required surgery to abolish the synkinesis and correct the subsequent ptosis. In this case, bilateral levator extirpation combined with frontalis suspension using autogenous fascia lata was successful in achieving the desired result.

## References

1 Wartenberg R. 'Inverted Marcus Gunn phenomenon' (so called Marin Amat syndrome). *Arch Neurol Psychiatr* 1948; **60**: 584–596.
2 Chattopadhyay A, Srinivas K, Sharatchandra B, Kannan N. The Marcus Gunn phenomenon: discussion and report of three cases. *Quintessence Int* 1995; **26:** 563–566.
3 Crawford JS. Repair of ptosis using frontalis muscle and fascia lata: a 20-year review. *Ophthalmic Surg* 1977; **8**(4): 31–40.
4 Pratt SG, Beyer CK, Johnson CC. The Marcus Gunn phenomenon: a review of 71 cases. *Ophthalmology* 1984; **91:** 27–30.
5 Pavone P, Garozzo R, Trifiletti RR, Parano E. Marin-Amat syndrome : case report and review of literature. *J Child Neurology* 1999; **14:** 266–268.
6 Sano K. Section of the portio minor of the trigeminal nerve for the treatment of the Marcus Gunn phenomenon. *Mod Probl Paediatr* 1976; **18:** 258–262.
7 Pavesi G, Medici D, Macaluso GM, Ventura P, Allegri I, Genignani F. Unusual synkinetic movements between facial muscles and respiration in hemifacial spasm. *Movement Disord* 1994; **9**: 451–454.
8 Creel D. Problems of ocular miswiring in albinism, Duane's syndome and Marcus Gunn phenomenon. *Int Ophthalmol Clin* 1984; **24**: 165–176.
9 Weaver Jr RG, Seaton AD, Jewett T. Bilateral Marcus Gunn (jaw-winking) phenomenon occurring with CHARGE association. *J Paediatr Ophthalmol Strab* 1997; **34**: 308–309.

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Sir,

**Pseudo-Terson's syndrome: bilateral simultaneous rhegmatogenous retinal detachment**

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Vitreous haemorrhage secondary to subarachnoid haemorrhage was first described by Terson[1] in 1900. We report an unusual case of pseudo-Terson's syndrome presenting to Stoke Mandeville Hospital's Eye Casualty with bilateral spontaneous vitreous haemorrhages and occipital headache.

### *Case report*

A 57-year-old man presented to the eye casualty with an acute onset of bilateral blurred vision, photopsia, associated with sudden onset of occipital headache, tinnitus, and fever. Nausea was the predominant symptom with no vomiting, neck stiffness, or neurological complaints. He was hypertensive, on atenolol and amitriptyline.

He was fully alert and oriented. Examination revealed a visual acuity of 6/9 in the right eye and 6/60 in the left eye. Retinal examination was obscured because of vitreous haemorrhage in both eyes. A provisional diagnosis of bilateral vitreous haemorrhage secondary to subarachnoid haemorrhage (Terson's syndrome) was made. A full neurological assessment excluded signs of meningeal irritation or neurological deficit. CT scan of the brain showed high signal in the superior sagittal sinus; however, it was reported as normal. Absence of an increased intracranial pressure and red blood cells or xanthocromia on lumbar puncture excluded subarachnoid haemorrhage. B-scan of orbits revealed dense vitreous haemorrhage in both eyes. Systematic survey of each of the eye's four quadrants did not show evidence of small retinal tears or rhegmatogenous retinal detachment in the peripheral fundi. Full blood count, biochemical profile, clotting profile, and electrocardiogram were all normal. Blood pressure was 141/95. MRI of the brain was reported normal.

Vitreous haemorrhage cleared rapidly by day 3 in both eyes. Ocular examination showed a horseshoe retinal tear with minimal subretinal fluid in the right superotemporal quadrant and a suspicious area in the left superotemporal quadrant. Right retinal detachment repair was performed together with cryotherapy to the left eye.

After 1 week later, examination revealed a second horseshoe retinal tear with local subretinal fluid in the right inferotemporal retinal quadrant and three horseshoe retinal tears and bullous retinal detachment in the left superotemporal quadrant. Neither macula was affected by retinal detachment. Visual acuity recovered to 6/12 in the right eye and 6/6 in the left eye. Vitrectomy and fluid–gas exchange repair of the left retinal detachment and a second explant for the right eye were carried out.

