Sir,

Atypical acute retinal necrosis (ARN) responding to late treatment

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Acute retinal necrosis (ARN) is a distinct ocular inflammatory syndrome whose prominent features include severe occlusive vasculitis, diffuse necrotizing retinitis, and moderate-to-severe vitreous cellular reaction.[1] It preferentially affects the peripheral retina, and involvement of the posterior pole is uncommon.[1] We describe a case of an atypical macular lesion as a late complication of ARN, which responded favourably despite delayed treatment.

Case report

A 68-year-old immunocompetent woman presented complaining of reduction of vision in the left eye over the prior 3 weeks. On examination, her corrected visual acuity in the affected eye was 6/24 and there was evidence of left minimal anterior uveitis and moderate vitritis. Intraocular pressures were normal, and bilateral moderate cataracts were noted. Fundoscopy in the left eye revealed peripheral confluent geographic areas of retinal necrosis and extensive vasculitis involving predominantly the retinal arteries (Figure 1). Vitreous and retina in the fellow eye were unremarkable. Unilateral ARN was diagnosed on her clinical features, but the patient declined treatment and further follow-up. After 8 months, she attended the eye clinic reporting further decrease of her vision in the affected eye. Her visual acuity in the left eye had decreased to perception of light, and on retinal examination along with peripheral necrotic areas, a nodular lesion with ill-defined borders associated with retinal haemorrhage, exudation, and swelling at the macula was noted (Figures 2 and 3). The patient was commenced on oral acyclovir 800 mg five times per day, and 3 days later methylprednisolone 16 mg t.d.s. was introduced. After 1 week, best-corrected visual acuity had improved to 6/60 and the nodular lesion at the posterior pole had significantly reduced in size (Figure 4). Treatment was tapered and retinitis remained quiescent over 6 months follow-up.

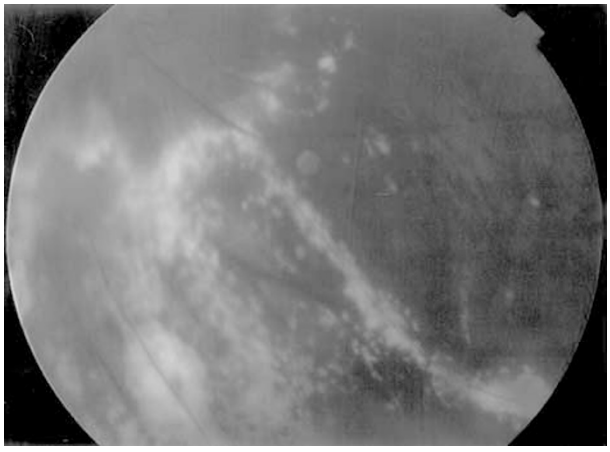

Figure 1 Vasculitis and characteristic multifocal yellow-white areas of retinitis which coalesce in the midperiphery.

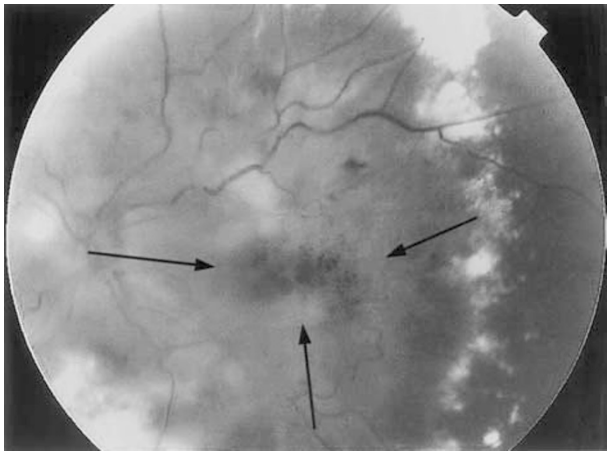

Figure 2 Large, poorly demarcated area of macular swelling (arrows) associated with retinal haemorrhage and exudation.

