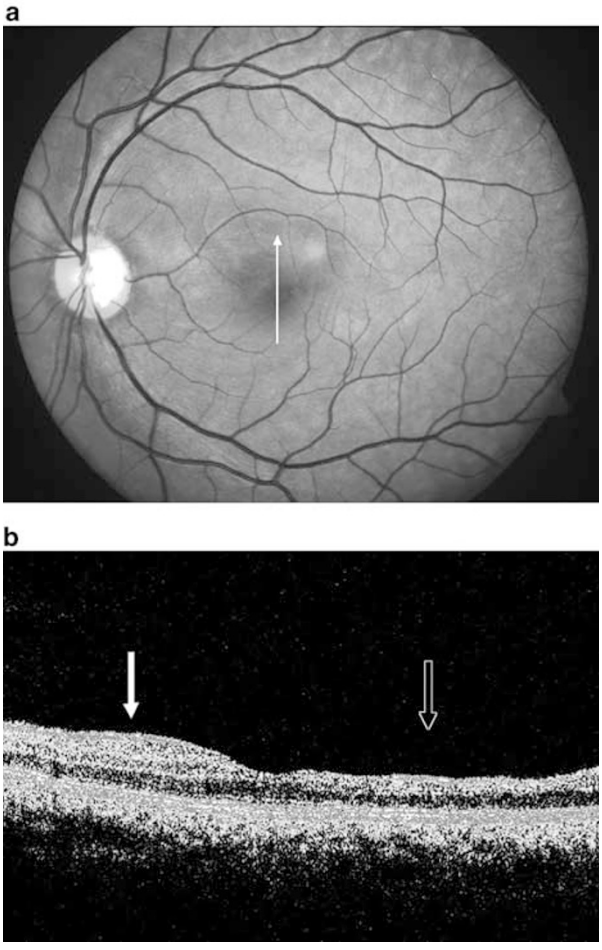

Figure 1 (a) Red-free photograph showing a subtle wedge-shaped dark lesion just above the centre of the fovea, pointing downwards. The vertical arrow shows the direction of the optical coherence tomography scan. (b) Optical coherence tomography image of the left eye, showing an area of retinal thinning (177 μm in thickness, marked by the hollow arrow) corresponding to the lesion in (a). The solid arrow points to an area of normal retina (241 μm).

case. Our OCT findings were different from those of their study. The differences could partly be explained by the long duration of the lesions in our patient. In late AMNR, the focal retinal thinning is almost impossible to appreciate by biomicroscopy or stereo photography.[4] We found a definite evidence of focal retinal thinning in our patient in the area affected by AMNR, more evident in the inner retina, although it may not be possible to pinpoint the exact retinal layers involved.

Acknowledgements

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Sir,

A unique case of mistaken identity

It is often debated whether all lesions are in need of biopsy, particularly when reasonable working diagnoses can be made on good radiological imaging. We report a unique case in which biopsy threw a different light on what was thought to be a terminal condition.

Case report

A 74-year-old woman initially presented to the general surgeons at another hospital with a history of prolonged nausea and vomiting. As part of the investigations, she underwent computerised tomography (CT) of her

abdomen that demonstrated a pancreatic mass (Figure 1a). It was described as an 8-cm mass in the neck and body of the pancreas with vascular invasion of the splenic and portal veins but no associated lymphadenopathy. The diagnosis of inoperable terminal pancreatic adenocarcinoma was made and the patient was offered palliative oncology referral with the understanding that she had at most a few months to live.

Within a few weeks, she presented to the ophthalmic department with discomfort from a rapidly enlarging left orbital swelling. (Figure 2a). She had count fingers vision and an inferotemporally displaced globe. CT scan of the orbit (Figure 1b) was performed, demonstrating a 4-cm solid orbital mass obliterating the orbital fat but with no invasion of the globe or bone. Although likely to be an orbital metastasis from the pancreatic adenocarcinoma, the decision to biopsy this lesion via an anterior orbitotomy was made.

