eye. The capsule surrounding the IOFB was opened and the IOFB mobilised and dislodged with a membrane pick. The pars plana incision was enlarged to accommodate the foreign body that was removed in all cases with intraocular forceps, under direct observation. No retinopexy was performed in any of the cases. Total fluid/air exchange was performed in 3 cases. The whole procedure was performed under indirect ophthalmoscopic monitoring using a +20 dioptres lens (John Scott, Cambridge, UK, personal communication). The follow-up periods ranged from 2 to 10 months. In all cases the retina remained attached and a chorioretinal scar was present at the retinal break caused by the foreign body (Fig. 2).

Discussion

Five cases of metallic foreign bodies embedded in the retina and choroid but without retinal detachment were managed successfully by pars plana vitrectomy and foreign body removal without intraoperative or post-operative retinopexy. A spontaneous chorioretinal adhesion subsequently developed around the retinal break induced by the foreign body and the retina remained attached at the end of the follow-up period. Ambler and Meyers[3] managed similar cases by pars plana vitrectomy and foreign body removal using an intraocular rare earth magnet without retinopexy. In all their cases, chorioretinal adhesion was present at the retinal break caused by the foreign body and the retina remained attached.

These data indicate that retinopexy around the retinal break induced by metallic foreign bodies embedded in the retina and choroid without retinal detachment is not necessary and should be avoided.

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Sir,

Ocular Injury Caused by a Retractable Dog Lead

Ocular injuries caused by elasticated cords with metal or plastic hooks are well described.[1–4] We describe the first reported ocular injury caused by a retractable dog lead.

Case Report

A 45-year-old man was walking his Border Collie which was being restrained by a retractable dog lead (Fig. 1).

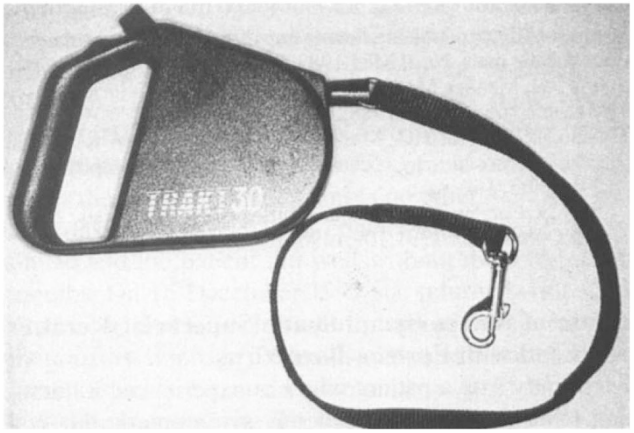

Fig. 1. *The retractable dog lead with spring-loaded metal gate clip.*

The dog's attention was attracted by another dog and she bolted down an embankment in pursuit. The lead uncoupled from the dog collar due to failure of its spring gate mechanism, causing the lead to recoil and deliver a serious blunt injury to the left eye.

On examination the patient's visual acuity was counting fingers. The crystalline lens had subluxated blocking his pupil and he had sustained a vitreous haemorrhage. The lens was immediately removed and an anterior vitrectomy carried out. Two weeks later the patient was found to have developed an inferonasal retinal detachment. This was repaired with vitrectomy and tyre. At a later stage he underwent sutured posterior lens implant, with repair of iris and botulinum toxin injection into the lateral rectus to correct exotropia that had developed due to his aphakia. Following this the patients now attains a visual acuity of 6/9 and was orthophoric.

Discussion

A variety of uses of elasticated cords have been cited as causing ocular injury, the most common being to secure luggage to car roof racks[1,2] but also to keep suitcases and backpacks closed and to secure tent posts.[4] We report the first ocular injury caused by a retractable dog lead. We challenge the suggestion that the spring-loaded metal gate clip[2–4] prevents accidental release of metal and plastic hooks, as it was the spring gate mechanism on this occasion which proved to be defective and led to the uncoupling of the lead. The recommendation of Litoff *et al.*[4] that polycarbonate safety spectacles should be worn when securing elastic straps is impracticable when walking a dog.

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Sir,

A Case of Severe Symptomatic Superficial Keratitis Associated with Epstein–Barr Virus

We recently saw a patient who has experienced a fluctuating (chronic) course of severely symptomatic bilateral superficial punctate keratitis with pannus formation and without any conjunctival injection who has had no mononucleosis-like symptoms throughout the duration of her illness and who shows no evidence of immunological dysfunction, but who has associated serological evidence of chronic Epstein–Barr virus (EBV) infection. Other than the pannus, the lesions appeared almost identical to Thygeson's superficial punctate keratitis (TSPK). While EBV infection is frequently subclinical (especially in children), it is commonly associated with several pathological conditions including infectious mononucleosis, African Burkitt's lymphoma, lymphoproliferative disorders in immunocompromised patients, chronic fatigue syndrome and nasopharyngeal carcinoma. Ocular involvement is uncommonly reported in EBV infection. Follicular conjunctivitis is the most frequent ocular finding associated with EBV, but any orbital/ocular tissues may be involved.[1–6] We suggest an EBV panel test on suspected TSPK patients.

