anterior uveitis.

The full visual recovery seen in our case could be attributed to immediate surgical intervention. The lens cortex retained in the eye after cataract extraction usually undergoes lyses by aqueous but may persist. The techniques that can be used to aspirate such sub-incisional cortex could be widening of the incision, mobilisation of the mass with IOL, verticaлизation of irritation/aspiration tip, using 180° bent canula by Binkhorst, bent and angled coaxial cannulas, and bimanual (one for irrigation and one for aspiration) technique.

G Prakash, A Kumar, A Purohit, A Kumar

Dr Rajendra Prasad Centre for Ophthalmic Sciences, All India Institute of Medical Sciences, Ansari Nagar, New Delhi – 110029, India

Figure 1 Retained cortical lens matter in the anterior chamber.

Figure 2 Eight week postoperative status of the same eye.

References


Posterior segment complications of graft versus host disease after bone marrow transplantation

The efficacy of bone marrow transplantation (BMT) for the treatment of selected diseases of the haemopoietic system such as chronic myeloid leukaemia (CML) is well recognized. Graft versus host disease (GVHD) is however a common and potentially life threatening complication of this treatment, occurring in up to 75% of cases. It is thought that when immunocompetent donor T lymphocytes mount an immune response against host tissues, GVHD is characterised by a triad of enteritis, dermatitis, and hepatitis, but almost all organs may be targeted. Ocular involvement is frequently seen but is usually limited to the anterior segment. Posterior segment manifestations are rare.

This report describes two cases of GVHD with unusual posterior segment involvement that highlight the diversity of presentations in this condition.

Case 1

A 45 year old male presented with progressive bilateral blurred vision and floaters 10 months post-BMT for CML. He had no history of ocular disease. His symptoms started 10 days after discontinuation of cyclosporin A as a routine protocol and were accompanied by alopecia, poliosis, vitiligo, and oral mucositis. A presumptive diagnosis of acute GVHD was made and cyclosporin restarted together with prednisolone. His other medications were azathioprine, aciclovir, fluconazole, and ranitidine.

Best corrected visual acuity was 6/9 bilaterally, with no afferent pupillary defect. There was no evidence of inflammation in anterior segments or vitreous and normal intraocular pressures. There was mild disc pallor with swelling and surrounding radial perivascular folds and several pale subretinal perivascular lesions on the left. Systemic examination revealed widespread patchy alopecia with poliosis, vitiligo of the arms, and mild oral mucositis. Fluorescein angiography showed mild dilatation of the disc capillaries and extensive focal leakage from the retinal pigment epithelium, but no evidence of cystoid macular oedema. Ultra-

Sub-incisional cortical lens matter in anterior chamber

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sonography showed a thickened posterior sclera. Optical coherence topography (OCT) showed subretinal fluid bilaterally. Cerebral magnetic resonance imaging (MRI) and lumbar puncture revealed no abnormalities. The clinical appearances were consistent with posterior scleritis together with a diffuse retinal pigment epitheliopathy. A reducing regimen of high dose steroids in combination with acetazolamide resulted in clinical improvement and visual stabilisation.

Case 2
A 31 year old white female underwent total body irradiation and BMT for γδ-T cell splenic lymphoma. One month later she developed acute GVHD related erosive enteropathy resulting in life threatening exsanguination. Following successful resuscitation (which precipitated admission to intensive care for 6 weeks), she noted blurred left eye vision and described difficulty in dark adaptation and differentiating between shades of grey; there was right strabismic amblyopia. The patient’s medication comprised aciclovir, cyclosporin, penicillin, propranolol, and lansoprazole.

Visual acuity was 6/18 and N14 with the right eye, and 6/12 and N5 with the left. Colour vision was normal and visual fields were full. There was no afferent pupillary defect. The anterior chambers and vitreous were quiet. The optic discs were normal. At both maculas (Fig 1), there were deep subretinal cream coloured spots and retinal thickening and OCT evidence of subretinal fluid without cystoid changes. Fluorescein angiography showed a few hyperfluorescent spots consistent with focal retinal pigment epithelium dysfunction. Electrodiagnostic tests identified diffuse rod dysfunction.

Since there was biochemical evidence of renal impairment, acetazolamide was considered to be contraindicated to treat the subretinal fluid. By 4 months, the best corrected visual acuities were 6/12–2 right; 6/6+2 left. Repeat electrophysiology was unchanged, however by ten months the full field electroretinograms had improved to normal limits.

Comment
GVHD is presumed to be caused by donor T lymphocytes recognising minor histocompatibility antigens on recipient tissues that are then subjected to CD8-T lymphocyte mediated attack. Commonly reported ocular manifestations include pseudomembranous conjunctivitis, keratoconjunctivitis sicca, corneal epitheliopathy, and cataract. Posterior segment involvement is rare and includes cotton wool spots as well as central serous chorioretinopathy.

In both of our cases, there seems to be a striking temporal association between the onset of visual symptoms and an adverse event in the course of the disease. In case 1, in whom the cessation of cyclosporin resulted in acute GVHD, the ocular findings were consistent with scleritis, a feature only once previously reported.

Postmortem studies have demonstrated choroidal infiltrates in GVHD patients containing histiocyte-like large eosinophils and clinically these may be represented by the pale perifoveal lesions observed in the left eye. Subsequently this patient was shown to be HLA-DR4 positive, a finding common in individuals with Harada’s disease and frequently associated with chronic GVHD.

By contrast, the ocular findings in the second case were not a result of acute but a consequence of previous life threatening GVHD during which exsanguination occurred. While interruption of blood flow to the optic nerve or visual cortex can account for visual loss following extreme haemorrhage, retinal ischaemia has also been documented. The rod photoreceptor system appears most vulnerable, a feature consistent with the visual field loss seen in both patients.
tent with the electrophysiological findings in this case, and the patient’s difficulty with dark adaptation is in keeping with rod dysfunction. Of interest was the subsequent improvement in acuity and electrophysiological responses. Such a pattern parallels electrophysiological studies of children after respiratory or circulatory arrest where initially subnormal ERG responses return to normal levels within 8 months. The mechanism that mediates this recovery is not known.

Graft versus host disease is a common complication of bone marrow transplantation that usually presents to the ophthalmologist with anterior segment signs. However, GVHD may also present with posterior segment presentations of the types described here.

