anti-viral action by preventing the replication of latent virus in the tissues.²

Recombinant Interferon alfa-2b is used for various forms of leukaemia, chronic hepatitis, and in the treatment of laryngeal papillomas caused by HPV.³ Its safety for ocular use has been demonstrated in viral keratitis⁴ and in conjunctival malignancies.^{5,6} Although systemic (intramuscular) therapy has been described for conjunctival papillomas,⁷ topical interferon use for primary or recurrent lacrimal papillomas has not been reported previously.

Topical interferon therapy achieved complete resolution in the case described. A similar beneficial effect on conjunctival papillomas has been reported with another immunomodulatory agent, Cimetidine.⁸ Immunomodulatory agents may help achieve lasting remission in viral papillomas, with maintenance or repeat therapy for recurrences.⁷ Local administration of interferon would avoid systemic side effects. Longer term studies are required to determine the long-term efficacy of interferon treatment.

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Sir,

Acute suprachoroidal haemorrhage with acute angle closure glaucoma as a presenting sign of chronic myelomonocytic leukemia

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Spontaneous suprachoroidal haemorrhage is very rare.^{1–3} We describe a case of acute suprachoroidal haemorrhage presenting as acute angle closure glaucoma. The haemorrhage was eventually found to be secondary to chronic myelomonocytic leukemia (CMML).

Case report

A 79-year-old man presented with a 2 days' history of severe pain and decreased left visual acuity. The pain was relieved by the use of simple analgesics. He had a past history of poor vision in both eyes secondary to age-related macular degeneration, diagnosed 8 years previously. He had hypothyroidism, hypertension and chronic renal failure secondary to prostatism. There was nothing else of note in his history.

On examination, his right visual acuity was 6/60 and his left visual acuity was perception of light (PL). The left conjunctiva was injected, corneal oedema and fine keratic precipitates were present, but there was no hypopyon. His anterior chamber was shallow and the pupil was dilated with moderate cataract. His right intraocular pressure measured 16 mmHg and the left measured 54 mmHg. The right iridocorneal angle was wide open with the ciliary body clearly seen. No view of the left angle was obtained. He had dry age-related macular degeneration in the right eye. An ultrasound B-scan of the left eye indicated a dense vitreous haemorrhage with haemorrhagic choroidal detachment (Figure 1).

The patient was admitted and commenced on intensive topical steroids, apraclonidine and latanoprost and intravenous acetazolamide. His intraocular pressure reduced to 34 mmHg. Oral acetazolamide was started. His anterior chamber remained shallow. A Yag laser peripheral iridectomy

failed to increase the depth of his anterior chamber. A routine full blood count indicated a leucocytosis ($13.2 \times 10^9/l$) (normal = $4.5\text{--}11 \times 10^9/l$) which was predominantly monocytic. He was markedly thrombocytopenic ($70 \times 10^9/l$) (normal = $150\text{--}450 \times 10^9/l$). Surgical drainage of his suprachoroidal haemorrhage was not considered in view of thrombocytopenia and past history of poor vision in his left eye.

Haematological consultation resulted in a diagnosis of CMML on the basis of his blood counts and blood film (Figure 2). The main feature of myelodysplasia in this patient is monocytosis and thrombocytopenia. The combination of two cell lines affected with a low platelet count, hypogranular neutrophils and the relatively unusual finding of monocytosis made this the only likely diagnosis. A bone marrow biopsy was thus not performed.

The patient subsequently developed a dense cataract in his left eye. His vision deteriorated to no perception of light and his intraocular pressure remained at 30 mmHg. There was no pain. He developed a paraneoplastic vasculitis in both feet for which he was treated with systemic steroids.

Comment

CMML is a form of Myelodysplastic syndrome (MDS). MDS are acquired, progressive cytopenias associated with a cellular bone marrow and ineffective haemopoiesis. MDS usually affects adults over the age of 50 years and presents with anaemia, fever or bleeding manifestations. Anaemia, which is usually normocytic and normochromic or macrocytic is the most common feature. Leucocytosis with monocytosis

Figure 1 Transverse B-scan showing 'kissing' choroidal detachment. Echoes in suprachoroidal space indicate haemorrhage.

