

are observed in generalized malignancy and are rarely the presenting symptom.^{1,2} Metastases to the eyelid present as a painless nodule, a diffuse swelling or an ulcerating lid, and both lower and upper eyelids may be involved.^{1,2} Most of the patients are between 50 and 80 years of the age, and are women because of association with breast carcinoma. Differential diagnosis of the eyelid nodule includes benign lesions such as chalazion, cyst, granuloma, and xanthoma.³ Malignant lesions should also be considered including basal cell carcinoma, squamous cell carcinoma, melanoma, sebaceous cell carcinoma, and primary neuroendocrine of the skin or Merkel cell carcinoma.^{1,2,4} In our patient, the histologic differential diagnosis consisted of poorly differentiated primary eccrine carcinoma, metastatic poorly differentiated carcinoma, poorly metastatic carcinoid tumour, and Merkel cell carcinoma.^{4,5}

Immunohistochemical analyses were useful in this case and Merkel cell carcinoma was unlikely because tumour cells did not express cytokeratine 20.⁶

In conclusion, diagnosis of eyelid metastases requires a high index of suspicion in every patient, even those with no history of cancer, since it may indicate the condition and therefore allows rapid instauration of treatment. A careful histologic examination with immunohistochemical studies is mandated.

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Sir,

Bilateral Ulnar nerve palsies: an unusual complication of posturing after macular hole surgery

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Gas tamponade with face-down posturing has been regarded as a crucial step in the success of macular hole surgery. Most surgeons using long-acting gases recommend face-down posturing for 45–50 min of each hour for 10–15 days. However, posturing is tiring and demanding for patients and is not without its ill effects.

We present the case report of a professional part-time singer who developed bilateral ulnar nerve palsies as a result of face-down posturing after macular hole surgery.

Case report

A 75-year-old man was referred to the eye casualty department by his GP with a 3-month history of distortion of the central field of vision in the left eye. Best corrected visual acuities were 6/12 OD and 6/36 OS. The right eye was amblyopic. Anterior segment examination was normal. Fundus examination revealed a Grade IV macular hole in the left eye with a positive Watzke Allen sign. A vitrectomy with 16% C₃F₈ under general anaesthetic was performed. Despite an uneventful surgery and good compliance with the postoperative posturing regimen, the VA failed to improve beyond 6/36.

He attended a follow-up appointment at the orthopaedic clinic for a routine 12-month assessment after a total hip replacement, which had been performed for osteoarthritis. On examination an incidental finding of bilateral ulnar nerve palsies was discovered. There was obvious wasting and weakness of the interossei, a positive Froment's sign bilaterally, hypoaesthesia along the ulnar border of both hands, and a classical ulnar claw hand deformity worse on the right hand (Figure 1a and b). The patient reported that the onset of the sensory disturbance coincided with his recuperation from ophthalmic surgery. On close questioning, it was found that he was resting his forehead on the dorsal aspects of his wrists with elbows held in approximately 100° flexion.

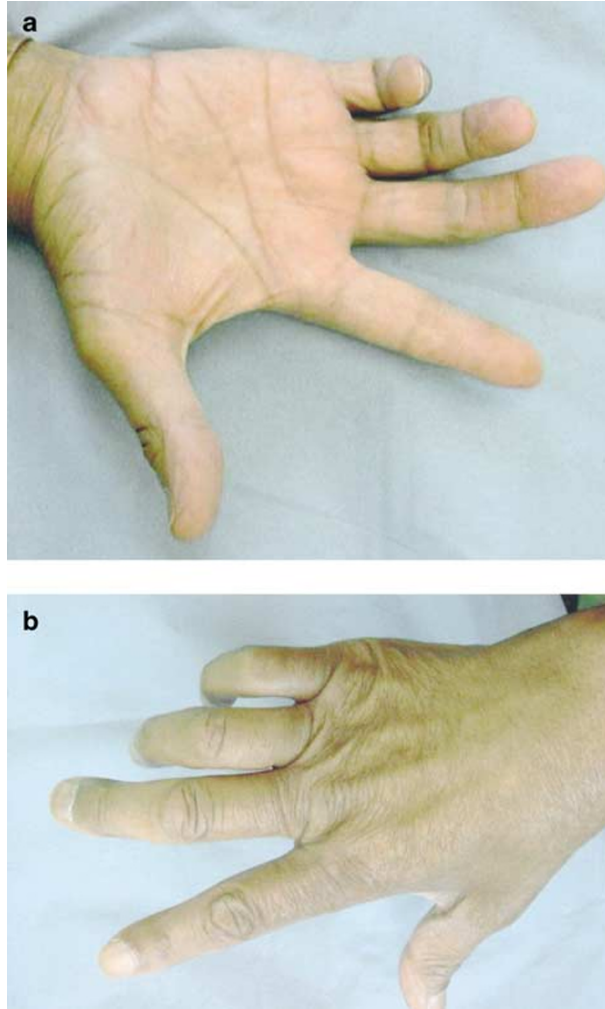


Figure 1 (a) Ulnar claw hand with flexion deformity of the ring and little fingers. (b) Muscle wasting of the first web space (first dorsal interosseus and adductor pollicis muscles).

Nerve conduction studies confirmed bilateral ulnar neuropathy at the elbow with reduced conduction velocities.

An appointment to see the occupational therapist was arranged and static splints were provided for the right hand to prevent further progression. The most recent outpatient review 10 months postophthalmic surgery showed minimal recovery.

