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Sir,

Advanced Coats' disease successfully managed with vitreo-retinal surgery

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Coats' disease or idiopathic retinal telangiectasia is characterized by unilateral retinal telangiectasia associated with subretinal lipid exudation and exudative retinal detachment usually seen in young boys. The natural history is variable but is typically progressive. Patients who develop extensive exudative retinal detachment commonly progress to total retinal detachment, neovascular glaucoma, and phthisis bulbi despite use of laser photocoagulation, cryotherapy, or diathermy.[1] We describe a case of advanced Coats' disease with exudative retinal detachment in which vitreo-retinal surgery was effective in providing retinal reattachment.

Case report

A 6-year-old boy first presented to our office for evaluation of poor visual acuity in his right eye of one year's duration. Past medical history and family history were unremarkable. Visual acuity was counting fingers at two feet OD and 20/20 OS. There was an afferent pupillary defect OD. Slit lamp examination revealed quiet anterior segments OU. Ophthalmoscopy of the right eye revealed severe submacular lipid exudation (Figure 1). A lesser amount of exudation was seen in the nasal retina. An exudative retinal detachment extended from 6 o'clock to 8 o'clock peripherally. Multiple telangiectatic vessels were found on the temporal retina. The left fundus was normal. A clinical diagnosis of Coats' disease was made.

He underwent pars plana posterior vitrectomy and removal of vitreous and preretinal membranes. However, the posterior hyaloid face was firmly adherent to the retina and difficult to remove completely. Drainage of subretinal fluid through a temporal retinotomy was completed following air-fluid exchange. Endolaser photocoagulation was then applied to all telangiectatic vessels around the retinotomy and circumferentially for 360 degrees around the midperiphery. At 2 and 4 months postoperatively his retina was flat and attached, and visual acuity improved to 20/400. However, 7 months after surgery he developed recurrent vitreous membranes associated with a tractional detachment of the macula. He underwent repeat pars plana vitrectomy, removal of preretinal and epiretinal membranes and cryoablation of residual telangiectatic vessels temporally. His retina has remained attached with decreased submacular lipid exudation and absence of telangiectatic retinal vessels. At last follow-up, 27 months after initial surgery, his vision was 20/400. The retina was attached, but a significant posterior subcapsular cataract had developed (Figure 2).

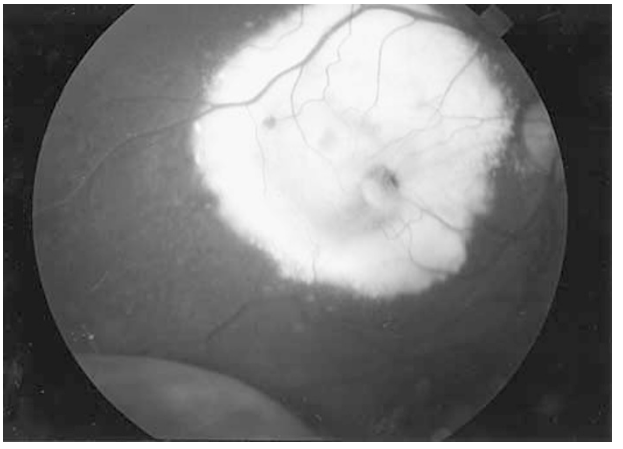

Figure 1 Preoperative fundus photograph: severe submacular lipid exudation with exudative retinal detachment.

Comment

The management of early Coats' disease is best achieved with prompt laser treatment or cryotherapy of leaking telangiectatic vessels. The best form of management of advanced Coats' disease after exudative retinal detachment has occurred is unclear. Siliodor *et al*[2] showed a series of 13 patients for which neovascular glaucoma could be prevented through subretinal drainage and cryotherapy. In their study all untreated eyes required enucleation. However, eyes that were salvaged had no useful vision. Wessing[3] has pointed out that advanced disease with detachment in two quadrants is almost untreatable.

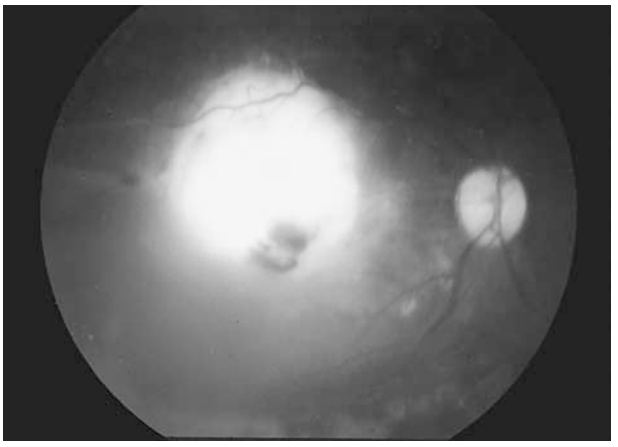

Figure 2 Postoperative fundus photograph showing reattachment of the retina with decreasing submacular lipid exudation.

More recently, Schmidt-Erfuth and Lucke[4] reported eight patients with advanced Coats' disease who were managed with scleral buckle, pars plana vitrectomy, removal of epiretinal membranes, drainage of subretinal fluid through a retinotomy and tamponade with silicone oil. All three retained useful vision (20/500–20/700), but complications from silicone oil did occur in two patients requiring removal of silicone oil in one patient.

Yoshizumi *et al*[5] reported success in three out of four patients with advanced Coats' disease or Coats'–like reaction after vitrectomy surgery. All three successful operations included internal air–fluid exchange and one unsuccessful operation did not include internal air–fluid exchange. Final visual acuity ranged from light perception to 20/300.

Our case represents the first case report of advanced Coats' disease managed with vitrectomy, membrane peeling, internal gas–fluid exchange not employing scleral buckling in which useful vision was obtained. Progressive loss of vision secondary to retinal detachment in advanced Coats' disease is avoidable. We feel scleral buckling plays a very limited role in the management of retinal detachment in Coats' disease which is due to combined exudative and tractional mechanisms. The removal of vitreous and preretinal membranes is an integral step to successful surgery, and vitreous membranes may recur.

Aggressive vitreo-retinal surgery with vitrectomy, drainage of subretinal fluid, air–fluid exchange, and pneumatic retinopexy may offer the best hope for preventing progressive loss of vision.

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Sir,

Optic neuritis: a rare manifestation of nasopharyngeal carcinoma

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Nasopharyngeal carcinoma (NPC) typically presents to ophthalmologists with one or more cranial nerve palsies. The fifth and sixth nerves are the most commonly affected.[1] Although ocular symptoms with cranial nerve involvement are not uncommon in patients with NPC, they often become evident several months or years after the malignancy is diagnosed. We present a case of optic neuritis as the first clinical manifestation of NPC.

Case report

A 55-year-old Taiwanese woman presented with pain and decreased vision in the right eye of about one week duration. There were no other systemic symptoms, in particular symptoms suggestive of NPC. There was no significant past medical or ocular history. General physical examination was normal. Best-corrected visual acuity was 6/10 in the right eye and