Comment

Sudden visual loss due to thrombolytic therapy is rare. In this case it is necessary to explain the occurrence of combined retinal and choroidal detachment. It is possible that the patient developed rhegmatogenous retinal detachment causing hypotony leading to sudden choroidal detachment and suprachoroidal haemorrhage after treatment with streptokinase. However, we failed to find any retinal breaks and the retina was flat at follow-up. Thus the diagnosis of combined exudative retinal detachment with suprachoroidal haemorrhage is more likely.

Although rare, combined exudative retinal detachment and choroidal detachment have been reported previously in cases associated with nanophthalmos,[2] scleritis,[3] carotid cavernous fistula,[4] orbital pseudotumour[5] and following glaucoma filtering surgery.[6]

Of course it is impossible to prove a definite causal relationship between treatment with streptokinase and the ocular symptoms; however, the short time interval between treatment and the suprachoroidal haemorrhage is highly suggestive. There have been several recent reports of visual loss after the use of thrombolytic agents but these involved tissue plasminogen activator.[7,8]

To our knowledge this is the first case report of visual loss due to suprachoroidal haemorrhage following the use of streptokinase in a patient without previous ocular surgery.

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Sir,

Valsalva retinopathy associated with blowing balloons

Valsalva retinopathy is an uncommon condition which occurs in response to the Valsalva manoeuvre. It is characterised by the spontaneous appearance of unilateral macular haemorrhages. We report a case of Valsalva retinopathy associated with the blowing up of a party balloon and discuss its management.

Case report

A 47-year-old man presented with an acute reduction of central acuity in his left eye whilst inflating a long party balloon. He was otherwise well with no past medical or past ophthalmic history of note. Snellen acuity was 6/24 left eye and 6/6 right eye. Intraocular pressures were 16 mmHg bilaterally. There was no relative afferent pupil defect and anterior segment examination was unremarkable.

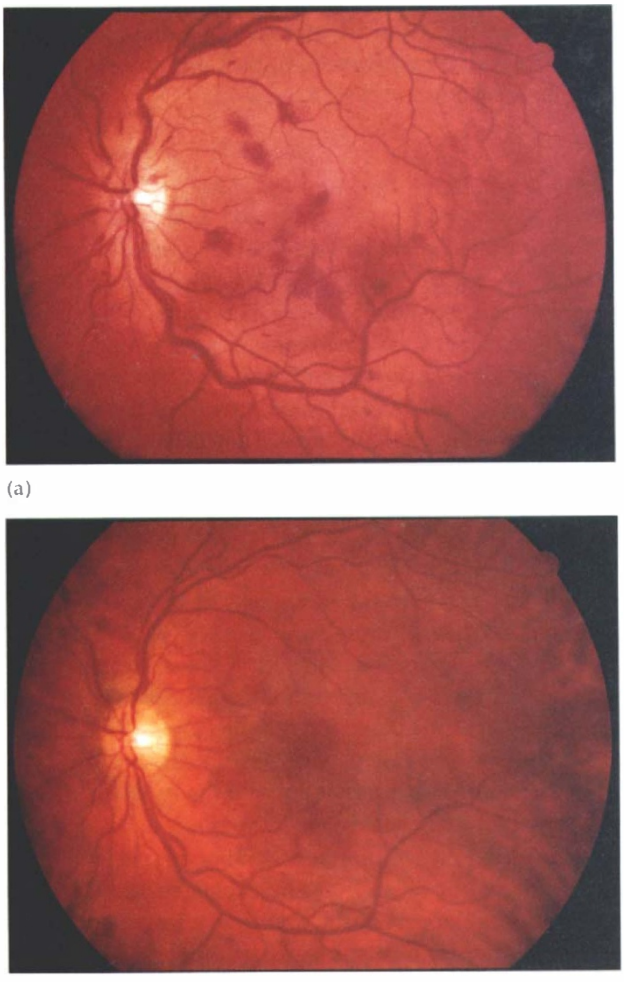
Dilated fundal examination revealed deep and superficial retinal haemorrhages scattered in the posterior pole of the left eye (Fig. 1a). There was no evidence of any preretinal haemorrhages, cotton wool spots or macular oedema. Investigations including blood pressure, urinalysis, full blood count and clotting studies were all normal. Fluorescein angiography of the left fundus demonstrated masking of the background choroidal fluorescence by the haemorrhages. There was no leakage from the retinal vessels.

At 4-week follow-up, visual acuity of the left eye improved to 6/9 and dilated fundal examination revealed marked resolution of the haemorrhages (Fig. 1b). At the 8-week follow-up, visual acuity returned to 6/6 in the left eye and the retinal haemorrhages had completely resolved with no evidence of any retinal sequelae.

Comment

Valsalva haemorrhagic retinopathy is characterised by unilateral macular haemorrhages occurring in healthy individuals due to a rapid rise in intrathoracic or intra-abdominal pressure against a closed glottis or the physiological equivalent.[1] Due to the absence of valves in the venous system, this pressure is transmitted to the eye causing rupture of the superficial retinal capillaries.

Valsalva haemorrhagic retinopathy has been described following vigorous sexual activity,[2] aerobic exercise,[3] weight-lifting,[4] constipation,[5] dental and prostate surgery.[6,7] This is the first reported case of



(a)

(b)

Fig. 1. *Left fundus photograph showing retinal haemorrhages at presentation (a) and after 4 weeks (b).*

Valsalva retinopathy following inflation of a party balloon. We believe the rise in the intrathoracic pressure needed to inflate these long balloons produces a significant Valsalva stress. The reason why the retinopathy occurs unilaterally is unknown. A review of 16 cases[1–7] shows no preference for the left or right eye to be affected (7 cases left, 9 cases right).

Although the macular haemorrhages are accompanied by an acute reduction of visual acuity, resolution occurs by 6 months and most resolve within 1–3 months. No specific treatment is recommended but we advise patients to rest and avoid strenuous activity until resolution. Fluorescein angiography is helpful to exclude any other causes of retinal haemorrhage.

A recent report has highlighted the risk of ocular blunt trauma with party balloons exploding during inflation[8] and recommended the use of an inflation device. We support this recommendation to avoid Valsalva retinopathy.

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Sir,

Pedunculated dermolipoma with overlying upper lid coloboma and absent lateral canthus: cause and effect?

Dermolipoma is a subconjunctival choristoma and commonly appears as a soft, yellow, movable subconjunctival mass at the temporal fornix.[1] Coloboma of the upper eyelid is a rare congenital defect and usually involves the medial part of the lid. The two may rarely coexist, usually in the oculofacial syndromes such as Goldenhar's syndrome and epidermal naevus syndrome.[2]

We report here the case of an infant with a pedunculated dermolipoma at the lateral canthus associated with coloboma of the lateral third of the upper lid and absent lateral canthus without associated oculofacial syndrome. This rare combination along with the unusual histology of the tumour prompted us to report the case. We discuss the surgical management of this tumour and propose a hypothesis regarding its possible role in causing the lid coloboma.

Case report

A 6-month-old Omani girl was seen because of a mass protruding from the left eye since birth. Examination showed a pedunculated, soft mass 6 mm × 4 mm in size at the lateral canthus, replacing the canthal angle. The mass was covered on the medial side by thickened conjunctiva changing gradually into skin-like epithelium laterally with fine hairs on the surface. The posterior limit of the mass could not be defined, as its thick pedicle extended subconjunctivally into the orbit (Fig. 1). Eye movements were free and full. The upper eyelid was incomplete, ending abruptly at the mass and without any