However, both of these custom-made iris implants are costly, and their long-term safety profile is not yet known. Nevertheless, these new implants have the potential to provide patients with iris defect both good functional and aesthetically acceptable results.

Acknowledgements

I agree to assign the copyright of the article to the journal as evidence of consent to publication. This article has not been previously published in any other peer-review journal.

Reference

1 Srinivasan S, Yuen C, Watts M, Prasad S. Endocapsular iris reconstruction implants for acquired iris defects: a clinical study. *Eye* 2007; **21**: 1109–1113.

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Sir,

IRIS reconstruction implants

We thank Mr Chung for his interest in our article on iris reconstruction implants.[1] We agree that the types 50 D and 50 E have been incorrectly labelled.

The reason for choosing 50 C implants in case 2 was to provide a 'good' pupil size postoperatively for a detailed retinal examination. In our experience, we have found that patients with ocular trauma not only present with anterior segment injuries but also have traumatic retinal dialysis/detachments, which require adequate pupillary aperture size for the retinal surgeon to work with.

Choosing an implant model in eyes with these kinds of extensive injuries is a trade-off between obtaining a reasonable cosmetic appearance and achieving a pupil size, which does not interfere with performing a detailed retinal exam.

Reference

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Sir,

Primum non nocere

We read with interest N Ahmad and J Wests' survey with regard to treatment of asymptomatic retinal detachments.[1] We would like to offer a cautious warning illustrated with sobering case report.

Case report

A 27-year-old woman with a refractive error of −7.00DS bilaterally presented to the eye casualty with a subconjunctival haemorrhage. She had no previous ocular or medical history; in particular no ocular trauma. Her visual acuity was 6/6 bilaterally. Dilated fundal examination revealed no posterior vitreous detachment and an incidental retinal detachment associated with two round holes inferotemporally on the right eye. A small retinal detachment with no posterior vitreous detachment associated with a round hole was also noted on the temporal retina of the left eye. Faint demarcation lines were noted. Argon laser demarcation was carried out bilaterally. Subsequently, cryotherapy with buckle attachment to the right eye was undertaken. She returned 2 months later with blurring of the vision bilaterally. Her visual acuities were 6/6 and 6/36 on the right and left eye. Examination showed bilateral granulomatous pan uveitis, Dallen Fuchs deposits (Figure 1) with choroidal thickening, confirmed by ultrasonography (Figure 2). Investigations excluding other causes, fundus fluorescein angiography (Figure 3), and indocyanine green angiography suggested the diagnosis of sympathetic ophthalmia. She was started on oral and topical steroids. She developed ocular hypertension, which was managed topically. She improved, and at her last check, 3 months since the onset of the uveitis, her visual acuities were 6/6 bilaterally.

Comment

Although the association between cryotherapy and the development of sympathetic ophthalmia has been reported in the past,[2–5] all these cases were after cyclodestructive procedures. This is the first such case associated with cryotherapy for retinal holes in the

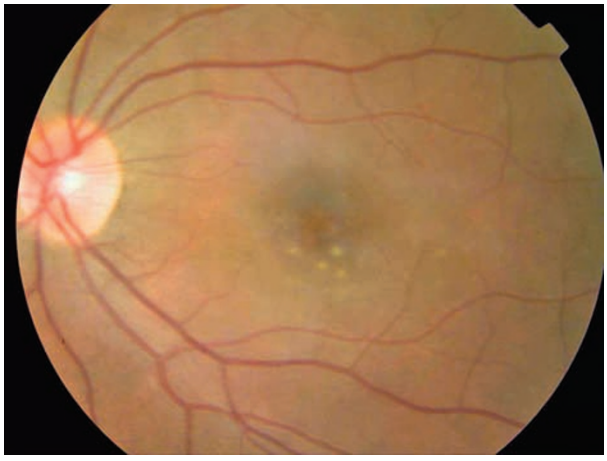

Figure 1 Left fundus showing Dallen Fuchs deposits.