N G Strouthidis, P J Francis, M R Stanford, E M Graham
The Medical Eye Unit, 9th Floor, North Wing, St Thomas’ Hospital, Lambeth Palace Road, London SE1 7EH, UK

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References

Anterior pathway vision loss due to subdural haematoma

Patients with vision loss associated with subdural haematomas typically present with homonymous hemianopias secondary to compression of the posterior cerebral artery during trans-tentorial herniation. In these cases, necropsy studies have demonstrated pregeniculate involvement in addition to occipital lobe lesions. We present a case illustrating a rarely reported phenomenon of anterior pathway vision loss associated with a subdural haematoma without any evidence of optic disc swelling, occipital lobe disease, or radiographic signs of chiasmal or optic nerve compression.

Case report

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Case report

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Figure 1 Fundus photograph with right (A) and left (B) optic nerves without oedema or pallor on initial presentation. Humphrey visual fields (C) on presentation and (D) 6 months following craniotomy with decompression of the subdural haematoma.
Magnetic resonance imaging (MRI) of the brain showed that the right subdural haematoma was still present but was decreased in size to 2.1 cm on coronal section (Fig 2A) compared to the study performed 1 month earlier. No intraorbital abnormalities were present, and the optic nerves and chiasm appeared free of direct compression by the haematoma. The blood did not appear to surround the optic nerves (Fig 2B). The patient’s haematocrit and blood pressure remained within normal limits during the initial presentation and subsequent treatment. The patient underwent craniotomy with further drainage of the subdural haematoma. After 6 months, the patient’s vision in the left eye improved to 20/200. Follow up peripheral vision showed less constriction on the right and improved performance on the left (Fig 1D). Funduscopic examination revealed mild optic nerve pallor in the left eye and a normal appearing right optic nerve.

Comment
This case represents a rare example of anterior pathway vision loss due to subdural haematoma. Most cases of vision loss with subdural haematoma affect the posterior visual pathway, with mechanisms including occipital infarct and compression of the posterior cerebral artery during trans-tentorial herniation. Posterior lesions may present with anterior signs—for example, optic atrophy was seen in three patients with occipital infarcts, two of whom initially presented with severe disc oedema. Necropsy studies have shown that trans-tentorial herniation can result in damage at the level of the optic tract, chiasm, or optic nerves.

The anterior visual pathway can be compromised directly by gyrus herniation into the suprasellar cistern, a mechanism associated with meningiomas. Prechiasmal vision loss due to intracranial optic nerve infarction has also been reported in the setting of subdural haematoma; in this case the mechanism was presumably due to direct compression of the nerve against basal skull structures, although this specific radiographic finding was not described.

The precise mechanism of anterior pathway vision loss due to subdural haematoma in our patient, as well as in the few previous reports, remains poorly understood. MRI showed no signs of blood in the orbits, direct compression of the optic nerves or chiasm, or gyrus herniation into the suprasellar cistern. The occipital lobes also appeared normal. Right to left midline shift due to the right sided haematoma was present, probably leading to vascular compromise or nerve compression that could not be visualised on MRI. Visual impairment following chiasmal decompression of mass lesions has been reported, and this mechanism may explain our patient’s improved visual acuity and peripheral fields following the drainage of the haematoma. Surprisingly, the subdural haematoma in our patient was smaller at the time of onset of visual symptoms than it had been 1 month earlier.

Subdural haematomas may affect vision through compression or vascular compromise at many points along the visual pathway. This case illustrates that optic neuropathy can occur late in the setting of a subdural haematoma, after the volume of the haematoma has begun to decrease because of the many ways in which patients with subdural haematomas can lose vision, they require close follow up, and a sudden change in vision necessitates immediate radiological testing, ophthalmological examination and, possibly, urgent surgical intervention and drainage.

Figure 2  Magnetic resonance imaging (T1 weighted coronal) of (A) right subdural haematoma with significant right to left midline shift but without direct compression of the prechiasmal optic nerves and (B) without compression of the intraorbital optic nerves.
severe atopic dermatitis (one) and traumatic cataract (one). The types of cataract included total/mature (seven), nuclear (two), lamellar (three), subcapsular (two), posterior lenticular (two), and posterior polar (two).

All eyes underwent lens aspiration through a longer anterior capsulotomy or continuous curvilinear capsulorhexis (CCC) under general anesthesia. Fourteen eyes had either posterior capsulotomy (with the vitreoretinal cutter) or a posterior CCC (surgeon’s preference). Anterior vitrectomy was done in 13 eyes. Eleven eyes (61.1%) were implanted with a foldable intraocular lens (IOL) (Acrysof lens MA60BM, 10 and MA30BM, 1) (pseudophakic group) (Table 1). This group was older (mean age 84.81 months) than the aphakic group (mean age 14.31 months). Only seven eyes (63.6%) of the pseudophakic group underwent posterior CCC/capsulotomy and anterior vitrectomy, compared to all eyes in the aphakic group. Complications were encountered in four eyes in the pseudophakic group (36.4%)—malposition of IOL, vitreous strand in AC, posterior synechiae and raised intraocular pressure. Two in the aphakic group did not receive additional postoperative topical steroids (prednisolone acetate 1%). This decision was made for patients 4 and 12 as there was minimal manipulation and iris trauma intraoperatively. These children were older (ages 131 and 115 months at surgery) allowing for easier follow up examination. Patient 13 had developmental delay and was difficult to manage. All four eyes were assessed to be quiet by slit lamp examination 2–4 weeks postoperatively. Additional steroids were not indicated and there was no indication of postoperative inflammation and safety are incomplete without the measurement of flare and endothelial cell counts but these are difficult in children, although endothelial cell count studies in adult eyes have shown no significant change. Finally, gonioscopy to visualise the angles to look for PAS was not done.

Surodex has previously been shown to be safe and effective in uncomplicated cataract surgery in adults. This retrospective review provides preliminary data to suggest that Surodex may be an effective and safe adjunctive anti-inflammation agent that in some paediatric eyes may eliminate the need for other steroid administration. Further studies will be required to determine the ultimate safety of Surodex in paediatric eyes.

We acknowledge that there are several limitations to these findings. Firstly, being a retrospective review, the efficacy of Surodex in preventing posterior capsular opacification, an indicator of postoperative inflammation, could not be assessed. We are also unable to establish if Surodex alone is sufficient for postoperative control of inflammation, this would require a prospective randomised clinical controlled trial. The efficacy of control of postoperative inflammation and safety are incomplete without the assessment of flare and endothelial cell counts but these are difficult in children, although endothelial cell count studies in adult eyes have shown no significant change. Finally, gonioscopy to visualise the angles to look for PAS was not done.

