Wegener’s granulomatosis

Wegener’s granulomatosis (WG) is a systemic granulomatous inflammatory disease of unknown origin. It occurs at any age, with the peak incidence in the third and fourth decades. The classic diagnostic triad of WG is necrotising granuloma of the upper or lower respiratory tract, vasculitis, and nephritis. Identifying a raised ANCA titre is virtually diagnostic of the disease, especially with the classic granular cytoplasmic staining pattern of neutrophils (C-ANCA). This disease is usually fatal if untreated; however, early diagnosis and instigation of immunosuppressants such as cyclophosphamide can induce long term remission.1

Case report

A 79 year old woman presented with a 2 week history of a painful, red left eye. She had mild arthritis and was also noted to be profoundly deaf, requiring hand written notes for communication. There was no history of sinus problems.

Her best corrected visual acuities were 6/18 in the right eye and 6/12 in the left eye. The left peripheral supratemporal cornea showed three areas of 80% corneal thinning, 1 x 1 mm in size, with an overlying epithelial defect (Fig 1). There was adjacent conjunctival injection and moderate anterior chamber cellular activity. The other eye was normal with no signs of inflammation. Examination of her hands showed no obvious rheumatoid abnormalities. Initial investigations performed were full blood count, electrolytes, C reactive protein, erythrocyte sedimentation rate (ESR), and rheumatoid factor. Corneal scraping and cultures were also undertaken to exclude an infective cause. The only significant test result was a raised ESR of 94, with other tests including creatinine being within the normal range. A provisional diagnosis was made of rheumatoid corneal melt and treatment was commenced with topical dexamethasone 0.1% non-preserved hourly and oral prednisolone at 40 mg/day.

After 5 days of steroid treatment, the corneal thinning was resolving and the conjunctival injection settling (Fig 2). Also by the fifth day, the patient’s hearing had dramatically improved. She could now conduct a conversation at normal volume. On further questioning, she said her hearing had deteriorated only over the past few months and had ascribed it to “natural” old age deterioration. This suggested a link between her corneal changes and hearing loss and she was investigated for Wegener’s granulomatosis (WG). Her serum antineutrophil cytoplasmic antibodies (cANCA) titre was found to be raised (>160). Rheumatoid factor was negative.

Oral cyclophosphamide was commenced on diagnosis of WG and the oral prednisolone slowly tapered. Her ocular inflammation, hearing, and arthritis continued to improve on treatment and at the 2 month follow up, there was minimal peripheral corneal thinning and no inflammation. Corrected visual acuity in the left eye remained at 6/12. Examination by an otolaryngologist found mild hearing impairment and no significant sinus pathology. Rheumatological review found only mild arthropathy.

Comment

The majority of the ocular involvement in WG is caused by focal vasculitis, involving the anterior and/or posterior segment of the eye and corneal melting has been reported in 11–16% of patients with WG.2,3 Profound sensorineural deafness is a less common feature, occurring in about 6% of patients on presentation.4,5 It occurs either secondary to inflammation of the cochlear vessels or serious otitis media.6 Other important systemic features include pyrexia, weight loss, recurrent epistaxis, sinus discharge, haemoptysis, peripheral neuropathy, cerebral vasculitis, and renal failure (major cause of death). Fortunately in this case, the patient had the limited form of WG, with no renal involvement.

This patient presented with an uncommon combination of corneal melt and profound deafness. As deafness is a relatively common problem among the elderly patient population, it may be overlooked as an important symptom, especially if ocular pathology is the main feature at presentation. It was not until the patient’s hearing improved on treatment with oral prednisolone that its significance became apparent. WG is a rare condition and early recognition and treatment are essential as the disease carries a significant risk of serious complications. A full systemic history in patients with corneal melt is important in formulating the correct diagnosis and thereby expediting the appropriate treatment.

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References


Figure 1 Peripheral corneal melt with adjacent conjunctival injection.

Figure 2 Resolving peripheral corneal melt and conjunctival injection.

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Pigmentary retinopathy, macular oedema, and abnormal ERG with mitotane treatment

Adrenocortical carcinoma is a rare tumour with a poor prognosis. Mitotane (o,p’-DDD), a chemotherapy drug that suppresses the adrenal cortex and modifies peripheral steroid metabolism has been reported to cause ocular side effects including visual blurring, diplopia, cataract, toxic retinopathy with retinal haemorrhage, oedema, and papilloedema. We present a 32 year old woman with reduced visual acuity, retinal pigmentation, macular oedema, and abnormal ERG after taking mitotane. While primary hypoadrenalism in Addison’s disease has never been reported to cause any retinal problem, secondary hypoadrenalism in adrenolectodystrophy is associated with pigmentary retinopathy and other ocular findings. We postulate that the retinal problems secondary to mitotane treatment may act via a similar mechanism.

Case report

A 30 year old woman had a left nephrectomy, adrenalectomy, and chemotherapy in September 1997 following diagnosis of an adrenal carcinoma. In 1999, she was found to have secondary tumours in her lungs and liver. She was commenced on intra-arterial cisplatin and oral mitotane of up to 4.5 g daily for 6–8 months, ceasing in December 1999 because of weight loss, malaise and, soon after that, marked decrease of visual acuity in both eyes. The patient had no family history of any retinal disease. She had worn glasses for myopia for 9 years with best corrected visual acuity of 6/4 each eye previously.

On 2 March 2000 her visual acuity was 6/12 in the right eye and 6/60 in the left eye. She also had facial pigmentation. Funduscopy showed extensive pigmentary clumping in each eye and macular oedema in the left side (Fig 1). She was commenced on cortisone acetate and fludrocortisone to attempt to improve her vision.
our knowledge neither pigmentary retinopathy nor abnormal ERG findings have been reported previously. Previous studies also did not mention side effects reversibility except for a case of lenticular opacities that disappeared 5 days after discontinuation of mitotane. In our case, the patient’s visual acuity did improve significantly, with drying out of macular oedema after cessation of therapy and initiation of steroid replacement. It is possible, however, that the ocular changes in this patient were not caused by mitotane but were secondary to cancer associated retinopathy (CAR). Its characteristic findings include attenuated retinal arterioles, with limited, if any, clinically apparent retinal pigmentary changes and cells in the vitreous humour. CAR was considered to be unlikely in this case because of the normal calibre of the retinal arterioles, the absence of vitreous cells, and the timing of the onset. Patients with CAR experience visual symptoms that often precede or are concurrent with the tumour diagnosis. Although primary hypoadrenalinism in Addison’s disease has never been reported to cause retinal problems, secondary hypoadrenalinism in adrenoependyctomy is associated with pigmentary retinopathy and other ocular findings. Adrenoependyctomy is a group of rare lipid storage disorders with increased serum level of long chain fatty acids (C24–C30). Ocular findings in adrenoependyctomy include visual loss secondary to visual tract demyelination and primary retinal ganglion cell degeneration, squint, cataracts, loss of corneal sensation, abnormal visual evoked potentials, and macular pigmentary changes. The retinal pigmentary changes observed histologically were different from those in retinopathy of prematurity.14 We postulate that the retinal side effects of mitotane could occur via a similar mechanism that affects the metabolism of long chain fatty acids. Mitotane causes a reduction in plasma cholesterol, liver enzymes, corticosteroid binding globulin, and sex hormone binding globulin. At the time of writing, there was no published information on whether mitotane treatment affects serum long chain fatty acid levels. The availability of such data will be valuable for evaluating this postulation.

Figure 2 Right fundus showing mottled pigmentation at the macula.

One week later her visual acuity was 6/18 in the right and 6/24 in the left. Fundus examination showed mottled pigmentation at the macula and mid-periphery of both eyes but macular oedema in her left eye had resolved. Disc and vessels were normal. Full field electroretinography (ERG) was performed. Her rod response (scotopic, dim blue stimulus) b-wave was 50% of normal, the rod response (photopic, red stimulus) b-wave was 4% in a study of 132 patients. The amplitude of 30 Hz cone response (photopic, red stimulus) b-wave was 50% of normal, the implicit time (Fig 2). The amplitude of 30 Hz flicker responses was also reduced. There was no significant asymmetry between the two eyes. On 30 March 2000, her visual acuity improved to 6/12 in the right and 6/9 in the left. Her facial pigmentation had also faded.

Comment
Surgical resection is the treatment of choice for adrenocortical carcinoma.1 Mitotane (o,p’-DDD) is the only drug that causes regression of metastases and improves survival.12 Its biochemical action is unknown but data suggest that it modifies peripheral steroid metabolism and directly suppresses the adrenal cortex. The incidence of ocular side effects was 4% in a study of 132 patients.13 These effects include visual blurring, diplopia, lens opacities, optic neuritis, and a toxic retinopathy that included papilloedema, small opacities, optic neuritis, and a toxic retinopathy with features of papilloedema and associated retinopathy (CAR). Its characteristic findings include attenuated retinal arterioles, with limited, if any, clinically apparent retinal pigmentary changes and cells in the vitreous humour. CAR was considered to be unlikely in this case because of the normal calibre of the retinal arterioles, the absence of vitreous cells, and the timing of the onset. Patients with CAR experience visual symptoms that often precede or are concurrent with the tumour diagnosis. Although primary hypoadrenalinism in Addison’s disease has never been reported to cause retinal problems, secondary hypoadrenalinism in adrenoependyctomy is associated with pigmentary retinopathy and other ocular findings. Adrenoependyctomy is a group of rare lipid storage disorders with increased serum level of long chain fatty acids (C24–C30). Ocular findings in adrenoependyctomy include visual loss secondary to visual tract demyelination and primary retinal ganglion cell degeneration, squint, cataracts, loss of corneal sensation, abnormal visual evoked potentials, and macular pigmentary changes. The retinal pigmentary changes observed histologically were different from those in retinopathy of prematurity.14 We postulate that the retinal side effects of mitotane could occur via a similar mechanism that affects the metabolism of long chain fatty acids. Mitotane causes a reduction in plasma cholesterol, liver enzymes, corticosteroid binding globulin, and sex hormone binding globulin. At the time of writing, there was no published information on whether mitotane treatment affects serum long chain fatty acid levels. The availability of such data will be valuable for evaluating this postulation.

