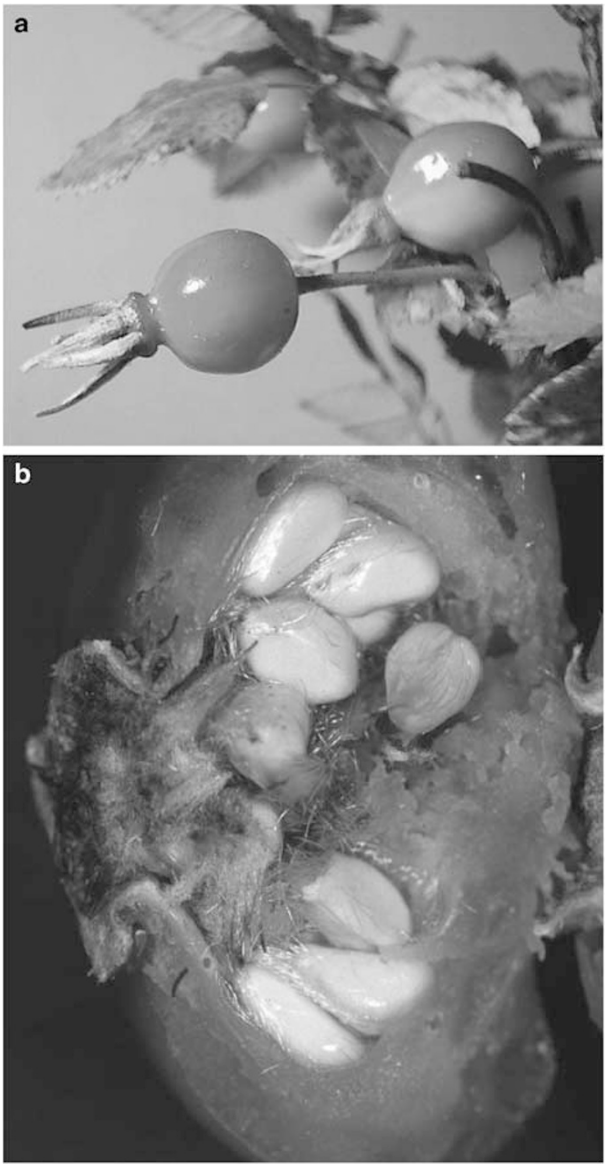

Figure 2 Photograph showing rose-hip fruits (a), cut section of a fruit showing the seeds covered with hairs (b).

flowers appear in June and July. The fruit (the hip) is an orange-red, oblong berry (Figure 2a). They appear in late summer but are not fully ripe until October or November. The seeds of the hip are covered with stiff, sharply pointed non barbed hairs (Figure 2b) that are highly irritant to the human skin.[4] This is in contrast to the barbed hairs seen in certain species of caterpillars and spiders, which can migrate through ocular tissues and cause severe intraocular inflammation that is, uveitis, retinitis, etc.[5–6] The irritant property of rose-hip hairs has made it popular among some school children who use it as itching powder.[4]

Rose-hip is a very rich source of vitamin C.[4] The extract from the fruit is well known for its medicinal qualities such as antisepsis, antidepressant, antispasmodic, anti-inflammatory, and antiviral properties and also used in a number of recipes like puddings, ice-cream, in almost any sweet, wine, tea, etc., to name a few.

To our knowledge, this is the first case of rose-hip keratitis reported in the literature. We think our patient's ocular signs and symptoms could be a result of either irritation by the stiff hairs covering the rose-hip seeds or a result of a direct chemical effect or a hypersensitivity response to the rose-hip or due to a combination of these factors.

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Sir,

Spontaneous improvement of serous maculopathy associated with congenital optic disc pit: an OCT study

Congenital optic disc pits result from an imperfect closure of the superior edge of the embryonic fissure, which leads to a two-layered maculopathy consisting of a

primary inner retinal layer separation (schisis) and a secondary outer layer detachment (OLD) frequently associated with a lamellar macular hole.[1,2] The OLD is the primary cause of the visual dysfunction in this condition with its displacement from the macula being the rationale of procedures such as gas tamponade to effect an improvement in central vision.[3] Spontaneous resolution of the OLD has been reported previously with serial fundus examinations,[4–6] but there are no optical coherence tomographic (OCT) studies to document the same. The visual acuity improvement after such spontaneous reattachments are also not very impressive.[4–6] We present a case of rapid improvement in visual acuity following a spontaneous decrease of the OLD in an adult patient. This is the first report to document the OCT findings in this condition, to the best of our knowledge (as per medline search).