Surodex is an ocular steroid pellet containing dexamethasone 0.1% that is developed for children with cataract surgery. The Surodex pellet is placed in the anterior chamber. It is designed to release dexamethasone for 28 days. At the end of 28 days, the dexamethasone release stops. The patients then receive topical drops. Surodex is a one-off treatment. Surodex has previously been shown to be safe and effective in uncomplicated cataract surgery in adults. This retrospective review provides preliminary data to suggest that Surodex may be an effective and safe adjunctive anti-inflammatory agent that in some paediatric eyes may eliminate the need for other steroid administration. Further studies will be required to determine the ultimate safety of Surodex in paediatric eyes.

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Comment
Fibrinous anterior uveitis is common after paediatric cataract surgery, occurring in varying severities in up to 100% of cases. In our series, only two eyes (11.1%) developed inflammation that required additional steroid therapy. The remaining 16 eyes achieved good control of inflammation, particularly the two eyes that received Surodex without postoperative topical steroids. None experienced rebound uveitis after 1 week, when the pellet had ceased its release of dexamethasone. This suggests that in selected eyes, a Surodex pellet alone may be adequate to control postoperative inflammation. A randomised controlled trial comparing Surodex versus conventional steroid eye drop therapy will be needed to determine the ultimate efficacy of Surodex in paediatric eyes.

The efficacy of eye drops is dependent on compliance and timely application for drug penetration and absorption. In infants and young children, the systemic absorption of the steroid may have potentially serious complications such as hyperglycaemia and immunosuppression. Surodex significantly reduces the total dose delivered, as the 60 μg of dexamethasone in one pellet is approximately equivalent to that in just one drop of 0.1% dexamethasone.3 A system such as the DDS allows for direct application of the drug to the target site, potentially eliminating the problems of compliance.

The single complication encountered, which may be related to Surodex insertion, is the late onset of raised IOP (patient 6) despite the lack of marked postoperative inflammation. The fellow eye had also undergone cataract surgery with insertion of Surodex without complications. Steroid responsive glaucoma is an unlikely cause as the drug has been shown to persist only for 7 days in rabbits, although this has not been demonstrated in human eyes. Gonioscopy may reveal focal peripheral anterior synechiae (PAS) at the site of residual pellet, but it is unlikely that this minor degree of synechiae may cause angle closure glaucoma, although the pellet may persist for weeks in the angles. Unfortunately, gonioscopy was not performed in this eye. Glaucoma after paediatric cataract surgery is, however, a complication that increases in frequency with longer durations of follow up (3–22%).
Pars plana ciliary epithelial proliferation in 13q deletion syndrome

The 13q deletion syndrome is an uncommon chromosomal disorder affecting the long arm of chromosome 13 which is deleted to a variable degree. This syndrome is phenotypically characterised by mental retardation, structural malformations, facial dysmorphisms, and a predisposition to develop retinoblastoma. This intraocular tumour is diagnosed in approximately 80% of cases with this syndrome.

Moreover, the incidence of bilateral retinoblastoma is much higher in individuals with this syndrome. The retinoblastoma susceptibility gene (RB-1), which encodes for the nuclear phosphoprotein of the retinoblastoma susceptibility gene (RB-1), is associated with retinoblastoma. The RB-1 gene, or a gene close to the RB-1 locus, may have a role in the proliferation of the other neuroepithelial structures of the eye, including the pars plana ciliary epithelium.

The extent of the deletions affecting the long arm of chromosome 13 may result in various developmental anomalies that constitute 13q syndrome. Proliferation of the pars plana ciliary epithelium, as noted in the present case, and its association with retinoblastoma suggests that the RB-1 gene, or a gene close to the RB-1 locus, may have a role in the proliferation of the other neuroepithelial structures of the eye, including the pars plana ciliary epithelium.

In embryological terms, the non-pigmented ciliary epithelium is derived from the inner layer of the optic cup which also gives rise to the neural retina. Proliferation of the pars plana ciliary epithelium in an eye that harbours retinoblastoma suggests that the RB-1 gene may play a part in such epithelial proliferation. However, this epithelial proliferation has not been previously reported in eyes with retinoblastoma.

Although the cause of proliferation of the ciliary epithelium is not clear, this case suggests that the non-pigmented ciliary epithelial proliferation at the pars plana ciliary in an eye that harbours retinoblastoma may be related to 13q deletion syndrome. Such findings may be unique to this syndrome, but previous reports about it have not mentioned them. The lack of previously reported cases with findings of pars plana epithelial proliferation suggests that this syndrome may have variable phenotypic expression.

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References


Phacoemulsification of posterior polar cataracts—a surgical challenge

Posterior polar cataracts are relatively uncommon yet they pose a significant chal-
lengte to the cataract surgeon. Cataract surgery in these cases is frequently accompanied by a high incidence of posterior capsule rupture (PCR).

Morphology
Posterior polar cataracts are associated with remnants of the hyaloid system or the tunica vasculosa lentis.1 These cataracts may also occur without any relation to hyaloid remnants and appear as circular or rosette shaped opacities; they are hereditary and usually transmitted as a dominant trait. The gene for this has been mapped to chromosome 16q22.6

Classification
See Table 1 and Figure 1.

Methods
The incidence of posterior polar cataracts in our centre is approximately 3 per 1000. We conducted a retrospective review from 1994 to 1999 and identified 31 patients (36 eyes) who had surgery for posterior polar cataracts.

Results
Four eyes had PCR (11.1%) and the other 32 had uncomplicated surgery; 34 eyes achieved a best corrected visual acuity of 6/12 or better (94.4%).

Comment
Our series showed a PCR rate of 11.1% in contrast with the 26% incidence reported by Osher et al2 and 36% by Vasavada and Singh.5 No hydrodissection was attempted and only careful controlled hydrodelineation was performed. This was done using small aliquots of balance salt solution (BSS) to loosen the nucleus while simultaneously watching the capsular bag to ensure that the fluid wave passed gently. In some cases, no hydroprocedures were necessary as there was slow separation of the nucleus by the BSS flowing from the phaco tip.

Vasavada and Singh described the use of step by step chop in situ and lateral separa-
tion to minimise stress on the capsule-zonule complex.7 We preferred the use of the “lambda” technique which involved sculpting in the shape of the Greek letter (λ), followed by cracking along both “arms” and removal of the central piece first. The advantage of this is its gentleness in not stretching the capsule while removing the quadrants, especially the first one. We emphasise that this is our preferred technique and other techniques would be equally effective in skilled hands.

We also used low vacuum, low aspiration, and low inflow parameters to ensure a more stable anterior chamber; bottle height was at 50 cm, vacuum at 100 mm Hg, and aspiration flow rate at 20 ml per minute. Optimum power setting was achieved when minimal movement of the nucleus occurred while sculpting.

