



Figure 2 (a) Fundus fluorescein angiogram (late venous phase) of the right eye showing pooling of the dye in the subfoveal lesion. (b) Fundus fluorescein angiogram (late venous phase) of the left eye showing pooling of the dye in the subfoveal lesion.

other hand, that occurs from longer exposure to bright sources damages only the outer retina.⁶

In conclusion, we think these new OCT findings that are presented would help in better understanding of chronic welder's maculopathy. We also present OCT-based evidence for the photochemical nature of damage and the site of damage to be the photoreceptor outer segments and the retinal pigment epithelium.

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References

- 1 Mainster MA, Turner PL. Photoc retinal injury and safety. In: Ryan SJ, Ogden TE, Hinton DR, Schachat AP (eds) *Retina*, Vol 2. 3rd ed. Mosby Inc: St. Louis, Mo, 2001, pp 1797–1809.

- 2 Brittain GPH. Retinal burns caused by exposure to MIG-welding arcs: report of two cases. *Br J Ophthalmol* 1988; **72**: 570–575.
- 3 Jorge R, Costa RA, Quirino LS, Paques MW, Calucci D, Cardillo JA *et al*. Optical coherence tomography findings in patients with late solar retinopathy. *Am J Ophthalmol* 2004; **137**: 1139–1142.
- 4 Arend O, Aral H, Reim M, Wenzel M. Welders maculopathy despite using protective lenses. *Retina* 1996; **16**: 257–259.
- 5 Hope RMS, Gardiner MTA, Archer DB. Ultrastructural findings in solar retinopathy. *Eye* 1993; **7**: 29–33.
- 6 Ham Jr WT, Ruffolo Jr JJ, Mueller HA, Clarke AM, Moon ME. Histologic analysis of photochemical lesions produced in rhesus retina by short-wavelength light. *Invest Ophthalmic Vis Sci* 1978; **17**: 1029–1035.

V Vedantham

Retina – Vitreous Service,
Aravind Eye hospital and Postgraduate Institute of
Ophthalmology,
1, Anna Nagar,
Madurai – 625 020,
Tamilnadu, India

Correspondence: V Vedantham,
Tel: +91 452 2532653;
Fax: +91 452 2530984.
E-mail: drvasumathy@yahoo.com

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Sir,

An unusual cause of acute lid swelling

Case report

A 34-year-old caucasian man attended eye casualty complaining of unilateral left upper lid swelling, which had occurred over a 24-h period. On examination visual acuity was 20/20 in both eyes with marked left upper lid oedema and minimal papillary reaction. Anterior segment examination, intraocular pressures, and fundoscopy of both eyes were unremarkable. A diagnosis of allergic preseptal oedema was made and the patient was prescribed a topical antihistamine.

An hour later the patient returned to eye casualty, anterior segment examination at this second attendance identified a translucent worm under the temporal bulbar conjunctiva (Figure 1a). On direct questioning the patient reported a visit to rural Cameroon 12 years previously, where he had explored an uncharted river. Under topical



Figure 1 (a) A frontal photograph showing left periorbital swelling. (b) Anterior segment appearance showing a subconjunctival filarial nematode loa loa.

anaesthesia (Tetracaine 0.5%), the subconjunctival worm was removed and microscopy identified an adult 4 cm female loa loa worm (Figure 1b). Blood analysis demonstrated a peripheral eosinophilia of $1.52 \times 10^9/l$ and a microfilarial load of 2000/ml. The patient was treated with albendazole 400 mg twice daily for 21 days, his ocular symptoms resolved within 2 days of commencing therapy.

Loa loa is a filarial nematode endemic in the rain forest regions of West and Central Africa. The nematodes are transmitted by Chrysops flies and upon infection many patients remain asymptomatic for up to 17 years. The adult worms move through the subcutaneous tissues often appearing transiently at the eye, where uveitis, cataract, and exudative retinal detachment have been reported.^{1,2,3,4,5} Life-threatening complications including cardiomyopathy, encephalopathy, nephropathy, and pleural effusion may occur. Definitive diagnosis may be made following histological examination of the loa loa worm or microfilaraemia. In addition, patients require skin biopsy to exclude coexistent onchocerciasis. The global treatment of choice is chemotherapy with diethylcarbamazepine; however, albendazole is used in the UK as a result of licensing restrictions.^{2,3} Removal of the subconjunctival worm is not essential; however, it may lead to the diagnosis and relieves ocular irritation. In an era of increasing global travel, this case highlights the importance of direct questioning of previous travel as signs may be nonspecific and transitory.

References

- 1 Klion AD, Massougbodji A, Sadeler BC, Ottesen EA, Nutman TB. Loiasis in endemic and nonendemic populations:

immunologically mediated differences in clinical presentation. *J Infect Dis* 1991; **163**(6): 1318–1325.

- 2 O'Donnell D, O'Connor L, Atherton P. There's a worm in my eye. *Med J Aust* 1992; **157**(11–12): 833–834.
- 3 Patel CK, Churchill D, Teimory M, Tabendeh H. Unexplained foreign body sensation: thinking of loiasis in at risk patients prevents significant morbidity. *Eye* 1993; **7**(Part 5): 714–715.
- 4 Jolly BT, Foley KA. Loiasis: a case of an unusual ocular foreign body. *Ann Emerg Med* 1992; **21**(9): 1153–1156.
- 5 Workman DM, McNab AA. Loa Loa disease. *Aust N Z J Ophthalmol* 1990; **18**(3): 357–358.

DJ De Silva¹, NG Strouthidis², S Tariq³ and N Davies²

¹Department of Ophthalmology, Western Eye Hospital, Marylebone Road, London NW1 5YE, UK

²Ophthalmology Department, Chelsea and Westminster Hospital, London SW10 9NH, UK

³Hospital for Tropical Diseases, Mortimer Market, Capper Street, London WC1E 6AU, UK

Correspondence: DJ De Silva, Ophthalmology Department, Western Eye Hospital, Flat 6, 55 Queens Gardens, London W2 3AF, UK

Tel: +44 7818 248 751;

Fax: +44 207 706 1262.

E-mail: drdjdesilva@yahoo.co.uk

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