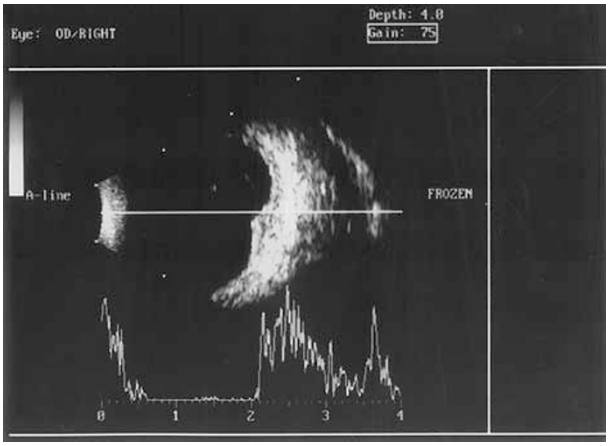

Figure 3 B-scan showing marked, discoid elevation at the posterior pole.

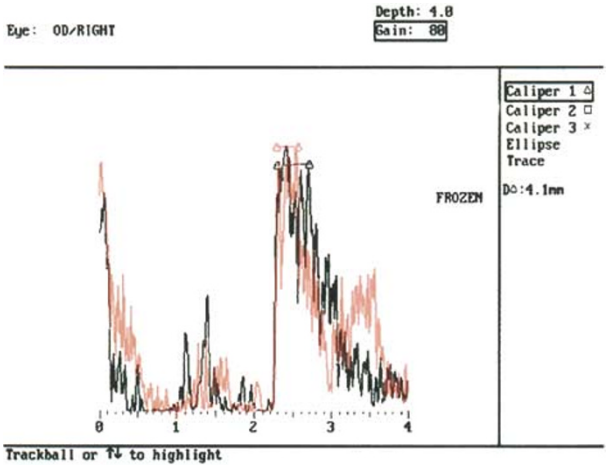

Figure 4 Composite of A-scans performed prior to and 1 week following administration of systemic treatment. There is significant reduction in the size of the elevated macular lesion from 4.1 to 2.4 mm.

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.

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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

significant in his past ophthalmic and family history. He had no refractive error. He vehemently denied any ocular or head trauma, but used to engage in boxing as sport at the age of 8 years which he left within a year and was a known recovering drug abuser.

His best corrected visual acuities were 6/6 OD and counting finger OS. The intraocular pressure was 12 mmHg OD and 8 mmHg OS, respectively. Slit-lamp examination of the anterior segment of both eyes was normal with no objective evidence of ocular trauma.

Fundus examination of the left eye revealed a subtotal retinal detachment involving the macula and an inferotemporal dialysis extending from 4 to 8 h meridian with a demarcation line. The vitreous base was attached to the posterior edge of dialysis. There were five round holes in superotemporal quadrant and two equatorial u-shaped tears at 3 h. The right fundus also revealed an inferotemporal dialysis extending from 5 to 8 h with subretinal fluid limited to inferotemporal quadrant with macula on; three round holes inferiorly and a horse shoe tear at 10 h. Partial posterior vitreous detachment was present in both eyes (Figure 1). Fundus examination of siblings, one brother and a sister were normal.

Both eyes were treated with scleral buckling procedures using segmental circumferential 9 mm silicone tire (287) and retinal cryopexy in the same sitting. Postoperatively, both retinae remain attached with visual acuity of 6/6 OD and 6/18 OS 3 months after the surgery.

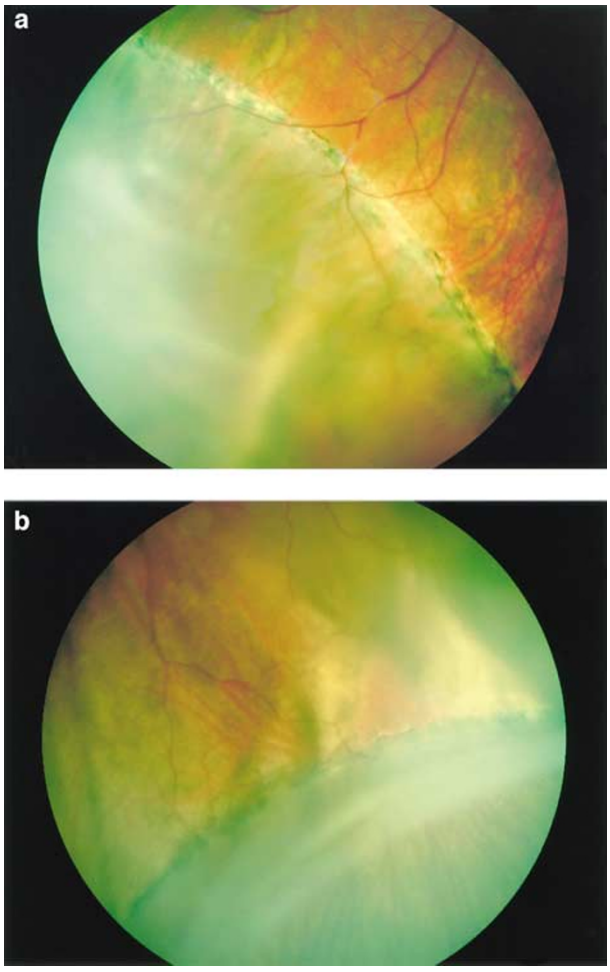

Figure 1 (a) Right eye showing inferotemporal retinal dialysis. (b) Left eye showing macula off rhegmatogenous retinal detachment and inferotemporal retinal dialysis.