The epinucleus and cortex were removed using manual dry aspiration with Simcoe cannula. This method is gentler as we believe that the aspiration pressure is more controllable with our “million dollar” hands. There is also no “after aspiration” effect which in the automated unit can continue for several milliseconds even after the foot has been taken off the pedal. The disadvantage of manual aspiration is the increased surgical time.

The status of the posterior capsule (PC) dictated the action of the surgeon. If the PC was absent or torn but with no vitreous loss, a dispersive viscoelastic was injected over the defect to tamponade and push the vitreous face backwards. A dispersive rather than a cohesive viscoelastic is preferable as it is more adapted to maintaining a space and stabilising the anterior vitreous face. If there was PCR with vitreous loss, a two port anterior vitrectomy was performed. Intraocular lens implantation in these cases would depend on the extent of the PCR and the integrity of the remaining PC.

Surgical management of posterior polar cataracts poses a special challenge to the cataract surgeon. It is important that the surgeon and the patient understand the technical difficulties associated and are aware of potential complications. It may be prudent to address these cases at the end of an operating list or to shorten the list in anticipation of prolonged surgical time. The surgeon should use a technique that he or she is most familiar and comfortable with. With emphasis on gentleness, together with patience and a well practised technique, the incidence of PCR can be minimised in phacoemulsification for posterior polar cataracts.

Table 1 Classification of posterior polar cataracts

| Type 1 | Opacity associated with posterior subcapsular cataract. |
| Type 2 | Opacity with ringed appearance like an onion. |
| Type 3 | Opacity with dense white spots at the edge often associated with thin or absent posterior capsule. |
| Type 4 | Combination of the above 3 types with nuclear sclerosis. |

References
1 Luntz MH. Clinical types of cataracts. Duane’s Ophthalmology 1996;CD-ROM.

Molluscum contagiosum in an immune reconstituted AIDS patient
In spite of lower viral loads and increasing T cell counts, AIDS patients receiving highly active antiretroviral therapy (HAART) are not always successful in mounting an immune response to some opportunistic pathogens. In fact, CMV retinitis, which was known to occur in HIV patients with CD4 counts below 50 × 10⁹/L, has been described in immune reconstituted patients with CD4 counts above 200 × 10⁹/L.8 It is therefore important to make observations about the clinical spectrum of infectious disease in immune reconstituted AIDS patients. Here we report an isolated case of CMV retinitis in an immune reconstituted patient.
lesion of molluscum contagiosum in an immune reconstituted AIDS patient.

Case report
A 46 year old Hispanic female presented with a history of burning, tearing, and itching of her left eye for 1 month. Three years earlier she had been diagnosed with AIDS during a hospital admission for Pneumocystis carinii pneumonia (PCP). At that time her CD4 count had been $27 \times 10^3/l$ and her viral load $905 \ 000$. After 3 months of HAART her viral load became undetectable at $15 \ 000$ and her CD4 count rose to $184 \times 10^3/l$. Her viral load became undetectable 6 months after inititation of therapy and has remained so for 2½ years. Her recent CD4 count was $435 \times 10^3/l$.

Best corrected visual acuity was 20/25 in each eye. A 2 mm smooth, dome-shaped, translucent papule with central umbilication and was present inferior to the medial aspect of the left lower lid margin (Fig 1). The lesion had been present for just 2% of ocular malignancies.

Comment
Immunocompetent patients with molluscum contagiosum involving the eyelid typically suffer from an isolated lesion that is self limited. Larger, more numerous and widespread molluscum contagiosum lesions have been documented in patients with AIDS, individuals immunosupressed from using prednisone and methotroxate, or patients with lymhoreticular malignant neoplasms or sarcoidosis. In HIV infected individuals the disease runs a more protracted course with persistent lesions and there appears to be an inverse relation of the CD4 count and the number of molluscum contagiosum lesions.

The present case shows that the patient’s reconstituted immune system from HAART can limit molluscum contagiosum infection to a single lesion at the eyelid, clinically and histologically identical to molluscum contagiosum lesions found in immunocompetent hosts. Such limited expression of molluscum contagiosum could be from a competent T cell response as noted in individuals with normal immune function or those with reconstituted immune response from HAART. Thus, clinically the presence of a solitary molluscum contagiosum lesion in an HIV infected individual suggests appropriate response to HAART.

Figure 1 Note solitary umbilicated lesion involving lower eyelid margin.

Figure 2 Histologically, the molluscum contagiosum shows intracellular eosinophilic inclusion bodies (haematoxylin and eosin x120).

Malignant melanoma of the conjunctiva metastasising to the parotid gland
Conjunctival melanoma is rare, accounting for just 2% of ocular malignancies. We present an unusual case of conjunctival melanoma with subsequent metastasis to the parotid gland. A diagnosis was made after fine needle aspiration cytology of the parotid gland was performed in light of the previous history.

Figure 2 Pedunculated lesion arising from the natal limb conjunctiva, right eye.

Case report
A 79 year old white man presented to the eye clinic in September 1999. He had been noted 3 years previously to have a small inclusion cyst of the bulbar conjunctiva in his right eye, which he complained had increased in size and was becoming red and sore. Examination showed an inflamed pedunculated lesion 1 cm in diameter arising from the nasal limb conjunctiva (Fig 1). The lesion was granulomatous and amelanotic. There was adjacent corneal opacity. Ocular examination was otherwise unremarkable.

The appearance of the lesion was felt to be unusual with a presumptive diagnosis of conjunctival malignancy. Excision biopsy with conjunctival autografting was performed.

Histology revealed a primary nodular melanoma, at least 7 mm thick, composed of epithelioid sparsely pigmented melanocytes positive for S100 and vimentin immunostains. Excision was deemed incomplete.

The patient was referred for adjuvant treatment with cryotherapy. To date, there has been no sign of local recurrence.

In June 2001, the patient was referred by his general practitioner to the oral surgery service at the same hospital with a 6 month history of pain on the right side of his neck. He had also noticed some right facial swelling. Clinical examination disclosed a diffuse, firm mass over the lower pole of his right parotid gland, measuring 4 cm in diameter. There were no overlying skin changes.

Magnetic resonance imaging (MRI) of the head and neck showed a well defined lesion within the right parotid gland involving the deep lobe and the deeper portion of the

Figure 2 FNA cytology of the parotid swelling. Highly pleomorphic malignant epithelioid melanocytes with scattered lymphocytes in the background. Scale bar = 25 mm.
superficial lobe. A few small lymph nodes were visible at several sites bilaterally but none appeared enlarged. Computed tomography (CT) of the chest, abdomen and pelvis revealed single nodules measuring 3–5 mm at both lung bases, which may represent lung metastases.

