

- 11 Loewenstein A, Goldstein M, Winder A, Lazar M, Eldor A. Retinal vein occlusion associated with methylenetetrahydrofolate reductase mutation. *Ophthalmology* 1999; **106**: 1817–1820.
- 12 Sanborn GA, Magargal LE. Arterial obstructive disease of the eye. In: Tasman WS, Jaegar EA (eds). *Clinical Ophthalmology*, Vol. 3, No. 14. Lippincott: Philadelphia, 1993, pp 1–29.

Ş Özdek, F Yülek, G Gürelik, B Aydın and B Hasanreisoglu

Ophthalmology Department, School of Medicine  
Gazi University, Ankara, Turkey

Correspondence: S Ozdek  
Tel: +90 312 2141000/6326  
Fax: +90 312 212 57 94  
E-mail: ozdek@ttnet.net.tr

*Eye* (2004) **18**, 942–945. doi:10.1038/sj.eye.6701355  
Published online 5 March 2004

Sir,  
**Retinal tear arising adjacent to the optic disc: a case report**

Posterior retinal breaks are most commonly associated with trauma, macular holes, high myopia or proliferative retinopathies.<sup>1</sup> We present a case of a peripapillary retinal tear in a highly myopic eye.

#### Case report

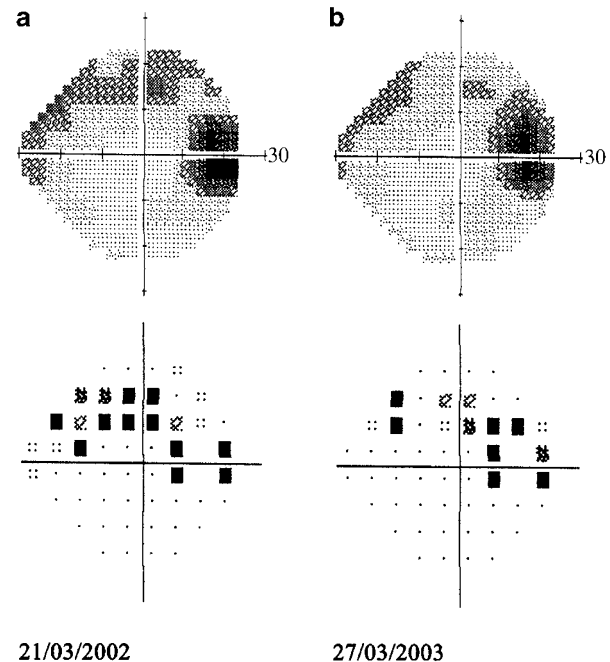
A 45-year-old man with high myopia (−16.0 dioptres spherical equivalent OD) presented with a 2-day history of right eye floaters, without photopsia. Corrected visual acuity was 6/9 OD. There was a posterior vitreous detachment (PVD) with a Weiss ring, but cells and pigment were absent from the anterior vitreous. Optic disc examination revealed a slit-like retinal break at the disc margin inferiorly overlying an area of peripapillary atrophy (Figure 1). No visible operculum was attached to the Weiss ring. Automated visual field assessment showed a superior arcuate defect consistent with the retinal break (Figure 2). The patient was managed conservatively, with regular observation. After 12 months follow-up, the patient is now asymptomatic of floaters, visual acuity and visual field defect are unchanged, and the retina remains attached.

#### Comment

Peripapillary retinal tears are rare, and sometimes only recognised after failure of initial retinal detachment



**Figure 1** The posterior pole of the right eye. There is a retinal tear at the disc margin in the 6 o'clock position. Note the myopic appearance of the fundus with peripapillary atrophy and larger choroidal vessels easily visible.



**Figure 2** The greyscale and pattern deviation plots from a Humphrey 24-2 Central Threshold Test using SITA-Standard software. Tests A and B were taken 12 months apart and the scotoma remains stable.

surgery.<sup>2</sup> Other unusual retinal break locations include the margin of staphylomas, colobomas, commotio retinae, retinal laser photocoagulation sites, and Morning Glory Syndrome.<sup>3,4</sup>

The absence of RPE within the peripapillary atrophy underlying this break made localised retinopexy impossible. Without vitreoretinal traction forces, retinal breaks are unlikely to progress to retinal detachment. However, even with an apparently complete PVD,

ophthalmic ultrasound and optical coherence tomography imaging can reveal persistent strands of vitreous adherent to the retina.<sup>5</sup> This patient is currently asymptomatic with unchanged clinical features after 12 months follow-up.

Conservative management of asymptomatic retinal detachments, with patient instruction on self-testing their visual field, is well known.<sup>6</sup> Surgically, for very posterior retinal breaks, pars plana vitrectomy with gas or silicone oil tamponade are most commonly used,<sup>2,7,8</sup> but external buckling procedures have been described, with good success rates reported for all modalities.<sup>5,6</sup> In this case, a peripapillary retinal break has not produced a retinal detachment, due to the absence of vitreoretinal traction.