Case Report

A 29-year-old white woman presented to our clinic on 21 May 1992 desiring further evaluation of her diagnosis of 'bilateral keratitis'. She first experienced blurred vision, severe photophobia and corneal irritation bilaterally in December 1991. She was debilitated from the photophobia and irritation to the point of not being able to work properly. In January 1992 she sought care from her ophthalmologist who began treating her for 'bilateral keratitis', and by the time we examined the patient, approximately 5 months after the onset of the symptoms, she had tried several courses of therapy including fluoromethalone, prednisolone phosphate 1%, and diclofenac. None of these treatments offered the patient significant relief. As a last resort she had been offered superficial keratectomy for removal of 'blood vessels' from her cornea. She came to us for a second opinion.

On presentation to our clinic the patient complained of continuing blurred vision, severe photophobia and irritation. She reported that her eyes had never turned red throughout the course of her illness, even while her symptoms were at their worst. She denied any systemic complaints, and denied any flu-like symptoms over the past 6–9 months. She also denied previous ocular trauma, significant past medical or ocular history, or medical or environmental allergies. Family history was positive for glaucoma (mother's father). She was not taking any medications, either topical or systemic.

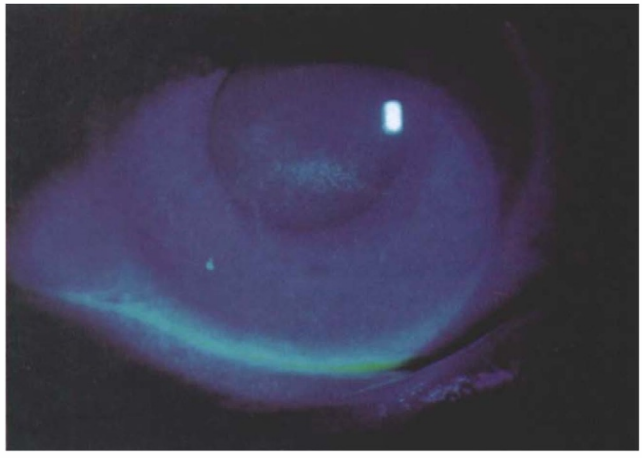

Fig. 1. *Right eye showing active 3 mm inferior pannus and superficial punctate keratopathy.*

Visual acuities were 20/30 in the right eye and 20/40 in the left, and ocular tensions (aplanation) were 16 and 14 mmHg. Fluorescein stain showed 3+ interpalpebral superficial punctate staining in both eyes, with a 1 mm round erosion centrally in the right eye. The punctate staining was coarse, pleomorphic, and too numerous to count. Thick, active pannus was noted inferiorly in both eyes, extending from 5 o'clock to 7 o'clock with vessel ingrowth reaching approximately 3 mm anterior to the limbus in the right eye, and 2.5 mm in the left (Figs. 1, 2). Anterior chambers were without reaction in either eye, and conjunctivae were not injected and had no significant follicular or papillary response. Schirmer's test with anaesthesia showed more than 15 mm of tear production bilaterally.

The lesions were cultured for bacteria, *Chlamydia* and viruses, and the patient was started on topical trifluorothymidine (Viroptic, Burroughs Wellcome). A complete blood count revealed a normal haemoglobin level with a white blood cell count of 4.1. A differential count revealed

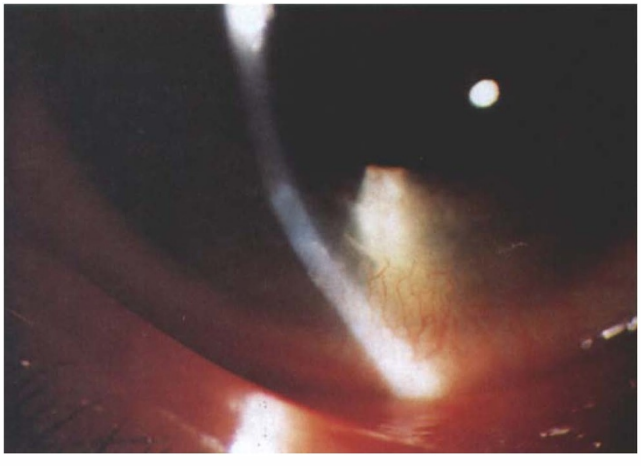

Fig. 2. *Left eye showing active 2.5 mm inferior pannus and superficial punctate keratopathy.*