An orthopantomogram was normal, and fine needle aspiration (FNA) cytology was performed. This showed scattered lymphocytes and highly pleomorphic non-lymphoid malignant cells, some containing flecks of pigment (Fig 2). While these appearances alone would not allow definitive diagnosis of melanoma, in the clinical context they were sufficient to conclude that the parotid swelling was likely to be metastatic melanoma. This was confirmed on subsequent parotid excision biopsy, which revealed extensive involvement of the parotid nodes and parotid parenchyma, extending into the external jugular vein.

**Comment**

Malignant melanoma is a relatively rare tumour in the parotid gland, with most tumours representing metastasis from cutaneous head and neck primaries. Very occasionally, as in this case, the primary tumour is non-cutaneous in origin.

 Conjunctival melanoma metastasising to the parotid has been noted in previous series, but remains rare. This case is unusual with respect to the initial size and appearance of the tumour, the previous history of a conjunctival cyst, and that definitive diagnosis of a metastatic lesion from a conjunctival primary was made by FNA. This method has been helpful in the diagnosis of other types of tumour in the parotid, and indeed in parotid melanomas of different origin. In this case, the patient’s previous ophthalmalic history had been unknown to the maxillofacial surgeon managing the case, and the diagnosis only became clear during reporting of the cytology, when the FNA findings could be compared with previous histology. This illustrates the importance of exhaustive history taking and the value of a cohesive local histopathology service.

F Cuthbertson
Department of Ophthalmology, St James’s University Hospital, Beckett Street, Leeds LS9 7TF, UK

J Luck, S Rose
Royal United Hospital, Combe Park, Bath BA1 3NG, UK

Correspondence to: Dr Fiona Cuthbertson, Department of Ophthalmology, St James’s University Hospital, Beckett Street, Leeds LS9 7TF, UK, fcuthbertson@hotmail.com

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**References**


**Bilateral Aspergillus endophthalmitis in a patient with chronic lymphocytic leukaemia**

*Aspergillus* species are ubiquitous saprophytic moulds, commonly growing in soil, stored hay, and decaying vegetation. Even though exposure to *Aspergillus* is universal, infection in humans is uncommon. *Aspergillus* infection of ophthalmic interest usually causes keratitis or orbital cellulitis. *Aspergillus* endophthalmitis is a relatively rare condition that has a devastating course, with blindness as its usual outcome. The clinical diagnosis is difficult and the treatment is disappointing. In most cases, ocular involvement results from spread of aspergillus infection from other organs and typically occurs in injecting drug users and in patients with immune deficiency of various causes. The leucopenia appears to be a predisposing condition for the occurrence of aspergillus.

We report an unusual case of bilateral endogenous *Aspergillus* endophthalmitis in a patient with chronic lymphocytic leukaemia in the absence of any detectable focus of aspergillus infection elsewhere in the body and that showed a good response to specific systemic therapy.

**Case report**

A 51 year old white man with a previous diagnosis of chronic lymphocytic leukaemia and use of an immunosuppressive agent was referred to ophthalmological examination because of a red eye, pain, and blurred vision in his right eye. The clinical picture worsened and diagnosis of endophthalmitis was made. Intravenous amphotericin B injection was performed and did not control the case. Culture of vitreous fluid was positive for Candida. This eye was eviscerated because of increasing pain, progressive infection, and poor response to treatment. Posterior histopathological study was conclusive for *Aspergillus* endophthalmitis in the right eye (Fig 1B and 2). At the same time, fundus examination of the left eye showed two subretinal exudatives lesion located at nasal and inferior retina with retinal oedema associated with superficial haemorrhages (Fig 1A). The vitreous was clean and the central macula remained intact. Visual acuity was 6/6 in this eye.

Vitreous biopsy or culture may yield negative results in some cases of early intraocular *Aspergillus* endophthalmitis. We did not take a vitreous biopsy of the left eye, since we already had the diagnosis in the right eye and the visual acuity was 6/6. This eye was treated with intravenous amphotericin B and oral itraconazole with a good result. The patient remained stable with resolution of the lesions and no focus of systemic aspergillus was found.

**Comment**

Fungal endophthalmitis is uncommon. In most of the cases *Candida* is the causal organism. Few cases of *Aspergillus* endophthalmitis in a patient with chronic lymphocytic leukaemia have been described, and according to the literature endogenous *Aspergillus* endophthalmitis represents a manifestation of disseminated aspergillus, usually a fatal infection. This is a good result because it is bilateral and no focus of systemic aspergillus was found.

The cases of intraocular inflammation secondary to *Aspergillus* are more common in the central macula and have a poor prognosis. In our case the localisation of the chorioretinitis in the left eye was out of the posterior area and the patient’s visual acuity remained 6/6.

The major antifungal agent used in aspergillus is amphotericin B. Without host immune competence, treatment is rarely effective. Penetration of intravenous amphotericin B into the vitreous cavity of the normal or inflamed eye is poor. The azole compounds have been used to reduce the significant toxicity and enhance the efficacy.
of intravenous amphotericin B; oral fluconazole is the drug of choice because it has excellent penetration in central nervous system and vitreous. Intracanal are may be used. Intravitreal amphotericin B and vitrectomy have given the best results in the treatment of these cases. Our patient received intravenous amphotericin B and oral itraconazole and this therapy was sufficient to control the infection.

This case shows that Aspergillus endophthalmitis should be considered in all patients with immune deficiency even in the absence of systemic aspergillosis. Treatment with intravenous amphotericin B may be able to control these cases and should be attempted more often.

D de O Machado, R Gonçalves, E M Fernandes, W R Campos, F Oréfice
Department of Ophthalmology, Federal University of Minas Gerais, Brazil

A L L Curi
Department of Ophthalmology, Federal Fluminense University Niterói, Brazil

Correspondence to: André L L Curi, R Francisco Dutra 163/701, Icarai, Niterói, RJ, Brazil cep 24220150; curiid@yahoo.com

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References

Late bleb needling
Surgical manipulation of the trabeculectomy bleb has become a recognised postoperative procedure to increase the success of glaucoma surgery. The first needling revision of a glaucoma drainage bleb was described in 19411 and there are several reports of the successful restoration of failing blebs within the first 3 years following trabeculectomy.2,3

We report the results of five cases of late bleb needling with 5-fluorouracil (5-FU) where trabeculectomy had been performed between 8 and 30 years earlier.

