subconjunctival haemorrhages; however, the exact relationship was unclear. The specific concerns regarding resolution of this usually inconsequential event were pressure spikes and/or an associated dysfunctional bleb. Fortunately, neither complication occurred while the patient was being monitored.

FHC has a well-recognised association with hyphaema first described by Amsler.[5] Bloch *et al*[6] attempted to quantify Amlser's sign and found 60% FHC developed a hyphaema after parecentesis. Additionally, hyphaema can occur in these patients following minor trauma such as gonioscopy, applanation tonometry, and myadrasis.[7] Spontaneous hyphaema has been described; Liesegang reported 6.8% and Jones' 4% rates in FHC.[8,9] Given the association of FHC and hyphaema, it is plausible for the patient to have had a spontaneous hyphaema which tracked back into the bleb. However, this seems unlikely given the severity and simultaneous appearance of both the bleb haemorrhage and hyphaema.

Whatever the mechanism, spontaneity remains speculative as we cannot quantify the relationship between minor trauma (rubbing/wiping the eye), FHC and hyphaema, and in this case intrableb haemorrhage with antiplatelet therapy. The authors agree that it may in fact be a combination of all of the above.

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Sir,

Suprachoroidal silicone oil: recognition and possible mechanisms

Silicone oil (SO) was first used in the early 1960s by Cibis *et al*[1] and its use as a surgical tool since has increased surgical success rates. Suprachoroidal SO is a recognised complication of surgery.[2] We report two cases with suprachoroidal SO noted postoperatively following uneventful retinal reattachment surgery.

Case reports

Case 1

A 78-year-old myopic man presented with a superotemporal rhegmatogenous retinal detachment (RD) in his left eye. Visual acuities were 6/18 in the right eye and 6/9 in the left. The patient underwent pars plana vitrectomy (PPV), fluid–gas exchange using 20% sulphur hexafluoride and cryotherapy to the retinal break. The postoperative course was complicated by inferior RD and proliferative vitreoretinopathy (PVR), which were managed by PPV, membrane peel, and SO/air exchange.

At 10 days postoperatively, a localised choroidal elevation was noted inferotemporally. Anterior segment examination and intraocular pressures were normal and the retina was attached. An ultrasound scan (Figure 1a) showed that the elevated lesion had similar echogenicity to the SO in the vitreous cavity. After 3 months, the patient underwent 360° prophylactic laser, cataract extraction, and removal of SO. A repeat B scan (Figure 1b) showed a 'staphylomatous' profile in the corresponding area of choroidal elevation (Figure 2a). This artefact demonstrates the aqueous/SO interface as the velocity of ultrasound drops from approximately 1480 m/s in aqueous to 986 m/s in SO.[2]

Case 2

A 34-year-old man presented following blunt trauma to his right eye. He had undergone a penetrating keratoplasty in this eye 2 years previously for keratoconus. Visual acuities were hand movements (HM)

