Comment

Ocular cryptococcosis often manifests as a consequence of systemic disease. However, isolated ocular involvement may present as choroiditis and endophthalmitis from hematogenous spread, or ophthalmoplegia and papilloedema secondary to raised intracranial pressure or direct infiltration of the optic nerve.[1] Cryptococcal endophthalmitis itself is a rare disease; fewer than 20 cases worldwide, including 5 in AIDS-related cases have been reported (none of these patients regained normal vision).

Despite being well documented in animals (especially cats),[2] cryptococcal-related exudative detachment has only been reported in cases of endophthalmitis.[3] Our case is unique as there was only evidence of cryptococcal meningitis and absence of concomitant endophthalmitis. Exudative retinal detachment in HIV patients are more commonly related to CMV infection,[4] immune recovery uveitis, acute retinal necrosis,[5] and progressive outer retinal necrosis.[6] We report an unusual case of exudative detachment secondary to cryptococcal infection that responded to systemic anti-fungal therapy.

Conflict of interest

The authors declare no conflict of interest.

References

1 Bisseru B, Bajaj A, Carruthers RH, Chhabbra HN. Pulmonary and bilateral retinochoroidal cryptococcosis. *Br J Ophthalmol* 1983; **67**: 157–161.
2 Paule B, Cello RM. Experimental ocular cryptococcosis, preliminary studies in cats and mice. *Invest Ophthalmol Vis Sci* 1980; **19**: 21–30.
3 Malton ML, Rinkoff JS, Doft BS, Kennerdell JS. Cryptococcal endophthalmitis and meningitis associated with acute psychosis and exudative retinal detachment. *Am J Ophthalmol* 1987; **104**: 438–439.
4 Cheung TW, Teich SA. Cytomegalovirus infection in patients with HIV infection. *Mt Sinai J Med* 1999; **66**: 113–124.
5 Clarkson JG, Blumenkranz MS, Culbertson WW, Flynn Jr HW, Lewis ML. Retinal detachment following the acute retinal necrosis syndrome. *Ophthalmology* 1984; **91**: 1665–1668.
6 Engstrom Jr RE, Holland GN, Margolis TP, Muccioli C, Lindley JI, Belfort Jr R *et al*. The progressive outer retinal necrosis syndrome. A variant of necrotizing herpetic retinopathy in patients with AIDS. *Ophthalmology* 1994; **101**: 1488–1502.

J Chen[1], C Chai[1] and SC Teoh[2]

[1]Department of Ophthalmology, Tan Tock Seng Hospital, Singapore
[2]Vitreo-retina and Uveitis Service, Department of Ophthalmology, Tan Tock Seng Hospital, Singapore
E-mail: chenjianping86@gmail.com

Eye (2011) **25,** 1234–1235; doi:10.1038/eye.2011.100; published online 6 May 2011

Sir,

Angle closure glaucoma associated with ectopia lentis in a patient with Sturge-Weber syndrome

Sturge-Weber syndrome (SWS) is a rare, sporadic phakomatosis characterized by cutaneous facial angioma, leptomeningeal angioma, and ocular manifestations.[1] We report a case of ectopia lentis associated with angle closure glaucoma (ACG) and pigment dispersion, ipsilateral to the angioma in a patient with SWS.

Case report

A 45-year-old woman with SWS was referred for blurred vision OS and left-sided headaches. The visual acuities were 20/20 OD and 20/25 OS with a 2-D myopic shift OS, and intraocular pressure (IOP) was 15 mm Hg OD, and 30 mm Hg OS ipsilateral to the SWS lesion, which extended from the left upper eyelid to the vertex, with minimal conjunctival involvement. Gonioscopy was open OD, but mostly closed OS. Laser iridotomy OS deepened the anterior chamber (AC), with IOP 15 mm Hg 1 week later. However, the AC remained shallow and the patient underwent further evaluation. At that time the IOP was 26 mm Hg OS. Gonioscopy remained narrower OS with heavy pigment, but without synechiae; neither Krukenberg spindle nor iris transillumination defects were present. Dilated examination revealed temporal and anterior subluxation of the left lens (Figure 1); no pigment was seen on the few visible zonules. The cup : disc ratio was 0.3 OD and 0.7 OS. No choroidal hemangioma was seen OS, and ultrasound biomicroscopy OS was normal. She was 6-feet tall with normal mentation; echocardiogram, chest X-ray, and electrocardiogram revealed no evidence of Marfan disease. There was no history of trauma.

The patient underwent pars plana lensectomy/vitrectomy OS. At 28 months post-operatively, the

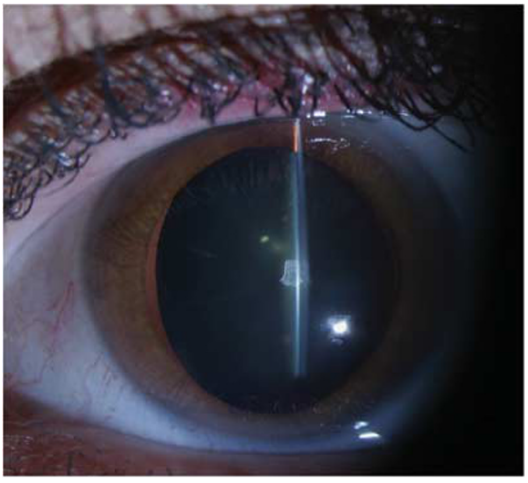

Figure 1 Slit-lamp biomicroscopy. Dilated left eye demonstrating temporal subluxation of the crystalline lens (red reflex visible nasal to lens).

corrected visual acuity was 20/25 and the angles were equally open OU with light pigmentation OD and moderate pigmentation OS, and without synechiae OS, but the IOP was 26 mm Hg OS on Timolol.

