

is there a place for lipid lowering therapy? *Eye* 2002; **16**(6): 689–693.

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Sir,

Reply

I read with keen interest, the article titled 'contact lenses in the management of high anisometropic amblyopia by Roberts and Adams.¹ The authors pointed out that high anisometropic amblyopia is challenging to treat, and there is a good chance of improvement in visual acuity using contact lenses and occlusion in anisometropia of 6 diopter.²

In India, social and climatological circumstances make the wearing of contact lenses by children difficult, since most of our patients are from lower socioeconomic strata. These patients are commonly lost to follow-up, and are not available for timely examination of cornea and optical adjustments in contact lens wearing. We are of the opinion that in such cases, clear lens extraction with intraocular lens implantation is appealing, because most ophthalmologists use this procedure and good visual outcome can be achieved. Lyle and Jin² achieved a visual acuity of more than 6/12 in 89% eyes with clear lens extraction and intraocular lens implantation. We also observed an improvement in visual acuity of more than two lines in 80% patients.

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Sir,

Reply

We thank Dr Dadeya for his comments on our paper. We are well aware of the social and climatological difficulties that can be experienced when suggesting the use of contact lenses in children and note his comments on the difficulties of follow-up in certain patient groups. However, we do have significant concerns about intraocular surgery for anisometropia in the paediatric age group because of the potential for serious complications including posterior capsule opacification, glaucoma, marked anterior uveitis with synechiae or membrane formation, and retinal detachment. Unpredictable refractive outcomes and higher reoperation rates are well recognised in paediatric cataract surgery. The issues surrounding paediatric lens implantation have recently been highlighted in an editorial in the *Journal of AAPOS*.¹ It is true that some groups have reported excellent visual results from implant surgery in older children; however, close follow-up is important and posterior capsular opacification is still an issue. Occlusion therapy for amblyopia is still required to gain a visual result after surgery and will require regular attendance at clinic. In the context of a society in which follow-up may be challenging, the amblyogenic effect of capsule opacification is of great concern and certainly may prove to be more amblyogenic than the original presenting anisometropia.

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Sir,

Optic neuritis: a rare manifestation of nasopharyngeal carcinoma

We read with interest a case report by Tsai *et al*¹ describing a case of optic neuritis as a presenting feature of nasopharyngeal carcinoma. As the authors have described, nasopharyngeal carcinoma commonly manifests as a neck mass, nasal obstruction, nasal bleeding, or hearing loss. Ophthalmologists are usually involved because of either the compressive or invasive effect of the tumour affecting one of the cranial nerves. Optic nerve involvement as described is usually because of direct compression or invasion of the nerve by tumour cells.² Neuroimaging aids in establishing the cause. Although a computed tomography (CT) scan can be used to access the relation of the mass to the nerve, magnetic resonance imaging (MRI), because of its superior soft-tissue contrast resolution and multiplanar imaging capabilities, is the investigation of choice in evaluating nasopharyngeal carcinoma.³ MRI has also been reported to reveal the extent of invasion of the tumour into the structures around the mass more accurately than a CT,⁴ and has been reported to be superior than a CT in demonstrating the lesions in the retropharyngeal node, skull base, intracranial area, carotid space, longus colli muscle, and levator palatani muscles.⁵ It has also been commented that infiltration and destruction of the skull base is more easily visualized on an MRI than a CT.⁶ It would therefore be very interesting to know if an MRI scan was performed to look for possible compression or invasion of the nerve by the tumour before postulating a dual pathology or a paraneoplastic effect, as it appears that such an important investigation has not been performed. Even so, a microinvasion of the nerve causing the neuritis cannot be ruled out. Improvement in the vision following methylprednisolone can be explained on the basis of the reduction in the compressive effect following treatment. A reduction in tissue oedema and a resultant reduction in tumour volume following treatment with steroids is a well-documented phenomenon.^{7,8} We have experienced a similar scenario in a 76-year-old lady who had presented with optic nerve inflammation that had

resolved on steroid treatment, but imaging revealed the cause to be a nasopharyngeal carcinoma. Further improvement following radiotherapy (which led to reduction in tumour volume) also supports the compressive hypothesis. Although a dual pathology or a paraneoplastic effect can be postulated as a cause, we believe that further imaging in the form of an MRI would provide vital clues regarding the exact relation of the mass and the nerve; however, microinvasion as a cause of optic neuritis can still not be ruled out.

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