Correspondence: C-S Yang,
Tel: +886-2-2875-7325;
Fax: +886-2-2876-1351.
E-mail: csyang@vghtpe.gov.tw

Proprietary interest: None

Eye (2006) **20,** 265–268. doi:10.1038/sj.eye.6701843;
published online 4 March 2005

Sir,

Metastatic choroidal melanoma to the ipsilateral orbit 7 years after enucleation

Metastasis of choroidal melanoma to the contralateral orbit is rare.[1] Only one case with bilateral orbital involvement has been previously reported.[2] To our knowledge, we present the first case of choroidal melanoma metastasis to the ipsilateral orbit, 7 years after enucleation.

Case report

In 1993, a 47-year-old man was referred because of a tumour in the right eye. His general history was unremarkable. He had no family history of cutaneous or ocular malignant melanoma or dysplastic naevus syndrome. On examination, the best-corrected visual acuity of both eyes was 1.0 (logmar scale). Fundoscopy showed a prominent pale tumour superotemporal to the fovea. The left eye was normal. Ultrasonography showed a tumour base of $9 \times 10\,mm^2$ and a thickness of 8 mm. Choroidal excavation was obvious with decreased internal amplitudes in the tumour on the diagnostic A scan. There were no signs of extrascleral extension. General physical examination and laboratory tests were unremarkable. With a diagnosis of primary malignant choroidal melanoma the patient was treated with brachytherapy using a Ruthenium applicator (apical dose: 143 Gy) combined with transpupillary thermotherapy (TTT).[3] After 2 years of tumour regression, a vitreous haemorrhage occurred with a complete retinal detachment. The visual acuity of the right eye was reduced to hand movements. In 1995, the eye was enucleated and an Allen-type orbital implant was placed.

Histological examination showed scar tissue and some loose pigment at the site of the irradiated tumour, without evidence of residual melanoma. Extrascleral outgrowth could be excluded. At 5 years after enucleation, the patient developed multiple biopsy-proven metastases in the liver, the diaphragm, skin, and the spine. He received palliative treatment.

In 2002, 7 years after enucleation, he presented with sudden onset of ptosis of the right upper eyelid and poor prosthesis fit (Figure 1). On examination, the prosthesis as well as the orbital implant were displaced inferiorly and anteriorly. The right vertical eyelid fissure was 3 mm and the levator function was 7 mm. There was a mass palpable in the right upper eyelid. Orbital CT-scans revealed two soft tissue lesions. One was located in the anterior part of the superior rectus muscle (Figure 2, top left), the other was localized in the posterior section of the medial rectus muscle and extended into the optic nerve canal (Figure 2, top right, bottom). No informed consent was obtained for diagnostic confirmation. In September 2003, the patient died from carcinomatosis. Regrettably, consent for postmortem examination was not obtained.

Comment

Metastatic orbital melanoma usually originates from the skin.[1] Nine cases of metastasis of a choroidal melanoma to the contralateral orbit after enucleation have been reported.[1] Massy *et al*[2] described an 81-year-old man who developed multiple orbital metastases bilaterally 8 years after enucleation. Our patient developed metastases in two extraocular muscles 7 years after enucleation. Although local recurrence of the choroidal melanoma cannot be ruled out, this seems highly unlikely, because two separate lesions were present and both occurred in the extraocular muscles, which are a predilection site for metastatic melanoma.[4] In addition, both the sudden onset of blepharoptosis and the histopathology after enucleation, which revealed no extrascleral extension, point to metastasis as main cause. Our case is in agreement with previous reports that melanoma

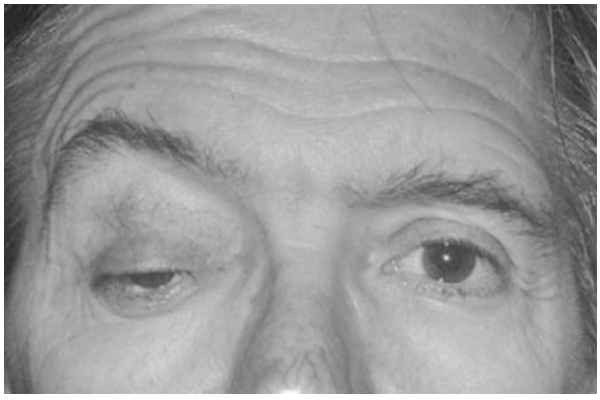

Figure 1 Clinical appearance of patient showing ptosis and prosthesis displacement on the right side.

