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Sir,

Uveitis–glaucoma–hyphema syndrome and systemic anticoagulation

Uveitis–Glaucoma–Hyphaema (UGH) syndrome is more commonly associated with anterior chamber intraocular lenses (IOLs),[1] and less commonly with posterior chamber IOLs.[2–4] We report a case of UGH syndrome in a patient with posterior chamber IOL who was on treatment with warfarin.

Case report

An 83-year-old male initially presented to eye casualty with an embolic left inferotemporal branch retinal occlusion. He had undergone bilateral extracapsular cataract surgery with posterior chamber IOLs 18 years previously. Both IOLs were noted to have subluxed inferiorly (Figure 1a**),** with iris atrophy superiorly in the left eye and a mild anterior uveitis. He had suffered a pulmonary embolus 1 month prior to his attendance and was on warfarin. His International Normalized Ratio (INR) was 1.7 (therapeutic range 2.0–3.0).

After 10 days, he reattended with loss of vision to perception of light in his left eye. Examination revealed a total hyphaema with an intraocular pressure (IOP) of 30 mmHg (Figure 1b**)**. The INR was elevated at 3.8. He was commenced on topical and systemic ocular hypotensives. After 2 days, his hyphaema remained unchanged but the IOP had normalized. The hyphaema resolved over 6 weeks and acuity improved to 6/9. IOP remained normal off treatment, but a residual anterior uveitis required topical corticosteroids. At review 3 months after the initial presentation, his INR was 2.1, the uveitis had virtually resolved and topical steroids were gradually stopped. His warfarin was stopped 1 month later and no further problems relating to UGH syndrome

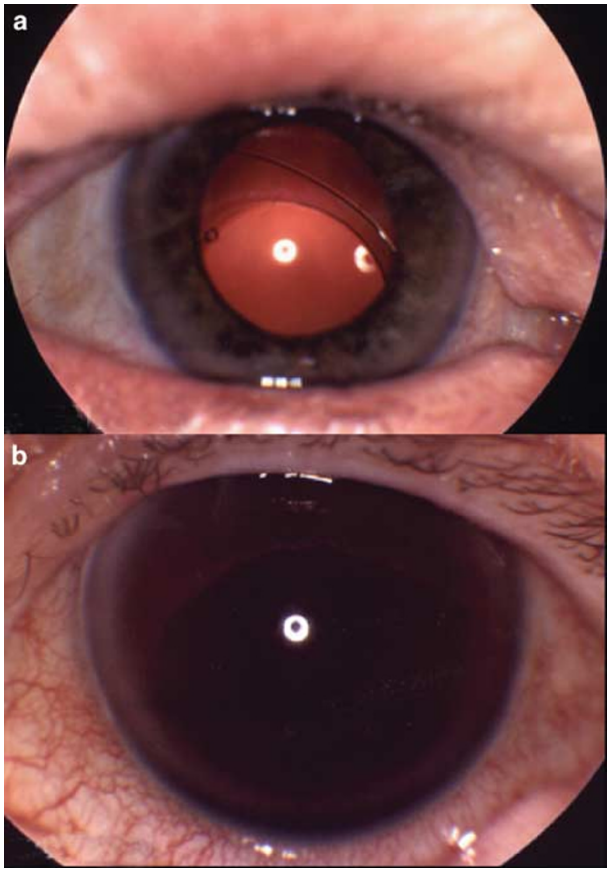

Figure 1 (a) The IOL is seen subluxed inferiorly; (b) 70% hyphaema in the same eye.

occurred. The patient was discharged from regular review 18 months following initial presentation.

Discussion

Systemic anticoagulation rarely causes spontaneous intraocular haemorrhaging and does not require cessation prior to intraocular surgery.[5]

UGH syndrome appears to arise from repetitive mechanical iris trauma by a malpositioned or subluxed IOL.[6–8] In our case, superior iris transillumination was noted and was likely due to chafing by a displaced haptic. Iris melanosomes have previously been isolated from haptic tips in this condition.[9]

The British Society for Haematology recommends an INR of 2.5–3.5 for patients with prosthetic heart valves.[10] Such patients remain at risk of spontaneous hyphaema where IOL malposition has occurred. Small incision phacoemulsification and a correctly positioned IOL will reduce this risk considerably.

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Sir,

Orbital metastasis from a choroidal melanoma

Uveal melanomas are the most common intraocular tumours in adults and treatment of the lesion locally including radiation or enucleation does not prevent metastasis.[1] The common sites of metastasis are the liver, lung, and bone. We present a case of metastasis to the contralateral orbit from a choroidal melanoma in a patient 10 years after successful treatment.

Case report

A 47-year-old female was referred to the ocular oncology clinic in 1992 with a history of photopsia for 4 months in the right eye associated with a reduction in visual acuity. There was no significant ocular or medical history. On examination, the visual acuity was 6/18 and 6/5 in the right and left eye, respectively. Anterior segment examination was normal. Fundus examination revealed a raised pigmented lesion, which was subfoveal in location. The lesion had overlying lipofuschin. The size of the lesion was 10.3 mm in basal diameter and 3 mm in thickness on B scan ultrasound. A diagnosis of choroidal melanoma was made and the patient was admitted and investigated to exclude any evidence of systemic metastasis.

The melanoma was treated with Ruthenium 106 plaque brachytherapy combined with two sessions of argon laser photocoagulation over the next 4 months. On subsequent visits, the vision in the right eye was counting fingers and the tumour was completely treated leaving a flat scar. The patient was followed up regularly with a dilated fundus examination and liver function tests to exclude local recurrence and systemic metastasis. In 1995, the patient developed a lump in her right breast for which she had an excision