Differential diagnosis included Behcet's disease, sarcoidosis, systemic lupus erythematosus, viral retinitis, and Eales disease. He did not have any systemic signs and symptoms such as oral aphtha, genital lesions, and skin lesions. The absence of these systemic symptoms and laboratory results indicative of autoimmune diseases excluded many of the aforementioned diseases, especially Behcet's disease. Viral retinitis will yield more severe exudates than preretinal or vitreous haemorrhage. It is uncommon in Eales disease that anterior uveitis and dense vitritis exist as seen in our case.[4]

This patient and his father have HLA-B27, which is possessed only in 0.8% of the Japanese population.[1] His father had a past history of unknown uveitis. It is quite possible that his disease was also related to the haplotype of HLA-B27. Furthermore, HLA-B27 AAU occurs in B27-positive members of the patients' families (approximately 10%) more frequently than in B27-positive healthy controls (1–2%).[5] Posterior segment involvement in HLA-B27-associated uveitis occurs somewhere between 4 and 17.4% in Caucasians.[2,6] Benitez del Castillo reported that the blood–aqueous barrier had been broken when HLA-B27-positive acute anterior uveitis was in active stage.[7] However, these cases usually have good responses to corticosteroid or immunosuppressive therapy. HLA-B27-associated uveitis in Japanese have also good visual prognoses.[8] However, there was no report of PVR despite intensive therapy. Our case, thus, verifies the fact that severe and refractory inflammation can happen in HLA-B27-associated uveitis that could lead to the development of PVR in a short period.

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Sir,

Iris microhaemangioma presenting with total hyphaema and elevated intraocular pressure

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Ah-Fat and Canning[1] have described a patient with recurrent visual loss related to spontaneous hyphaema. The source of the hyphaema was thought to be an iris microhaemangioma at the pupil margin and was preceded by ocular pain and amaurosis fugax. We describe a patient with spontaneous hyphaema from a similar vascular iris lesion but *without* any preceding ocular symptoms.

Case report

A 74-year-old lady presented with a 6-h history of sudden loss of vision in her right eye. There was no history of trauma. Visual acuity was 'hand movements'. There was a total hyphaema with no anterior chamber details visible. Applanation tonometry showed an intraocular pressure of 72 mmHg. The left eye was unremarkable. Her general health was good apart from systemic hypertension, which was well controlled on oral atenolol. She had no previous ocular complaints.

The lady was admitted and commenced on oral acetazolamide, topical beta-blockers and fluoromethalone. A full-blood count and clotting

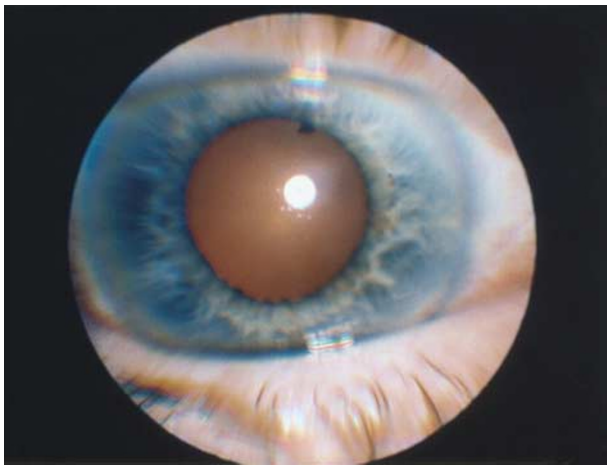

Figure 1 Vascular tuft at 1 o'clock position on pupillary margin.

screen were normal. The intraocular pressure decreased steadily and was 14 mmHg by the following morning.

The hyphaema also resolved, and as the clot retracted a fleshy red vascular tuft became visible on the iris at the pupillary margin. It was about the size of a pinhead (Figure 1) and was situated at 1 o'clock position. The lady was reviewed in outpatients 4 days later. The hyphaema had resolved and vision had improved to 6/9. The vascular iris lesion had remained unchanged. Gonioscopy showed an open angle and no abnormality. The right fundus showed a hyperaemic disc with a splinter haemorrhage, and tortuous veins. The disc appeared normal 6 weeks later. All topical medication was stopped and her condition remains unchanged.

Comment

We feel that this is a case of iris microhaemangioma similar to the one described by Ah-Fat and Canning.[1] However, unlike their case, our patient never had any preceding visual symptoms such as amaurosis fugax. Similar vascular iris lesions have been described in association with systemic conditions such as hereditary haemorrhagic telangiectasis[2] and myotonic dystrophy.[3] The treatment of these vascular lesions is not clear. Apart from a single report of an iris tuft successfully treated with laser,[4] there is not much literature dealing with the treatment of such lesions, and clearly the rarity of these patients limits the development of a management protocol.

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Sir,

Horner's syndrome following chest drain migration in the treatment of pneumothorax

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Horner's syndrome is a well-recognized complication of various thoracic surgical procedures. We present a case of Horner's syndrome that had arisen as the complication of chest drain migration in the management of spontaneous pneumothorax.

Case report

A healthy 25-year-old Chinese male presented to the Accidents and Emergency Department of United Christian Hospital with 3 days' history of right-sided chest pain and shortness of breath. The patient had no