### Comment

Rhegmatogenous retinal detachment has a strong bilateral tendency. It results from chronic degenerative process, wherein both eyes are involved. The incidence of bilateral retinal detachment is 10% in normal population

and 16% in aphakic patients.[2] However, simultaneous retinal detachment of both eyes is a rare finding. An annual incidence of 0.35 patients with bilateral simultaneous retinal detachment per 100 000 populations was estimated recently in Norway.[3] These patients were significantly younger. They are usually myopic with multiple round retinal holes.[4]

Unilateral and bilateral retinal or vitreous haemorrhages are common features secondary to subarachnoid haemorrhage. They occur in 3–5% of cases of subarachnoid haemorrhages[5] and usually come to the attention of an ophthalmologist during recovery after the patient regains consciousness. Any patient presenting with retinal or vitreous haemorrhages associated with neurological symptoms such as headache, nausea, or altered consciousness should be investigated to exclude intracranial haemorrhages; however, bilateral vitreous haemorrhages and headache are not pathognomonic of Terson's syndrome. A non-diabetic vitreous haemorrhage most frequently arises as a result of vitreous separation. Our case demonstrates the importance of careful inspection as vitreous haemorrhage clears together with ultrasound B-scan to exclude rhegmatogenous retinal detachment even when the cause of vitreous haemorrhage is not considered to be related to vitreous separation.

## References

1 Terson A. De l'hémorrhagie dans le corps vitre au corps de l'hémorrhagie cérébrale. *Clin Ophthalmol* 1900; **6**: 309–312.
2 Laatikainen L, Harju H. Bilateral rhegmatogenous retinal detachment. *Acta Ophthalmol* 1985; **63**(5): 541–545.
3 Krohn J, Seland JH. Simultaneous, bilateral rhegmatogenous retinal detachment. *Acta Ophthalmol Scand* 2000; **78**(3): 354–358.
4 Bodanowitz S, Hesse L, Kroll P. Simultaneous bilateral rhegmatogenous retinal detachment. *Klin Monatsbl Augenheilkd* 1995; **206**(3): 148–151.
5 Garfinkle AM, Danys IR, Nicolle DA, Colohan ART, Brem S. Terson's syndrome: a reversible cause of blindness following subarachnoid haemorrhage. *J Neurosurg* 1992; **76**: 766–771.

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Sir,

**Extrascleral extension of choroidal malignant melanoma following transpupillary thermotherapy**
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Several studies have reported on the effectiveness of transpupillary thermotherapy (TTT) for the treatment of small-sized choroidal melanomas.[1–4] Significant complications owing to the TTT include tumour recurrence,[2,4] vascular occlusions,[5] and retinal detachment.[4] In this report we present a case of small-sized choriodal melanoma treated with TTT, which showed tumour recurrence in the form of extrascleral extension requiring modified enucleation.

### *Case report*

A 64-year-old man presented in October 1996 with reduced vision and metamorphopsia in the left eye. The medical and family history was noncontributory. On examination, the corrected visual acuity was 20/20 in the right eye and 20/80 in the left eye. The right was normal. On ophthalmoscopic examination of the left eye, a small choroidal melanocytic lesion (2.5 mm × 0.5 mm) with overlying orange pigment and minimal subretinal fluid was identified in the macular region (Figure 1a). Owing to the presence of four out of five risk factors predictive of growth,[6] various options including observation and treatment were offered. It was mutually elected to proceed with the TTT (2 mm spot size, 450 mW power, 1 min duration, five spots).

For the next 20 months, the tumour appeared well regressed (Figure 1b). In June 1998, a marginal recurrence was suspected and additional TTT was performed TTT (3 mm spot size, 700–900 mW power, 1 min duration, 14 spots). The tumour appeared regressed for a period of another 20 months when he developed neovascularization of the disc and mild vitreous haemorrhage. In January 2001, further TTT was performed for marginal recurrence (3 mm spot size, 450 mW power, 1 min duration, two spots). There was no evidence of extrascleral extension at that time. Subsequently, the patient was followed only ophthalmoscopically and there was no evidence of recurrence. On a recent ophthalmoscopic examination (April 2002), the tumour appeared regressed and stable (Figure 1c). However, on B-scan ultrasonography, a 5 mm well-circumscribed nodular extrascleral extension along the base of the original tumour was noted (Figure 1d). The globe and the nodular extrascleral extension were removed by modified enucleation (Figure 1e).

Histopathologically, retina appeared atrophic and was replaced by a fibrotic membrane (Figure 1f).