quadrants in the right eye. The central foveal thickness was 218 μm in the right eye and 183 μm in the left eye.

After informed consent, the patient underwent uneventful pars plana vitrectomy. A microvitreoretinal blade was used to free the RIOFB at the superior surface and the foreign body was removed completely with an intraocular magnet. Postoperative tamponade was given with C_3F_8 gas injection followed by prone positioning. At 6 weeks follow-up, the patient had a stabilized best-corrected visual acuity of 20/30 and attached retina. OCT revealed central foveal thickness of 190 μm in the right eye and 183 μm in the left eye with reduction in macular oedema and full-field electroretinography b-wave amplitude was slightly delayed (34 μV in the right eye, 40 μV in the left eye).

Comment

OCT is a useful diagnostic tool for performing high-resolution cross-sectional imaging of the retina in macular diseases including macular oedema, macular holes, detachments of the neurosensory retina, and pigment epithelium along with nerve fibre layer defects in glaucoma.[3,4] Besides initial visual acuity that is the most important predictive factor of visual outcome in patients with RIOFB,[1] assessment of the macular thickness on OCT may play an important role in predicting the postoperative visual outcome after RIOFB removal. Along with the depth of the RIOFB, OCT detected mild macular oedema preoperatively in this case, which may have accounted for a low visual acuity of 20/30, hence may prognosticate the visual potential. Radiological assessment of RIOFB with plain film X-rays, contact B-scan ultrasonography, CT scan, and MRI scanning are usually used in cases where the ocular media is opaque or physical examination is inconclusive.[2] Ultrasonography is more useful for localizing foreign bodies relative to the ocular coats than CTscan,[5,6] but is operator dependent[7] and MRI is avoided in cases of magnetic RIOFB.[2] Therefore, besides a direct visualization of RIOFB in clear media with ophthalmoscopy and slit-lamp biomicroscopy, OCT may emerge as a new modality for accurate localization of the depth of the foreign body on or within the retina, scanning the retina surrounding the RIOFB to assess consequent changes and postoperative assessment of the macula. However, OCT is operator dependent with a learning curve, with limited assessment of highly reflective foreign bodies due to back shadowing, allowing scanning only a limited area in the posterior pole near or within the retina. A study of varied RIOFB presentations will further clarify the role of OCT in such cases.

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Sir,

Metoprolol responding uveitis

I read with interest Yassif and coworkers' description of a challenging case of panuveitis responding to oral metoprolol therapy.[1] This is indeed a finding that deserves further investigation to elucidate the mechanisms involved, and clinical implications thereof.

Some early data in this regard have already been published; Er *et al*[2] demonstrated that topical beta blockade using timolol maleate was able to reduce aqueous levels of proinflammatory cytokines interleukin-6, interleukin-8, and tumour necrosis factor-α in a rabbit

model of ocular inflammation. In the case described, the patient was commenced on topical timolol in order to treat the secondary glaucoma; however, this had no effect on the inflammatory process. It is possible that that oral metoprolol was effective because it had a higher bioavailability within the posterior segment, as well as anteriorly. It was thus effective in suppressing ocular inflammation through the mechanisms described above.

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Sir,

Metoprolol responding uveitis: reply

We thank Dr Masood for his useful comments. The mechanism he suggested is tempting, however, it is speculative. It should be emphasized that at the time the patient received metoprolol tartrate he was no longer on timolol. Both $beta_1$- and $beta_2$-adrenergic receptors have been identified in the human iris and ciliary body.[1] Activation of $beta_2$ receptors increases the formation of cyclic adenosine monophosphate and stimulation of Na^+, K^+, Cl^- cotransport in the foetal nonpigmented ciliary epithelium.[2] Metoprolol may as well have an indirect effect on the Na–K pump via adrenergic receptors. This may either result in changes in aqueous production or in concentration of inflammatory mediators in the anterior segment and explains its clinical effect in the specific individual with type A personality. It should be clinically determined if metoprolol has a similar effect on different individuals and in which dosage. The drug may have different activities in different concentrations. The molecular mechanism of metoprolol effect should be evaluated also in cell cultures. Our study is intended to provoke research in these directions.

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Sir,

Reversible night blindness in a patient with neuroendocrine tumour of pancreas

Nutritional vitamin A deficiency is a common cause of blindness in developing countries. Around 2.8 million preschool children are affected with vitamin A deficiency in over 60 countries and subclinical vitamin A deficiency is considered a problem for at least 251 million people.[1] However, in Western world it is very rare. Most cases of vitamin A deficiency in developed countries are caused by malabsorption secondary to intestinal disorder or defective storage and metabolism due to liver disease.[2] We report a case of night blindness secondary to vitamin A deficiency in a patient with neuroendocrine tumour of pancreas.

Case report

A 79-year-old lady presented to the eye clinic with a 4-week history of poor vision in dimly illuminated