Table 1 Demographic details of patients

<table>
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<th>Case no</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Drainage procedure</th>
<th>Delay to needling (years)</th>
<th>No of needlings</th>
<th>No of 5-FU injections</th>
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<td>1</td>
<td>72</td>
<td>M</td>
<td>Bilateral Scheie’s</td>
<td>31</td>
<td>2</td>
<td>4</td>
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<tr>
<td>2</td>
<td>88</td>
<td>F</td>
<td>Left ECCE-trabeculectomy</td>
<td>10</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>80</td>
<td>F</td>
<td>Right trabeculectomy</td>
<td>12</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>71</td>
<td>M</td>
<td>Right trabeculectomy</td>
<td>8</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>71</td>
<td>M</td>
<td>Bilateral trabeculectomy</td>
<td>13</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

ECCE = extracapsular cataract surgery.

Case reports
The demographic details of all cases are summarised in Table 1.

Glaucoma surgery had taken place between 8 and 31 years before bleb needling and in no case had antimiotics been used after the original surgery. Before bleb needling the average intraocular pressure (IOP) among the patients was 29.4 mm Hg (range 19-58). Each patient showed glaucomatous deterioration despite being on maximum tolerated medical therapy, taking on average three ocular hypotensive agents, and in two cases oral acetazolamide. In all cases an open sclerotomy was confirmed by gonioscopy.

All procedures were performed in the outpatient clinic, by either a consultant or associate specialist, using a slit lamp. The eye was anaesthetised with amethocaine eye drops 1%, and phenylephrine eye drops 2.5% were used for vasoconstriction. After several drops of chloramphenicol the conjunctiva was entered several millimetres from the flap site with a 27 gauge needle mounted on an insulin syringe. In one case aqueous flow was established after perforating scar tissue around an encysted bleb, whereas in the others it was necessary to dissect beneath the scleral flap and enter the anterior chamber. After creating a bleb and confirming a reduction in IOP by applanation tonometry, 5 mg 5-FU (25 mg/ml) were injected into the subconjunctival space around the bleb. After needling, all hypotensive therapies were stopped and replaced by intensive topical steroids and chloramphenicol. The steroid was titrated, and repeat injections of 5-FU with or without needling were given, according to the IOP and appearance of the bleb.

After 12 months’ follow up from the last needling (Table 2), average IOP was reduced to 14 mm Hg (range 9-17). There was no change in the patients’ visual acuity. Two cases developed a mild corneal epitheliopathy that healed within 8 weeks. There were no other complications from the needling procedure.

Comment
Although trabeculectomy is the preferred glaucoma drainage procedure, only 67% of patients may achieve an adequate target pressure after 1 year.4 In recent years glaucoma surgery has developed with the use of antimiotics and intense postoperative surveillance with bleb manipulation. Reports show that bleb needling used in combination with subconjunctival 5-FU injections can rectify a failing bleb in the early postoperative phase but there are few reports confirming its effect in the late postoperative period.5 Some studies have indicated that the success of bleb needling is unrelated to the time lapsed from the original surgery.6 Though in these studies the maximum interim period was less than 4.5 years.

The patients presented in this study had had their original glaucoma surgery at least 8 years previously and bleb needling was carried out before listing the patient for a repeat trabeculectomy with mitomycin C. The only adverse effect noted was a temporary corneal epitheliopathy, probably related to toxicity of the 5-FU. Other reported adverse events after bleb needling include hyphaema, bleb leak, shallow anterior chamber, choroidal effusion and endophthalmitis, but there are no reports of long term hypotony as has been described following mitomycin C trabeculectomy.

These case reports indicate that bleb needling may be successful in achieving a long lasting IOP reduction even several years after the original surgery. The procedure does not require dextrous skills beyond that of a trained general ophthalmologist. It appears at least as safe as trabeculectomy and avoids a formal operation. If it does fail the surgical field is still intact for a “redo” trabeculectomy.

C T Ung, H Von Lany, K G Claridge
Taunton and Somerset NHS Trust, Musgrove Park, Taunton TA1 5DA, UK

www.bjophthalmol.com
Correspondence to: Ms Katherine Claridge, Taunton and Somerset NHS Trust, Musgrove Park, Taunton TA1 5DA, UK; kate.claridge@tst.nhs.uk

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References


MAILBOX

The success rates for endonasal dacryocystorhinostomy

Tsirbas and Wormald are to be congratulated on their landmark paper in lacrimal surgery. Their predecessor paper published in the Laryngoscope put this paper into perspective.

Their results are seemingly impressive, with anatomical success rate of 95% and functional success rate of 89%, closely approaching those of other endonasal DCR techniques. The success rates for mechanical endonasal DCR reported by Tsirbas and Wormald appear to be very good (95% anatomical and 89% functional success), but their follow up period varied from only 2 months on (mean 9.7). Some of the patients who had only a short follow up time may subsequently fail. A paper published in the American Journal of Ophthalmology by the same authors using the same technique, when they had a minimal follow up of 9 months, had a lower anatomical success rate (91%).

It is important to define success and what this really means, and for lacrimal surgeons to agree consistent outcome criteria. Perhaps lacrimal surgeons should agree the following criteria for DCR surgical success, irrespective of whether it is by an external or endonasal route:

- Assess the outcome a minimum of 6 months after surgery, being at least 3 months after removal of tubes. Is or 1 year after surgery better?
- Assess subjective success based on the patient’s symptoms.
- Assess objective success (anatomical success) based on (i) presence of a functioning rhinostomy and (ii) absence of stenosis.

Despite these minor quibbles, the authors are to be congratulated on advancing endonasal lacrimal surgery.

J M Olver
Western Eye Hospital, Marylebone Road, London NW1 5YE, UK; janeolver@oal.com

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References


Trypan blue stains the epiretinal membrane but not the internal limiting membrane

We read with great interest the paper by Li et al about staining of the internal limiting membrane (ILM) and epiretinal membrane (ERM) with trypan blue (TB). We would like to comment on one aspect of this paper, when the authors claimed that a good staining of both the ILM and the ERM was achieved with TB. We disagree that ILM is stained by TB, and propose that TB only stains the ERM, not the ILM.

The authors affirm “ILM staining” with TB as they observed histologically the presence of ILM in four eyes with macular holes at stage III and IV. In one of those eyes, immunohistochemistry was performed, and an epiretinal membrane was found. In the other three cases, immunohistochemistry examination was not performed because of insufficient tissue. Most of the stage III and IV macular holes are known to be associated with an epiretinal membrane, and probably an ERM would be seen in addition to the ILM in those three cases if immunohistochemistry for gliar elements were performed. Therefore, we believe that TB stained the ERM associated with the macular holes, but not the ILM. In their study, staining with TB of seven patients with idiopathic epiretinal membrane was successfully performed. ERM of proliferative vitreoretinopathy is also reported to be well stained by TB. We speculate that TB has binding affinity to some of the gliar cell elements of the highly cellular ERM, either those associated with macular holes or not.