Figure 2 Photomicrograph of peripheral blood film with monocytes and a neutrophil (H & E $\times 100$).

is common with CMML. Thrombocytopenia is seen in two-thirds of patients with this condition. Blood films commonly show abnormal neutrophils: (a) hypogranular or agranular forms; (b) cells with round or bilobed nuclei; and (c) hypersegmented nuclei. Diagnosis is made on the basis of blood counts and blood film. Treatment is supportive with platelet transfusions given only in emergencies. Patients are advised to avoid non-steroidal anti-inflammatory medications, which by reducing platelet adhesiveness increase the risk of bleeding.

Ocular involvement in all types of leukemia is very common with estimates ranging from 50–70% and appears to complicate acute leukemias approximately four times more commonly than the chronic forms.^{5,6} The ocular changes due to leukemia ranged from orbital involvement with proptosis, sterile corneal ulcers, scleral infiltration by leukemic cells, iritis with hypopyon and leukemic nodules.^{6,8} Choroidal involvement has been reported in over 50% of the cases and the choroid may in fact act as a sanctuary for the leukemic cells allowing them to escape the effects of radiation and cytotoxic therapy.⁹ Choroidal involvement can present with serous retinal detachment. Retinal involvement has been described in the form of preretinal, flame-shaped intraretinal (with pale centers) and subretinal haemorrhages. Perivascular infiltration with sheathing and vitreous haemorrhage is also described. Optic nerve infiltration and papilloedema due to central nervous system involvement is well documented.^{6,9}

Spontaneous suprachoroidal haemorrhage has been variously described in patients undergoing treatment with systemic thrombolytic agents, low molecular weight heparin and disseminated intravascular

coagulation.^{1-3, 7} To the best of our knowledge, our patient is the first reported case of leukemia causing spontaneous suprachoroidal haemorrhage and acute angle closure glaucoma. The ocular haemorrhage is most probably explained on the basis of thrombocytopenia. The anterior segment inflammation or iritis that was evident on initial presentation may have been secondary to leukemic infiltration of his anterior segment. We would like to stress the importance of performing routine blood tests in patients presenting with unexplained ocular haemorrhage and the importance of determining the exact cause of an acute elevation of intraocular pressure.

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Sir,

Unilateral lattice dystrophy in an elderly patient

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Lattice corneal dystrophy is an inherited, primary, usually bilateral corneal amyloidosis characterised by refractile lattice lines with a double contour in the corneal stroma.¹ LCD is classified into at least four clinical subtypes.² LCD type I (Biber-Haab-Dimmer) is an autosomal dominant, bilaterally symmetrical corneal disorder that is characterised by numerous translucent fine lattice lines that are associated with white dots and faint haze in the superficial and middle layers of the central stroma. The symptoms appear during the first or second decades of life.^{1,3} Visual acuity becomes progressively impaired and most patients require a corneal transplant by 40 years of age.⁴ LCD type II is associated with systemic amyloidosis (Meretoja's syndrome).⁵ The lattice lines in LCD type II are thicker and more peripheral than those of LCD type I. They extend from the limbus towards the central cornea involving the mid-stroma at the periphery to more superficial stroma centrally.⁶ The visual acuity is good until later in life. LCD type III is a late onset LCD that appears with decreased vision in the fifth to seventh decades of life. Asymmetrical findings are common. Lattice lines extend from limbus to limbus, are thicker and are more easily seen with direct illumination than that of LCD type I.^{4,7} LCD type III A differs from the type III by the presence of erosions, the occurrence in whites and the autosomal dominant inheritance pattern.

Though generally considered bilateral and symmetrical, unilateral and asymmetrical cases of LCD type I are reported.⁸ We report a case of lattice dystrophy the lesions of which clinically appeared like LCD type I and predominantly involved one eye.

Case report

An 85-year-old male presented to us on 20th July, 2001 with the complaint of diminution of vision of the left eye of 3 years duration. He gave a history of undergoing cataract surgery in the right eye with good visual recovery. On examination, his visual acuity was 6/6 in the right eye and 6/36 in the left eye. The corneal examination in both eyes revealed climatic droplet keratopathy lesions. In the left eye, multiple lattice lesions were seen which were prominent on retroillumination (Figure 1). The lattice lines seen in the nasal cornea involved the anterior to midstroma of the cornea, whereas the lesions involving the middle of