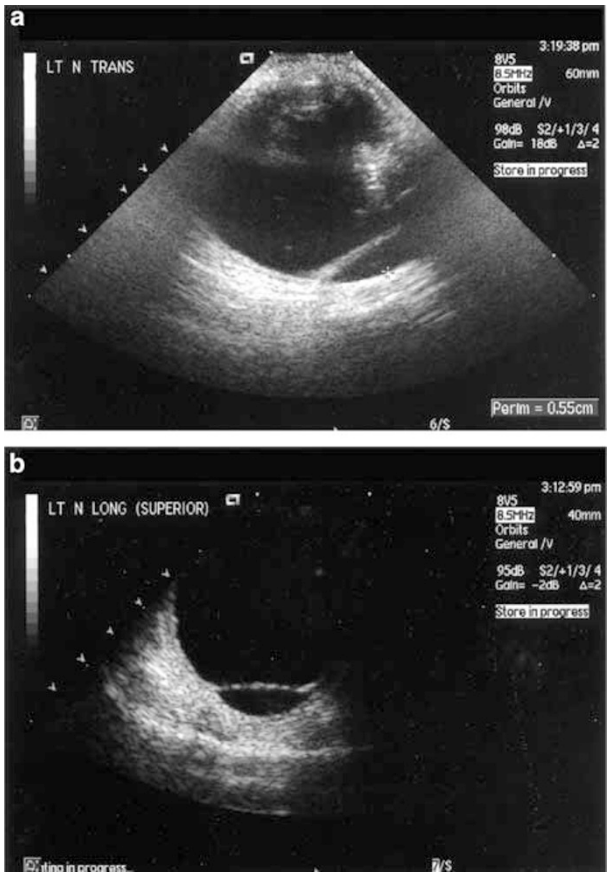

Figure 1 (a) Ultrasound scan of the left eye (case 1) prior to SO removal from the vitreous cavity shows similar echogenicity to the SO in the suprachoroidal cavity. (b) A difference in echogenicity is observed following SO removal.

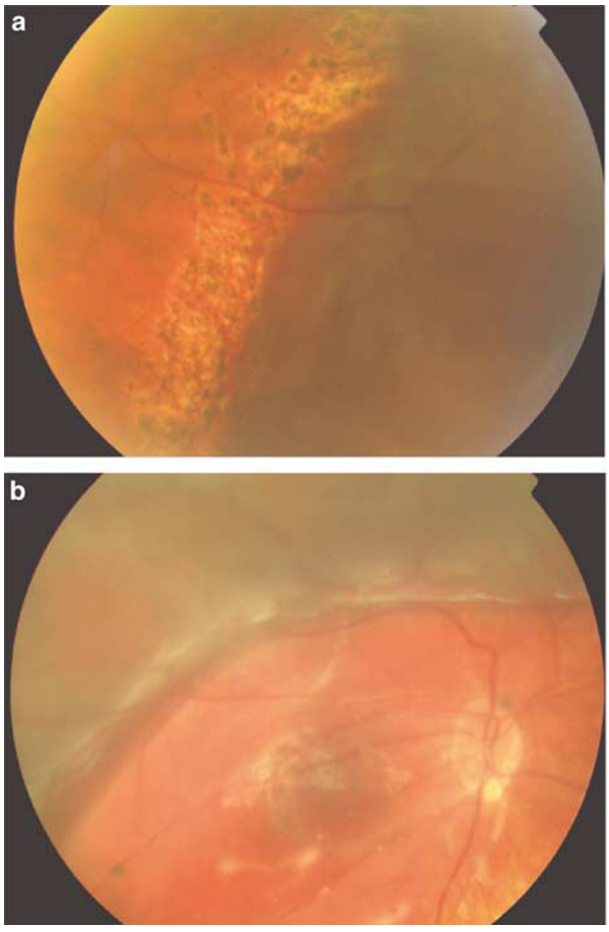

Figure 2 (a) Case 1—A colour fundus photograph of the left eye following removal of SO shows an elevation anterior to the laser scars. (b) Case 2—Fundus photograph of the right eye shows a marked superior elevation secondary to suprachoroidal SO.

in the right eye and 6/9 in the left. The corneal wound had dehisced with extrusion of the crystalline lens and iris tissue. Primary repair was performed by the referring surgeon. Following this, the anterior chamber had a subtotal hyphaema. An ultrasound scan revealed the presence of a total RD with nasal and temporal suprachoroidal haemorrhages. The patient underwent an anterior chamber washout, PPV, endolaser, and SO tamponade. The suprachoroidal haemorrhage persisted after the surgery.

A recurrent inferior RD and PVR developed 2 months later. This was managed by 360° retinectomy, epiretinal membrane dissection, and further SO exchange, combined with a temporary keratoprosthesis, and a penetrating keratoplasty. A superior suprachoroidal elevation was noted at the first postoperative visit 2 weeks after surgery (Figure 2b). Continued epiretinal traction combined with a firm chorioretinal adhesion (from laser retinopexy) had pulled open a rent between the choroid and sclera. B scan ultrasound showed this elevation to have similar echogenicity to the SO in the vitreous cavity. The eye remained stable for 2 years thereafter with SO *in situ*.