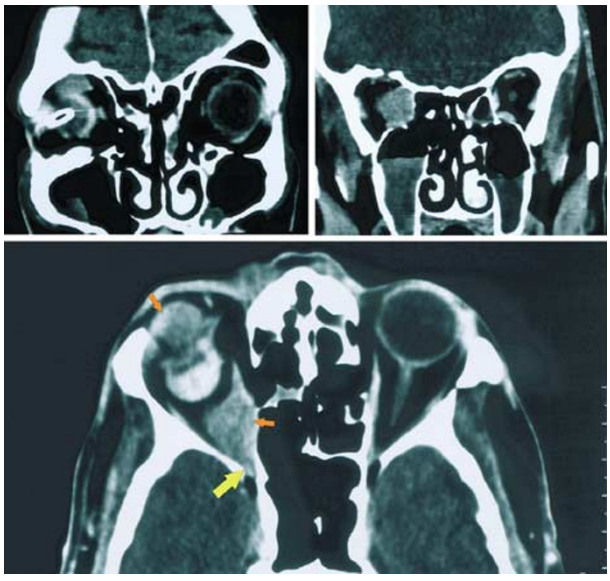

Figure 2 (Top left) Coronal CT-scan showing a mass anteriorly localized in the right superior rectus muscle depressing the Allen implant and the prosthesis. (Top right) Coronal CT-scan demonstrating a posteriorly located mass in the medial rectus muscle. (Bottom) Axial CT-scan showing two lesions in the superior and medial rectus muscle (small orange arrows). Note the tumour extension in to the optic nerve canal (big yellow arrow).

metastasis to the orbit tends to occur in patients that already suffer from widespread metastatic disease.[4,5]

Acknowledgements

Financial interest/support: None

References

1 Coupland SE, Sidiki S, Clark BJ, McClaren K, Kyle P, Lee WR. Metastatic choroidal melanoma to the contralateral orbit 40 years after enucleation. *Arch Ophthalmol* 1996; **114**(6): 751–756.
2 Massy J, Aouididi S, Si Ahmed K, Callonec F, Thiebot J, Brasseur G. Apropos of a rare case of bilateral orbital metastasis of malignant melanoma of the choroid. *J Fr Ophtalmol* 1998; **21**(7): 529–534.
3 Bartlema YM, Oosterhuis JA, Journée-de Korver JG, Tjho-Heslinga RE, Keunen JE. Combined plaque radiotherapy and transpupillary thermotherapy in choroidal melanoma: 5 years experience. *Br J Ophthalmol* 2003; **87**: 1370–1373.
4 Orcutt JC, Char DH. Melanoma metastatic to the orbit. *Ophthalmology* 1988; **95**(8): 1033–1037.
5 Goldberg RA, Rootman J, Cline RA. Tumors metastatic to the orbit: a changing picture. *Surv Ophthalmol* 1990; **35**(1): 1–24.

M Sotodeh[1,2], W van den Bosch[1], J Keunen[2] and D Paridaens[1]

[1]Department of Oculoplastic and Orbital Surgery, Rotterdam Eye Hospital, Rotterdam, The Netherlands

[2]Department of ophthalmology, Leiden University Medical Centre, Leiden, The Netherlands

Correspondence: D Paridaens, Department of Oculoplastic and Orbital Surgery, The Rotterdam Eye Hospital, PO Box 70030, 3000 LM Rotterdam, The Netherlands
Tel: +31 10 4017777;
Fax: +31 10 4111747.
E-mail: paridaens@icapi.nl;
M.Sotodeh@LUMC.nl

Eye (2006) **20,** 268–269. doi:10.1038/sj.eye.6701844; published online 11 March 2005

Sir,

Optical coherence tomography findings in a case of chronic welder's maculopathy

Maculopathy secondary to exposure to welding arc light occurs due to photochemical damage to the outer retina,[1,2] but the target intraretinal structures are unclear. We report the optical coherence tomographic (OCT) findings in a case of welder's maculopathy. We could not come across a similar previous publication (Medline search).

Case report

A 23-year-old welder, reported to us with a defective vision in both the eyes following occasional unprotected exposure to metal arc inert gas shielding (MIG) welding arc light over the past 6 months. There were no previous episodes of ocular pain. On examination, his best-corrected visual acuity in both the eyes was 20/40, N_8. Anterior segment examination was unremarkable, with no evidence of photophthalmia. Fundus examination revealed a reddish-yellow cystic lesion at the level of the retinal pigment epithelium (RPE) in both the eyes (Figure 1a and d). Fundus fluorescein angiography (FFA) revealed pooling of dye (Figure 2a and b).

OCT using (*STRATUS* OCT™ Model 3000, Carl Zeiss Meditech technologies) disclosed a hyporeflective space between the inner and outer high-reflective-layers (HRL); (with the outer HRL corresponding to the RPE -