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Eye (2006) **20,** 258–260. doi:10.1038/sj.eye.6701836;
published online 11 March 2005

Sir,

ROP was always there

I enjoyed reading the recent article by Cuthbertson *et al* (*Eye* 2004; **18**: 314–315) about a female born in the UK 1939 with what was considered retinal dragging due to cicatricial ROP. This timing meant 3 years prior to Terry's original observation of what soon after acquired the label of retrolental fibroplasia, and from 1984 ROP.

I cannot beat their record, but *my* first similar Danish case immediately popped into my mind. Male born 1945, 'abortive RLF' or 'regressed, but cicatricial ROP', 4 years prior to *our* first blind baby. Mainly, Europe was late in the ROP field, because the War postponed certain therapies, among them the luxury of oxygen to small prematures.

Perspective

We always had survival of small prematures. Likewise, the two cases suggest that we probably also had ROP 'always' although the disease morphology was not at all recognized in the pre-Terry era (from 1942).

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Eye (2006) **20,** 260. doi:10.1038/sj.eye.6701837;
published online 1 April 2005

Sir,

Famotidine-induced retinopathy

Famotidine is a competitive inhibitor of histamine H_2-receptors. The primary clinically important pharmacological activity of famotidine is inhibition of gastric secretion. It is widely used due to its relatively limited side effect profile compared to other H_2-antagonists. While transient and mild blurred vision has been reported, particularly with cimetidine,[1] severe and permanent visual loss induced by H_2-antagonists has not been reported. We describe the first case report of severe retinopathy as an adverse effect of famotidine.

Case report

A 57-year-old man was referred to our clinic with the complaint of sudden visual loss in both eyes after taking two doses of famotidine (20 mg/tab bid). He had no relevant underlying diseases, or family history of hereditary ocular diseases. He was not taking any other medications, and had no history of smoking. Regular health examination performed 1 month ago showed visual acuity of 20/15 in both eyes. He had suffered from a gastric ulcer for more than 1 year and had taken lansoprazole for about 6 months. No ocular side effect was noted using lansoprazole. Five days prior to visiting our clinic, his internist changed the prescription from lansoprazole to famotidine (20 mg/tab bid). After taking two doses of famotidine, he noticed sudden onset of blurred vision and darkening in both eyes. No photopsias was noted. He stopped taking famotidine, but no recovery in his vision occurred.

On visiting our clinic, best-corrected visual acuity was 20/200 in the right eye and 20/40 in the left eye. Automatic static perimetry showed severe generalized depression in both eyes (Figure 1). Slit-lamp examination was normal in both eyes. Indirect ophthalmoscopy and fluorescein angiography revealed no abnormalities (Figure 2). Electroretinogram demonstrated severely depressed response in both eyes (Figure 3a). Electrooculogram showed decreased Arden ratio (Figure 3b), and visual-evoked potential testing revealed poor waveform (Figure 3c). Severe retinopathy due to famotidine was impressed. Although cancer-associated retinopathy was not likely, computerized tomography of the chest was arranged and revealed negative findings. Visual function had not improved 6 months after the cessation of famotidine.