Indocyanine green (ICG) is another dye for intraretinal staining that has wide acceptance among retina surgeons in the past few years. In contrast with the cellular affinity of TB, ICG stains the acellular ILM, because of the fast binding of ICG to collagen proteins of the ILM. ERM tends to be stained negatively by ICG, well because the hydrophilic ICG does not penetrate cell membranes easily.

TB staining seems to be a good alternative to ICG staining in the surgical management of macular diseases. Further studies are warranted on the intraocular kinetics of that dye.

E B Rodrigues, C H Meyer, J C Schmidt, P Kroll Department of Ophthalmology, Philipps-University Marburg, Germany

Correspondence to: E B Rodrigues, MD; Department of Ophthalmology, Philipps-University Marburg, Germany, edubrodriques@yahoo.com.br

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References

1. Li K, Wong D, Hislop P, et al. Trypan blue staining of internal limiting membrane and...
Thermochemotherapy in hereditary retinoblastoma

Schueler and associates describe their experience with thermochemotherapy (TCT) in bilateral retinoblastoma. The results of transscleral thermochemotherapy used in combination with chemotherapy are encouraging with 86–96% tumour control.1 In the current series, however, local recurrence occurred in 38%.

The dosage of carboplatin used in the current series was 10 mg/kg body weight, which is lower than the standard dosage of 18.6 mg/kg body weight. Lower dose of carboplatin, the key drug in the chemotherapy regimen for retinoblastoma, could have influenced the higher recurrence rate.

The authors mention that they treated a large number of infants with phthisis bulbi. However, in our experience, tumours located in the macular area are better treated initially with chemotherapy for 3–6 cycles in order to achieve maximum possible reduction in tumour size before considering thermochemotherapy. Chemotherapy reduced macular tumours tend to shrink away from the fovea towards one of the major arcades or the optic nerve, thus exposing the foveal region. Recidual tumours beyond 3–6 cycles of chemotherapy could be treated with thermochemotherapy. A smaller scar thus produced may optimise residual central vision.

The high mean total duration of thermochemotherapy in the current series is probably because of a smaller spot size of 0.4 mm. The diode laser (Iris Medical Inc, Mountain View, CA, USA) with an operating microscope adapter allows for a spot size of 0.8, 1.2, and 2.0 mm.20 The relatively larger spot size is probably because of a smaller spot size of 0.4 mm. The diode laser (Iris Medical Inc, Mountain View, CA, USA) with an operating microscope adapter allows for a spot size of 0.8, 1.2, and 2.0 mm.19 The relatively larger spot size is probably because of a smaller spot size of 0.4 mm. The diode laser (Iris Medical Inc, Mountain View, CA, USA) with an operating microscope adapter allows for a spot size of 0.8, 1.2, and 2.0 mm.20

Corrections

An error occurred in the author listings for two letters in the September issue. In the letter by Lee et al (Br J Ophthalmol 2003;87:1184–5) the order should be D K Lee, E B Suhler, W Augustin, R R Buggage.

In the letter by Buggage et al (Br J Ophthalmol 2003;87:1190–1) the order should be R R Buggage, D G Callanan, D F Shen, C-C Cheng. The journal apologises for the error.

In the article by Williamson et al in the September issue (Br J Ophthalmol 2003;87:1126–9), the author list contained an error. The correct spelling is N Strouthidis. The journal apologises for the error.

In the article by Courtright et al in the September issue (Br J Ophthalmol 2003;87:1079–82), the author list contained an error. The correct spelling is V K Hoehmssmann. The journal apologises for the error.


Causes of severe visual impairment and blindness in children in Ethiopia

We read with great interest the article by Kello et al.1 The authors have to be congratulated for the hard hitting and well written article. A current concern for people involved in paediatric eye care is the emergence of what is probably the third epidemic of retinopathy of prematurity (ROP) in developing countries.2 It is therefore significant that no case of ROP was found in the population screened in this study. Several factors could account for this.

• The very low or nil prevalence of ROP in countries such as Ethiopia, where the study was carried out, is most probably because of lack of intensive care facilities for premature infants and their low survival rates.

• The variation in the incidence of ROP between ethnic groups could also account for this, with the available evidence suggesting that African-American infants are less prone to severe outcome ROP than white infants.3

• However, it is also important to note that the article mentions that children with mental retardation were not examined owing to the admission criteria of the blind schools that preclude their admission. This too could have accounted for the gross underestimation of the prevalence of ROP as suggested by Jacobson et al.6

In addition, these children with mental handicap could be suffering from cerebral palsy and would have been at high risk for ROP because of the higher incidence of retinal vascular anomalies associated with both cerebral ischaemia and prematurity.7

• A large number of infants had phthisis bulbi (51 cases). In children with bilateral phthisis bulbi, there is a possibility that an unknown proportion developed the condition secondary to end stage ROP.

In conclusion, if improvement in perinatal care occurs in Ethiopia, the overall numbers of children with ROP would increase as is seen in other developing countries like India with infant mortality rates (IMRs) between 10–60 per 1000 live births. Lack of ophthalmologists experienced in the management of ROP could be effectively circumvented by introduction of digital retina camera technology to improve access to subspecialty care for cases requiring treatment. As a lower cost option, screening infants under 1200 g alone might be more cost effective and could be the first step, with modification of the screening guidelines made later, consequent to research undertaken within the country itself.

V Vedantham, P K Rathagiri
Aaravind Eye Hospital and Postgraduate Institute of Ophthalmology, Madurai, Tamil Nadu 625 020, India

Correspondence to: V Vedantham, Department of Retina-Vitreous, Aaravind Eye Hospital and Postgraduate Institute of Ophthalmology, I Anna Nagar, Madurai, Tamil Nadu 625 020, India; drvusumathy@yahoo.com

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References


NOTICES

Elimination of avoidable blindness

The latest issue of Community Eye Health (No 46) discussed the resolution of the World Health Assembly on the elimination of avoidable blindness. For further information please contact: Journal of Community Eye Health, International Resource Centre, International Centre for Eye Health, Department of Infectious and Tropical Diseases, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK (tel: +44 (0)20 7924 7664; email: Anita.Shah@lshtm.ac.uk; website: www.jche.co.uk). Annual subscription (4 issues) UK £28/US$45. Free to developing country applicants.