Comment

Choroidal effusion and suprachoroidal haemorrhage are well-documented complications of posterior segment surgery and may have a similar clinical appearance to suprachoroidal SO. In both cases, a B scan confirmed the presence of SO by demonstrating the difference in velocity of ultrasound between SO and aqueous.

The mechanism by which the silicone entered the suprachoroidal space is speculative. In Case 1, an incorrectly placed infusion cannula could have initiated the passage of oil, but would have become apparent during the early stages of the procedure. Under normal circumstances, hydrostatic pressure in the suprachoroidal space is equal to intraocular pressure.[3] Thus transient hypotony towards the end of the procedure could have

also caused a local choroidal detachment, allowing the tip of the infusion cannula to enter the suprachoroidal space. Hence, care should be taken in maintaining the position of the infusion cannula as well as avoiding hypotony.

In Case 2, suprachoroidal SO developed postoperatively over a period of time. Epiretinal traction adjacent to the choroidal elevation appeared to have initiated a separation between the choroid and the sclera, allowing egress of SO into the suprachoroidal space. Effects of SO on the retina remain controversial;[4,5] however, there are no reported toxic effects on the choroid. No further surgery to remove the suprachoroidal oil has been undertaken due to poor general health (case 1) and poor visual prognosis in both cases. Neither case has shown any adverse effects from the presence of suprachoroidal SO to date. Surgical removal of SO however, may be performed via an external approach should signs of retinal toxicity develop as assessed by serial electrodiagnostic tests.

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Sir,

Wegener's granulomatosis and mucous membrane pemphigoid: a diagnostic challenge of coexisting autoimmune disease

Wegener's granulomatosis (WG) is characterised as one of the ANCA-associated small vessel vasculitides and is not typically recognised as a disorder causing a cicatrising conjunctivitis.[1] Mucous membrane pemphigoid (MMP) is a systemic autoimmune disease of progressive scarring of the mucous membranes. To our knowledge, occurrence of these two diseases, simultaneously, has been reported once previously [2] with the indication that ocular involvement marked uncontrolled systemic autoimmune activity.

Case report

A 46-year-old African lady with a history of haemoptysis and atypical asthma complained of decreased vision in the left eye. Previous investigations for an underlying vasculitis had been negative. Multiple episodes of red sticky eyes had been noted by the physicians in the past and ophthalmic examination revealed bilateral giant conjunctival papillae with extensive ulceration, left lower conjunctival fornix shortening, and temporal anklyloblepharon with restriction of horizontal ocular movements (Figure 1a, b). Lid and lash position were normal and intraocular examination showed a cataract in the left eye. Clinical examination suggested MMP; however, there was no effacement of the caruncle. A conjunctival biopsy demonstrated no evidence of granulomatous inflammation, giant cells or vasculitis, however, autofluoresence study showed linear basement membrane immunoglobulin deposition (Figure 2a, b) consistent with MMP.

At the same time she had developed severe sinus congestion, recurrent heavy epistaxsis and dyspnoea and was under investigation by the otolaryngologists. Blood parameters revealed strongly positive serum cytoplasmic antineutrophil cytoplasmic antibody (cANCA) and nasal endoscopy showed active sinusitis with a small granuloma in left Little's area. She has a working diagnosis of limited WG with coexisting MMP.

She was pulsed with intravenous methyl prednisolone 1000 mg, started on cyclophosphamide 200 mg and oral steroids. She had immediate relief of nasal congestion and epistaxsis with gradual reduction of ocular surface inflammation with normalisation of cANCA levels.

Comment

Limited WG (which does not affect the major organs) has a strong and specific association with autoantibodies directed against proteinase 3 a constituent of neutrophil