

Fig. 4. B-scan ultrasonogram done in March 1980, showing a dome-shaped choroidal mass with features typical of choroidal melanoma.

our patient, who was treated with a cobalt-60 plaque for a choroidal melanoma in the macular area, has enjoyed excellent tumour control and excellent vision for 18 years since treatment. A recent study of plaque radiotherapy for choroidal melanoma in the macular area showed that visual outcome was better than previously suspected. In that report of 630 patients with macular choroidal melanoma treated with plaque radiotherapy and followed for more than 5 years, the final visual acuity was better than 20/200 in 44% of patients and better than 20/40 in 9%.⁵ Many of the earlier patients in that series were treated with cobalt-60 plaques, which were associated with worse visual outcomes. With the more recent use of lower-energy isotopes and improved designs of radioactive plaques, even better visual results are anticipated in the future.

The reason for such a favourable response to cobalt-60 plaque radiotherapy in the patient reported here is unclear. However, it demonstrates that excellent tumour control and visual results can sometimes be obtained even though the melanoma is in the macular area.

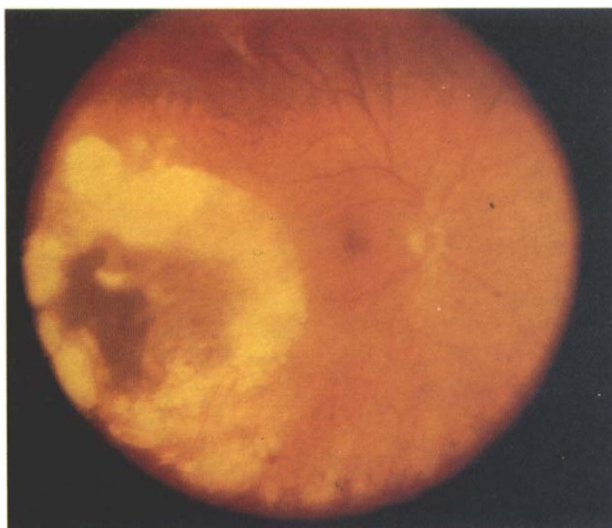


Fig. 5. Wide-angle fundus photograph (corresponding to Fig. 2) done in 1996, showing a flat scar in the area where previously there was tumour.



Fig. 6. Fundus photograph (corresponding to Fig. 3) showing the margin of treated area. The tumour has completely regressed with a well-delineated posterior margin to the scar. The optic disc and fovea show no radiation damage.

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Sir,

Angler's fishing line sinker causing rupture of globe and medial wall fracture

An angler sustained a left penetrating eye injury and fracture of the medial orbital wall from a flying fishing weight. The lead sinker found resting in his posterior nasal space was retrieved and the globe underwent primary repair but was later enucleated. The risks of

fishing line sinkers, the mechanism of this type of injury and the recommendation for the use of eye protection are discussed.

Case report

A 46-year-old male recreational angler overcast his line, which became caught in a bush. In an attempt to free the line he tightened the clutch on his reel, faced away from the bush holding the rod and began walking, tightening the line until it snapped. The trace snapped leaving the line attached to the lead sinker, propelling the weight towards him hitting the left side of his face. There was severe left facial pain and loss of vision in his left eye. He attended the local casualty and was immediately transferred to the local eye hospital.

Examination revealed marked swelling and bruising of his left upper and lower lids. A 40 cm length of fishing line was hanging from the closed left palpebral aperture. There was also a hard tender bruised swelling of the left side of the nose and a small 1 cm laceration at the left lateral canthus; otherwise the eyelids were unaffected.

Visual acuities were 6/6 in the right eye and NPL in the left eye with an afferent pupillary defect. The left eye had extensive subconjunctival haemorrhage and chemosis and a limbal split from 3 o'clock to 9 o'clock with scleral extension medially and laterally. A total hyphaema and uveal prolapse obscured further view. Examination of the right eye was unremarkable. Initial examination of his left nasal space was limited due to a blood clot and no foreign body was seen.

Transverse and frontal plain radiographs were performed that showed an elongated bell-shaped radio-opaque foreign body in the region of the posterior nasal space consistent with a lead sinker (Fig. 1). A CT scan was also performed that confirmed the position of the weight and a fracture of the medial orbital wall.

Removal of the foreign body under endoscopic control and primary closure of the globe were performed jointly by ophthalmic and ENT surgeons with the patient under general anaesthesia. The foreign body was visualised lying on the posterior nasal floor using a rigid nasal endoscope (Fig. 2). Once identified, the ring used to attach the line to the sinker was grasped using forceps,



Fig. 1. Transverse plain radiograph showing a radio-opaque foreign body in the region of the posterior nasal space.



Fig. 2. Endoscopic view of the foreign body lying on the left posterior nasal floor.

the line was cut and the sinker was retrieved from the post-nasal space via the left nostril under direct endoscopic visualisation. The fishing line was then removed by traction on the end protruding from the orbit. A peritomy was performed to explore the extent of the globe rupture. The rupture extended from the lateral rectus insertion to the limbus then circumlimbally between 3 o'clock and 9 o'clock superiorly and out medially beyond the insertion of the medial rectus. A primary repair was performed, prolapsed uveal tissue excised, the sclera sutured with 6/0 vicryl and the limbus with 10/0 nylon. The conjunctiva was then repaired using 8/0 vicryl.

