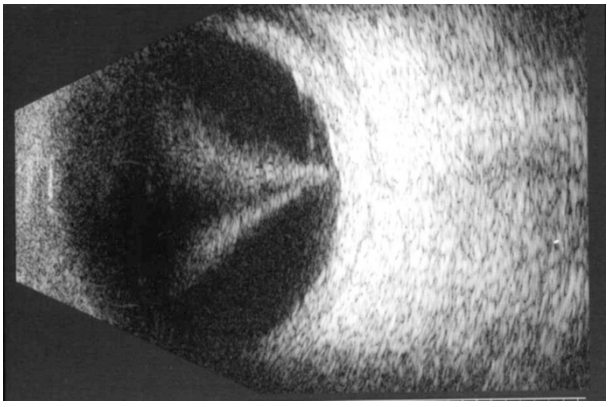

Figure 3 Progression of funnel-shaped retinochoroidal effusions to involve entire posterior pole 3 weeks after presentation.

cyclopentolate. An anterior chamber paracentesis was performed and quantitative aqueous polymerase chain reaction (PCR) analysis detected Epstein–Barr Virus (EBV) DNA. PCR was negative for toxoplasma, herpes simplex virus, varicella zoster virus, and cytomegalovirus. EBV was not detected in peripheral blood PCR. She was known to have EBV carrier status at the time aplastic anaemia was first diagnosed. Despite adjuvant high-dose oral prednisolone the choroidal effusions progressed to involve the posterior pole (Figure 3). Final acuity in the left eye remained at perception of light only. The effusions resolved but the eye remained hypotonous. The right eye remains unaffected at follow-up and she is maintained on a 1-year prophylactic course of oral famciclovir.

Comment

Clinical features of multifocal retinochoroiditis have been described in association with presumptive ocular EBV infection,[1] but diagnosis is usually based on serologic evidence of specific EBV antibodies.[2,3] Lau *et al*[4] identified EBV by vitreous sample PCR in two patients with acute retinal necrosis, however, to our knowledge there are no previous reports of EBV having been isolated from aqueous PCR. With our patient, choroidal effusions were a prominent feature along with focal retinitis; infiltration by cytotoxic polyclonal EBV-infected lymphocytes in the acute phase may be responsible.[5] EBV is a rare cause of retinochoroiditis and the most of the described cases have occurred in conjunction with haematological disease. Aciclovir has relatively low efficacy against EBV, as such our patient was commenced on famciclovir prophylaxis. It is, therefore, important for clinicians to include EBV in the PCR panel of such patients in order to optimise therapy.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

360° subconjunctival silicone oil after unsutured 23-gauge vitrectomy

Sutureless vitrectomy techniques gained widespread acceptance recently, and their indications have expanded. We describe a case in which silicone oil in an eye leaked out through unsutured sclerotomies and caused widespread conjunctival scarring.

Case report

A 58-year-old man with a complex ocular history of the right eye (OD) was referred for silicone oil removal. His surgical history OD at another institution included two retinal detachment repairs with 23-gauge pars plana vitrectomy using the Constellation Vision System (Alcon Laboratories, Inc., Fort Worth, TX, USA). Ports were created with conjunctival displacement and oblique-angled sclerotomies (30°) with the bevel facing up, parallel to the limbus. The wounds were watertight at the end of the operations and not sutured. Silicone oil was used in the second surgery. Eight months later, most of the oil was removed using the 23-gauge vitrectomy system, with minor residual intraocular emulsified silicone oil left behind. 10% SF_6 gas was injected at the end of surgery, and the sclerotomies were left unsutured. During the first postoperative week, the patient had hypotony that resolved without treatment.