To our surprise, the initial histology, and subsequent diagnostic immunohistochemistry, revealed that this lesion was in fact a high-grade diffuse B-cell non-Hodgkin's lymphoma (NHL). On the basis of this, the diagnosis was revised to extranodal pancreatic lymphoma with orbital metastasis. She was subsequently submitted to six cycles of Pmit CEBO chemotherapy (Prednisolone, Mitoxantrone, Cyclophoshamide, Etoposide, Bleomycin, Vincristine). She had a dramatic response with complete resolution of the orbital lesion clinically (Figure 2b) and of the pancreatic mass on CT. After 6 months, she remains in remission and has suffered few treatment side effects.

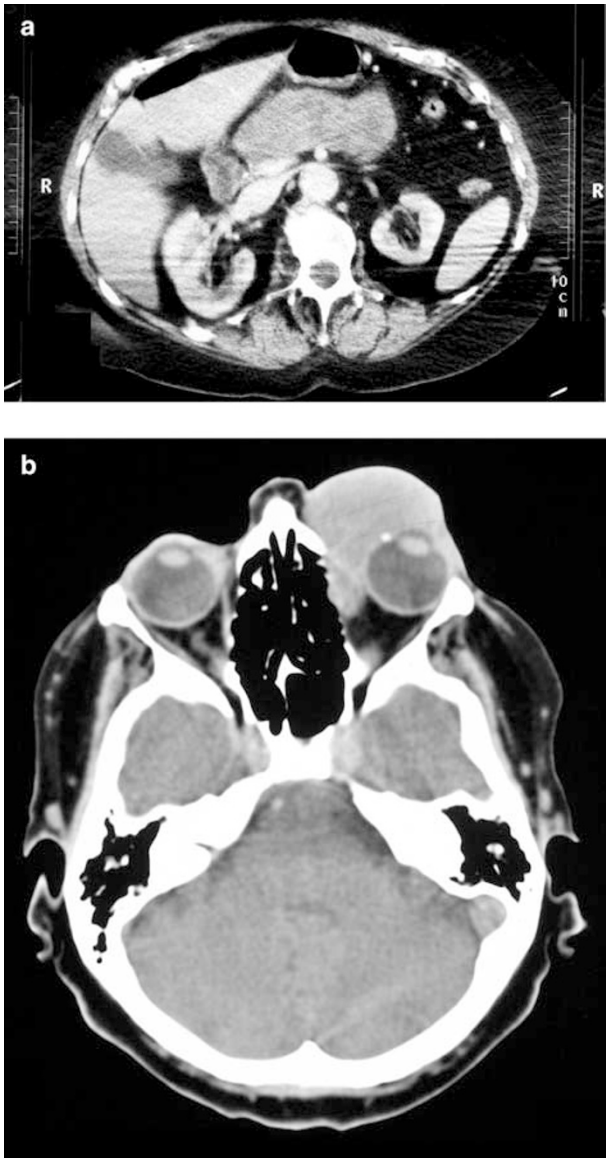

Figure 1 (a) An 8-cm mass of the pancreatic neck and body. (b) Homogeneous anteromedial orbital mass abutting the medial orbital wall and the medial rectus.

Comment

This case, to the best of our knowledge, represents the first case of pancreatic lymphoma metastasising to the orbit in the absence of any nodal involvement, as confirmed by CT chest, abdomen, and pelvis.

Diffuse B-cell lymphoma is a high-grade tumour of lymphoreticular tissue derived from clonal expansion of B cells. It represents 20% of all NHL and may occur either *de novo* or from pre-existing low-grade lesions. The orbit is a rare site for dissemination of lymphoma, and 5.3% of 187 cases has been reported.[1] Orbital metastasis from pancreatic adenocarcinoma is even rarer,[2] although it has been reported in a 38-years-old male in whom the orbital deposit was the presenting feature.[3]