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 ophthalmology, is regularly sending volunteer surgeons to India. Details can be found at the charity’s website (www.secondsight.org.uk) or by contacting Dr Lucy Matthen (lucymatthen@yahoo.com).

Specific Eye ConditionS (SPECS)

SPECS represents over 50 different organisations related to eye disorders ranging from conditions that are relatively common to very rare syndromes. The website acts as a portal giving direct access to support groups’ own websites. 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: k@eyeconditions.org.uk; website: www.eyeconditions.org.uk).

The British Retinitis Pigmentosa Society

The British Retinitis Pigmentosa Society (BRPS) was formed in 1975 to bring together people with retinitis pigmentosa and their families. The principle aims of BRPS are to raise funds to support the Global Initiative for the Elimination of Avoidable Blindness by setting up a national Vision 2020 plan by 2005; (2) Establish a national coordinating committee for Vision 2020; and (3) Help people with retinitis pigmentosa, their families. The website acts as a portal giving direct access to support groups’ own websites. 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: k@eyeconditions.org.uk; website: www.eyeconditions.org.uk).

Surgical Eye Expeditions International

Volunteer ophthalmologists in active surgical practice are needed to participate in short term, sight restoring eye surgery clinics around the world. Contact: Harry S Brown, Surgical Eye Expeditions International, 27 East De La Guerra, C-2, Santa Barbara, CA 93101-9858, USA (tel: +805 963 3303; fax: +805 965 3564; email: hsbrown.md@cox.net or seeintl@seeintl.org; website: www.seeintl.org).

Rise in organ transplant numbers

According to UK Transplant, the UK has seen the highest number of organ transplants in six years. Last year (1 April 2002 to 31 March 2003), 2777 patients had their lives saved or dramatically improved through the generosity of 1064 donors. This equated to a 6% increase compared to the previous 12 months (1 April 2001 to 31 March 2002). Furthermore, during 2002–3, the highest number of people benefited from organ transplant for at least five years (1997–98) and 240 more people had their sight restored than the previous year. For further information see UK Transplant’s website (www.uktransplant.org.uk).

Elimination of avoidable blindness

The 56th World Health Assembly (WHA) considered the report on the elimination of avoidable blindness (doc A56/26) and urged Member States to: (1) Commit themselves to supporting the Global Initiative for the Elimination of Avoidable Blindness by setting up a national Vision 2020 plan by 2005; (2) Establish a national coordinating committee for Vision 2020; and (3) Help people with retinitis pigmentosa, their families. The website acts as a portal giving direct access to support groups’ own websites. 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: k@eyeconditions.org.uk; website: www.eyeconditions.org.uk).

5th International Symposium on Ocular Pharmacology and Therapeutics (ISOPT)

The 5th International Symposium on Ocular Pharmacology and Therapeutics (ISOPT) will take place 11-14 March 2004, in Monte Carlo, Monaco. Please visit our website for details of the scientific programme, registration, and accommodation. To receive a copy of the Call for Abstracts and registration brochure, please submit your full mailing details to http://www.kenes.com/isopt/interest.htm. Further details: ISOPT Secretariat (website: www.kenes.com/isopt).

XVth Meeting of the International Neuro-Ophthalmology Society

The XVth Meeting of the International Neuro-Ophthalmology Society will be held on 18-22 July 2004, in Geneva, Switzerland. Further details: Prof. A Safran, University Hospital Geneva, c/o SYMPORG SA, Geneva (fax: +41 22 839 8484; email: info@symporg.ch; website: www.symporg.ch).

4th International Congress on Autoimmunity

The 4th International Congress on Autoimmunity will take place 3–7 November 2004 in Budapest, Hungary. The deadline for the receipt of abstracts is 20 June 2004. Further details: Kenes International Global Congress Organisers and Association Management Services, 17 Rue du Cendrier, PO Box 1726, CH-1211 Geneva 1, Switzerland (tel: +41 22 908 0488; fax: +41 22 732 2850; email: autoim04@kenes.com; website: www.kenes.com/autoim04).

Wake up call as dream time deadline looms

Scientists have less than a month left to apply for a new Dream Time award from NESTA, the organisation that invests in UK creativity and innovation. Dream Time supports exceptional achievers (with at least 10 years experience in their field) who want time to experiment or follow a passion, but who intend to continue with their career and put what they have discovered to good use. Up to 12 exceptional individuals from the fields of science, technology and the arts will each receive up to £40,000 to pursue their goals and push at the boundaries of knowledge and practice. NESTA is looking for people who can demonstrate evidence of exceptional achievement. This would include a significant body of work collated over at least a decade in their field, the ability to work in new ways and a commitment to the proposed area of development. Dream Time is a development of NESTA’s existing Fellowship Programme, which has helped talented and creative individuals to innovate and explore new ideas emerging through periods of personal or professional development. As with all its awards, NESTA is looking for people who demonstrate excellence, promise, creativity, innovation and commitment. Funding can be used on a full- or part-time basis, in tandem with professional careers if the candidate can meet the constraints of employment. Offered awards can be for any period of time up to 12 months.
one year. Dream Time Fellows will be asked to provide 10% in kind support for their plan and will be required to plan ways of disseminating their findings with their professional community. To apply, visit NESTA’s website: www.nesta.org.uk/dreamtime.

14th Meeting of the EASD Eye Complication study group

The 14th Meeting of the EASD Eye Complication (EASDEC) study group will take place on the 21–23 May 2004. There will be key lecture notes on the following topics:

Peter Gaede (Denmark)—Results of the Steno 2 study, Hans Peter Hammes (Germany)—Animal models of diabetic retinopathy, Massimo Porta (Italy)—Screening with the London protocols: 12 years after, and Anselm Kampik (Germany)—Surgical options in diabetic retinopathy. There will also be case presentations and oral and poster presentations. The EASDEC board comprises F Bandello (President), PJ Guillausseau (Vice President), C-D Agardh (Past President), P Massin (Secretary), M Porta (Treasurer). The Scientific and Organizing Committee includes: F Bandello, PJ Guillausseau, P Massin, C-D Agardh, M Porta, A Kampik, M Ulbig, and G Lang. There are three travel grants available, at 1000 Euro each, for young scientists (less than 35 years at the time of the meeting). Application for the grant should be made together with the submission of the abstract. For further information, contact: Department of Ophthalmology, Ingrid Mannl, Ludwig-Maximilians-University, Mathildenstr. 8, 80336 Munich, Germany (tel: +49-89-5160-3800; fax: +49 89 5160 4778; e-mail: easdec@ak-i.med.uni-muenchen.de. The deadline for abstracts is 2 March 2004.