ophthalmic ultrasound and optical coherence tomography imaging can reveal persistent strands of vitreous adherent to the retina.[5] 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.[6] Surgically, for very posterior retinal breaks, pars plana vitrectomy with gas or silicone oil tamponade are most commonly used,[2,7,8] but external buckling procedures have been described, with good success rates reported for all modalities.[5,6] In this case, a peripapillary retinal break has not produced a retinal detachment, due to the absence of vitreoretinal traction.

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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-haemorragic 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 μm 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

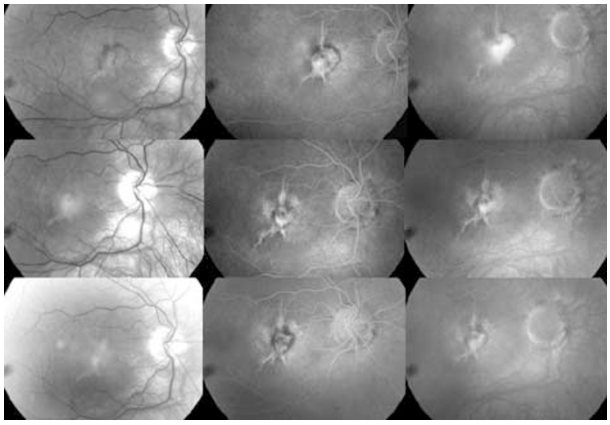

Figure 1 Top: right eye 12 months after trauma, just prior to PDT. Left: (a) red free: diffuse subretinal blood around centre of macula; middle (b) and right (c): fluorescein angiogram, early (b) and late (c) frames: large classic CNV at the centre of the rupture, with late leakage. Middle: right eye 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.

(Figure 1). Follow-up has been stable since (18 months post-treatment).

Comment

Observation may be warranted for early onset post-traumatic CNV (less than 6 months after trauma) as neovascularization appears to be part of the normal healing process, and may regress.[1] Argon laser treatment has been successful in extra-foveal post-traumatic CNV.[2,3] If subfoveal, visual prognosis is poorer.[4,5] Surgical removal has been reported in subfoveal cases,[1] but proof of one treatment over another or over observation has not yet been shown.

PDT reduces major visual loss secondary to CNV in diseases other than AMD: myopia, presumed ocular histoplasmosis syndrome, angioid streaks and idiopathic causes.[6] It appears more effective in cases where CNV is not related to AMD.[6] To our knowledge, this is the first report to document the use of PDT in treating CNV secondary to choroidal rupture. In this case, good VA prior to CNV, major exsudation with rapid aggravation and young patient age prompted us to offer PDT. In selected cases, we feel that PDT with veteporfin injection may be offered to patients presenting post-traumatic subfoveal CNV.

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Sir,

Ophthalmic presentation of hereditary haemorrhagic telangiectasia

Ocular abnormalities in hereditary haemorrhagic telangiectasia **(**HHT) have been described in the literature, but generally as incidental findings. We report a patient who presented with ocular abnormalities who was subsequently diagnosed as suffering from a mild variant of HHT.

Case report

A 55-year-old lady presented to the ophthalmology unit with a 4-week history of a red, painless left eye. There was no previous history of eye problems and visual acuity was 6/6 in both eyes. On examination of the left eye, there was injection of the medial bulbar conjunctiva. There was no abnormality of her palpebral conjunctiva and the intraocular pressure and fundus examination were normal. A diagnosis of episcleritis was made and she was commenced on a short course of prednisolone 0.5% eye drops. At her review 4 weeks later, there was no improvement in the injection of the left eye. The dilated vessels were mobile over the underlying episclera. It was then noted that there was also some injection of the medial limbal conjunctiva of the right eye resembling a small bulbar conjunctival telangiectasia (Figure 1). The right eye otherwise had no abnormality.

On questioning, the patient admitted frequent nosebleeds throughout her life ceasing spontaneously without medial assistance. She also reported occasional bleeding from her mouth and on examination she had several telangiectasia on her hard palate (Figure 2) and on the buccal mucosa. She had a small telangiectatic lesion on her chin but none visible elsewhere on her skin.