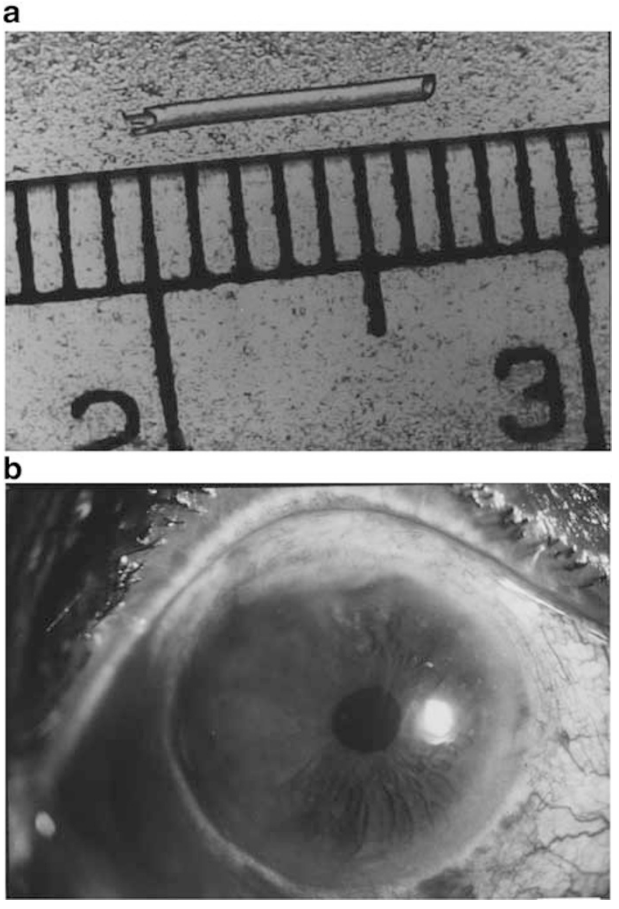

Figure 2 (a) Clinical photograph of the seton with a lumen and a bevelled edge. (b) Clinical photograph of the right eye in diffuse illumination on first postoperative day.

evidence of a retained episcleral plate either clinically or on ultrasound B-scan.[6] Hence we concluded that only a hollow tube was used by the previous surgeon as a glaucoma drainage device and this 'seton' had migrated into the anterior chamber in the absence of an anchor.

As the intraocular pressure was 20 mmHg on two medications, we were not sure whether the high intraocular pressure was pre-existing or secondary to anterior chamber inflammation. So we explanted the seton through a self-sealing clear corneal incision eliminating the possibility of bleb compromise and also leaving the adjacent conjunctiva untouched in anticipation of future filtering surgery if intraocular pressure continued to remain uncontrolled in the postoperative period.

Migration of the seton tube out of the AC, or implant erosion[4] are the known reported complications. To the knowledge of the authors, migration of the seton tube into the AC has not been reported. Another interesting feature of the case is the removal of the seton through a self-sealing clear corneal incision eliminating the possibility of bleb compromise.

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Sir,

Progressive ophthalmoplegia in arthrogryposis multiplex congentia

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Arthrogryposis multiplex congentia (AMC) is a syndrome characterised by multiple joint deformities present at birth.[1–3] Although there have been several reported ophthalmic associations with this syndrome[4–9] however, progression of ocular motility disorder in this condition is not well documented. We report a case of

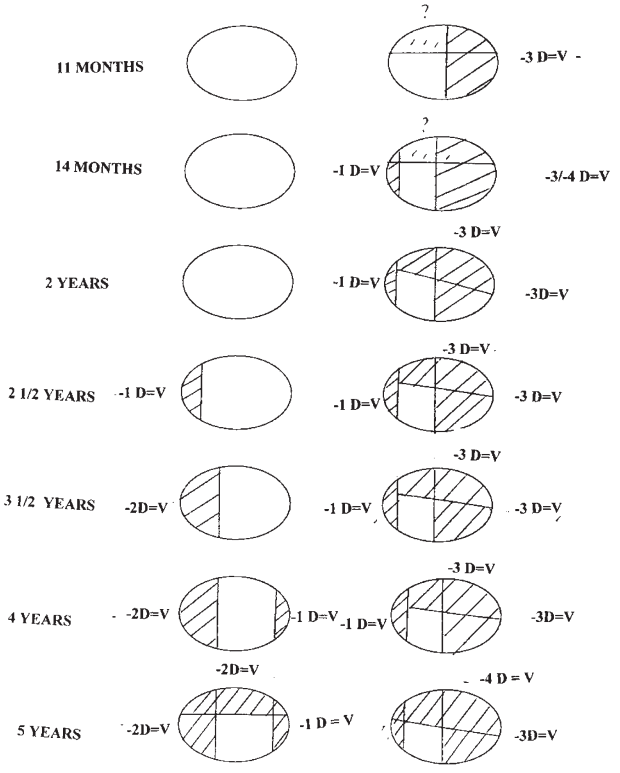

Figure 1 Diagrammatic representation of progression of the disease.

progressive ophthalmoplegia as it develops in a child with AMC.

Case report

An eleven-month-old child was referred to the paediatric ophthalmology clinic with a diagnostic query of strabismus. A diagnosis of AMC was made at birth when contractures of multiple joints including wrists, knees and ankles were noted. He had subsequently undergone multiple surgeries followed by splinting and physiotherapy.