Comment

We found two reports of ectopia lentis in patients with SWS,[2,3] one of which may have had traumatic lens dislocation.[3] Glaucoma in SWS is typically similar to congenital glaucoma in cases presenting from birth to 2 years, or is due to increased episcleral venous pressure later in life.[1] ACG has been reported in patients with ectopia lentis,[4,5] and some authors advocate lensectomy in the management of ACG associated with ectopia lentis.[5] In our patient, lensectomy widened the angle but did not resolve the IOP elevation. Pigment dispersion may have occurred because of friction between the subluxed lens and the iris pigment epithelium, or intermittent pupillary block. Our patient had SWS associated with ectopia lentis that caused both ACG and pigment dispersion; these findings are rare ocular complications of SWS.

Conflict of interest

The authors declare no conflict of interest.

References

1 Patrianakos TD, Nagao K, Walton DS. Surgical management of glaucoma with the Sturge Weber Syndrome. *Int Ophthalmol Clin* 2008; **48**: 63–78.
2 Del-Buano G, Brosi M. A case of Sturge-Weber-Krabbe syndrome with bilateral lens subluxation. *G Ital Oftal* 1962; **15**: 123.
3 Filatov V, Guer DR, Lustbadder JM, Berkow JW. Dislocation of the crystalline lens in a patient with Sturge-Weber syndrome. *Ann Ophthalmol* 1992; **24**: 260–262.
4 Liebmann JW, Ritch R. Glaucoma associated with lens intumescence and dislocation. In: Ritch R, Shields MB, Krupin T (eds). *The Glaucomas*. St Louis: Mosby, 1996, pp 1033–1054.
5 Dagi LR, Walton DS. Anterior axial lens subluxation, progressive myopia, and angle-closure glaucoma: recognition and treatment of atypical presentation of ectopia lentis. *JAAPOS* 2006; **10**: 345–350.

DB Moore[1], SD Reck[2] and PP Chen[1]

[1]University of Washington, Department of Ophthalmology, Seattle, WA, USA
[2]Clarus Eye Centre, Lacey, WA, USA
E-mail: pchen@uw.edu

Eye (2011) **25,** 1235–1236; doi:10.1038/eye.2011.101; published online 6 May 2011

Sir,

Idiopathic uveal effusion syndrome causing unilateral acute angle closure in a pseudophakic patient

Pseudophakic angle closure is a rare occurrence. Most frequently it occurs secondary to pupil block with iris bombe, capsular bag distention syndrome, or aqueous misdirection, with an anterior shift of the iris-lens diaphragm. We present a case of acute angle closure in a

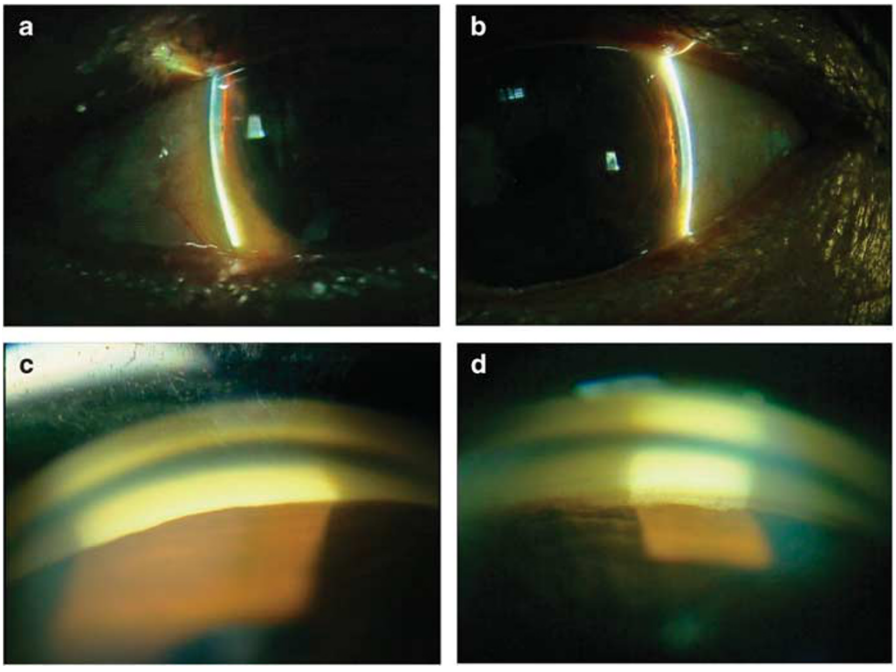

Figure 1 Van Herrick examination of the right eye showing iridiocorneal contact (a); in the left eye anterior chamber depth is >25% of the corneal thickness (b). On gonioscopy, no angle structures were visible in the right eye (c). There was a normal configuration in the left eye (d).