Comment

ARN is a necrotizing vaso-occlusive retinitis caused mainly by varicela zoster or herpes simplex virus (types 1and 2) and rarely by cytomegalovirus.[1] Standard diagnostic criteria include chorioretinal vasculitis, retinal necrosis, anterior uveitis, and vitritis.[2] Lesions characteristically develop in the midperipheral retina, and in the absence of treatment retinitis progresses circumferentially with subsequent disappearance of the intraocular inflammation usually between 6 and 12 weeks following the onset of symptoms.[2,3] Since ARN typically affects healthy patients, the stimulated inflammatory response is usually contained in the peripheral retina because of intact, effective immune resistance to the virus.[4] Posterior pole involvement is very rare and typically occurs late in the disease course.[1,4] This may manifest as advancement of the leading edge of the retinal whitening towards the macula, formation of macular holes, or development of macular edema.[1,3] Treatment of ARN includes administration of systemic acyclovir, antithrombotic agents, high dose of systemic corticosteroids, and

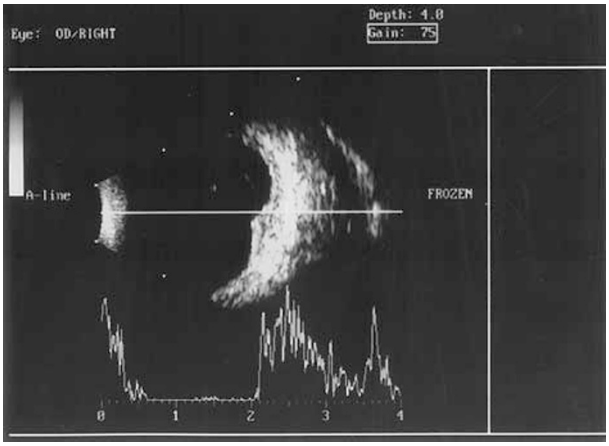

Figure 3 B-scan showing marked, discoid elevation at the posterior pole.

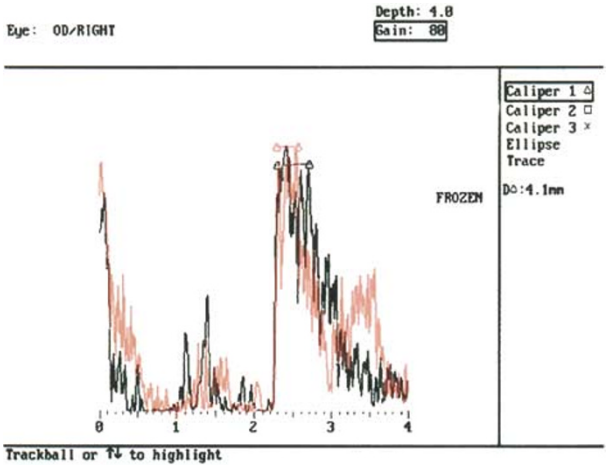

Figure 4 Composite of A-scans performed prior to and 1 week following administration of systemic treatment. There is significant reduction in the size of the elevated macular lesion from 4.1 to 2.4 mm.

prophylactic application of laser photocoagulation posterior to the area of retinitis.[1]

The above case shows that intraocular inflammation can be present many months after diagnosis, resulting in unusual manifestations at the posterior pole and consequent devastating reduction of central vision.

Although prompt treatment is mandatory for the resolution of retinal lesions, we clearly demonstrated that even late administration of antiviral and anti-inflammatory agents may lead to significant improvement in visual acuity.

Acknowledgements

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I Tsinopoulos[1], P Tranos[2], F Topouzis[1], K Hundal[3] and P Brazitikos[1]

[1]AHEPA General Hospital, Thessaloniki, Greece

[2]Department of Ophthalmology, Royal Free Hospital Medical School, Pond Street London NW32QG, UK

[3]Radcliffe Infirmary, Oxford, UK

Correspondence: P Tranos
Tel: +44 0208 365 8563
Fax: +44 0207 830 2208
E-mail: ptranos@doctors.org.uk

Sir,

Bilateral rhegmatogenous retinal detachment secondary to retinal dialyses associated with multiple retinal breaks

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Simultaneous bilateral rhegmatogenous retinal detachment is uncommon, accounting for 1.18–2.5% of all retinal detachments.[1,2] Most of these detachments are due to multiple round atrophic holes, which may be associated with lattice degeneration and u-shaped tears.[1,2] We report an unusual case of bilateral retinal detachment secondary to retinal dialyses associated with multiple retinal breaks.

Case report

A 28-year-old man presented with 5 weeks history of blurred vision in the left eye. He noted this following a fall of foreign body in his left eye while welding. He was asymptomatic in his right eye. He had no complain of floaters or flashes in either eye. There was nothing