

the orbital apex. Although patient had been reluctant to undergo enucleation for several years, when possibility of impending exenteration was mentioned he readily agreed to undergo enucleation combined with orbitotomy. Simple enucleation would not have been possible without the risk of transecting the orbital component. Our technique avoided the exenteration with its consequent morbidity. Combined enucleation and orbitotomy should be considered for choroidal melanoma with circumscribed extension of melanoma into the orbit.

## References

- 1 Anonymous . Histopathologic characteristics of uveal melanomas in eyes enucleated from the Collaborative Ocular Melanoma Study. COMS report no. 6. *Am J Ophthalmol* 1998; **125**: 745–766.
- 2 Singh AD, Shields CL, Shields JA. Prognostic factors in uveal melanoma. *Melanoma Res* 2001; **11**: 255–263.
- 3 Hykin PG, McCartney AC, Plowman PN, Hungerford JL. Postenucleation orbital radiotherapy for the treatment of malignant melanoma of the choroid with extrascleral extension. *Br J Ophthalmol* 1990; **74**: 36–39.
- 4 Shammas HF, Blodi FC. Orbital extension of Choroidal and ciliary body melanomas. *Arch Ophthalmol* 1977; **95**: 2002–2005.
- 5 Fenton S, Sandinha T, Lee WR, Kemp EG. Massive extraocular extension as the presenting feature of a choroidal melanoma. *Eye* 2001; **15**: 550–551.
- 6 Kersten RC, Tse DT, Anderson RL, Blodi FC. The role of orbital exenteration in choroidal melanoma with extrascleral extension. *Ophthalmology* 1985; **92**: 436–443.
- 7 Rini FJ, Jakobiec FA, Hornblass A, Beckerman BL, Anderson RL. The treatment of advanced choroidal melanoma with massive orbital extension. *Am J Ophthalmol* 1987; **104**: 634–640.
- 8 Starr HJ, Zimmerman LE. Extrascleral extension and orbital recurrence of malignant melanomas of the choroid and ciliary body. *Int Ophthalmol Clin* 1962; **2**: 369–385.
- 9 De Potter P, Shields JA, Shields CL, Santos R. Modified enucleation via lateral orbitotomy for choroidal melanoma with orbital extension: a report of two cases. *Ophthalm Plast Reconstr Surg* 1992; **8**: 109–113.
- 10 Weissgold DJ, Gragoudas ES, Green JP, Kent CJ, Rubin PA. Eye-sparing treatment of massive extrascleral extension of choroidal melanoma. *Arch Ophthalmol* 1998; **116**: 531–533.

AD Singh<sup>1</sup>, R Jacques<sup>2</sup>, PA Rundle<sup>2</sup>, HS Mudhar<sup>3</sup> and IG Rennie<sup>2,4</sup>

<sup>1</sup>Department of Ophthalmic Oncology, Cole eye Institute, Cleveland Clinic Foundation (i3-129), Cleveland, OH, USA

<sup>2</sup>Department of Ophthalmology, University of Sheffield, Sheffield, UK

<sup>3</sup>Department of Histopathology, University of Sheffield, Sheffield, UK

<sup>4</sup>Department of Royal Hallamshire Hospital, University of Sheffield, Sheffield, UK

Correspondence: AD Singh,  
Tel: + 216 445 9479;  
Fax: + 216 445 2226.  
E-mail: SinghA@CCF.Org

*Eye* (2006) **20**, 615–617. doi:10.1038/sj.eye.6701939;  
published online 17 June 2005

Sir,  
**Subconjunctival cilia**

Eyelashes have been documented as growing in anomalous lid locations including meibomian gland orifices<sup>1</sup> and burrowing beneath eyelid tissues—cilium incarnatum internum and externum.<sup>2</sup> A paucity of literature exists regarding ectopic lashes, particularly conjunctival cilia. Scarring of the mobile bulbar and forniceal conjunctiva encourages the formation of blind pockets in which lashes can become trapped.<sup>3</sup> We describe a case of cilia originating beneath the bulbar conjunctiva in a setting of previous intraocular surgery.

## Case report

An 81-year-old lady attended outpatients in August 2004, describing recurrent foreign body sensation in the right eye. Past history included surgery for right total retinal detachment and bilateral YAG laser iridotomies for angle closure glaucoma. Best-corrected acuity was counting fingers right, 6/18 left. Slit-lamp examination revealed ectopic eyelashes originating from beneath the healed conjunctival peritomy made at the previous retinal surgery. There were around 13 lashes near the temporal limbus, approximately 10 had their bases inferiorly, extending superiorly, the remaining ones started superiorly and projected downwards. One lay horizontally (Figure 1). The overlying conjunctiva was mildly injected. Lid position and cornea appeared normal, and other than nuclear sclerotic cataract, there was no pathology of the left eye.