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References

Coxsackievirus B4 associated uveoretinitis in an adult
Coxsackievirus is a kind of enterovirus, which may cause respiratory and gastrointestinal symptoms, erythema, meningocoecephalitis, myocarditis, pericarditis, and myositis. Although Coxsackievirus B4 is apparently a rare cause of chorioretinitis, Coxsackievirus infection and concurrent posterior segment inflammation have been disclosed in a few cases. However, iridocyclitis, scattered hemorrhagic dots, and occlusive retinal vasculitis have not previously reported as being features of Coxsackievirus B4 infectious ocular disease.

Case report
A 34 year old man was referred to our hospital with a 2 week history of inferior visual field defect and visual loss in his right eye. His left eye was asymptomatic. A few days before the onset of visual manifestations, the patient noted a prodrome of viral infection, consisting of severe headache and high grade fever of 39.2°C, joint pain, and general malaise. There was no significant medical or family history. At the initial ophthalmic examination, his best corrected visual acuities were 10/20 in the right eye and 25/20 in the left eye, and intraocular pressure was normal in both eyes. Slit lamp examination showed moderate cellular infiltration in the anterior chamber in both eyes. Humphrey central visual field testing demonstrated relative scotoma inferior fixation in the right eye. Goldman peripheral visual field testing was within normal limits in both eyes. Ophthalmoscopic examination disclosed subretinal exudates with haemorrhage in the parafovea and the mid-periphery of bilateral eyes (Fig 1). Moreover, scattered

Figure 2 Full field ERG.
This patient as uveoretinitis induced by scotoma persisted in his right eye. Antibody the left eye. However, relative paracentral.

haemorrhagic dots and dots were observed along retinal vessels. The optic discs appeared normal. Fluorescein angiography demonstrated occlusive retinal vasculitis characterised by blocked fluorescence and mild dye leakage from the retinal vessels corresponding to the lesions detected clinically, and irregular choroidal background fluorescence (Fig 2). Laboratory examination findings were normal except a white blood cell count of 10 500 ×10^6/l, GOT of 76 IU/L, GPT of 209 IU/L, gamma-GTP of 88 IU/L, and LDH of 771 IU/L. Serological tests, however, revealed a slight elevation of serum antibody to Coxsackievirus B4, at a titre of 1:8 (neutralisation test).

The patient's general condition improved gradually without specific medication. Cellular infiltration in the anterior chamber gradually disappeared. The retinal exudative lesions reduced in size, and haemorrhage tended to decrease. Eight months after the initial ophthalmic examination, bilateral exudative lesions had improved and were replaced by scars, and most of the retinal haemorrhagic lesions had disappeared. Visual acuity was restored to 25/20 in the right eye and 30/20 in the left eye. However, relative paracentral scotoma persisted in his right eye. Antibody titre to Coxsackievirus B4 had increased, demonstrating a 16-fold rise between the acute (1:8) and convalescent sera (1:128). Retrospectively, we diagnosed the ocular lesions in this patient as uveoretinitis induced by Coxsackievirus B4 infection.

**Comment**

Viruses are one of the most common causes of infections involving the posterior segment of the eye. Such infections may be congenital or acquired, and may affect primarily the retina or the choroid. Retinitis and choroiditis caused by viruses such as measles, influenza, Epstein-Barr virus, and Rift Valley fever virus typically occur on an acquired basis, subsequent to an acute viral systemic illness. Coxsackievirus-associated chorioretinitis is thought to elicit the same clinical course as in other viral chorioretinitis. Coxsackievirus infection and concurrent posterior segment inflammation have been reported in a few cases, in which clinical and antibody titres suggested that Coxsackievirus was the responsible agent. Among them, two cases of chorioretinitis associated with Coxsackievirus B4 infection were reported. One was a paediatric case, and the ophthalmoscopic manifestation was described as scattered white lesions in mid-periphery of the retina. The other was an adult case, with chorioretinitis similar to the multiple evanescent white dot syndrome. However, the clinical features observed in our patient consisted of iridocyclitis, scattered haemorrhagic dots, and occlusive retinal vasculitis were apparently different from the two earlier reports.

Coxsackievirus infection is apparently a rare cause of uveoretinitis but, nevertheless, should be considered in the appropriate clinical setting, since it is possible that overt clinical manifestations and complications may occur depending on the severity and the location of the uveoretinal lesions.

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**References**


**Evaluation of telemedicine for slit lamp examination of the eye following cataract surgery**

Ophthalmic surgery is well suited to the use of telemedicine in diagnosis and management, but diagnostic accuracy and reliability are critical if it is to be widely introduced. Moorfields Eye Hospital is located in central London and runs community outreach clinics. One clinic and operating list in Ealing is 17 miles from the central hospital. The surgical teams operate in Ealing and return to the central hospital. We therefore investigated the use of a telemedicine link for review of postoperative cataract surgical patients aiming to assess what can be seen clearly and reliably using telemedicine and to identify what the observer using this link may potentially miss.

**Case report**

This study had Moorfields Eye Hospital research and ethics committee approval. Patients consecutively admitted for cataract surgery were recruited to this study and full informed written consent was obtained. A telelink of a pair of Global Teledem mobile workstations connected by three ISDN lines, with a video transmission rate of 384 bit/s was used for examinations with high resolution examination being achieved by static images. Two surgeons conducted examinations, one using the slit lamp and the other using the telemedicine link. Slit lamp signs graded by the two observers comprised the presence and degree of the following—central corneal oedema, corneal oedema at the limbal section, Siedel's sign, folds in Descemet's membrane, anterior chamber depth, flare and cells, intraocular lens decentration, and lens stability. Both observers in person independently examined a group of postoperative cataract patients in order to determine agreement between practitioners.

Twelve consecutive postoperative cataract patients were recruited to the study with 10 others as a control group to assess interobserver agreement by in-person examination. The results of the study are given in Table 1.

**Comment**

Although interobserver variation means that telelink reliability cannot be precisely calculated in terms of sensitivity and specificity, these findings give an indication of the accuracy of slit lamp examination after cataract surgery using 384 K bandwidth. Examination by video telelink was relatively reliable in detecting oedema at the central cornea but did not consistently detect oedema at the corneal section, or anterior chamber flare and failed entirely to detect DM folds or anterior chamber cells. Patients enjoyed the telemedicine experience finding it reassuring to see as well as interact with their surgeon via the telelink.

Video compression algorithms used in streaming video are “lossy” and higher bandwidth increases video quality. The process begins with a good video source with low noise, since noise does not compress well. A poor quality video input is very difficult to stream successfully because of this difficulty in compression. The videoconferencing standard H-261 was implemented to provide for video compression to a given ISDN bandwidth. With increasing bandwidth there is correspondingly better quality video. A televiselink link for corneal assessment in Canada using six ISDN lines (768 K) was found to be acceptable, whereas three lines (384 K) were unacceptable (personal communication, Dr M Pop, Montreal, Canada).

The video display also affects the information observed. Broadcast video monitors are accurately colour calibrated, whereas digital compressed video to 384 K bandwidth has
Table 1 Consistency of scoring by the two observers

<table>
<thead>
<tr>
<th></th>
<th>Control group (n=10)</th>
<th>Study group (n=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oedema of the incision $\chi^2=2.933, p=0.087$</td>
<td>7/10 (70%) 4/12 (33%)</td>
<td></td>
</tr>
<tr>
<td>Oedema of the central cornea</td>
<td>7/10 (70%) 10/12 (83%)</td>
<td></td>
</tr>
<tr>
<td>Descemets folds</td>
<td>10/10 (100%) 7/12 (58%)</td>
<td></td>
</tr>
<tr>
<td>Anterior chamber cells</td>
<td>9/10 (90%) 0/12 (0%)</td>
<td></td>
</tr>
<tr>
<td>Anterior chamber flare</td>
<td>9/10 (90%) 6/12 (50%)</td>
<td></td>
</tr>
<tr>
<td>Lens implant stability</td>
<td>9/10 (90%) 12/12 (100%)</td>
<td></td>
</tr>
<tr>
<td>Management decisions</td>
<td>9/10 (90%) 11/12 (93%)</td>
<td></td>
</tr>
</tbody>
</table>

Reduced colour depth. Recognition of corneal oedema is less about well defined structure as subtle display of colour and “haze.”

It is felt by the authors that telemedicine is a wholly different experience from a simple telephone conversation and for many situations is capable of facilitating postoperative assessment with trained operators. H-261 video at 384 K (triple ISDN) is sufficient for anterior segment overall examination but is not suitable for detailed corneal examination. Other practitioners have used data rates up to four times faster for more detailed examination.

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References

Inherited retinal dystrophy and asymmetric axial length

The prenatal and postnatal development of the eye is determined by complex interactions between a number of genes, their products, and certain environmental factors. Since each eye is influenced by precisely the same processes as its fellow, mutations in regulatory genes usually lead to symmetric phenotypes. In this report, we describe two siblings of Asian ethnicity, born to unrelated parents with no family history of ocular disease, who have an unusual bilateral retinal dystrophy associated with very asymmetrical ocular growth.

Case report

Sib 1 was a 6 year old girl born at term with no significant past medical history. Her corrected visual acuity was 3/60 in each eye; refraction –17.00 DS right, plano left. Anterior segment examination was normal. Funduscopy of the right eye revealed a “macula coloboma,” extensive retinal pigment epithelial and choroidial atrophy; intraretinal pigment migration and preretinal fibrosis. The appearances of the left eye were similar. No retinal detachment was noted. Axial lengths and ocular volumes were 26.1 mm and 9.4 ml right, 20.7 mm and 4.6 ml left respectively.

