

References

- 1 Saad N, Francis IC, Kappagoda MB, Bradbury R. Adult penicillinase-producing gonococcal keratoconjunctivitis. *Med J Aust* 1998; **149**: 710–711.
- 2 Lee JS, Choi HY, Lee JE, Lee SH, Oum BS. Gonococcal keratoconjunctivitis in adults. *Eye* 2002; **16**: 646–649.
- 3 White C. Sexually transmitted diseases continue to rise. *Br Med J* 2004; **329**(7460): 249.
- 4 Tjia KF, van Putten JP, Pels E, Zanen HC. The interaction between neisseria gonorrhoeae and the human cornea in organ culture. An electron microscopic study. *Graefes Arch Clin Exp Ophthalmol* 1988; **226**(4): 341–345.
- 5 Watt PJ. Pathogenic mechanisms of organisms virulent to the eye. *Trans Ophthalmol Soc UK* 1986; **105**: 26–31.
- 6 Clinical Effectiveness Group. *British Association of Sexual Health and HIV. National guideline on the diagnosis and treatment of gonorrhoea in adults 2005.* Available at: <http://www.bashh.org/guidelines/ceguidelines.htm>.
- 7 Soong HK, Farjo AA, Katz D, Meyer RF, Sugar A. Lamellar corneal patch grafts in the management of corneal melting. *Cornea* 2000; **19**: 126–134.
- 8 Shimmura S, Shimazaki J, Tsubota K. Therapeutic deep lamellar keratoplasty for cornea perforation. *Am J Ophthalmol* 2003; **135**: 896–897.
- 9 Vanathi M, Sharma N, Titiyal JS, Tandon R, Vajpayee RB. Tectonic grafts for corneal thinning and perforations. *Cornea* 2002; **21**: 792–797.
- 10 Tong L, Tan DTH, Abano JM, Lim L. Deep anterior lamellar keratoplasty in a patient with descemetocoele

following gonococcal keratitis. *Am J Ophthalmol* 2004; **138**: 506–507.

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Sir,  
**Homonymous hemianopia and exotropia: an important management issue**

We report a case of comorbidity of exotropia with homonymous hemianopia in whom a careful preoperative assessment helped avoid an unexpected surgical outcome.