Case report

A 25-year-old male patient presented to us with the complaints of progressive blurring of vision of his left eye for the previous 2 months. Ocular examination revealed a best corrected visual acuity of 20/20, N_6 and 20/60, N_{12} in the right and left eyes, respectively. The anterior segment examination of both the eyes was unremarkable. Fundus examination of the left eye revealed a large optic nerve head (ONH) with a grey oval pit at the inferotemporal margin and a serous macular detachment (see Figure 1a). Slit-lamp biomicroscopy revealed a small cyst in the nerve fibre layer (NFL) temporal to the ONH in the papillomacular bundle (PMB) and the two-layered nature of the detachment as reported previously:[1] there was a round, opaque OLD centred at the macula of about $\frac{1}{2}$ disc diameters (DD) in size with a suggestion of a lamellar macular hole that was surrounded by a relatively transparent, oval separation of the inner retinal layers, the inner layer schisis (ILS) that extended upto the arcades (see Figure 1a). There was no evidence of posterior vitreous detachment (PVD) or vitreous traction. The right eye was within normal limits.

Fundus fluorescein angiography (FFA) revealed a stippled hyperfluorescence in the area of the OLD, pooling in the area of the ILS and a persisting hypofluorescence of the ONH pit even at the late stage The nerve fibre layer cyst showed late hyperfluorescence (see Figure 2a, b). Visual field examination using a 1-m tangent screen revealed a dense central scotoma to 1/1000 object. OCT revealed the optic disc pit, the NFL cyst in the PMB, and the OLD under the foveola. The ILS communicated with the pit nasally and temporally it extended underneath the foveola and beyond in the parafoveal region (see Figure 3a, b). There was an outer layer macular hole at the nasal edge of the OLD through which the OLD communicated with the ILS. The patient was offered the option of vitrectomy but refused treatment.

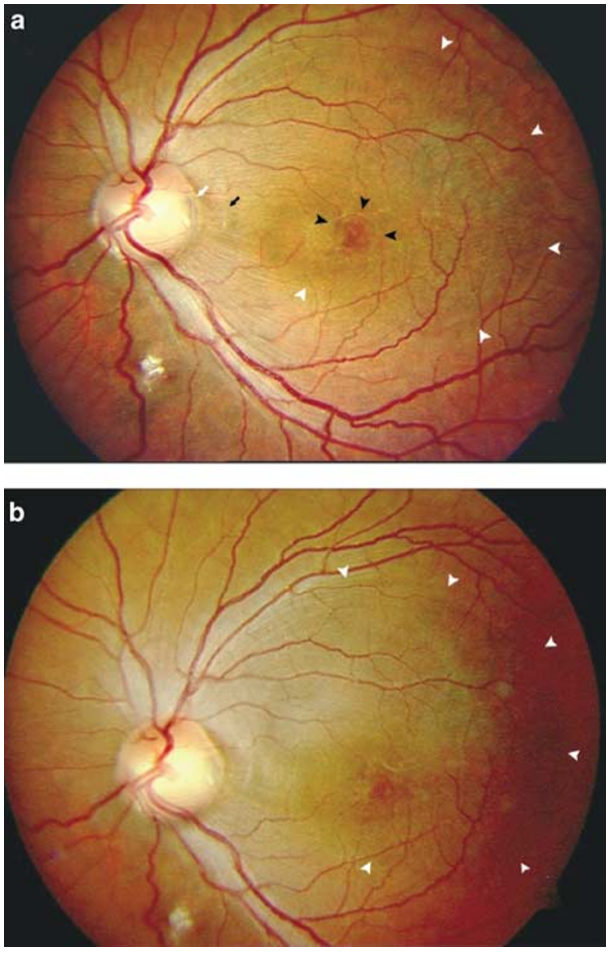

Figure 1 (**a**) Colour fundus photograph of the left eye at presentation showing the optic disc pit (small white arrow), and a transparent cystic lesion in the papillomacular bundle area suggestive of a nerve fibre layer cyst (small black arrow). There is a well-circumscribed opaque, rim of fluid surrounding the foveola (black arrow heads) suggestive of an OLD. An oval elevation surrounding the OLD is seen extending between the arcades suggestive of an ILS (white arrow heads). A whitish area of gliosis is seen inferior to the disc. (**b**) Colour fundus photograph of the left eye at follow-up after 1 month showing the optic disc pit and the ILS (white arrow heads). The nerve fibre layer cyst and the OLD appear to have collapsed. A whitish area of gliosis is seen inferior to the disc.

