chronic anterior uveitis, retinal periphlebitis, and choroiditis.⁴

Our patient was an immunocompetent young man. As the mass was slightly vascularized and yellowish-white in colour, we first made a differentialization from any tumoral or metastatic lesion. Sarcoidosis was also not applicable in our case because of the normal blood ACE level and lack of any other ocular or systemic sign specific for this disease.

For diagnosis of ocular TB, a high index of clinical suspicion, past medical history of patients and their families, ethnic origin, and socioeconomic circumstances are important.^{5,6} The presence of a family history of primary TB led us to investigate for TB in our patient. The diagnosis of ocular TB can be made by demonstrating *Mycobacterium tuberculosis* from ocular fluid or tissue specimen by a microbiologic or histopathologic study or can be made as presumed ocular TB with proven active systemic disease or as presumed ocular disease without any active systemic disease.⁶ Our case is included in the second group.

The ocular TB cases presenting with iris nodules or iridocyclitis in the literature demonstrated severe anterior uveitis with corneal involvement, responding to anti-TB therapy.⁵⁻⁷ On the contrary, in our case, the anterior chamber reaction was more localized and slight probably owing to the topical steroid treatment.

The PPD test has low sensitivity and specificity, especially in countries where previous BCG vaccines may cause a hypersensitivity response.^{1,3} In the absence of symptoms and/or chest radiographic findings, a positive result consisting of indurations less than 10 mm is generally attributed to a history of BCG in childhood.⁸ The specificity of the PPD skin test increases with larger skin reactions and with a history of exposure to an active case of TB, as for our patient. In a series, selected PPD-positive patients with clinical findings consistent with intraocular TB had a favorable response to anti-TB therapy. Treatment protocols for ocular TB are similar to those used for pulmonary TB and should be adapted to the immune status of the host. The most commonly used one is the four-drug regimen that our patient received.¹

Ocular disease can occur with or without the evidence of any systemic focus of TB, or as a metastatic spread from a primary focus.^{6,9} Our case demonstrates the importance of the ocular signs because the systemic disease had until this time been latent.

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Sir,

Traumatic rupture of the lateral rectus

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We present a case of rupture of the lateral rectus that followed a violent assault. Rupture of the lateral rectus is an infrequently encountered injury in isolation from other ocular injuries. The surgical management of this case is described. The various treatment options and a review of current literature are discussed.

Case report

A 39-year-old patient presented to the eye casualty department complaining of double vision following an assault. He was attacked from behind in an attempt to gouge out his eyes. He had no significant medical or ophthalmic history.

On presentation his visual acuity was 6/6 OU. He had a marked right esotropia. There were bilateral lid ecchymoses and subconjunctival haemorrhages. There were bilateral conjunctival lacerations consistent with fingernail gouging. The right lateral rectus muscle was exposed, and the belly of the muscle was completely severed with the insertional end falling onto the lower lid margin (Figure 1). He had a complete loss of right abduction. His posterior segment examination was normal. Radiological investigations showed no orbital fractures.

An examination under anaesthesia confirmed complete avulsion of the right lateral rectus. There was 15 mm of the distal muscle attached to the globe. This segment of the muscle was excised at its insertion. The proximal end of the lateral rectus was identified by tracing the intermuscular septum of the superior and inferior recti posteriorly. The capsule was opened and the dark bruised muscle was visualised, contrasting with the pale capsule. The proximal muscle was attached to the insertion on a 'hangback' adjustable 6/0 vicryl suture.

On the first postoperative day, the sutures were adjusted to give orthophoria in the primary position. He had a residual esophoria on right lateral gaze. At 2 weeks follow-up, he was symptom free. He had a minimal ($<5\Delta$) esophoria for near and distance. His Hess chart was near normal. At 6 months follow-up, he remained asymptomatic but had a small esophoria ($<5\Delta$) for near and distance.

Comment

Traumatic rupture of a rectus muscle is an infrequent injury. The medial rectus muscle is the most frequently traumatised extraocular muscle followed next by the inferior rectus muscle, the superior rectus muscle, and

Figure 1 Ruptured lateral rectus.

the lateral rectus muscle respectively.¹ Rupture of the inferior rectus has been described as a sequelae of a blow-out fracture.² Medial rectus laceration has occurred post-medial orbital fracture.³ When extraocular muscle injury has been previously described following trauma, it has usually been associated with extensive orbital and ocular damage. It is unusual that the muscle was damaged in isolation in our case.

A disinserted or severed muscle is a recognised complication of strabismus surgery. When exploring such a case, Parks advises that the eye should not be forced into the opposite field of action of the suspect muscle.⁴ This may result in the muscle slipping backwards through its penetration site in Tenon's capsule. He suggests that the eye be displaced against the opposite orbital wall and retroplaced into the orbit, retracting Tenon's capsule with a Desmarres lid retractor in order to visualise the lost muscle. We advise that the most effective approach to this problem is to suture the proximal end with 6-0 vicryl and resect the distal portion, cutting it away from the original insertion. The proximal end is then sutured to the original insertion using 'hangback' technique. The position is then adjusted the following day as if the procedure had been an elective resection.

This report presents the successful surgical management of a difficult ocular motility problem following trauma.

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