Comment

Bilateral simultaneous, retinal detachment has an annual incidence of 0.35 patients per 100 000 population.[1] They are more likely to occur in young, myopic, or male patients and tend to present with unilateral visual symptoms.[1] In comparison, the incidence of bilaterality in the entire retinal detachment population in one series was 10%, with 18% of the bilateral detachment presenting simultaneously.[3]

Retinal dialysis is often unilateral, and accounts for 10% of all rhegmatogenous retinal detachments.[4] The incidence of simultaneous bilateral rhegmatogenous retinal detachment due to retinal dialysis is very low. In one series, bilateral involvements were seen in 7.7% of all dialyses and only 5.6% of the total cases had bilateral inferotemporal retinal dialysis,[5] comparable to another series with incidence of bilaterality (3.5%) and bilateral inferotemporal dialysis (1.5%).[6]

A history of trauma is often elicited in these patients, with most dialyses seen in the superonasal quadrant, while in eyes with inferotemporal dialysis a history and objective evidence of ocular trauma is less likely to be found.[4–6] Compared to unilateral cases, the eyes with bilateral involvement were less likely to have trauma.

The problem of recalling antecedent ocular injury in the past, especially in childhood, makes it more difficult to dismiss blunt trauma as the cause of dialysis. Clues of forgotten or denied trauma may be obtained by looking for other evidences of blunt injury.

The debate over the existence of a nontraumatic form of retinal dialysis surface from time to time in the literature.[6] However, many case reports suggested a nontraumatic form with possible genetic predisposition in twins[7] and siblings.[8–10] The nontraumatic form is mostly bilateral with preponderance for the inferotemporal quadrant.[9,10] In contrast, Ross *et al* found that none of the relatives of patients with nontraumatic retinal dialyses had retinal dialysis on indirect

ophthalmoscopy with scleral indentation. He suggested that the genetic basis for simultaneous bilateral inferotemporal retinal dialysis is poorly supported.

Interestingly, none of the cases of simultaneous bilateral rhegmatogenous retinal detachment due to retinal dialysis were associated with other multiple retinal breaks. Our patient has a combination of retinal breaks in the form of horseshoe retinal tears and atrophic holes in the absence of any generalized progressive vitreoretinal disorders. Trauma seems to be the most likely a etiology in our case.

We believe that this is the first case ever reported with simultaneous bilateral inferotemporal rhegmatogenous retinal detachment secondary to dialysis with multiple retinal breaks. Our case emphasizes the importance of binocular indirect ophthalmoscopy with scleral indentation in all cases of bilateral inferotemporal retinal dialysis, despite the absence of history or evidence of ocular trauma.

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Sir,

Acute bilateral blindness in meningeal carcinomatosis
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Diffuse or multifocal seeding of the leptomeninges by carcinoma, so-called meningeal carcinomatosis, often presents as simultaneous or rapidly sequential cranial neuropathy, with or without headache, altered mental status, or signs of meningeal irritation. Visual loss may occur in up to 30% of these patients, usually rapid, painless, and unilateral, and often progressing to the other eye.[1] Only a few cases of meningeal carcinomatosis owing to ovarian carcinoma have been reported. To the best of our knowledge there are no reports in the literature on acute bilateral blindness occurring during hours owing to meningeal carcinomatosis or ovarian malignancies. We present a case of acute bilateral blindness secondary to ovarian adenocarcinoma with meningeal infiltration.

Case report

A 50-year-old woman presented in May 2000 with abdominal distention and ill-defined abdominal pain. Examination revealed a firm pelvic mass. Ultrasound showed a mass compatible with ovarian cancer. Surgical exploration and pathologic examination assessed an ovarian serous cystoadenocarcinoma stage IIIc (with abdominal implants over 2 cm in diameter and positive retroperitoneal and inguinal nodes). Total hysterectomy with bilateral salpingo-oophorectomy was performed, and three cycles of systemic chemotherapy of cisplatine and cyclophosphamide were administered. During the follow-up period, no visual complaints were reported. After 2 years, the patient presented with altered mental status and headaches, without visual complaints, or pupil abnormalities. Lumbar puncture revealed elevated cerebrospinal fluid (CSF) protein, and cytology of the centrifugated CSF sediment demonstrated numerous cells consistent with adenocarcinoma. Magnetic resonance imaging (MRI) Tl-weighted scan of the orbit showed thickening of both apical intraorbital optic nerves with slight enhancement postgadolinium (Figures 1 and 2). MRI of the brain demonstrated minimal meningeal enhancement and normal postchiasmatic visual pathways.

During admission, the patient complained of acute painless bilateral loss of vision, and mental status deteriorated. The patient reported that the loss of vision occurred within less than 12 h. At examination, visual acuity was no light perception in both eyes. Anterior segment and intraocular pressure were normal in both eyes. Pupils were amaurotic and nonreactive to light. Optic disc and fundus examination were normal in both