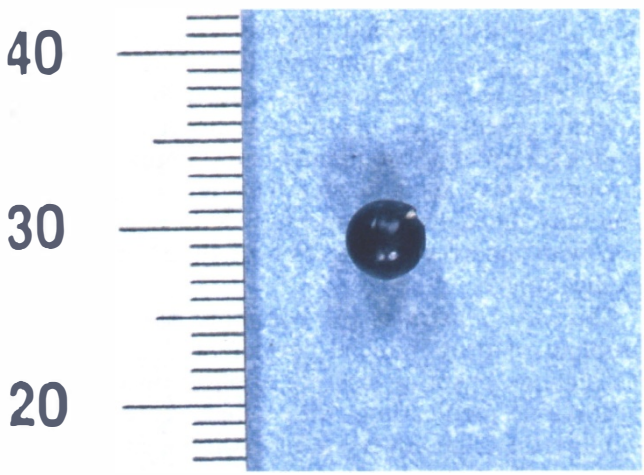

Fig. 3. *Retrieved air gun pellet alongside a millimetre scale.*

rest, and was given analgesia for pain. On the following day during eversion of the upper lid, an air gun pellet fell from the superior fornix onto the floor. Although this was initially not detected by the examining doctor, the attending nurse fortunately saw the pellet fall and promptly retrieved it (Fig. 3).

The patient was then discharged but kept under close ophthalmic observation. Five weeks later there was complete resolution of the vitreous haemorrhage with a flat retina and an unaided visual acuity of 6/5.

Discussion

Having been shot from such close range, this youngster was undoubtedly fortunate not to have sustained a more severe injury. We assume that the pellet took the following course: it perforated the left upper lid, ricocheted from the upper part of the globe, and lodged in the upper fornix, which subsequently became oedematous. It follows that, once the oedema started to resolve, the foreign body became dislodged and, helped by mechanical eversion, fell out under its own weight.

The localisation of an intraorbital foreign body is sometimes difficult and requires careful examination of the orbit and globe. Radiological imaging techniques such as plain radiography, ultrasound, CT and MRI (useful where wooden foreign bodies are suspected) are therefore employed accordingly. In this case, the anterior location of the pellet on radiography and good visualisation of the posterior segment of the left eye led to the conclusion that the pellet was not intraocular, hence the conservative management.

This case is very similar to that described by Votruba.[1]

The authors would like to thank their nurse Ms J. Mohammed for the care and enthusiasm demonstrated. They also acknowledge the help of the audiovisual departments of Stobhill General Hospital and the Glasgow Eye Infirmary, Glasgow.

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Sir,

Skin Depigmentation Associated with Ophthalmic Medication

Periorbital skin is often exposed to ophthalmic medications intended for disorders of the eye or its adnexae. Adverse effects include contact dermatitis and allergic reactions. A case of depigmentation of lid skin following incorrect application of an ophthalmic medication is reported.

Case Report

A 73-year-old West Indian man presented to the eye department with a 2 week history of lid skin depigmentation which came on 5 days after starting treatment with Fucithalmic (Leo) eyedrops for bacterial conjunctivitis. Further questioning established that the medication was rubbed onto lid skin rather than being instilled in the lower conjunctival sac. He was found to have two asymmetric and inflamed depigmented patches involving the skin of lower lids, measuring 3.5×1.5 cm on the right and 2×1 cm on the left (Fig. 1). The lesions did not change in size after the medication was stopped. Direct questioning excluded previous skin condition, known allergies and family history of skin disease. There was no evidence of autoimmune conditions or depigmentation affecting other parts of the body.

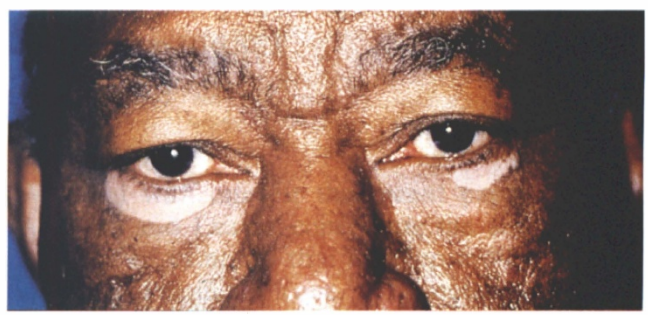

Fig. 1. *Lower lid skin depigmentation following incorrect application of Fucithalmic.*

Skin patch testing with Fucithalmic was negative. He was treating with betamethasone 0.1% cream for 2 weeks. On review 2 months later, there was no change in the pigmentation of the affected area.

Discussion

Causes of cutaneous depigmentation include autoimmune, post-inflammatory, toxic and traumatic loss of pigment cells. Vitiligo is characterised by patches of depigmented skin due to loss of cutaneous melanocytes. It is a relatively common condition affecting 1–2% of the population, may occur at any age and is rarely symmetrical. In one-third of patients it is precipitated by factors such as emotional stress, physical illness, sunburn or trauma. Vitiligo may also be a manifestation of Vogt–Koyanagi–Harada syndrome or sympathetic ophthalmitis. The pathogenesis is not well established; autoimmune, neuronal, self-destructive and genetic mechanisms have been implicated.[1]

Fucithalmic is a widely used ophthalmic preparation containing fusidic acid 1%, benzalkoniun chloride, disodium etatate, mannitol, calbopol, NaOH and water for injection. Reported side effects include acute and chronic conjunctival allergic reaction, urticaria and exanthema.

In the case reported, depigmentation followed incorrect application by massaging the medication into the skin of the eyelids. Possible mechanisms include post-traumatic inflammation, a toxic effect on the melanocytes, and autoimmune or allergic reaction to any of the above components. The normal skin patch test excluded the possibility of a chemically induced or autoimmune depigmentation. It is likely that repeated trauma, caused by the gentle rubbing, precipitated an inflammatory reaction in the epidermis which subsequently led to depigmentation through loss of melanocytes. This non-specific reaction may therefore be expected to occur in association with incorrect application of other ophthalmic medications.

This case illustrates the common, but avoidable, problem of drug-induced periocular disease. Clear instructions ensuring correct application of topical ophthalmic medications with avoidance of spillage would reduce the adverse effects on the surrounding skin.

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