### References

- 1 Benson W, Tasman W. Rhegmatogenous retinal detachments caused by paravascular vitreoretinal traction. *Arch Ophthalmol* 1984; **102**: 669–670.
- 2 Rosen P, Wong H, McLeod D. Indentation microsurgery: internal searching for retinal breaks. *Eye* 1989; **3**: 277–281.
- 3 von Fricken M, Dhungel R. Retinal detachment in the morning glory syndrome pathogenesis and management. *Retina* 1984; **4**(2): 97–99.
- 4 Coll G, Chang S, Flynn T, Brown G. Communication between the subretinal space and the vitreous cavity in the morning glory syndrome. *Graefes Arch Clin Exp Ophthalmol* 1995; **233**: 441–443.
- 5 Ripandelli G, Coppe A, Fedeli R, Parisi V, D'Amico D, Stirpe M. Evaluation of primary surgical procedures for retinal detachment with macular hole in highly myopic eyes. *Ophthalmology* 2001; **108**: 2258–2265.
- 6 Brod R, Flynn H, Lightman D. Asymptomatic Rhegmatogenous retinal detachments. *Arch Ophthalmol* 1995; **113**: 1030–1032.
- 7 Russell S, Blodi C, Folk J. Vitrectomy for complicated retinal detachments secondary to branch retinal vein occlusions. *Am J Ophthalmol* 1989; **108**: 6–9.
- 8 Saika S, Hayashi Y, Miyamoto T, Yoshitomi T, Ohnishi Y. Multiple retinal holes in the macular region: a case report. *Graefes Arch Clin Exp Ophthalmol* 2002; **240**: 578–579.

AJ Buller and SJ Charles

Manchester Royal Eye Hospital  
Manchester, UK

Correspondence: SJ Charles  
Manchester Royal Eye Hospital  
Oxford Rd., Manchester M13 9WH, UK  
Tel: +44 161 276 1234  
E-mail: steve.charles@cmmc.nhs.uk

*Eye* (2004) **18**, 945–946. doi:10.1038/sj.eye.6701356  
Published online 5 March 2004

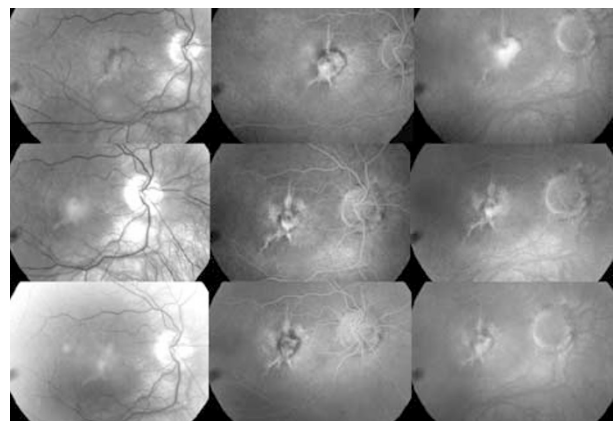
### Sir, Photodynamic therapy for subfoveal CNV complicating traumatic choroidal rupture

We wish to present a case of choroidal neovascularization (CNV) complicating choroidal rupture that was successfully treated by verteporphin photodynamic therapy (PDT).

### Case report

A 56-year-old patient presented with sero-haemorrhagic detachment of the right macula, with white striae of choroidal rupture partially masked by blood (Figure 1). VA was 20/320 (20/40 3 months earlier, a year after severe closed globe trauma).

Fluorescein angiography showed large subfoveal CNV with leakage (Figure 1). The patient underwent PDT with a 3000  $\mu\text{m}$  diameter spot. After 3 months, visual acuity increased to 20/100 and subretinal fluid and haemorrhage had resorbed (Figure 1). Fluorescein angiography showed a better-defined, smaller neovascular membrane (Figure 1). A year later, visual acuity was stable at 20/100, with a small fibrotic scar in the middle of the choroidal rupture and fluorescein angiography showed a small, retracted neovascular membrane with concave borders and no leakage



**Figure 1** Top: right eye 12 months after trauma, just prior to PDT. Left: (a) red free: diffuse subretinal blood around centre of macula; middle (b) and right (c): fluorescein angiogram, early (b) and late (c) frames: large classic CNV at the centre of the rupture, with late leakage. Middle: right eye 3 months after PDT. Left: (a) red free: resorption of subretinal blood; middle (b) and right (c): fluorescein angiogram, early (b) and late (c) frames: a smaller classic CNV membrane is seen, with minimal leakage. Bottom: right eye 12 months after PDT. Left: (a) red free: fibrous scar tissue at center of vertical choroidal rupture; middle (b) and right (c): fluorescein angiogram, early (b) and late (c) frames: a small CNV with hypofluorescent ring surrounding concave edges with no remarkable leakage.