At presentation his visual acuities were equal with some tentative BSV. Extraocular movements (EOM) testing revealed a definite restriction of abduction of the left eye (−3) and a possible restriction of elevation. Three months later, adduction of the left eye was also slightly restricted with some narrowing of the left palpebral fissure and retraction of the globe, giving rise to the diagnosis of left Duane's retraction syndrome.

The restriction of left elevation was confirmed by the age of 2 years and by 2 and a half years the abduction of the right eye was beginning to show some restriction (−1). A year later the restriction of right abduction had increased to −2 with the left elevation now quite marked (−3).

At 4 years of age abduction of the right eye was also restricted (−1) leading to a diagnosis of bilateral Duane's retraction syndrome.

By the age of 5 years co-operation had improved enough to allow a full EOM examination which showed bilateral restrictions of adduction and abduction L>R with marked restriction of left elevation but now the right eye was also restricted in elevation (−2) (Figure 1).

Most recently, the child (now aged 5 and a half years) has good and equal vision at 6/9/R+L. Both eyes are restricted in all positions of gaze except downgaze and a small L hypotropia is present in the primary position (Figure 2). With the use of a small head posture of chin elevation the child remains binocular and achieves stereo acuity of 80° arc.

Computerised topography (CT) scanning of the orbits showed no abnormality in the size or density of the extraocular muscles. Unfortunately the child's parents refused examination under anesthesia or electromyography (EMG).

Comment

AMC is a congenital syndrome characterized by multiple joint contracture.[1] Although rare it has been reported with an incidence of 3 in 10 000 live births.[1–3] Joint malformations, which have their onset during intrauterine life, are a result of the alteration in one of the structures comprising the final common neural pathway leading to a decreased fetal movement during pregnancy.[2] Treatment essentially involves multiple surgery, serial casting and physiotherapy to improve joint mobility.[2]

Although a number of ophthalmic findings including Mobeius syndrome,[3] hypertelorism,[4] microphthalmia,[5] congenital glaucoma,[6] congenital cataracts,[6] lateral rectus palsy,[5] Duane's syndrome[7] and optic atrophy are reported in literature,[8,9] documentation of true progression of the ophthalmologic motility disorder is absent.

In the present case, the child initially presented with a loss of abduction of the left eye, which was followed by a limitation of adduction, which was thought to be a result of medical rectus contracture. Ocular motility at this visit appeared to simulate Duane's syndrome. Subsequently there was a progressive loss of elevation and depression.

It might therefore appear that the reported cases of lateral rectus palsy and Duane's syndrome might be the sequential stages of ophthalmoplegia as seen in the present case. The progressive ophthalmoplegia as in the present case could be the probable result of a hypoplasia or early degeneration of the III, IV and VI

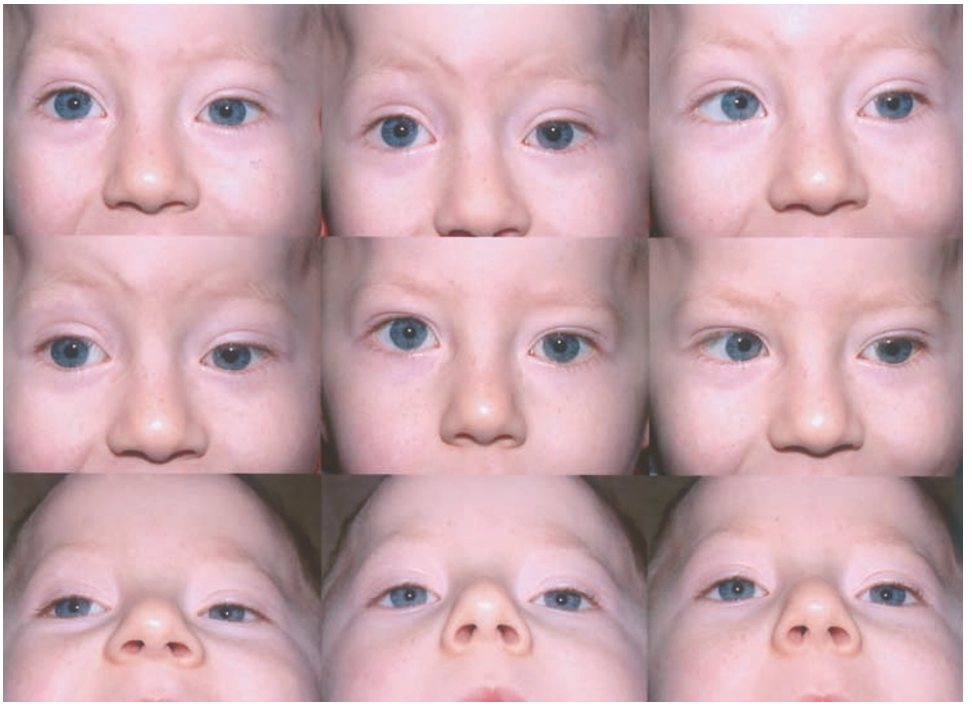

Figure 2 Facial view in nine positions of gaze showing bilateral ocular motility restriction.

nerve or due to the localized dystrophic changes in the ocular muscles, a fact that can be speculated but not substantiated. It would therefore be reasonable to presume that there are sequential ocular motility changes in a patient with AMC; a larger series would be required to establish the sequence.

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Sir,

Nasolacrimal duct obstruction following chickenpox
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A case of epiphora and dacryocystitis following an attack of chickenpox is presented. The child was well before the onset of the attack. The ocular symptoms during the illness suggest local viral infection.