Primary extranodal pancreatic lymphoma forms less than 5% of all pancreatic tumours.[4] On occasion, it has only been discovered after resection of a pancreatic mass[5] and has even been known to mask as acute pancreatitis.[6] Although elevated CA19-9 and SPAN-1 serum levels may throw suspicion on NHL as the diagnosis,[7] there is no substitute for biopsy, as the radiological findings are not definitive.[4] In total, 63–76% of elderly patients undergo complete remission to CHOP therapy[8] (cyclophosphamide, doxorubicin, vincristine and prednisolone), and Pmit CEBO has been shown to be useful in CHOP-resistant/relapsing cases. Her prognosis still remains in the balance with 5-year survival quoted somewhere between 12 and 41%.[9]

Clearly biopsy in this case has significantly altered the management and subsequent prognosis, which untreated, would have been in the range of weeks to months. This case highlights that biopsy of orbital lesions

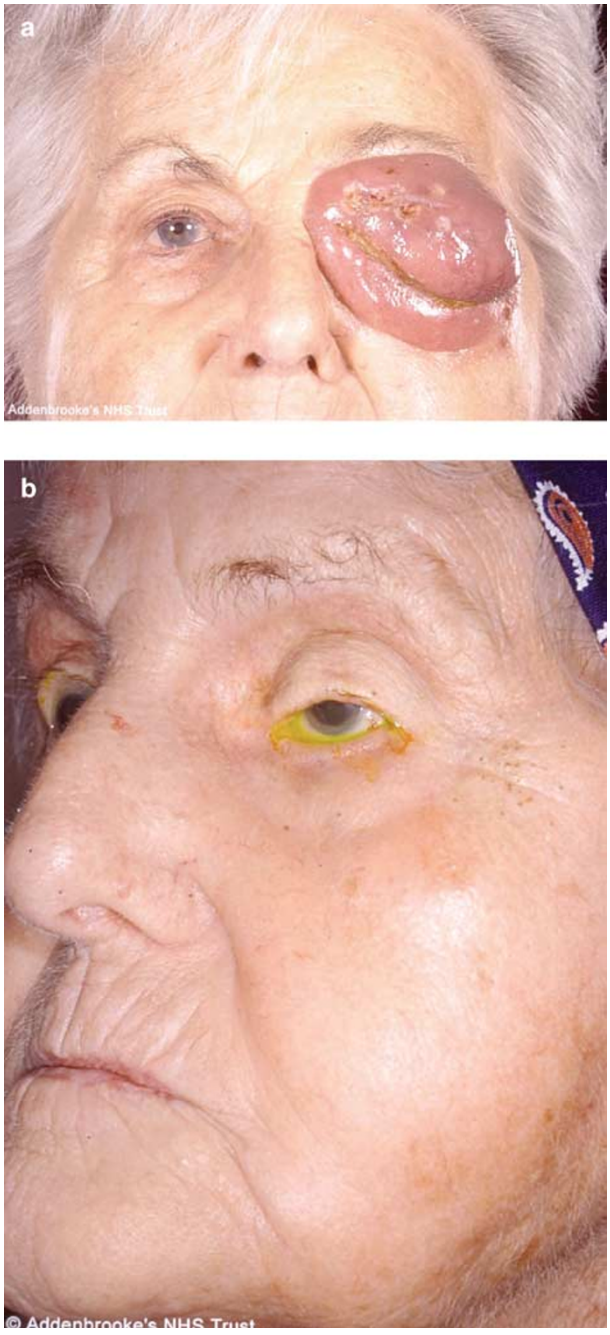

Figure 2 (a) Rapidly enlarging left orbital mass. (b) Clinical resolution of the mass postchemotherapy.

can prove invaluable and should be performed even when the diagnosis appears to be clear.

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Sir,

Orbital amyloidosis presenting as ptosis

Amyloidosis is a condition characterised by the deposition of amorphous proteinaceous material that may involve many organs (systemic form) or be localised to a single organ (localised form). It can be deposited in any part of the orbit, globe, or adnexa. Orbital involvement is uncommon with varied presentations. We report two patients who presented with ptosis that was initially thought to be involutional in nature.