Sib 2 was a 6 year old boy with epilepsy who had been born at term after an uneventful pregnancy. Pendular nystagmus had been noted soon after birth and his visual acuity in each eye was 3/60; refraction –17.00 DS right, plano left. Anterior segment examination was unremarkable with normal intraocular pressures. Examination of the right eye (Fig 1A and B) revealed generalised retinal pigment epithelial and choroidial atrophy, a macula “coloboma,” sheathed and occluded retinal vessels inferotemporally, and a shallow inferior longstanding retinal detachment with subretinal fibrosis. The left eye appeared similar; however there was no macula abnormality. By ultrasound, the axial length and ocular volume were 26.70 mm and 9.9 ml right, 20.70 mm and 4.6 ml left respectively.

Figure 1 Colour photographs of right fundus of sib 1 (A) showing macular “coloboma,” generalised retinal pigment epithelial and choroidial atrophy, and evidence of sheathed and occluded retinal vessels inferotemporally; (B) same eye, shallow inferior retinal detachment with subretinal fibrosis.
Adenoma of ciliary pigment epithelium: a case series

Adenoma of ciliary pigment epithelium is a rare tumour. Many are diagnosed retrospectively either after excision or enucleation, as malignant melanoma is suspected. We report a series of four patients found to have adenoma of ciliary pigment epithelium and discuss the clinical features and unusual behaviour of these neoplasms.

Case reports
We reviewed the histopathological reports in the ophthalmic pathology archive dating from 1980 to date and identified four patients who had the histopathological diagnosis of adenoma of ciliary pigment epithelium. We crosschecked the details with the clinical oncology database. We reviewed their notes for features that would help us to identify this ciliary body tumour clinically. The salient features of these patients are given in Table 1.

Patient 1 was reported elsewhere in 1994.1 He had a dark brown multinodular mass in the inferotemporal anterior chamber angle of the left eye. His tumour was a relatively small but invasive lesion. Patient 2 was the only non-white patient with this condition in our series. Her tumour was an incidental finding when she presented to an ophthalmologist with allergic conjunctivitis. The tumour was small and dark brown. The tumour had invaded the anterior chamber angle and the root of the iris occupying one clock hour of the iris. The tumour had invaded the anterior chamber angle and the root of the iris occupying one clock hour of the root of the iris, also showing the localised cataract through the pupil. The patient was found to have a lesion behind the crystalline lens. He underwent phacoemulsification with intraocular lens implantation to improve visualisation of the lesion. A black ciliary body mass was seen (Fig 1E). This prompted his referral to the oncology service in June 1999. Control of the intraocular pressure proved refractory even with additional medical treatment.

Patient 4 was initially treated for acute angle closure glaucoma in another hospital. Trabeculectomy was performed to achieve control of intraocular pressure. Postoperatively, he was found to have a lesion behind the crystalline lens. He underwent phacoemulsification with intraocular lens implantation to improve visualisation of the lesion. A black ciliary body mass was seen (Fig 1E). This prompted his referral to the oncology service in June 1999. Control of the intraocular pressure proved refractory even with additional medical treatment.

Table 1  Clinical details of the patients with adenoma of the pigment epithelium of ciliary body

<table>
<thead>
<tr>
<th>No</th>
<th>Age/sex/race</th>
<th>VA</th>
<th>Size (mm)</th>
<th>Clinical features</th>
<th>Surgery</th>
<th>Recurrence</th>
<th>Year of diagnosis</th>
<th>Complication</th>
</tr>
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<tr>
<td>1</td>
<td>40/M/W</td>
<td>6/5</td>
<td>8x7x1</td>
<td>Angle invasion</td>
<td>Local resection</td>
<td>No</td>
<td>1992</td>
<td>RD repair</td>
</tr>
<tr>
<td>2</td>
<td>62/F/A</td>
<td>6/6</td>
<td>5x3x1</td>
<td>Angle invasion, cataract</td>
<td>Local resection</td>
<td>No</td>
<td>1996</td>
<td>RD repair</td>
</tr>
<tr>
<td>3</td>
<td>65/F/White</td>
<td>6/18</td>
<td>5x4x4</td>
<td>Sentinel vessel, pigment dispersion</td>
<td>Local resection</td>
<td>No</td>
<td>1998</td>
<td>RD repair</td>
</tr>
<tr>
<td>4</td>
<td>54/M/W</td>
<td>1/60</td>
<td>5x4x4</td>
<td>Secondary glaucoma, pigment dispersion</td>
<td>Enucleation</td>
<td>No</td>
<td>1999</td>
<td></td>
</tr>
</tbody>
</table>

M = male, F = female, W = white, A = Asian, RD = retinal detachment, VA = visual acuity.
Pigment dispersion was seen in patients 3 and 4. This was mainly in the vitreous of patient 3 but in both the vitreous and the anterior segment of patient 4. There was heterochromia of the iris in patient 4. No angle invasion was seen in these two patients.

Other associated features were a localised cataract in patient 2, tracional retinal detachment and secondary glaucoma in patient 4. Patient 3 had an episcleral sentinel vessel over the tumour. None of these patients had any history of ocular trauma or intraocular inflammation. Ultrasound biomicroscopy (Fig 1C) helped us to evaluate these tumours in more detail.

The first three patients underwent local resection of the tumour in the form of iridocyclectomy under hypotensive anaesthesia. The last patient had enucleation as he opted to have the eye removed because of the poor visual prognosis for that eye as a result of secondary glaucoma, extensive pigment dispersion, and tracional retinal detachment.

Histopathologically, these tumours showed highly differentiated adenomas of ciliary pigment epithelium. Secondary lesions invaded the angle and larger lesions caused extensive pigment dispersion although non-invasively. Angle invasion resulted in these tumours being seen and recognised in the presentation of patients 1 and 2. Blurred vision due to pigment dispersion in the vitreous resulted in the presentation of patient 3. Angle closure glaucoma and pigment dispersion were the main features of patient 4. Shields et al reported a series of eight patients with adenoma of ciliary pigment epithelium and described their clinical features. In their series they found an association with cataract, vitreous haemorrhage, and neovascular glaucoma.

Pigment dispersion was seen in two of our patients. The presence of pigment clumps and extensive pigment dispersion in the vitreous of patient 3 (Fig 1D) is unique and has not been reported before. Chang et al in 1979 reported the presence of pigment in the retro-ocular space adjacent to the tumour in a case of adenoma of ciliary pigment epithelium. Extensive pigment dispersion in vitreous had been reported in malignant melanoma of the choroid but to our knowledge not in adenoma of ciliary pigment epithelium.

Secondary glaucoma from intracocular tumours is well known. In their survey of intracocular tumours causing secondary glaucoma Shields et al reported on 2704 eyes. Of the five adenomas of the ciliary body one was from ciliary pigment epithelium. None of these had secondary glaucoma. Of the ciliary body melanomas, 17% had secondary glaucoma. Angle closure was responsible for secondary glaucoma in 12% of the eyes with choroidal melanoma. In their series in 1999 Shields et al had one patient who had neovascular glaucoma secondary to adenoma of ciliary pigment epithelium. Patient 4 in our series presented with secondary angle closure glaucoma.

Malignant melanoma of ciliary body is known to invade the anterior chamber angle. Chang et al reported angle invasion in adenoma of the pigment epithelium of ciliary body. Shields et al reported a patient in whom invasion of the iris-stroma by an adenoma of ciliary pigment epithelium was documented with progressive growth. They initially suspected this to be a tumour of the iris but on later evaluation showed the origin from the ciliary body. The presenting feature in patients 1 and 2 in our series was similar, although the ciliary body origin was recognised initially. In patient 2 the diagnosis of adenoma of ciliary body was strongly suspected preoperatively, as the tumour that had invaded the angle was very small. Invasion of the angle by ciliary body melanomas usually does not occur until they have attained a larger size. Invasion of the angle has also been described in melanocytoma of the ciliary body. They too tend to be relatively larger when they invade the angle, unlike the adenomas that we described. Iris melanocytomas undergo central necrosis and cause pigment dispersion and glaucoma. However the necrotic centre is absent in adenomas.

One of our patients (patient 1) had a sentinel vessel. Sentinel vessels are typically thought to be associated with malignancy. However, this was not the case. Presence of a sentinel vessel indicates ciliary body involvement. Fine needle aspiration biopsy may be considered for aiding diagnosis of malignancy. However, its role in the diagnosis of these lesions may be limited. Absence of malignant cells does not always rule out the presence of malignancy.

Our study highlights the paradoxical behaviour of adenoma of the pigment epithelium of ciliary body that has not been emphasised before. Adenoma of the pigment epithelium of the ciliary body should be kept in mind if there is extensive pigment dispersion by larger tumours and invasion of the anterior chamber angle by relatively small tumours.

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Phenylephrine 2.5% and 10% in phacoemulsification under topical anaesthesia: is there an effect on systemic blood pressure?

Phenylephrine 10% leads to a faster and more pronounced mydriasis but cardiovascular effects like hypertension and arrhythmias have been reported. In a young healthy adult the upper limit of safety for intravenous administration of phenylephrine is 1.5 mg and Kumar et al had found phenylephrine plasma levels after administration of topical 10% viscous solution to their patients to be 1.842–11.526 ng/ml after 20 minutes while topical 2.5% aqueous solution produced plasma levels of 0–1.720 ng/ml after 20 minutes. They concluded that the mean pressure tended to be higher with the 10% viscous solution.

Chin et al in their study on 89 patients, concluded that significant hypertensive effects can arise after topical phenylephrine; however, no significant difference between the two groups (2.5% v 10%) was shown. Symons et al reported no significant change in the mean systolic and diastolic blood pressure in 126 patients receiving 10% phenylephrine. Mahbobra et al in their study on 54 cases showed no difference in systemic cardiovascular effects of either the 2.5% or the 10% concentration.

