model, as much as 50 μg of amphotericin has been shown not to cause corneal or lenticular toxicity, and liposome incorporation of amphotericin reduces ocular toxicity in the rhesus monkey.[7] In the three cases of severe keratomycosis treated with intracameral amphotericin B the total dose varied from 10 to 25 μg with no clinical evidence of corneal decompensation.[5]

The presence of corneal involvement has been shown to be the single most independent predictor of poor final outcome[8] in exogenous fungal endophthalmitis. In this case, we aggressively managed the patient and a total of 67 μg amphotericin B was given (49 μg intracamerally; 16 μg intravitreally, and 2 μg intrastromally). No visible adverse effects on the cornea or retina were noted and a good visual outcome was achieved. The exact source of the infection is unknown, although colonisation at the time of cataract surgery, endogenous seeding or postoperative self-inoculation by the patient may have occurred. This illustrates a difficult case of candida endophthalmitis that was successfully treated with repeated intracameral amphotericin B.

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Sir,

Atypical manifestation of neurofibromatosis type 2 in a boy

Patients with neurofibromatosis type 2 (NF-2), a rare autosomal dominant disease caused by mutations in the NF-2 tumour-suppressor gene on chromosome 22q12,[1] are predisposed to central nervous system tumours. Paediatric presentation is not yet well defined and differs from adult onset as the diagnostic criteria[2] are often not met at initial clinical manifestation.[3]

This report describes a boy with a trigeminal and a plexiform schwannoma and juvenile cataract without bilateral vestibular schwannomas and lacking a positive family history, who was diagnosed with NF-2.

Case report

A 10-year-old boy was referred by the paediatric ward with a 3-week history of recurrent vomiting, lack of appetite, weight loss, frontal headaches, and inattentiveness at school. Psychiatric assessment indicated an onset of anorexia/bulimia with functional headaches possibly due to social and school problems.

Pre-existing diagnoses were posterior subcapsular lens opacity in the right eye (Figure 1) with amblyopia, esotropia, and dissociated vertical divergence. Strabismus surgery had been performed at 7 years of age.

Figure 1 The left eye presents with a posterior subcapsular lens opacity.

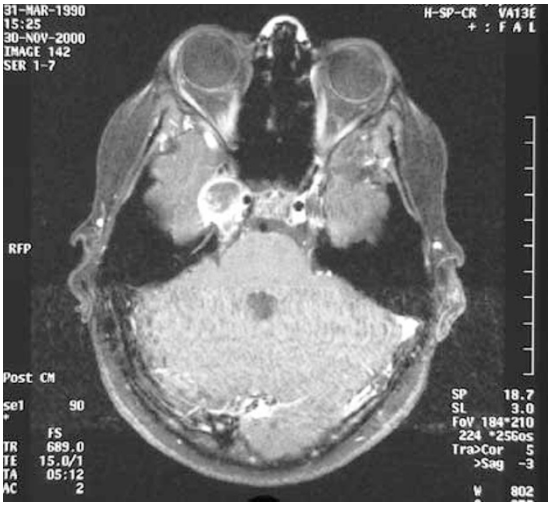

Figure 2 Gadolinium-enhanced axial T1-weighted MRI shows a mass at the right petrous apex extending forward into Meckel's cave and the cavernous sinus with intense inhomogeneous peripheral ring enhancement.

Ocular motility had not been restricted. A plexiform schwannoma of the thorax had also been excised.

On ophthalmologic examination, visual acuity measured 20/50 in the right and 20/25 in the left eye. Ocular motility testing showed extensive limitation of right abduction. Sensory function of the right trigeminal nerve was markedly diminished.

At 2 weeks after a CT scan of the head—that notably had been reported as unremarkable—a subsequent MRI detected an extraaxial mass at the right petrous apex extending forward into Meckel's cave and the cavernous sinus (Figure 2). This tumour had originated from the right trigeminal nerve and was subtotally removed in a one-stage procedure. Histological examination confirmed the diagnosis of schwannoma. Concurrence of juvenile cataract and schwannomas led to the suspicion of NF-2. Genetic testing revealed a nonsense-mutation of the NF-2 gene.

Comment

Further refinement of the diagnostic systems[2] for NF-2 in both children and adults is of great importance for early detection of this debilitating disease. NF-2 should be included in the differential diagnosis in patients with isolated schwannomas comprising a close look for further features typical of NF-2 and the use of genetic testing as a diagnostic tool.

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Sir,

Cataract surgery using phacoemulsification may reactivate angiogenic growth factors in ocular ischaemic syndrome

Neovascularisation is a recognised complication of intraocular surgery performed during retinal ischaemia.[1] We describe its occurrence in a patient with severe carotid artery atherosclerosis and ocular ischaemic syndrome who underwent phacoemulsification and intraocular lens implantation. To our knowledge this phenomenon has not been previously reported in ocular ischaemic syndrome.

Case

A 65-year-old man with bilateral ocular ischaemic syndrome due to carotid atherosclerosis underwent left cataract surgery.[2–5] Vision was 2/60 in the left eye due to