Six months later, the patient presented to our hospital with shiny subconjunctival droplets, consistent with silicone oil, in all quadrants (360°). These extended 4 mm posterior to the equator (Figure 1). The patient complained of foreign body sensation and reported that his acquaintances had commented upon the unusual appearance of his eye. At surgery to remove residual oil, it was noted that the conjunctiva was tightly adherent to

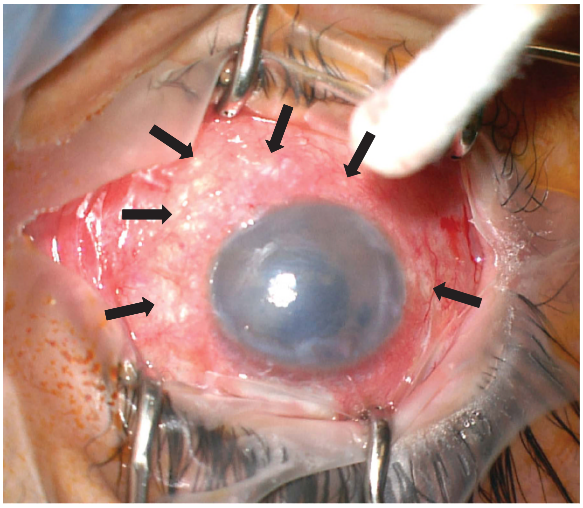

Figure 1 An intraoperative photograph shows extensive subconjunctival silicone oil accumulation (arrows).

the underlying Tenon's capsule and sclera in all quadrants secondary to oil and scarring. It was not felt that removal of the oil was feasible, as it was invested in the scarred conjunctiva. The previous sclerotomy sites could not be visualized. At postoperative month 2, the extensive subconjunctival silicone oil was still present.

Comment

Our case confirms that unsutured sclerotomies may be associated with diffuse subconjunctival oil spillage. Mild subconjunctival silicone oil leakage occurs commonly after vitrectomy.[1] Histopathological studies have found that small subconjunctival silicone oil deposits occur 30% of the time and often cannot be detected on slit lamp exam.[2] Using a similar wound construction technique as in our patient, case series with 23-gauge systems have detected small subconjunctival silicone oil bubbles 8–10% of the time, sometimes with mild postoperative discomfort.[3,4] We recommend a lower threshold to suture sclerotomies in silicone oil cases.

Acknowledgements

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Sir,

Delayed diagnosis of occult ocular juvenile xanthogranuloma mimicking non-accidental injury

We present a case of juvenile choroidal xanthogranuloma (JXG) in a child, mimicking non-accidental injury.

Case report

A 3-year-old boy presented with a 2-week history of drowsiness and left eye redness. His father reported that the child fell from a height of about 20 cm. The fact that a doubt had arisen for the cause of the eye problem raised the suspicion of non-accidental injury. No abnormality was detected on physical examination and magnetic resonance imaging of the brain. His past medical history was unremarkable. On ophthalmological examination, visual acuity was 0.2 LogMAR in the right eye and perception of light in the left eye. Slit-lamp examination revealed a total hyphaema in the left eye, while the right eye showed no ocular abnormality. The intraocular pressure was 63 mm Hg in the left eye and dropped to 10 mm Hg after washing-out of the blood from the anterior chamber. No iris lesions were evident. Additionally, there was no fundal view of the left eye due to a dense vitreous haemorrhage. Ocular ultrasound examination showed a thicker choroid temporally, but no evidence of retinal detachment or calcification.

Following a left eye vitrectomy and lens aspiration, the retina demonstrated retinal infiltrates and a pale optic disc (Figure 1). A vitreous biopsy was taken, and immunocytochemistry analysis showed the cells to stain strongly with CD68 and weakly with S-100. PAS was found to be positive within the cytoplasm. A diagnosis of choroidal JXG was made.

The family had been assessed by social services and no concerns had been raised. Fourteen months after the initial presentation, there is no involvement of the fellow eye.

Comment

Our case is the first to use a vitreous biopsy to diagnose this condition and the fourth in the literature of JXG with ocular involvement and absence of cutaneous manifestations.[1–3] If spontaneous hyphaema and vitreous haemorrhage are present, one should include in the differential diagnosis the possibility of JXG, along with non-accidental injury and malignancy, even in the