

posturing the patient either face down or supine, respectively, is a much safer and more effective technique than the use of miosis. Although we have not reviewed surgical techniques for lens extraction in ectopia lentis, we would suggest that repositioning of the lens posteriorly is associated with less endothelial trauma. The risks of a posterior approach with a pars plana vitreolensotomy can be reduced in Marfan's patients with intraoperative laser retinopexy to areas of lattice.⁶

If miosis is to be attempted, then a laser iridotomy is also advisable not only to prevent pupil block from subluxating lenses in the posterior chamber but also to protect against pupil block if the lens dislocates anteriorly.

Our case series demonstrates the significant risk of precipitating pupil block glaucoma and potentially delaying surgery for ectopia lentis by the emergency use of pilocarpine without iridotomy.

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Sir, Optical coherence tomography findings in acute macular neuroretinopathy

Acute macular neuroretinopathy (AMNR) is a rare condition characterized by a sudden onset of mild visual impairment in one or both eyes of young patients, predominantly women. Typically, the neuroretinopathy consists of reddish-brown wedge-shaped macular lesions, pointing towards the centre of the fovea.¹ The diagnosis is clinical, aided by the exact correspondence of the lesion with the scotoma identified on the Amsler grid. The precise location of the lesions is uncertain.¹ We evaluated a case of AMNR with optical coherence tomography (OCT) and fundus fluorescein angiography (FFA).

Case report

A 30-year-old man presented with blurring of vision in the left eye for 6 months. His best-corrected visual acuity was 6/6 in the right eye and 6/9 in the left. There was no history of headache, flu-like illness, trauma, or administration of intravenous epinephrine/contrast agents. Anterior segment examination was normal in both eyes. Slit-lamp biomicroscopy of the left fundus showed a subtle red wedge-shaped lesion above the fovea pointing towards its centre (Figure 1(a)). The right fundus was normal. Amsler grid examination of the left eye showed a scotoma corresponding exactly to the macular lesion. FFA revealed no hypofluorescence of the affected area. Optical coherence tomography of the left eye revealed distinct retinal thinning in the area of the lesion, more prominent in the inner retinal layers (Figure 1(b)).

Comment

The dark-red appearance of the lesions in AMNR is attributed to a focal atrophic thinning of retina.¹ Opinion is divided on the location of the lesions. Biomicroscopic interpretation is variable.^{1,2} The striking correspondence of the lesions to the paracentral scotomata on Amsler grid and documentation of an abnormality of the early receptor potential point to the involvement of the outer retinal layers.^{1,3} The retinal haemorrhages, acute oedematous appearance of the macula, suspected retinal capillary dilation, and an association with epinephrine administration indicate inner retinal involvement.^{1,2,4} To the best of our knowledge, there is only one earlier report of OCT findings in AMNR: Feigl and Hass⁵ observed a band of high reflectivity over the retinal pigment epithelium, and implicated an inflammatory process in the outer retina. They found no retinal thinning in their

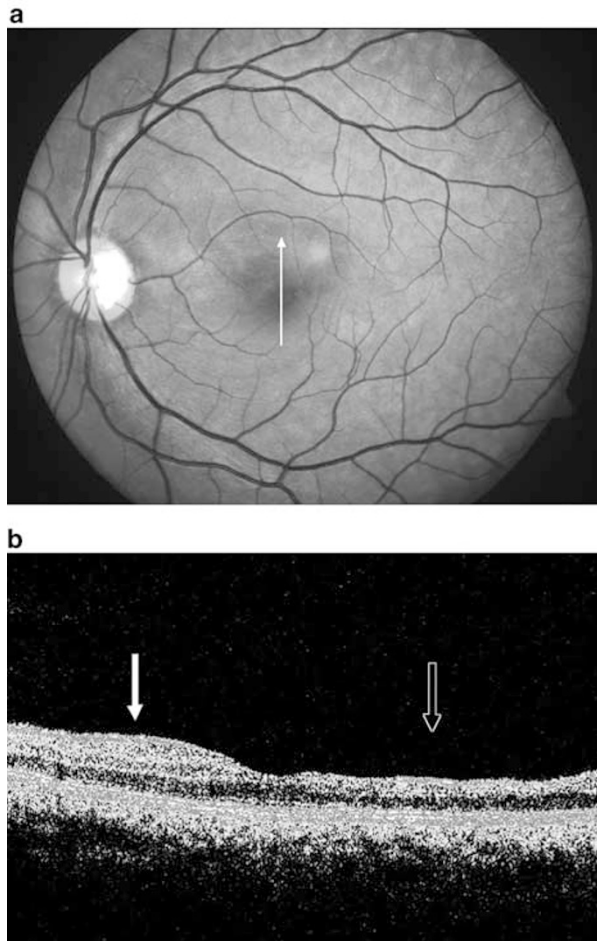


Figure 1 (a) Red-free photograph showing a subtle wedge-shaped dark lesion just above the centre of the fovea, pointing downwards. The vertical arrow shows the direction of the optical coherence tomography scan. (b) Optical coherence tomography image of the left eye, showing an area of retinal thinning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

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.

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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