The patient reported a dramatic improvement in vision at the first follow-up examination at 1 month. The best corrected visual acuity was 20/30, N_8 in the left eye, with the disappearance of the central scotoma on visual field testing. The OLD and the NFL cyst were not clearly apparent and appeared to have resolved on fundus biomicroscopy (see Figure 1b). OCT showed a decrease of the NFL cyst and the OLD that had also migrated from the subfoveal to a nasal parafoveolar location. The outer

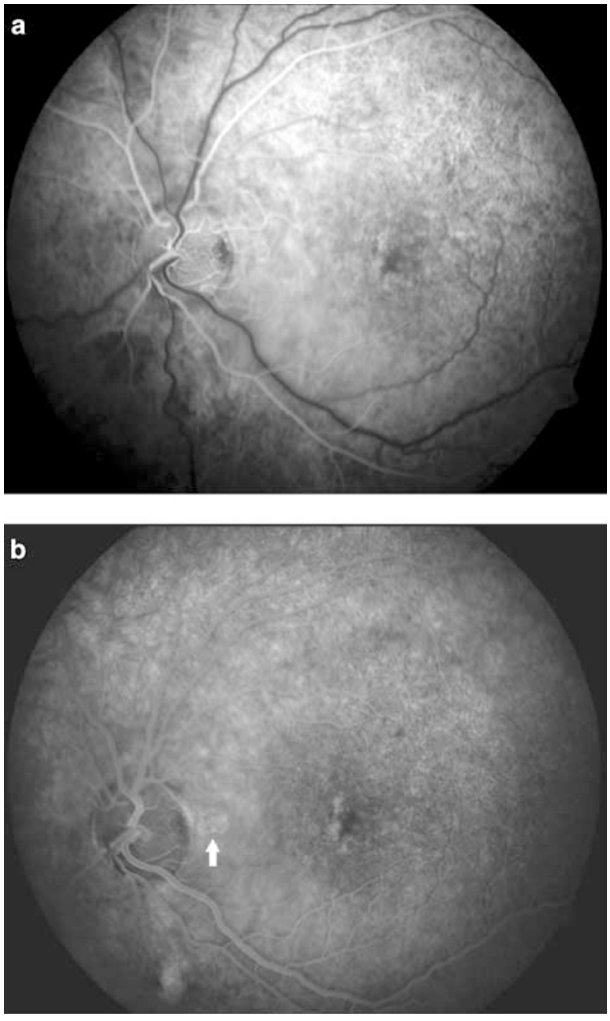

Figure 2 (**a**) Arteriovenous phase of the fundus fluorescein angiogram at presentation showing the early hypofluorescence of the optic nerve pit and the stippled hyperfluorescence due to the window defects in the OLD. (**b**) Late stage of the fundus fluorescein angiogram at presentation showing the persistent hypofluorescence of the optic nerve pit and the pooling of the dye in the ILS. The temporal margin of the optic disc and the nerve fibre layer cyst show late hyperfluorescence (white arrow).

layer hole was less obvious, while the ILS was persistent but less pronounced (see Figure 3c, d).

The patient was under regular follow-up. The clinical and OCT picture were unchanged when the patient was last seen at 6 months after presentation.

Comment

The source of the fluid in our case was not abnormal leaky blood vessels within the pit, as previously suggested[5] since the pit remained hypofluorescent till the late stages on FFA. There was no evidence of PVD or vitreous traction to suggest liquified vitreous to be the cause of the fluid as proposed by Sugar.[4] The occurrence of the NFL cyst and its subsequent flattening (as documented by OCT) is also interesting and has never been reported before. Of note, both the temporal margin of the optic nerve head and the NFL cyst showed late hyperfluorescence in our case, suggesting that the peripapillary RPE was conducting the fluid from the pit to the NFL cyst.