Hospital records revealed that 5 days prior to retinal surgery in 1995, the patient had fallen and preoperatively had periorbital ecchymoses. A single cilium beneath the bulbar conjunctiva was first observed in the patient's right eye in November 1996 and epilated. Following this, she presented at yearly intervals in September 2001, October 2002, and October 2003, with irritation of the



**Figure 1** Subconjunctival cilia near temporal limbus of right eye.

right eye. Each time, multiple subconjunctival lashes in the temporal aspect were epilated.

In October 2004, the patient underwent conjunctivoplasty with *en bloc* removal of the lashes and cautery to the underlying sclera. So far, there has been successful resolution of symptoms.

### Comment

Ectopic cilia are rarely encountered. Some reports describe congenital lash tufts in the temporal aspects of upper eyelids.<sup>4,5</sup> Eyelashes have also been reported emerging from the iris *de novo* and following trauma.<sup>6</sup> The aetiology of the former remains uncertain, posteriorly located dermoids or teratomas have been postulated. In the latter case, displacement of lash follicles is felt to be causative.<sup>6</sup>

The few reports of subconjunctival cilia mainly concern single lashes<sup>1,7,8</sup> and include granuloma formation secondary to conjunctival embedding of a cilium<sup>7</sup> and dermolipomas allowing lash ingress to the conjunctiva.<sup>1</sup> To the authors' knowledge, there is only one other published report of ectopic cilia in the setting of previous intraocular surgery, that patient having had retinal surgery, pterygium removal, and cataract extraction.<sup>3</sup> In our case, given that the ectopic cilia were first observed 1 year following surgery, it is likely that displacement occurred perioperatively. The mechanism may have been a cumulative effect of the fall suffered by the patient preoperatively, and surgery. Following traumatic displacement of lash tissue to the conjunctiva, the peritomy folds gave recess for any dislodged follicles. The yearly recurrence contrasts with trichitic lash regrowth. This unusual case illustrates the need for such patients to be reviewed for recurrence necessitating surgical intervention.

### Acknowledgements

There are no proprietary interests and this work has never been published or presented elsewhere before.

### References

- 1 Gutteridge IF. Case Report. Curious cilia cases. *Clin Exp Optom* 2002; **85**(5): 306–308.
- 2 Belfort B, Bruce Ostler H. Cilia incarnata. *Br J Ophthalmol* 1976; **60**: 594–596.
- 3 Hunts JH, Patrinely JR. Conjunctival cilia entrapment: an unrecognized cause of ocular irritation. *Ophthalm Plast Reconstr Surg* 1997; **13**(4): 289–292.
- 4 Dagleish R. Case Notes. Ectopic cilia. *Br J Ophthalmol* 1966; **50**: 592–594.
- 5 Owen RA. Ectopic cilia. *Br J Ophthalmol* 1968; **52**: 280.
- 6 Mackintosh GIS, Grayson MC. Case reports. Atraumatic iris cilia. *Br J Ophthalmol* 1990; **74**: 748–749.
- 7 Kiesel RD. Conjunctival granuloma due to an imbedded cilium. *Am J Ophthalmol* 1961; **51**: 706–708.
- 8 Mathur SP. Cilia emerging through the conjunctiva. *Int Surg* 1968; **50**(1): 14–16.

S George and G Silvestri

Ophthalmology Department,  
Eye and Ear Clinic,  
Royal Victoria Hospital, Grosvenor Road, Belfast  
BT12 6BA, UK

Correspondence: S George,  
Tel: +44 2890240503;  
Fax: +44 2890330744.  
E-mail: sonja\_AC@yahoo.com

*Eye* (2006) **20**, 617–618. doi:10.1038/sj.eye.6701940;  
published online 27 May 2005

---

### Sir, Occurrence and reactivation of cytomegalovirus retinitis in systemic lupus erythematosus with normal CD4 counts

Cytomegalovirus retinitis is the most common opportunistic ocular infection in patients with acquired immune deficiency syndrome (AIDS), accounting for up to 30–40% of all ocular manifestations.<sup>1</sup> CMV retinitis is also known to occur in patients with rheumatic disease, postorgan transplant and leukaemia on immunosuppressive therapy. A strong risk factor for the development of CMV retinitis is a CD4<sup>+</sup> T-lymphocyte count of <50 cells/ $\mu$ l.<sup>2</sup> With counts greater than 100 cells/ $\mu$ l, reactivation or occurrence of this disease is unusual.<sup>2,3</sup> We report two cases of CMV retinitis in patients with systemic lupus erythematosus (SLE)