
LETTERS TO THE EDITOR

Sir,

We read with interest the recent article by Gillespie *et al.*¹ on the spectrum of ocular toxocariasis. They, and previous authors,^{2,3} stress the variety of different clinical presentations of ocular toxocariasis, yet little is documented on recurrence of the intraocular inflammation. In our Uveitis Clinic we have seen two such cases where panuveitis has recurred years after the initial presentation.

Case 1

A 15-year-old girl presented in 1985 with a large nasal chorioretinal scar in her right eye associated with severe panuveitis and visual acuity reduced to light perception. A *Toxocara* ELISA test was positive with an optical density (OD) reading of 0.35. She was treated with oral prednisolone and thiabendazole with good effect and regained 6/6 vision.

In 1991, she re-presented with a 2 month history of blurred vision in the same eye. The visual acuity was 6/60, and she had a panuveitis, macular oedema and raised intraocular pressure. The chorioretinal scar appeared inactive with no evidence of local recurrence. The intraocular inflammation and macular oedema resolved on oral prednisolone and the visual acuity returned to 6/6.

Case 2

A 19-year-old man presented in 1985 with right-sided focal retinochoroiditis, panuveitis and macular oedema. In the retinal periphery, two granulomas were seen with a fibrous traction band extending from the largest granuloma to the optic disc. The *Toxocara* ELISA test was positive with an OD of 0.42. Thiabendazole was not tolerated but he regained 6/9 vision on oral prednisolone.

Since then he has had frequent exacerbations of panuveitis without any evidence of recurrent inflammation in the granulomas. This has required numerous courses of oral prednisolone but recently azathioprine has been added as a steroid-sparing agent in an attempt to limit steroid side-effects. The visual acuity is currently reduced to 2/60 due to a combination of chronic macular change, vitritis and a corneal scar following a penetrating injury in 1991.

Although a chronic exudative endophthalmitis has been a well recognised manifestation of ocular toxocariasis,⁴ it is usually seen in children when it is frequently misdiagnosed as retinoblastoma.

Eye (1993) 7, 810-813

We believe that recurrent panuveitis, in the absence of any evidence of recurrence of the original chorioretinal lesion, is a distinct entity in the clinical spectrum of ocular toxocariasis and may represent some form of local immunological/hypersensitivity reaction.

N. J. Rowson
P. Stavrou
P. I. Murray

Academic Unit of Ophthalmology
Birmingham and Midland Eye Hospital
Church Street
Birmingham B3 2NS, UK

References

1. Gillespie SH, Dinning WJ, Voller A, Crowcroft NS. The spectrum of ocular toxocariasis. *Eye* 1993;7:415-8.
2. Shields JA. Ocular toxocariasis: a review. *Surv Ophthalmol* 1984;28:361-81.
3. Molk R. Ocular toxocariasis: a review of the literature. *Ann Ophthalmol* 1983;15:216-31.
4. Duguid IM. Chronic endophthalmitis due to *Toxocara*. *Br J Ophthalmol* 1961;45:705-17.

Sir,

I was very interested to read the article by Rose *et al.*¹ on intraocular malignant melanomas presenting with orbital inflammation. I should like to discuss a similar case seen recently at Hull Royal Infirmary.

A 62-year-old man presented to the Eye Casualty Department with a 3 day history of headaches and 2 days of a sticky left eye with swollen eyelids. There was no

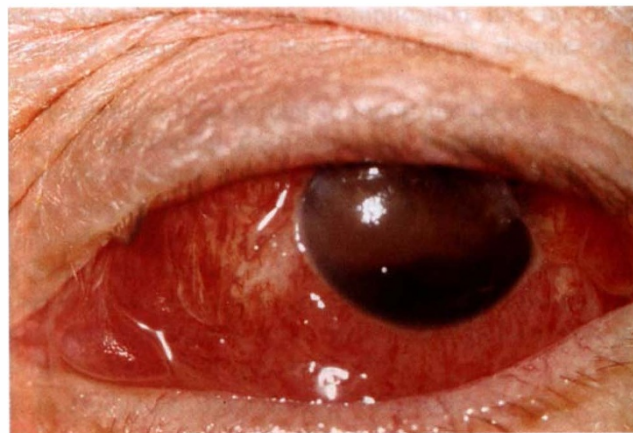


Fig. 1. Left periocular inflammation settling after 1 week of topical and systemic antibiotics.