Spontaneous improvement in the serous maculopathy associated with optic disc pits has been reported previously, but occurs after a long and variable period ranging upto a few years.[4–6] The visual acuities after such improvements are also not very impressive primarily because of the retinal pigment epithelial alterations and possible outer-retinal damage associated with the long-standing detachments.[4–6] Our patient demonstrated a dramatic improvement in visual acuity within a month of follow-up (the shortest recovery period to be reported). Moreover, there are no previous OCT studies to document the morphological changes in such cases of spontaneous improvement in the serous maculopathy. OCT demonstrated the decrease and the parafoveolar migration of the OLD in this patient. (The flattening and/or displacement of the OLD after surgical interventions has been reported to result in visual improvement previously.[3]) The observation of the tendency of the outer macular hole to close also suggests that this could be the mechanism for the improvement by blocking the conduit of fluid from the schisis to the OLD. The schisis remains persistent since its connection to the pit remains patent. This is the first report to document the OCT findings in this condition to the best of our knowledge (as per medline search). This case suggests that the natural history in such conditions of spontaneous resolution of the detachments could be good if the resolution occurs within a short period of time prior to the development of permanent RPE alterations.

Acknowledgements

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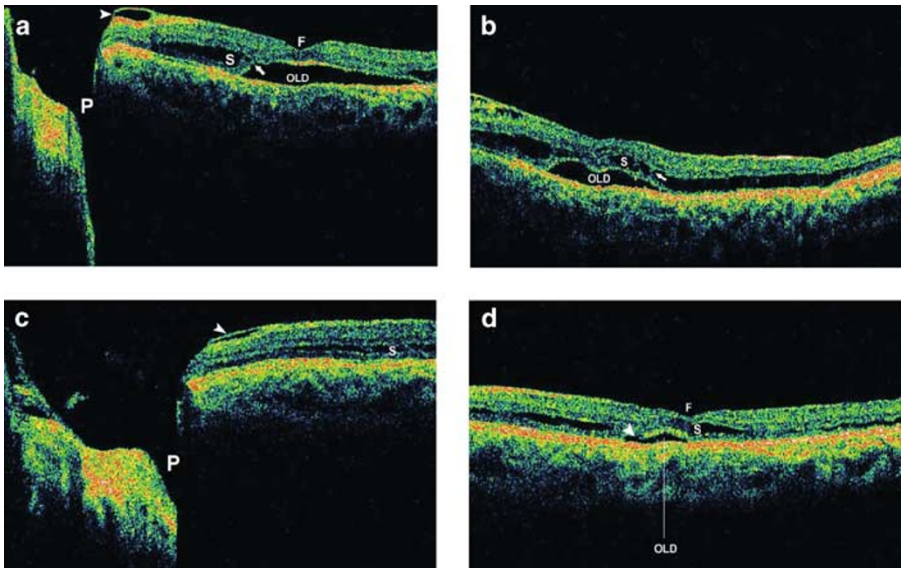

Figure 3 (**a**) Linear OCT scan of the patient at presentation, through the disc and the fovea showing the optic nerve pit (P) and the nerve fibre layer cyst (white arrow head). F denotes the fovea. Also seen are the inner layer schisis (S) communicating with the pit and the OLD in a subfoveal location. An outer layer hole is seen as a discontinuity in the nasal margin of the OLD (white arrow). (**b**) Linear OCT scan of the patient at presentation, through the fovea shows the schisis (S) extending subfoveally. The white arrow depicts the bridging septae characteristic of the schisis. (**c**) Linear OCT scan at follow-up after 1 month, through the disc and the fovea showing the optic nerve pit (P) and the schisis (S). The nerve fibre layer cyst has considerably decreased in size (white arrow head). (**d**) Linear OCT scan at presentation after 1 month, through the fovea shows the persistence of the schisis (S) underneath the foveola (F). The OLD has also decreased in size and has shifted to a nasal parafoveolar location. The outer layer hole is less obvious and is seen to have come closer to the retinal pigment epithelium (white arrow head).

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Sir,

Neovascular glaucoma and sarcoidosis

Neovascular glaucoma (NVG) occurs when new fibrovascular tissue proliferates onto the anterior chamber angle obstructing the trabecular meshwork. Retinal ischaemia is thought to be the main stimulus.[1] Sarcoidosis can lead to retinal ischaemia and neovascularisation in the setting of ischaemic vasculitis.[2] Uveitis without retinal ischaemia is a rare cause of NVG. We report the first case of NVG secondary to panuveitis of sarcoidosis in the absence of retinal ischaemia.

Case report

A 62-year-old woman with known sarcoidosis was referred from the uveitis clinic with a 2-week history of bilateral elevated intraocular pressure (IOP). A mediastinal lymph node biopsy had confirmed the diagnosis of sarcoidosis approximately 1 year prior to presentation to our clinic. Her systemic sarcoidosis required high-dose oral prednisone to control the disease. Since she suffered from prednisone-induced diabetes as well as other side effects, her treatment with prednisone was