Methods

We carried out a prospective randomised and double masked study on 53 patients undergoing phacoemulsification under topical anaesthesia (Amethocaine 0.1% and Marcaine 0.75%) and no exclusion of cases with hypertension, heart failure, or diabetes was made. All patients received one drop of each of tropicamide 1%, cyclopentolate 1%, and 0.4% proparacaine hydrochloride. All patients were administered in three doses starting half hour before surgery at 5 minute intervals. All patients had their blood pressure measured before dilatation and in the anaesthetic room preoperatively then postoperatively.

Results

The study included 49 cases aged 52–91, 24 cases were known to have cardiovascular problems and seven were also diabetic. Comparison of the blood pressure changes before

Figure 1 Blood pressure (mm Hg) with phenylephrine 2.5%. Numbers 1 and 2 = systolic and diastolic reading preanaesthetic; 3 and 4 = systolic and diastolic reading in the anaesthetic room; 5 and 6 = systolic and diastolic reading in recovery.

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Effect of preoperative detection of photoreceptor displacement on postoperative foveal findings in eyes with idiopathic macular hole

In idiopathic macular hole formation, Gass' hypothesised that macular holes enlarge with displacement of the photoreceptors without tissue loss around the fovea. Jensen and Larsen' developed binocular kinetic perimetry that could evaluate local retinal photoreceptor displacement and also confirm centrifugal photoreceptor displacement away from the fovea in eyes with a macular hole. Using the binocular perimetry technique and scanning laser ophthalmoscope microperimetry, we confirmed that the patients with a unilateral macular hole with preoperative photoreceptor displacement had better postoperative visual function when compared to patients without preoperative photoreceptor displacement. We also previously reported that the postoperative foveal findings were correlated with the postoperative visual function in eyes with a macular hole.

The purpose of the present study was to investigate whether or not detecting photoreceptor displacement preoperatively affects the postoperative foveal findings in eyes with an idiopathic macular hole.

Methods and results

Fifteen patients (12 women, three men; mean age 62 (SD 5) years) with a unilateral idiopathic macular hole that resolved after vitreous surgery were examined. All had undergone surgery at our institution. Eleven eyes were classified as having a stage 3 hole, four stage 2, and one stage 4. The best corrected visual acuity (VA) levels in the unaffected eyes were 0.7 or better, and no patients had ocular diseases except for mild cataract.

To detect photoreceptor displacement in eyes with the disease preoperatively, we performed binocular kinetic perimetry. The anatomical status of the repaired macular holes was assessed 3 months after the operation using optical coherence tomographic equipment (OCT 2000, Humphry Instrument, division of Carl Zeiss, San Leandro, CA, USA). Good postoperative foveal findings were defined as the presence of a foveal depression, as previously reported by Imai and associates (Figs 1 and 2). Photoreceptor displacement was detected in 11 of the 15 (73%) patients preoperatively. Good postoperative foveal findings were observed in nine of the 11 (82%). Photoreceptor displacement was detected preoperatively in all nine patients. The prevalence of good postoperative foveal findings was significantly higher in patients in whom photoreceptor

References

Instruments used in this study.

Tomographical foveal recovery in eyes after macular holes were better when compared to patients in whom displacement was not detected preoperatively, the reason why patients with a macular hole in whom photoreceptor damage influences not only visual function, but also anatomical appears have not been described previously. Although limitations of this study are based in its sample size, we think that a degree of preoperative photoreceptor damage influences not only postoperative visual function but also anatomical recovery.

The authors have no proprietary interest in any instruments used in this study.

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Nodular scleritis in a patient with sarcoidosis

Sarcoidosis is an immune mediated disease that may affect any organ. Scleral involvement has rarely been described with sarcoidosis.1 We report on a patient with unilateral nodular anterior scleritis who was found to suffer from sarcoidosis. Here, the clinical and histopathological features are described.

Case report
A 33 year old white woman had persistent moderate tenderness in her left eye that lasted for several weeks. Visual acuity was 20/20 in both eyes. The slit lamp appearance of the right eye was unremarkable. A scleral nodule in the inferior nasal quadrant was found in the left eye (Fig 1), and a moderate tenderness was determined in this area. The intraocular pressures were within normal ranges. On optical coherence tomography, the posterior segment of both eyes was normal. The ultrasound images did not indicate posterior scleritis.

The medical history was remarkable for an episode of hepatitis A 20 years ago, and the patient suffered from exercise dependent dyspnoea, night sweats, and repeated headaches. An extensive examination for associated systemic diseases was performed, including serological tests for syphilis, CRP, ESR, ANCA, RF, CIC, ANA, and PPD tests: all were within normal ranges and consultant examinations by the internal medicine, rheumatology, neurology, and ENT departments were performed. The chest x ray examination revealed a bilateral hilar lymphadenopathy and basal interstitial pulmonary infiltration typical of sarcoidosis stage 2. In the body plethysmography, a mild restriction and a moderately reduced diffusion capacity was determined. The bronchoalveolar lavage revealed an increased proportion of CD3+ T cells and an increased CD4/CD8 ratio, consistent with active pulmonary sarcoidosis. The level of angiotensin converting enzyme was 51.8 U/l (normal, 8-52) in the high normal range. The magnetic resonance images revealed an increased enhancement and thickening of the inferior nasal part of the sclera of the left eye. A biopsy was taken from the scleral nodule under peribulbar anaesthesia. Histopathological studies on the paraffin embedded tissue that was performed by the pathologists revealed a perivascular lymphocytic cell infiltration, with non-casing granuloma-like cell accumulation (Fig 2). Some histiocytes and very few giant cells were found. The scleral tissue was oedematous and the vessels were dilated, but necrosis, vasculitis or malignant cell configurations were absent. Additionally, Ziehl-Neelson and Groton's silver methanamine stains excluded the possibility of causative infections.

Treatment with oral prednisone with an initial dosage of 1 mg/kg was performed. The corticosteroid dosage was tapered within 6 weeks, and was maintained at 20 mg. Under this regimen, the pain and the scleral nodule resolved immediately, and the ACE level fell to 24 U/l (normal).

Comment
Scleral involvement has been previously reported in a few patients with sarcoidosis. In a series of 537 patients with histologically proved sarcoidosis,1 scleral plaques anterior to the equator have been found in four cases, and this was seen in the acute stage of disease and in association with erythema nodosum and bilateral lymphadenopathy. In another series by Jabs and Johns,2 within a group of 183 patients with chronic sarcoidosis, scleral involvement was detected in one patient. However, the clinical course and histopathological appearances have not been described previously. Posterior scleritis has been seen only rarely with sarcoidosis.3

In our patient, the sparse systemic symptoms made the diagnosis difficult and, therefore, scleral biopsy was done in order to rule out infections or malignancies and to disclose the histopathological evidence for sarcoidosis. Although a classic non-casing granuloma

Figure 1 Scleral nodule of the left eye with tenderness in a patient with sarcoidosis.

Figure 2 Histopathology of a scleral nodule in a patient with sarcoidosis. The scleral tissue with oedema and vessel dilatation, perivascular lymphocytic cell infiltration with non-casing granuloma-like cell accumulation, some histiocytes and giant cells. Haematoxylin and eosin staining, magnification, ×200.

Figure 2 Histopathology of a scleral nodule in a patient with sarcoidosis. The scleral tissue with oedema and vessel dilatation, perivascular lymphocytic cell infiltration with non-casing granuloma-like cell accumulation, some histiocytes and giant cells. Haematoxylin and eosin staining, magnification, ×200.

References
has not been found in our patient, a granuloma-like perivascular cell infiltration was seen, consisting primarily of lymphocytes, some histiocytes, and very few giant cells, which are typical for sarcoidosis. To the best of our knowledge, this is the first histopathological description of two thirds of eyes with sarcoidosis in the sclera. The mainstay of treatment for sarcoidosis is corticosteroids, and the scle-

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Panophthalmitis following contact diode laser cyclophotocoagulation in a patient with failed trabeculectomy and trabeculotomy for congenital glaucoma

Diode laser trans-scleral cyclophotocoagulation (TSCPC) is a well accepted method for the management of patients with refractory glaucoma. A lasting decrease in IOP has been reported in one third of eyes with intractable glaucoma following this procedure.1 2 In our patient, however, the reduction in IOP was 20/60 in the left eye and 20/40 in the right eye, accompanied by poor vision. One week earlier he had undergone 360 degrees diode laser trans-scleral cyclophotocoagulation using contact G-probe in the right eye for uncontrolled glaucoma. He had thrice undergone filtering surgeries in both eyes for uncontrolled glaucoma. He had thrice undergone cyclophotocoagulation in the treatment of severe glaucoma. The Diode Laser Ciliary Ablation Study Group. Ophthalmology 1996; 103: 1294–302.


Bilaminar interepithelial bodies within fingerprint dystrophy-like changes in bilateral iridocorneal endothelial syndrome

In most cases the iridocorneal endothelial (ICE) syndrome affects women unilaterally and shows endothelial degeneration, thickening of Descemet's membrane in patients with glaucoma, affecting only one eye. The spectrum of the ICE syndrome includes the Chandler's syndrome, the essential iris atrophy, and the Cogan-Reese syn-

Case report

Ten years earlier a now 45 year old patient presented with a bilateral ICE syndrome and fingerprint dystrophy. On slit lamp microscopy the epithelial layer showed fingerprint lines, while the endothelial layer had a “hammered” appearance. Iris atrophy, corectopia, ectropion uveae and anterior synechiae were obvious (Fig 1A) and progressive in both eyes, nevertheless the intraocular pressure and the visual acuity were normal. Eight years later both corneas developed oedema (Fig 1B) and the left eye displayed cataract with reduction of visual acuity from 1.0 to 0.25 and 0.9 to 0.7 in the left and right eye, respectively. Com-

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the ICE syndrome, owing to obvious morphological changes of the iris despite non-specific endothelial changes. The striking features of Chandler's syndrome are corneal endothelial dystrophy and subsequent oedema. Corneal, glaucoma, and iris atrophy are less compared to the two other ICE syndromes—that is, the essential iris atrophy and the irisscar syndrome, possibly owing to differences in endothelial proliferative activity.'