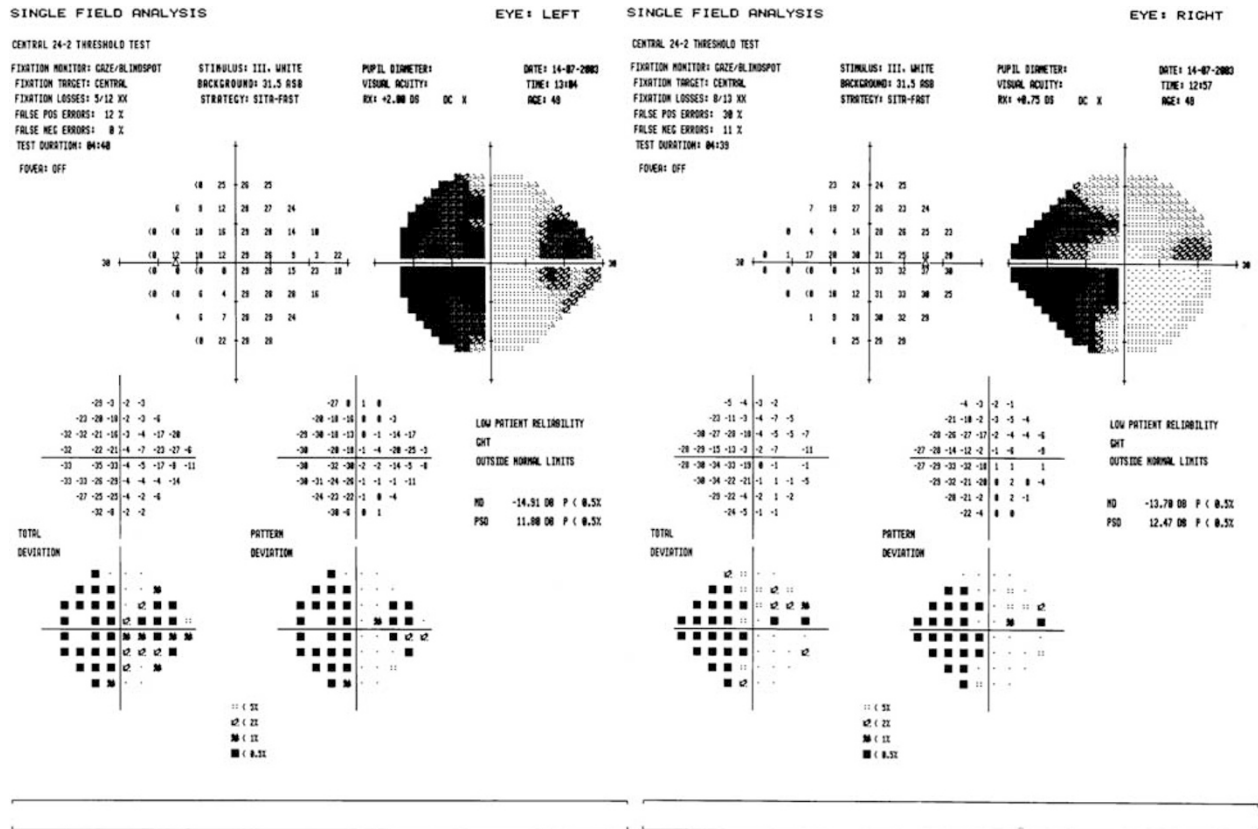


Figure 1 Left homonymous hemianopia.

**Case report**

A 50-year-old male presented with a long-standing exotropia, requesting intervention for cosmetic purposes. He gave a history of an early-onset exotropia and amblyopia, with cosmetic strabismus surgery at the age

of 20 years. Visual acuities were 6/6 OD and 6/12 OS. He described a consecutive exotropia within a year of surgery, which had remained stable since.

Examination revealed a concomitant exotropia, measuring 40 prism dioptres (PD) base in (BI) at 1/3 m

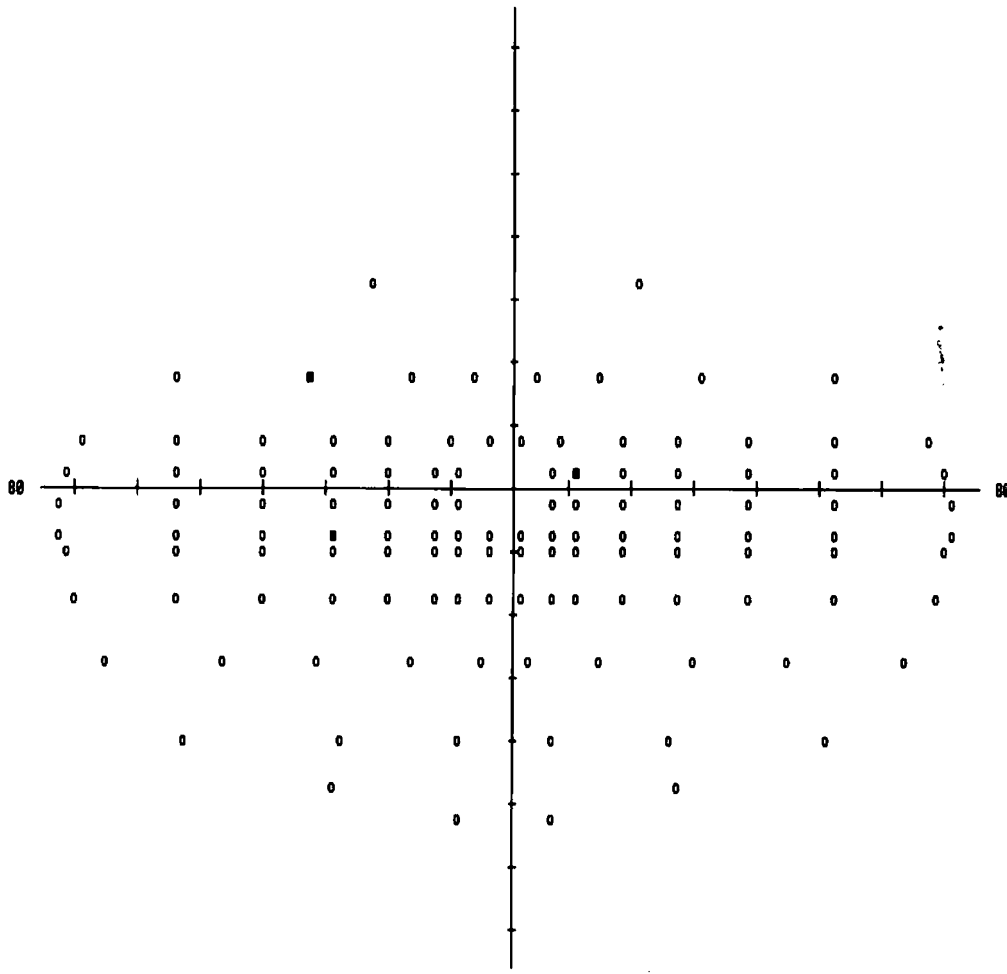
**ESTERMAN BINOCULAR**

FIXATION MONITOR: OFF  
FIXATION TARGET: CENTRAL  
FIXATION LOSSES: 0/0  
FALSE POS ERRORS: 3/10  
FALSE NEG ERRORS: 1/11  
TEST DURATION: 05:21  
STIMULUS INTENSITY: 10 DB