Post-operatively the patient's vision remained no perception of light and he continued to be troubled by ocular discomfort whilst on regular topical steroids and antibiotics. One month after his initial repair he underwent enucleation of the left globe and a primary porous polyethylene orbital implant.

Comments

In 1995 the Leisure Accident Surveillance System reported 3546 injuries to anglers requiring hospital attention. Two hundred and nineteen injuries involved the eyes and 183 involved other parts of the face.¹ Ocular injuries from fish hooks are usually due to the hook recoiling after an attempt to free a snagged line.²⁻⁵ Injuries due to fishing line sinkers have been reported and usually have a worse prognosis.⁶ Orbitocranial involvement is also a recognised risk.⁶⁻⁸

Recreational angling is a popular sport in the UK attracting many people to spend long periods of time beside lakes and rivers. This case highlights a serious potential risk from flying lead sinkers, given the common practice of pulling snagged tackle free, similar to the more common mechanism of fish hook injury to the face and eyes.²⁻⁷

The existence of at least two other anecdotal reports of injuries caused by fishing line sinkers in the last 12 months suggests the need for a review in the code of practice and safety published by the National Federation of Anglers.⁹ Recommendations may include advice on the use of flying lead sinkers and the use of protective

eye wear whilst fishing. Hard or soft contact lenses offer no protection against angling injuries. Plastic or polycarbonate spectacle lenses rather than glass streetwear lenses offer excellent protection and should be worn by anglers.¹⁰

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Sir,

Surgical management of an unexpected lacrimal sac mass

Patients with lacrimal sac masses can present with symptoms mimicking primary acquired nasolacrimal duct obstruction (PANDO). We present a case of a failed endoscopic endonasal surgical dacryocystorhinostomy (EES-DCR), performed in a patient who was inadequately investigated pre-operatively. We also discuss the surgical options available in the management of this problem.

Case report

A 29-year-old woman was troubled with epiphora for 4 years with one episode of acute dacryocystitis treated medically. She was diagnosed to have PANDO, having no other predisposing factors. She was concerned about the possibility of facial scarring and therefore elected to undergo surgery using the endonasal approach.

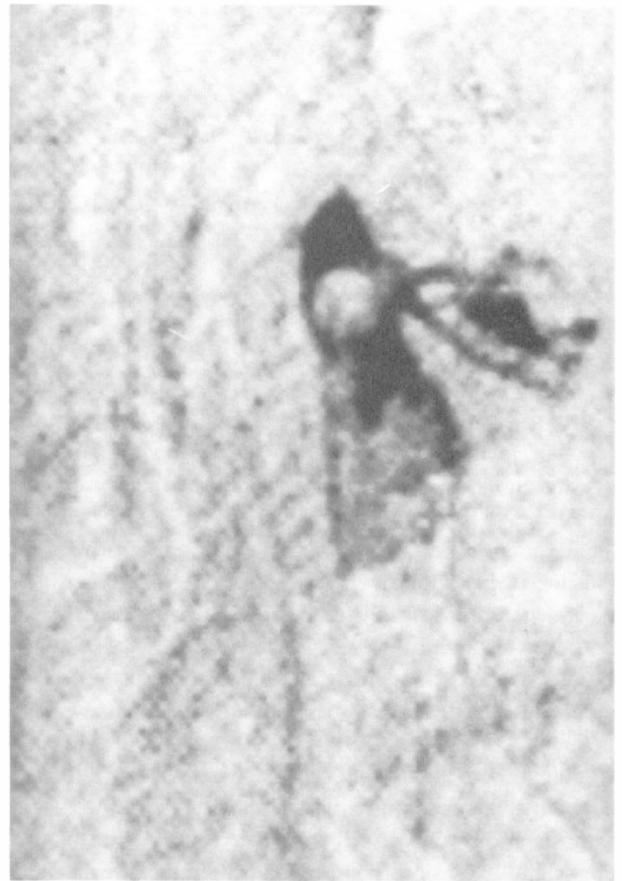


Fig. 1. Digital subtraction dacryocystogram showing a rounded, space-occupying mass in the lacrimal sac, blocking the nasolacrimal duct.

A routine EES-DCR with O'Donoghue tubes was performed with no abnormal findings reported. While the tubes were left *in situ* for 2 months, the patient reported recurrent episodes of mucus discharge. Immediately following removal of the tubes her lacrimal duct system was syringed and was patent.

However, she remained asymptomatic for only 2 weeks, after which her epiphora recurred. On syringing 4 months post-operatively, she had developed a mucocoele. The patient was still keen to undergo repeat surgery; therefore, a dacryocystogram (DCG) was performed pre-operatively. The DCG showed a smooth rounded mass in the lacrimal sac and an obstructed upper nasolacrimal duct (Fig. 1). Based on these findings, an external approach dacryocystorhinostomy was planned.

At surgery the lacrimal sac was distended and, when opened, mucus extruded. A pink, round, pedunculated lesion was identified attached to the medial lacrimal sac wall. This was excised for histopathological examination, which showed that this lesion was a polyp consisting of granulation tissue surrounded by chronic inflammatory changes (Fig. 2). The DCR was completed with both posterior and anterior sutured mucosal flaps. Tubes were inserted and left *in situ* for 3 months. The patient remains almost completely symptom-free 2 years after repeat surgery, with only minimal epiphora.