Our case is unique in several aspects. Firstly, our patient is a man and is affected bilaterally. Most often women are affected unilaterally by ICE syndrome, nevertheless an exception of essential iris atrophy with bilateral changes have been described.1

Secondly, an epithelial dystrophy—namely, a fingerprint dystrophy—is present in addition to the ICE associated changes. To our knowledge this association has not been described in the literature before.

Thirdly, the fingerprint striae contain bilaminar deposits with an electron dense core. Several types of deposits have been described in association with epithelial dystrophies. Patches of “unknown substance” were noticed in fingerprint dystrophy along basal plasmalemmas of the basal epithelial cells with no similarity to the bilaminar structures described here.2 Broderick et al mentioned intercellular dense oblong bodies which were embedded in condensed matrix and were much smaller than the deposits in our case.1

In a cornea with a Meesmann dystrophy intraepithelial “peculiar electron dense substance” were shown, also with a totally different appearance compared to that seen in the fingerprint striae of the specimen we present here. In a patient with ocular tumoral calcinosis, nodules from the palpebral conjunctiva contained calcified “spherules”,3 which show some similarity to our—nevertheless, uncalcified—deposits. Our deposits were located within the fingerprint striae close to the epithelium. It seems to be obvious that the epithelial cells must have produced those bilaminar bodies, since no other cell type was present nearby, but there was no evidence of extrusion from the basal cells.

Our case shows that ICE syndrome can occur bilaterally in men, and can be associated with a fingerprint-like dystrophy. Further studies should be carried out to confirm our electron microscopic observation of bilaminar deposits within fingerprint-like striae and directed towards an analysis of their chemical composition of the extracellular material and origin.

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This case was presented as a poster at the meeting of the Association for Research and Vision in Ophthalmology in Fort Lauderdale in May 2001.

References

Fine retinal crystalline deposits observed by confocal scanning laser ophthalmoscopic examination using infrared light

Bietti's crystalline retinopathy is a tapetoretinal degeneration characterised by numerous tiny sparkling yellow-white spots mainly located in the deeper layer of the posterior pole retina. Since crystalline deposits tend to become small and decrease in number over time,1,2 the fundus appearance becomes indistinguishable from other retinal dystrophies with time.3 The advent of confocal scanning laser ophthalmoscopy (SLO) with infrared light has enabled high sensitive examination of the deep layer of the retina.3

We studied the deep retinal abnormalities in a case with a typical Bietti's crystalline retinopathy and in another case with myopic chorioretinal atrophy throughout the posterior pole. Consequently, we detected numerous fine crystalline deposits in both cases, which were not detected with other funduscopic examinations.

Case reports
Case 1
A 52 year old man was referred to our hospital by his ophthalmologist who found an abnormal fundus appearance. There was no consanguinity. Best corrected visual acuity was 20/24 right eye and 20/30 left eye. No abnormalities were found in the anterior segment and media. Fine crystalline deposits were not detected in the corneal stroma of either eye. Funduscopic examination revealed numerous fine reflective crystalline deposits throughout the posterior pole and mid-peripheral retina of both eyes. Most of these deposits were in the deep retina and subretina but some deposits were superficial. Goldmann perimetry showed relative scotomas in a zone within 30–40 degrees of the central field in both eyes. Fluorescein angiography of both eyes showed island-like hypofluorescent lesions surrounded by hyperfluorescent lesions in the early phase. Indocyanine green angiography also showed the atrophy of the choriocapillaris in the posterior pole. Crystalline deposits did not show any fluorescence in either fluorescein or indocyanine green angiography.

The retinal crystalline deposits were more clearly visible with the fundus examination by SLO (Rodenstock, Germany) using infrared light compared to the routine funduscopic examinations (Fig 1). Each crystallite deposit appeared larger in size. In addition, numerous fine crystal deposits were evident, which were not observed by conventional funduscopic examinations including ophthalmoscopy and
Ocular fundus of case 2. Fundus photograph (A), grey scale image of the same fundus photograph (B) and SLO image with infrared light (C) are shown. Note that the crystalline deposits are most evident with the infrared imaging.

Comment
The diagnosis of Bietti's crystalline retinopathy in case 1 is based on the retinal crystalline and supported by the characteristic island-like hypofluorescence observed by fluorescein angiography. Fundus examination by SLO with the infrared light disclosed numerous tiny crystalline deposits in the posterior pole (Fig 2), which were not evident with other funduscopic examinations, including ultrasonoscopy and biomicroscopy with a contact lens, or with fluorescein and indocyanine green angiographic studies. The deposits scattered light when the source of light was moved to cause them sparkle, similar to the fine crystalline deposits observed in the fundus of case 1.

Amino acid analysis and other examinations did not show any abnormal value.

Tonic pupils from giant cell arteritis
The tonic pupil is characterised by poor reactivity to light, a slow tonic constriction and redilation to a near target, and supersensitivity to topical dilute pilocarpine. Most instances do not have an identifiable cause; however, a variety of conditions including herpes zoster, orbital trauma including surgery, and paraneoplastic syndromes may result in tonic pupils. The mechanism(s) which produce tonic pupils are not known, although axonal loss within the ciliary ganglion is generally believed to result in supersensitivity of the iris sphencter muscle. Giant cell arteritis (GCA) has been reported as an uncommon cause of tonic pupils. Further, the cause of tonic pupils in GCA is unknown and direct evidence for an ischaemic cause is not convincing.

We used orbital colour Doppler imaging to study orbital and ocular blood flow in a patient with GCA, unilateral visual loss, and bilateral tonic pupils.

Case report
A 58-year-old woman presented with visual loss of the left eye for 2 days. She had had
pupils constricted slowly and tonically to an eye and neuro-ophthalmic examination was positive on the right. Although her ESR fell to 4 mm in the first hour and her jaw claudication resolved, the prednisone dose was maintained because of the attenuated blood flow within the right orbit. Her vision remained unchanged and her pupils remained non-reactive to light but with denervation supersensitivity, confirmed by constriction to 0.125% pilocarpine, 2 months after the onset of visual loss.

Comment
Five earlier reports have documented tonic pupils in patients with GCA. Davis and coworkers described a 69 year old woman who developed polymyalgia and anisocoria. The involved pupil constricted to 2.5% methacholine. In another report of tonic pupils from GCA mild supersensitivity to 0.1% pilocarpine was noted; however, the patient had counting fingers vision in each eye from bilateral optic neuropathy, suggesting that the light near dissociation may have been caused by bilateral afferent dysfunction. The authors cited pathological studies which have suggested ischaemia of the extraocular muscles as a cause of ophthalmoplegia in some patients with GCA, and they implied that ischaemia was the cause of tonic pupils in their patient, although the site of damage was not specified. Currie and Lessell reported a 63 year old woman who had jaw claudication and loss of vision bilaterally from sequential anterior ischaemic optic neuropathy owing to biopsy proved GCA. After losing vision in each eye she developed bilateral tonic pupils which constricted markedly to 0.08% pilocarpine. These authors suggested that impaired orbital blood flow, including the blood supply to the ciliary ganglia or its postganglionic ciliary nerves, resulted in loss of axons and denervation supersensitivity, although no orbital blood flow studies were performed. They speculated that tonic pupils in patients with GCA may be overlooked because of the severity of visual loss.

Other authors have suggested that ischaemic damage may not be the sole cause of tonic pupils in patients with GCA. Bilateral tonic pupils with conjunctival injection were the only ocular manifestations in a 60 year old woman with biopsy proved GCA. Because there was no other clinical evidence of orbital or ocular ischaemia the authors postulated that damage to the ciliary ganglion may be mediated by an immunological mechanism. However, they did not quantitate the orbital or ocular blood flow, and our patient shows that clinical signs of ischaemia, except for tonic pupils, may be absent despite markedly decreased orbital blood flow.

Wilhelm reported five patients with bilateral visual loss from anterior ischaemic optic neuropathy or central retinal artery occlusion and tonic pupils from GCA. Assessment of orbital blood flow was performed using ultrasonography in three of these patients. In two patients no flow was noted in the supratrochlear arteries, while blood flow in the third was normal. The author noted that the ultrasonographic results supported ischaemia as a cause for the tonic pupils. In the patient with normal orbital blood flow, ischaemia below the resolution of ultrasonography was presumed to cause the tonic pupils.

The blood supply to the ciliary ganglion arises from several sources. Eliskova studied 18 human cadaveric orbits after injection of dye into the internal carotid artery. The ciliary ganglion was supplied with blood from one to four arteries, with the posterior lateral ciliary artery and the lateral muscular artery the most common sources, followed by the ophthalmic and central retinal artery. The vasculature of the ganglion itself is composed of a network of capillaries.

Orbital colour Doppler imaging is a non-invasive way to quantitate blood flow to the orbit and eye. Decreased blood flow in the ophthalmic artery, central retinal artery, and short posterior ciliary arteries may be detected on orbital colour Doppler imaging in patients with GCA. Markedly reduced blood flow was found with orbital colour Doppler imaging in both orbits in our patient, despite her visual loss being unilateral. We were unable to find a previous report of bilateral tonic pupils in a patient with unilateral visual loss from GCA. Although anterior segment ischaemia can cause loss of iris sphincter tone, we do not believe that the pupillary findings in our patient resulted from iris ischaemia. Iris ischaemia would result in poorly reactive pupils to both light and accommodation, without a tonic near reaction or denervation hypersensitivity. Therefore, the findings in our patient strongly suggest that the tonic pupils resulted from ischaemic damage to the ciliary ganglion or the postganglionic ciliary nerves which are responsible for pupillary constriction.

