Figure 1 Fundus photograph of left eye showing venous stasis retinopathy, Roth spots and macular haemorrhages.

ophthalmic condition improved with resolution of macular haemorrhages and Roth spots.

I feel this case highlights the high index of suspicion of leukaemia necessary when a patient presents with Roth spots or venous stasis retinopathy. As ophthalmologists, we play a pivotal role as prompt diagnosis and treatment can benefit patients with both acute and chronic leukaemia.

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SM Salvi

Department of Ophthalmology
Royal Gwent Hospital, Cardiff Road
Newport NP20 2UB, UK

Correspondence: SM Salvi
Tel: +44 1633 238444
Fax: +44 1633 656294
E-mail: karansalvi@aol.com

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Sir, Pneumatic displacement of subretinal haemorrhage followed by transpupillary thermotherapy of choroidal neovascular membrane secondary to multifocal choroiditis

Multifocal choroiditis with panuveitis commonly occurs in middle-aged women. It is characterized by multiple punched out chorioretinal spots with vitritis.¹ This disorder is complicated by the development of choroidal neovascularization (CNV) or progressive subretinal fibrosis. Subfoveal CNV is an important cause of severe visual loss² in these patients. Methods of treating subfoveal CNV in multifocal choroiditis include observation (smaller than 100 μ m),² oral corticosteroids,³ thermal laser, surgical removal,⁴ and photodynamic therapy (PDT).⁵

Transpupillary thermotherapy (TTT) is an established modality of treatment for occult CNV.⁶ TTT for CNV in multifocal choroiditis has not been reported (Medline search).

We report a case of CNV secondary to multifocal choroiditis treated with pneumatic displacement of subretinal haemorrhage followed by TTT.

Case report

A 45-year-old male presented with an episode of diminished vision in the left eye of 15 days duration. A previous episode of decrease in vision in both eyes was followed by resolution of vision in the left eye only.

On examination, his best-corrected visual acuity was 1/60 in the right eye and 6/60; N36 at 20 cm in the left eye. Anterior segment examination was unremarkable. Fundus evaluation showed multiple chorioretinal atrophic scars in both eyes. One of the atrophic scars involved the fovea of the right eye. Subfoveal haemorrhage was noted in the fovea of the left eye (Figure 1a). Fundus fluorescein angiography (FFA) showed predominantly classic CNV with an indistinct temporal margin adjacent to a chorioretinal atrophy scar due to subretinal haemorrhage (Figure 1b). The subretinal haemorrhage was partially displaced with 0.5 ml of intravitreal air and prone positioning for 3 days (Figure 1c).

After 1 week, the patient's distant vision remained stable at 6/60 and near vision improved to N24 at 30 cm. FFA could now delineate the temporal margin of classic CNVM (Figure 1d). The options of PDT and TTT were discussed, and the patient chose to undergo TTT. TTT was delivered using an 810 nm diode laser (Iris Medical Oculight SLx, Iridex Corporation, Mountain View, CA, USA). The laser parameters were: power—130 mW; spot size—2 mm; duration—60 s. At 2 months post-treatment,

Figure 1 (a) Shows subfoveal haemorrhage with multiple adjacent chorioretinal atrophic patches. (b) FFA showing hypofluorescence (arrow) due to subretinal haemorrhage. (c) Shows the displacement of subretinal haemorrhage after intravitreal air injection. (d) FFA showing disappearance of hypofluorescence (arrow) following displacement of subretinal haemorrhage by intravitreal air injection. (e) Shows scarred CNV 2 months following TTT. (f) FFA showing staining of the scarred CNV.

his vision improved to 6/24, N10. Regression of CNVM was noted clinically (Figure 1e) and angiographically (Figure 1f). Vision and CNV remained stable 12 months following laser treatment.

Discussion

Choroidal neovascularization can occur in about 32% of patients with multifocal choroiditis.² There are no proven methods of treating subfoveal CNV in this condition. The efficacy of treating classic CNVM with PDT has been established.⁷ PDT could be a good option in the treatment of CNV secondary to multifocal choroiditis as they are predominantly classic. Our patient opted for TTT due to the expense of PDT.

In our patient, subretinal haemorrhage obscured the temporal margin of CNV. Pneumatic displacement was attempted due to the short history. Intravitreal air was used because of its short half-life and since subretinal haemorrhage displacement could be noted within 2 days.⁸ Displacement allowed the temporal margin to be distinguished from the adjacent chorioretinal atrophic scar in our patient, thus helping us select a 2 mm spot size and avoiding an adjacent pigmented scar. Inclusion of the pigmented scar would have caused a non-homogenous reaction.⁹ Regressed CNV was noted clinically and angiographically at the end of 2 months and at the last follow-up at 12 months.

To conclude, TTT could be of value in the treatment of CNV in multifocal choroiditis. In case of associated subfoveal haemorrhage intravitreal air-aided

displacement of the haemorrhage helps in clear delineation of the CNV.

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A Pathengay, S Malhotra and Das T

Smt Kanuri Santhamma Retina Vitreous Center
LV Prasad Eye Institute
LV Prasad Marg
Banjara Hills
Hyderabad 500034, India

Correspondence: A Pathengay
Tel: +91 040 23608262
Fax: +91 040 23548271
E-mail: avinash@lvpei.org

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Sir,
Frosted branch angiitis

We read with interest the article by Walker *et al*¹ on frosted branch angiitis review, and would like to draw attention to our paper entitled 'Unilateral frosted branch angiitis with vitreous haemorrhage',² a case of an Indian patient, which they missed in referencing. There are very few patients from outside Japan, and this case of ours makes it two patients from India.

There are certain points, which we would want to make, that have not been stressed in the frosted branch angiitis review.¹ It is of note that frosted branch angiitis is usually bilateral and very rarely unilateral, there being very few cases of unilateral frosted branch angiitis.^{2–4} The uniqueness of our case, besides being the second reported patient of primary frosted branch angiitis from India, was its unilateral nature and development of a dense total vitreous haemorrhage; these patients may present with a vitreous haemorrhage, as happened in our case.²

Also, primary retinal phlebitis/Eales' disease being very common in India, we have seen about 10 cases of Eales' disease that at places had frosted branch angiitis-like appearance (Figure 1), again raising the issue whether frosted branch angiitis is a separate disease entity or a clinical sign being increasingly recognized in various inflammatory conditions,⁵ frosted branch angiitis-like clinical picture already having been described in

Figure 1 A 25-year-old Indian male presenting in the acute inflammatory stage of Eales' disease. He had blurred vision in right eye of 1 week; the retinal phlebitis gives the appearance of frosted branch angiitis at places. He improved with oral steroids in 1 month. The other eye was lost following neovascularization, vitreous haemorrhage, and tractional retinal detachment from old Eales' disease.

conditions like cytomegalovirus retinitis, etc.^{2,5} The course of these Eales' disease cases was similar to that found in frosted branch angiitis patients. No investigations were positive and all responded well to oral corticosteroids. Many patients of Eales' disease commonly develop neovascularization with intraocular haemorrhaging. This phenomenon, again, is being increasingly recognized in frosted branch angiitis as well.^{6,7}

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S Agrawal, J Agrawal and TP Agrawal

Ophthalmology Department
TP Agrawal Institute of Ophthalmology