STIMULUS: III, WHITE  
BACKGROUND: 31.5 ASB  
STRATEGY: TWO ZONE  
TEST MODE: SINGLE INTENSITY

PUPIL DIAMETER:  
VISUAL ACUITY:  
RX: +0.75 DS DC X

DATE: 02-03-2003  
TIME: 14:49  
AGE: 49



○ SEEN 117/120  
■ NOT SEEN 3/120  
△ BLINDSPOT  
ESTERMAN EFFICIENCY SCORE: 97

Figure 2 Full binocular field.

and 35 PD BI at 6 m, with full motility. Ocular examination was unremarkable except for a left homonymous hemianopic field defect (Figure 1). Magnetic resonance imaging (MRI) scan of the brain confirmed an infarction in the right occipital lobe.

A binocular driving visual field test resulted in a reasonably full field, presumably because the exotropia compensated for the hemianopia (Figure 2). Therefore, the patient declined surgery.

### Comment

This case illustrates an important exception to the rule that two defects of the visual system usually lead to a more pronounced visual deficit than one.

Under binocular conditions, the functional significance of a homonymous hemianopia can be reduced by an exotropia of the ipsilateral eye (ie deviation in the direction of the field defect), resulting in panoramic vision. A prism correction of the exotropia, or botulinum toxin to realign the eye, followed by a repeat binocular visual field test helps predict the impact of a surgical correction of exotropia.

This combination is uncommon. Three reports of patients with exotropia who developed ipsilateral homonymous hemianopia concluded that strabismus correction is contraindicated in these patients in order to preserve their panoramic vision.<sup>1-3</sup>

This case report highlights the fact that hemianopias should be excluded before strabismus surgery. Reduction in visual field as a result of 'cosmetic' surgical alignment where there is an undetected hemianopia may have serious implications, including loss of driving license.

### References

- 1 Herzau V, Bleher I, Joos-Kratsch F. Infantile exotropia with homonymous hemianopia: a rare contraindication for strabismus surgery. *Graefes Arch Clin Exp Ophthalmol* 1988; **226**: 148-149.
- 2 Gote H, Gregersen E, Rindziunski E. Exotropia and panoramic vision compensating for an occult homonymous hemianopia: a case report. *Binocular Vis Eye Muscle Surg* 1993; **8**: 129-132.
- 3 Gamio S, Melek N. When the patient says no. management of exotropia with hemianopic visual field defects. *Binocular Vis Strab Q* 2003; **18**(3): 167-170.

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Sir,  
**Bilateral vitreous hemorrhage associated with dengue fever**

We appreciate the interest shown in our article<sup>1</sup> by the Readers of your esteemed journal. According to the history given by the patient and her parents, she developed the ocular manifestations 2 days after the systemic manifestations of dengue fever i.e., high grade fever with chills, muscle pain, headache, and episodes of bleeding through mouth and during defaecation. This information is already mentioned in the 2nd paragraph of our article. After receiving the call by the Pediatric Physician, ophthalmic examination was done by the local Ophthalmologist on same day, and she was found to have vitreous hemorrhage in both eyes at the time of examination and advised review after couple of weeks. The laboratory diagnosis during admission revealed marked thrombocytopenia (Pletlet count <25000/cc).

After improvement of the general condition, the patient followed-up with the local Ophthalmologist.

When the vitreous hemorrhage didn't cleared after 4 months of conservative management, she was referred to our centre where we found to have organized vitreous hemorrhage OD and resolving vitreous hemorrhage OS.

Right eye pars-plana vitrectomy was performed that improvement the visual acuity up to 6/12 after 12 weeks postoperatively. No surgery was planned in left eye due to resolving vitreous hemorrhage and good (6/12) vision.

The reason of not mentioning the vast details was limitations to the number of words as per the norms of the journal. Once again we thank to the corresponders for showing their interests and valuable comments on the article.

### Reference

- 1 Nainiwal S, Garg SP, Prakash G, Nainiwal N. bilateral vitreous hemorrhage associated with dengue fever. *Eye* 2005; **19**(9): 1012-1013.