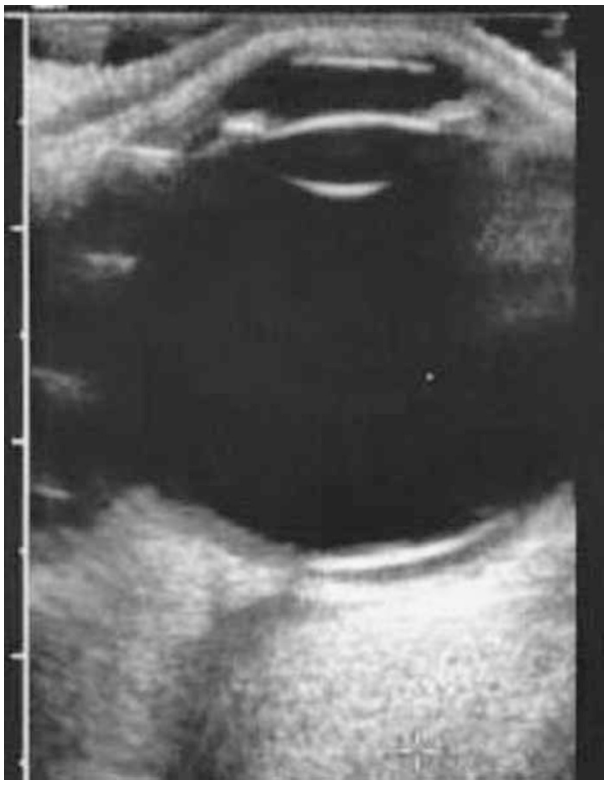

Figure 2 B-scan ultrasound of left eye showing thickened choroid.

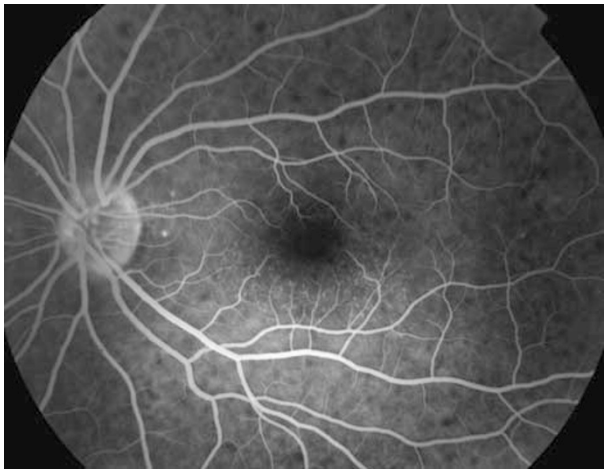

Figure 3 Left eye fundus fluorescein angiogram at 30 s.

management of retinal detachment. This patient's retinal detachment most closely related to scenario 4 in Ahmad's paper.[1] From the survey, 51–78% of respondents elected for surgical intervention, depending on the presence of a demarcation line. The management of these conditions is clearly controversial. The complication encountered here, although rare, is a cautionary tale and reminds us of the old adage *primum non nocere*.

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We thank the patient for allowing us to publish her case

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Sir,

Refractory discoid lupus erythematosis of the eyelid successfully treated with intra-lesional triamcinolone

A 24-year-old Caucasian woman presented with a 2-month history of a painful, erythematous, scaly lesion on the lateral aspect of the left lower eyelid. There were no cutaneous lesions elsewhere and no other symptoms. She had no significant past medical history and no allergies. Treatment for potentially infective causes including a course of oral flucloxacillin, topical fusidic acid, chloramphenicol, and acyclovir had produced no improvement.

A wedge biopsy of the lesion showed histological abnormalities consistent with a diagnosis of discoid lupus erythematosis (DLE). The erythrocyte sedimentation rate, full blood count, and liver function tests were normal and an autoimmune profile including anti-nuclear, anti-double-stranded DNA, anti-neutrophil cytoplasmic, anti-extractable nuclear, and anti cardiolipin antibodies was negative.

Initial treatment with topical corticosteroid ointment and factor 25 sunscreen produced no improvement. The patient was lost to follow-up for 16 months before she presented again with progression of the original lesion, now associated with significant madarosis and a new smaller lesion at the lateral border of the right lower lid. She was commenced on twice daily oral hydroxychloroquine 200 mg and topical corticosteroid. The topical corticosteroid was discontinued after 3 days owing to local side effects, but there was no clinical response to hydroxychloroquine therapy at 6 weeks.

Progression of the lesions and intolerance of topical corticosteroid led to a 2-week trial of oral prednisolone,