The authors do not have any proprietary interests in any of the contents of this manuscript.

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Frozen cucumber as a mount for processing cadaveric vitreoretinal specimens

Vitreoretinal specimens are extremely difficult to process as a frozen specimen because of their small size and tendency to roll up. However, in order to perform immunohistochemical studies, it is sometimes necessary to have frozen specimens as antigens may be destroyed if a fixative agent is used.

Dua et al. and Scott et al. suggested the use of frozen cucumber as a mount for conjunctival and corneal tissue, we modified this method for vitreoretinal specimens. We describe our technique and provide examples of our results.

Case report

Fresh cucumber (obtained from a greengrocer) was cut into small (1 cm²) blocks; the part devoid of seeds was used. We found that with cucumbers older than 2 days the membranes did not adhere sufficiently well. These blocks were then stored at 4°C until required. Pig eyes were obtained and stored at 4°C until required. Subsequently, the eye was placed under the dissecting microscope and basic salt solution injected in through the vitreous cavity to enable easier dissection. The cornea was removed and a vitrectomy performed. The retinal specimens were stained with Indian ink in order to facilitate subsequent localisation.

Following vitrectomy, membranes were removed from humans (these included diabetic membranes, subretinal neovascular membranes, and epiretinal membranes); they were initially placed in Hartmann's solution. Subsequently, they were placed on the cucumber under a dissecting microscope; it was possible to place the membrane flat without it rolling up because of the texture of the cucumber. These membranes were also stained with Indian ink before placing on the cucumber.

The cucumber with the membrane on its "side" surface was placed in an aluminium foil cup and covered with a cryomatrix of Tissue-Tek OCT compound. The membranes were cut in 4-5 µm sections. We stained one slide from each specimen with haematoxylin and eosin and performed immunohistochemistry on the others (Figs 2 and 3).

We were able to maintain the orientation of the specimens and managed to obtain sufficient material for immunohistochemical studies. The use of Indian ink allowed us to locate the specimen easily when cutting sections. Unlike previous studies we found that the specimen was attached to the cucumber without the use of albumin.

Comment

Swan and Davis first described the biopsy cucumber unit for processing cervical specimens. Frozen cucumber has been described as a mount for bladder and lung biopsies. Ocular tissues that have been processed in this fashion are conjunctiva and cornea. Whittle et al. described a technique using cucumber as a mount for processing cadaveric human retina, which enabled indirect immunofluorescence studies.

Retinal specimens are difficult to process because of their size, tendency to roll up and, hence, difficult orientation. Nevertheless, it is necessary to process specimens in this way in order to perform certain immunohistochemistry techniques.

We suggest that cucumber is a suitable mount for vitreoretinal membranes that are required as frozen specimens for immunohistology. It should be noted that most modern immunohistochemistry may be performed on fixed tissue.


Each author states that he has no proprietary interest in the development or marketing of any product used in this study.

References


Figure 1 The biopsy cucumber unit.

Figure 2 Diabetic membrane on cucumber mount stained with haematoxylin and eosin.

Figure 3 Diabetic membrane on cucumber mount stained with CD31.
cytomegalovirus and Epstein-Barr virus. The condition, which may present with synchronous or metachronous systemic or cerebral herpetic infection (encephalitis) is now recognised to occur at all ages, though VZV tends to affect the more elderly and herpes simplex the young.

The majority of patients present with a short history of blurred vision, floaters, and mild ocular discomfort. In the immunocompetent, clinical examination reveals one or more well demarcated foci of retinal necrosis outside the major arterial arcades typically with a dense vitritis that may preclude a detailed view of the posterior segment. Disease progression is rapid with coalescence and posterior extension of areas of retinitis. Often there is an exudative, sometimes haemorrhagic, vasculitis either adjacent to areas of retinitis or at the optic nerve. The visual prognosis for untreated cases is very poor.

We report three immunocompetent patients with no evidence of concurrent herpesvirus infection in whom ipsilateral optic neuritis associated with a panuveitis was the presenting feature of their acute retinal necrosis syndrome.

Case reports

Case 1

A 20 year old healthy white male, with no history of herpesvirus infection, presented with a 10 day history of progressive blurred right vision with floaters, and a right relative afferent pupillary defect (RAPD). There was swelling of the right optic nerve (Fig 1A) together with increasing non-granulomatous pan uveitis. The left eye was unaffected. Fluorescein angiography (Fig 1B) showed marked optic disc hyperfluorescence and peripheral retinal ischaemia. Seven days later (Fig 1C and D), several enlarging foci of retinitis, typical of ARN, developed in the retinal mid-periphery. PCR of a vitreous biopsy amplified HSV-1. There was no further reduction in visual acuity following intravitreal foscarnet and encephalitis doses (10 mg/kg three times daily) of intravenous aciclovir for 10 days.

Case 2

A 47 year old healthy white female, with no history of prior herpesvirus infection, presented with a 3 day history of progressive blurred left vision. She also complained of significant pericentral discomfort exacerbated by eye movement. Acuity was 20/40 left eye, 20/15 right eye, with a left RAPD. There was swelling of the left optic nerve head together with a moderate non-granulomatous panuveitis. The right eye was unaffected. Fluorescein angiography showed marked optic disc hyperfluorescence and peripheral retinal ischaemia. Six days later, several enlarging foci of retinitis, typical of ARN, developed in the inferior retinal periphery. Polymerase chain reaction (PCR) of a vitreous biopsy amplified HSV-1. There was no further reduction in visual acuity following encephalitis doses (10 mg/kg three times daily) of intravenous aciclovir for 10 days.

Case 3

An 81 year old white male, who had suffered herpes simplex meningoencephalitis and synchronous right acute retinal necrosis (acuity reduced to 20/200) 17 years earlier, presented with a 2 day history of profound reduction in left acuity to perception of light only. Clinical findings included a left RAPD, haemorrhagic optic disc swelling, and increasing hypertensive panuveitis. Five days later, three demarcated areas of retinal necrosis appeared superiorly in the same eye. PCR of a vitreous biopsy amplified HSV-1. There was no further reduction in visual acuity following intravitreal foscarnet and 10 days of encephalitis doses (10 mg/kg three times daily) of intravenous aciclovir.

Comment

There have been two previous reports in immunocompromised patients of optic neuritis preceding the development of ARN in these, preceding or concurrent cutaneous herpes zoster infection suggested altered viral behaviour in the context of deficient immunity. Even in the healthy individual, there is evidence of an immunogenetic predisposition to the development of the disease. The novel mode of presentation of our three immunocompetent patients suggests they might share a similar background of immunity that modifies viral behaviour, thereby predisposing to involvement of the optic nerve before the development of retinitis. In this regard, it is interesting that none of our cases developed clinically evident evidence of involvement of the optic nerve in the context of deficient immune. The ability of the host to resist this appears determined by the animal’s immune background.

The recent report in a single case of ARN subsequent to central retinal vascular obstruction in the fellow eye is most likely a manifestation of a different VZV mediated disease process but emphasises the ability of members of the herpesvirus family to directly invade blood vessel walls.

The combination of optic neuritis, peripheral retinal ischaemia, and panuveitis is very unusual. In white patients, the differential diagnosis would include conditions such as sarcoidosis and demyelinating disease. This is a common accompaniment to human HSV-1 ARN and observed in the Szily animal model in which inoculation of the anterior chamber or vitreous with HSV virus produces in ipsilateral anterior uveitis, relative sparing of the ipsilateral retina, and necrotising contralateral chorioretinitis with encephalitis. It has been shown that viral spread to the brain and the fellow eye results from viral invasion of the optic nerve. The ability of the host to resist this appears determined by the animal’s immune background.

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Cutaneous angiosarcoma of the eyelids

Angiosarcoma of the eyelid is a rare potentially life-threatening tumour arising from the vascular endothelium. Through the presentation of a case, the clinicopathological features and management of this condition are described.

Case report

A 69 year old white man presented with multifocal red-blue maculopapular lesions located in his right cheek and eyelids (Fig 1A). The patient had first noticed the lesions 9 months previously. An incisonal biopsy from the upper eyelid was performed. In subsequent staging investigations no metastases were found. The patient was otherwise in good health and was HIV negative. He underwent surgical resection of all clinically detectable lesions followed by adjuvant radiotherapy (total dose 45 Gy). After 34 months of follow up there was no evidence of local recurrence or distant metastases.

Histopathologically, the specimens consisted of skin and subcutaneous tissue. The lesions proved to be well differentiated angiosarcoma characterised by interlacing blood vessels lined by plump endothelial cells with hyperchromatic nuclei. Using Ki-67, the proliferative rate was assessed as 5%–7% (Fig 1B). Immunohistochemically, the tumour cells showed a positive reaction for vimentin, CD34 (human haemopoietic progenitor cell antigen) and FVIII-RA. They were consistently negative for S100 and HMB45 (results not shown).

Comment

Cutaneous angiosarcoma is a distinct subgroup of angiosarcomas most commonly seen in the skin and superficial soft tissues in patients over 55 years.1 The majority of these tumours arise in the head and neck area, particularly the scalp. They are aggressive and tend to recur locally and disseminate widely with a 5 year survival of approximately 12%–29%.2 To our knowledge, there are only seven well documented cases involving the eyelid.3–8 Clinically, the lesions in our patient resembled those previously reported in view of the lentiloid lesions. Histologically, angiosarcomas display a spectrum from well to poorly differentiated varieties. The present case was consistent with a well differentiated angiosarcoma with characteristic interlacing channels lined by atypical endothelial cells and expression of immunohistochemical markers of vascular differentiation (CD34 and FVIII-RA).9,10 Frequently tumours display both vasomorphic and undifferentiated areas.9 The present case was noteworthy, in that the entire tumour appeared to be well differentiated. The proliferation rate was low to moderate compared to the reported rate for angiosarcoma (>10% in 72% of cases assessed by Ki-67).11 Mitotic index has been observed as an independent histological prognostic marker for cutaneous angiosarcoma although other histological makers remain poorly defined.12 In the present case low proliferation index and well differentiated histological features may have contributed to a better outcome.