Discussion

Face-down posturing is not always possible, especially in the presence of other concurrent systemic illnesses, and alternative techniques have been described to avoid the need for posturing.¹ A number of studies have been carried out to explore the success rate of other means which can tamponade the retina and preclude the need

for postoperative posturing. Silicone oil has been used with fairly good results.¹⁻³ Goldbaum and co-workers, in their multicentre retrospective pilot study performed with silicone oil tamponade and no posturing, showed high seal rates and visual acuities in stage II, III, and IV macular holes, were comparable to the results of the macular hole study group.^{3,4} However, silicone oil tamponade has the obvious disadvantage of requiring a second procedure for its removal. Kumar *et al*² have reported good anatomic results but guarded visual outcomes. However, their study involved a small sample with only stage III and IV macular holes.

Tornambe *et al*⁵ reported a pilot study using C3F8 in 33 eyes with stage II, III, and IV macular holes. None of the patients was positioned face down, but all phakic eyes had a cataract extraction with an implant at the time of macular hole surgery. The results showed successful macular hole closure and this technique was suitable for phakic patients who cannot maintain prone positioning.⁵ Promising results have been shown by Simcock *et al*,⁶ with combined surgery as it facilitates the use of a large gas bubble and also precludes the need for posturing and additional cataract surgery that may reopen macular holes. With the exception of a few studies, the results have been found to be fairly similar in terms of final visual acuity as obtained by conventional procedures after vigilant postoperative posturing.

However, posturing still constitutes an important factor in achieving success after macular hole surgery as the floatation force of the gas bubble is greatest at its apex, and face-down positioning with a large bubble results in a greater floatation force on the macular hole than an upright position. A longer duration of intraocular gas tamponade has been found to correlate with a higher rate of macular hole closure.⁷ This is thought to enhance the tamponading effect of the gas bubble and allow Muller cell processes and glial cells to form a stable plug within the hole.⁸

It is best to carefully select patients who would be suitable candidates for posturing. The ulnar nerve is vulnerable to compression neuropathy at the elbow as the nerve runs behind the elbow in the condylar groove between the Olecranon and the medial epicondyle of the humerus. Flexion of the elbow narrows the cubital groove by tightening the roof and causing bulging of its floor.

To date, as there are no specific guidelines, a word of caution about avoiding any undue pressure on elbows and signs of warning about any imminent ulnar nerve damage should be given as a take-home message after macular hole surgery. In particular, adopting an attitude with elbow flexion of more than 90° would appear to be contraindicated.

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Sir,

Metastatic endogenous endophthalmitis secondary to *Staphylococcus aureus* iliopsoas abscess

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Endophthalmitis after haematogenous spread or septicaemia accounts for 10% of all cases of endophthalmitis.¹ Among the well-recognized causative microorganisms, *Staphylococcus aureus* is a common pathogen,^{1–4} often resulting in bilateral endophthalmitis.^{1,2,5} We present an unusual case of metastatic endogenous endophthalmitis secondary to *S. aureus* iliopsoas abscess.

Case report

A 45-year-old man presented with a 1-week history of a red, painful left eye with gradual reduction of vision.

Left visual acuity was 6/36 and examination revealed a large subretinal mass in the superior periphery with surrounding exudative retinal detachment and vitreous and anterior chamber cells.

Previous ophthalmic history was unremarkable. Previous medical history included alcoholism, splenectomy without subsequent antibiotic coverage, partial pancreatectomy 15 years ago with subsequent insulin-dependent diabetes mellitus (poorly controlled), angina, and a 6-month history of anorexia, weight loss, and severe right loin pain requiring oral morphine for pain relief.

Medical examination revealed tenderness and fullness at the right renal angle, significantly accentuated by palpation of the right iliac fossa and by passive right hip extension. His temperature chart showed a low-grade remittent fever.

Laboratory investigation showed neutrophilic leucocytosis (WBC 18.3×10^9 cells/l, neutrophils 14.6×10^9 cells/l), raised ESR (120 mm/h) and CRP (145 mg/l), and high blood glucose and HbA1c.

After obtaining blood and urine cultures, he was started on intravenous meropenem 2 g q.i.d. A vitreous biopsy was performed and intravitreal vancomycin 1 mg and ceftazidime 2 mg were given. An abdominal ultrasound and a CT scan (Figure 1) confirmed the presence of an iliopsoas abscess. Pus (500 ml) was drained percutaneously and its culture grew a fully sensitive *S. aureus*. His treatment was subsequently modified to oral rifampicin 600 mg b.d. and clindamycin 450 mg q.i.d. Vitreous, blood, and urine cultures were negative. His iliopsoas abscess source was not identified.

After 1 week, the patient was afebrile, his backache had improved, and the left eye was comfortable with visual acuity 6/36. A repeat CT scan at 2 weeks showed that the iliopsoas abscess had collapsed, while left visual acuity was 6/12, anterior chamber and vitreous were quiet, and the subretinal infiltrate and the exudative retinal detachment had resolved. The same oral antibiotic

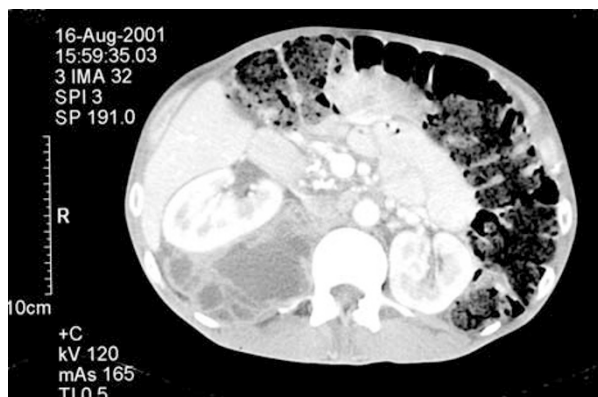


Figure 1 CT scan showing right large iliopsoas abscess, with anterior displacement of the right kidney.