A 43-year-old man presented with severe headaches and a unilateral panuveitis in the left eye associated with optic disc oedema and a serous retinal detachment involving the macula. The patient was treated with a 2-month course of oral prednisone. Eleven months later, the patient developed recurrent severe headaches and was observed to have a bilateral panuveitis associated with serous macular detachments. B-scan ultrasonography showed choroidal thickening and serous retinal detachment with minimal T-sign in both eyes. The patient was restarted on oral prednisone, resulting in excellent control of ocular inflammation.

DISCUSSION
VKH disease is almost always bilateral with fellow eye involvement at or within several weeks of presentation. Unilateral VKH disease, although rare, has been reported, however. Kouda and colleagues described a 38-year-old woman who was originally diagnosed as having posterior scleritis associated with a serous macular detachment in one eye who, 12 months later, developed bilateral VKH disease. Forster and colleagues also described a 4-year-old boy who presented with unilateral clinical findings consistent with VKH disease, though B-scan ultrasonography showed choroidal thickening in the fellow eye. We have presented three patients with VKH disease who had a significant delay in fellow eye involvement, ranging from 11 months to 6 years. Although typically bilateral, ophthalmologists should be aware that VKH disease may present unilaterally, with significantly delayed fellow eye involvement.

CASE 3
A 43-year-old man presented with severe headaches and a unilateral panuveitis in the left eye associated with optic disc oedema and a serous retinal detachment involving the macula. The patient was treated with a 2-month course of oral prednisone. Eleven months later, the patient developed recurrent severe headaches and was observed to have a bilateral panuveitis associated with serous macular detachments. B-scan ultrasonography showed choroidal thickening and serous retinal detachment with minimal T-sign in both eyes. The patient was restarted on oral prednisone, resulting in excellent control of ocular inflammation.

REFERENCES

CORRECTION
The paper by Elgohary et al (Br J Ophthalmol 2007;91:916–21) should have had the doi: 10.1136/bjo.2006.109660. We have corrected the online version.