The most important clinical prognostic factor is lesion size, with tumours <5 cm in diameter having a better prognosis.13 This underlines the importance of early diagnosis and appropriate management. The mainstay of treatment for cutaneous angiosarcoma includes surgery and/or radiotherapy although, due to the rarity of this condition, there are no standard guidelines.13–16 As illustrated by our case, the primary lesions were contained within the anterior lamella of the lids and it was possible to surgically encompass the primary lesions avoiding exenteration and without compromising prognosis. In such cases, the surgical aim is to resect all clinically identifiable disease. In areas of doubt, microscopic control of surgical margins may have a role in guiding the extent of resection. Angiosarcomas usually respond to radiotherapy to some degree and most authors suggest that combined surgery and radiotherapy offers the best chance for long term control.7 In one series of 28 head and neck angiosarcomas, Mark et al17 have reported better survival after 32 months (mean) with combined surgery and radiotherapy compared with surgery alone. In cases unsuited to surgery, radiotherapy alone may be considered, however usually only partial responses are achieved.17 The role of chemotherapy remains undefined.

In summary, cutaneous angiosarcoma should be included in the differential diagnosis of vascular or atypical eyelid lesions as early recognition is critical to optimise outcome. Classification of the mitotic index and degree of histopathological differentiation may be useful criteria in predicting the biological behaviour. Treatment needs to be individualised to the patient and in selected cases complete excision of clinically evident disease may be appropriate. Adjunctive radiotherapy is recommended due to the aggressive natural history of angiosarcoma.

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References


www.bjophthalmol.com
Permanenlt visual loss in a child with a rash

Endophthalmitis is an unusual but well described complication of bacteriaemia. Here we report endophthalmitis arising in the course of a mild illness resembling chicken pox.

Case report

A previously healthy 6 year old white girl was the only one still using the original term for fear they're saying it was. More erudite dissenters insist that it is not the plural for gutta, some of the older lesions appeared to be crusting over. She was noticed rubbing her eyes and showing of a puncture wound to the eye and the plan at publication was to provide the patient with a new lens.

Electron microscopy, immunofluorescence staining and polymerase chain reaction (PCR) testing of the vesicular material was negative for varicella zoster virus (VZV) and herpes simplex virus. Neither IgM nor IgG against VZV was detected in the blood. Cultures of blood and aqueous humour were negative but urgent Gram stain of the aqueous humour revealed scanty intracellular Gram negative diplococci. Meningococcus C DNA was detected in the afebrile in the upper temporal quadrant and highlights the potential for severe sequestration of primary VZV infection. Those excrescences on Descemet's membrane


Figure 1 Right eye showing panophthalmitis. There is a diffuse corneal infiltrate and a purulent exudate in the anterior chamber leading to the opaque cornea and the absence of any view of the iris or pupil. The sclera is infiltrated and thinned.

References


MAILBOX

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Those excrescences on Descemet’s membrane


Even the title made us question whether we were the only ones still using the original name for the condition cornea guttata. A quick perusal of MedLine reveals a trend away from guttata, and towards guttate (Fig 1). This trend may be even more pronounced, as the literature tends to be conservative. The next generation of cornea specialists, or at least the small sample that goes through our training programme, tends to fall into three categories: those who say guttata, those who correct others for saying guttata, and those who try their best not to mention the term at all, fearing the wrong thing. Many of our faculty have now entered this last group.

When asked what is so bad about guttata, some insist that it is not the plural for gutta, the Latin word for drop. We’re not sure that anyone ever said it was. More erudite dissenters recognise that not only is guttata not a plural, it is not even a noun—it’s an adjective. The closest English counterpart to guttata is probably guttate, drop-like, or speckled, so it’s incorrect to use guttata alone as a noun, or so the thinking goes. Some have chosen to use cornea guttata when referring to the condition, and guttate when referring to the excrescences themselves.1
“Guttata were present” may well have carried the eyes of an ancient Roman, since guttata is feminine singular, and Romans liked their subjects to agree with their verbs in number as much as the rest of us. However, it is not so certain that “Flavia’s guttata is impressive” would be at all offensive, particularly since blonde Flavia herself was named after an adjective, as were Augustus and, some say, even Caesar himself. In fact, early Roman grammarians barely distinguished between adjectives and nouns, using them interchangeably as any chance they could.¹ The learned still do, at least when they refer to themselves as the learned. Those particularly offended by using an adjective substantively (as a noun) should be careful not to slip up with words like corna. Both corna and conjunctiva started out their ophthalmological careers as adjectives, modifying tinea (feminine singular), which is why corna and, in turn, guttata are feminine singular in the first place.

What then should we call those excrescences on Descemet’s membrane? Well, if you were to call them excrescences, then by all means, call them drops, although you probably don’t need to invent yet another term from a dead language. Vogt called them “tropfige” (drop-like) like corna. Both terms can be used to modify tinea (feminine singular), which is why corna and, in turn, guttata are feminine singular in the first place.

Figure 1 References to guttata and guttae over the past 40 years in Medline. Some articles use both terms.¹

Acanthamoeba keratitis

We read with interest the report by Radford et al. on the incidence of acanthamoeba keratitis and the suggested relation between “water hardness” and the incidence of acanthamoeba keratitis.² However, we disagree with their findings and believe their study is flawed for two reasons.

Firstly, the incidence of acanthamoeba keratitis has been underestimated by approximately 33% since their monthly questionnaire reporting system yielded an average return rate of 50%. A high non-response rate over 35% is considered unreliable for making inferences for the whole population.³ Furthermore, the authors estimated the “incidence” rate using the “complete” cases, which is a biased sample. Even then, if the non-response rates were below 30% in this study, the authors did not provide the precision of the “incident” rate and attempt to apply a statistical weighting approach to reduce non-response bias.

Of 179 positive reports collected, only 106 (59%) met their case definition criteria. This further reduced their number of cases but will have contributed to diagnostic accuracy. A further five cases were excluded as non-UK residents but where did they acquire their infection—in the United Kingdom or overseas?

The incidence figures calculated for England and Wales for 1997-8 and 1998-9 of 0.21 and 0.18 per 10,000 contact lens wearers (CDW) are thus an underestimate of the expected true infection rate. The expected true figure needs to be increased by a factor of 1.493 (100/67) to account for the missed cases with the low reporting rate used of 67%. The English figures become 0.31 (0.21 × 1.493) and 0.27 (0.18 × 1.493) per 10,000 CDW respectively, of whom the majority (88%) were soft hydrogel lenses.

These latter figures for England and Wales are remarkably similar to the true figure estimated at the same time in a 17 month prospective cohort study in Hong Kong of 0.33 per 10,000 “soft” hydrogel CLW. Reporting “questionnaire” studies of infectious diseases is problematic; incidence figures for rare diseases are best recorded in the form of a cohort study, in which all cases occurring within a defined period are examined and tested in several refersal hospitals according to defined criteria in advance. In conclusion, the incidence of acanthamoeba keratitis reported for England and Wales by the authors is an underestimation of the true figure by at least 33%. The finding that the reporting of cases was “static” is of concern as it means that there is still need to reinforce ways of preventing this infection.² While there is considerably variation in the incidence of this infection, specifically in the reintroduction of multiple lens solutions 7 years ago,¹ the infection remains a problem to be avoided by all CL wearers as predicted by one of us 8 years ago.² If good hygiene is practised, however, with monthly changing of storage solutions, avoidance of tap water, and use only of sterile multipurpose solutions or overnight storage in hydrogen peroxide, then the risk of infection becomes negligible. The trend of daily disposable lens wear has also been virtually free of acanthamoeba infection.

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References


In conclusion, we are pleased that the article and editorial have led to further healthy discussion. Mermod and his colleagues are to be commended for the work they continue to do in non-penetrating filtration surgery. However, as we said in our editorial, current trials do reveal that none of the current operation modes for glaucoma are totally ideal yet, and further research, particularly on surgical methods and wound healing control, is needed so that optimal long-term pressure control can be achieved for all our patients with a minimum of complications.

References

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A randomised controlled trial of written information

Newsham’s effort to inform parents of children with amblyopia about occlusion therapy is laudable but incomplete. Ethical considerations of informed consent require full disclosure of all aspects of the proposed treatment. The following points might be considered for inclusion.

(1) Occlusion therapy has never been scientifically validated with a randomised, controlled study.

(2) The dose/response relation has never been defined. Flynn et al stated that “Success was not related to the duration of occlusion therapy, type of occlusion used …” The variety of treatment protocols accentuates another dilemma “owing to our paucity of knowledge of the dose-effect relation—a situation one finds hard to imagine for any comparably established therapy outside ophthalmology. In other words we have no understanding of the dose-effect relation of occlusion in amblyopia therapy.”

(3) The application of “greater levels of occlusion being prescribed for more severe amblyopia” is compromised by the observation “that success was related to . . . the depth of visual loss before treatment . . .”

(4) The benefits of treatment are likely to deteriorate following cessation of patching.

(5) Visual acuity improves as children get older. This is also true of amblyopic children younger than 7 years. Therefore, the comments about achieving normal vision may raise expectations that will not be achieved.

(6) Amblyopia in children younger than 7 years is compromised by the observation “that success was related to . . . the depth of visual loss before treatment . . .”

(7) Success in amblyopia treatment is usually defined as improvement by a minimum of three lines. Many of the successfully treated patients, by that criterion, will still not have normal vision at the end of presumably successful treatment. One quarter of treated patients with initial acuity better than 20/100 do not even achieve these limited goals.

(8) Occlusion therapy does have potential adverse effects beyond disruption of family and social life and interference with education.

(9) Despite decades of occlusion therapy the prevalence of amblyopia in the adult population is similar to that of the school age population. Moreover, “the prevalence of unilateral amblyopia was not found to be statistically higher in children than in adults.” This suggests that long-term benefits of conventional therapy are not demonstrated in demographic studies.

Patients and their families should be provided with comprehensive information concerning proposed treatments. Physicians are obliged to make this information accessible and inclusive.

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References


Ocular and financial health

We read with interest the article by Khanderkar et al detailing the results of the 1996–7 Omani Eye Study.1 They found a prevalence of blindness of 16.8% in those 60+ years of age, and comment that the population of this age group in Oman is predicted to double by the year 2020. This has serious implications for planning the provision of health care and specifically for eye care services.

This observation is true for most countries; the global population for the over 65 age group is projected to increase from approximately 400 million to 800 million people by the year 2020, contrasting with the under 5 years of age population, which is estimated to see a 6% growth in the same period.2 Vision 2020—the right to sight—was launched by the WHO and IAPB in 1999, aiming for the elimination of avoidable blindness by the year 2020. In 1995 the estimate of global blindness (<3/60 better eye) was 44 million, and this is projected to rise to 76 million by 2020 if there is no change in current trends.3 Vision 2020 prioritises five diseases for global attention—cataract, refractive errors, trachoma, onchocerciasis, and vitamin A deficiency. Action against diabetic retinopathy and glaucoma is also deemed important in countries where ocular infections have been controlled. Vision 2020 contends that the current increase in blindness, estimated at 1–2 million people per year, can be reversed if human and financial resources are targeted at these priority diseases in the countries with the highest prevalence and number of blind people. It is estimated that the result of a successful programme, achievable at a cost of $2 billion, will be 429 million blind person years avoided over the next 20 years, and a total saving in excess of $100 billion, by avoidance of lost productivity.4 This would make the effective implementation Vision 2020 not only ethically important but also a cost effective strategy for poverty alleviation.

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References
2 www.census.gov/ipc/prod/wp98/wp98.pdf

Ocular Pathology, 5th ed.

The fifth edition of this well-established ocular pathology text is excellent. The presentation, the photographs, the histopathology, and micrograph sections provide the reader with an array of outstanding examples of ocular pathology. The text is easy to read, agreeably not always in depths and gives enough information or direction in references for further reading. This is being hypercritical of an enjoyable text and there is no more to say except that every unit and library should update their edition.

A Dick


For those who specialise in the treatment of ocular motility disorders, it seems at times as though time has stood still. Compared with the technical and surgical innovations that strabismology developed and evolved not the history of the treatment of corneal and retinal diseases, strabismologists have continued to use techniques and instruments devised in the mid-19th century. However, after reading von Noorden’s The History of Strabismology, it becomes clear that the history of our specialty has been characterised by physicians and scientists possessing remarkable creativity and intellect striving to understand how the eyes move and the world around them.
The History of Strabismology is the ninth volume of The History of Ophthalmology, a planned 21 volume series of monographs intending to comprehensively review the history of ophthalmology from ancient times to the current day. The author has chosen to review the history of strabismology not with a traditional “art through the ages” chronological approach, but rather from a geocentric approach. By enlisting prominent strabismologists from around the world as contributing authors, von Noorden allows the reader to discover how the discipline and practice of ophthalmology developed and evolved not only in Europe and the United States, but in countries and regions such as Mexico, Japan, South America, and Australia. In thoroughly researched and referenced chapters, the authors describe, time and again, how an ophthalmologist visiting Europe learns a technique, returns to his or her country, refines the technique and applies it to the patient population unique to his or her country. We learn of scoundrels and rogues who feist themselves on the public as miracle workers, only to be publicly exposed and discredited by ethical ophthalmologists of the day (lessons we could stand to relearn now and again in the 21st century). We learn that aesthetic ideals are relative to time and place; such as the fact that in pre-Columbian times a slight degree of esotropia was found to be attractive and convergence was stimulated in infants by attaching a ball of beeswax to the child’s hair to be left dangling between the eyes (vision therapy at its birth).

An often neglected but historically important discipline within the field of strabismus is the practice of orthoptics. In a carefully researched and beautifully illustrated chapter, section author Roper-Hall outlines the origins of the specialty and introduces us to the pioneers of orthoptics—von Graefe, Muller, Donders, and Helmholtz—placed the study and treatment of strabismus at an equal level of importance as the treatment of diseases of the lens, cornea, and retina serves to notice contemporary vision scientists and ophthalmologists not to neglect this most challenging discipline of ophthalmology—strabismus.

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Role of optometry in Vision 2000

The latest issue of Community Eye Health (No 43) discusses the mobilisation of optometry to deal with uncorrected refractive error, which is now a major cause of functional blindness. 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; fax: +44 (0)20 7250 3207; email: eyeresource@ucl.ac.uk; web site: www.jceh.co.uk). Annual subscription (4 issues) UK£25/US$40. 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
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 3364; email: hsbrown.md@cox.net or seeintl@seeintl.org; web site: www.seeintl.org).

16th Annual Meeting of German Ophthalmic Surgeons
The 16th Annual Meeting of German Ophthalmic Surgeons will be held 8–11 May 2003 in Nürnberg, Germany, Messezentrum. Organised by the Professional Association of German Ophthalmologists Ophthalmic Surgery Group the conference will cover cataract surgery, refractive surgery, glaucoma surgery, vitreoretinal surgery, corneal surgery, eye surgery in developing countries, and orbita, lacrimal and lid surgery. Further details: MCN Medizinische Congress organisation Nürnberg AG, Zerrabelshofstr 29, 90478 Nürnberg, Germany (tel: +49 911 3931621; fax: +49 911 3931620; email: doc@mcnag.info; web site: www.doc-nuernberg.de).

3rd British Oculoplastic Surgery Society Meeting
The 3rd British Oculoplastic Surgery Society Meeting will be held 18–19 May 2003 in Birmingham, UK. For further details please contact the Secretary of the British Oculoplastic Surgery Society Jane Olver (tel: +44 (0)121 424 4464; fax: +44 (0)121 424 5464; email: Martinidi@heartsoliwości.m.acs.uk; web site: www.bopss.org).

13th Meeting of the EASD Eye Complication Study Group
The 13th Meeting of the EASD Eye Complication Study Group will be held on 23–25 May 2003, in Prague, Czech Republic. The scientific programme includes keynote lectures from Professor John H Fuller (UK) on The epidemiology of diabetic retinopathy; Dr P Marn van Hagen (The Netherlands) on Growth factors and diabetic retinopathy; Professor Terezie Pelikanova (Czech Republic) on Pathophysiology of diabetic microvascular complications; Dr Tomas Nosna (Czech Republic) on Risk and protective factors of diabetic retinopathy. Further details: Ortopedie Centrum, s.r.o., Steckovské nabrezí 51, 400 03 Usti nad Labem, Czech Republic (tel: +420 47 521 6588; fax: +420 47 533 40 77; email: ortcentrum-ul@volni.cz; web site: www.ortopedie-centrum.cz).

IOIS—VIIth International Symposium on Ocular Inflammation
The IOIS—VIIth International Symposium on Ocular Inflammation will be held 25–30 May 2003, in Padova, Italy.

Programme and Organising Committee: Prof. Antonio Secchi, Chairman of IOIS and Convener of Congress (email: ag.secchi@unipd.it). Further details: Congress Secretariat, Meet and Work, Mario Sballiiero (tel: +39 049 860 1818; fax: +39 049 860 2389; email: info@iois-2003.com; web site: www.meetandwork.com).

XXXII Retinal Detachment Course
The XXXII Retinal Detachment Course with International Faculty and Case Presentations will be held 5–6 June 2003, in Beijing, China. The Congress language is English with simultaneous translation in Chinese. Further details: Scientific programme: Prof Ingrid Kreissig, University of Tuebingen, Schleichstr. 12, Breuningerbau, 72076 Tuebingen, Germany (tel: +49 7071 295209; email: ingrid.kreissig@med.uni-tuebingen.de). Local organisation: Ningli Wang, Liang Xu, Wu Liu, Congress office: Wu Liu, Beijing Tong Ren Eye Center, Beijing 100730 China (email: wuliu@yahoo.com).

Detachment Course with international faculty on: Retinal and Vitreous Surgery with Case Presentations preceding the Annual Meeting of Iranian Society of Ophthalmology
The detachment course with international faculty on: Retinal and Vitreous Surgery with Case Presentations preceding Annual Meeting of Iranian Society of Ophthalmology will be held on 29–30 November 2003 and 1–4 December 2003 respectively, at the Razi Conference Center, Hemmat Hyw, Tehran, Iran. Further details: Scientific programme: Prof Ingrid Kreissig, University of Tuebingen, Schleichstr. 12, Breuningerbau, 72076 Tuebingen, Germany (tel: +49 7071 295209; email: ingrid.kreissig@med.uni-tuebingen.de). Local organisation: Dr Arman Masheyekhi, Dr Siamaq Moradian, Dept of Ophthalmology, Ladanfinejad Medical Center, Pasaradari Ave, Boostan 9, Tehran, Iran. (fax: +98 21 254 9039; email: labbafi@hotmail.com).

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 programme of medical research into an eventual cure for this hereditary disease, and through the BRPS welfare service, help members and their families copy with the everyday concerns caused by retinitis pigmentosa. Part of the welfare service is the telephone help line (+44 (0)1280 860 363), which is a useful resource for any queries or worries relating to the problems retinitis pigmentosa can bring. This service is especially valuable for those recently diagnosed with retinitis pigmentosa, and all calls are taken in the strictest confidence. Many people with retinitis pigmentosa have found the Society helpful, providing encouragement, and support through the Help line, the welfare network and the BRPS branches throughout the UK. (tel: +44 (0)1280 821 334; email: lynda@brps.demon.co.uk; web site: www.brps.demon.co.uk)