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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AK Patel, HJ Zambarakji, DG Charteris and PM Sullivan

Moorfields Eye Hospital, 162 City Road, London EC1V 2PD, UK

Correspondence: AK Patel,
Department of Ophthalmology,
HM Stanley Hospital, St Asaph,
Denbighshire LL17 0RS, UK
Tel: +44 1745 583910;
Fax: +44 1745 589770.
E-mail: amitpatel@doctors.org.uk

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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

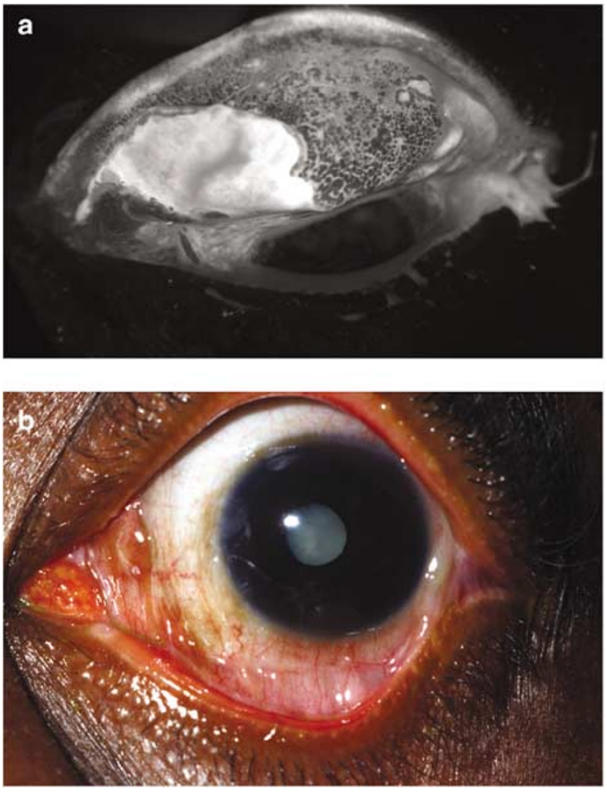

Figure 1 (a) Area of ulceration highlighted with fluoroscein staining, on superior subtarsus conjunctiva, left eye. (b) Colour photographs showing inferior cicatrisation and temporal ankyloblepharon of conjunctiva, with mature cataract, left eye.

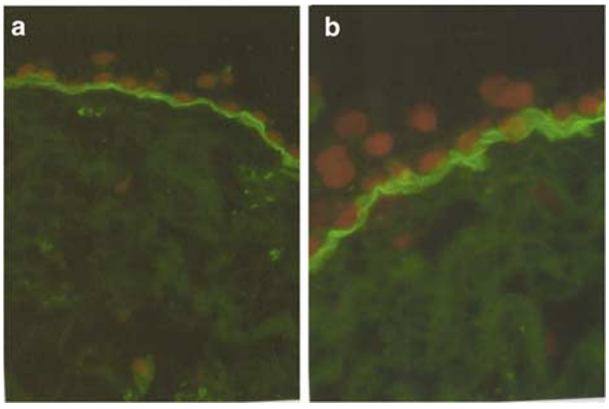

Figure 2 (a) Immunofluorecense study of conjunctival biopsy, snap frozen tissue, stained with fluorescein labelled anti-human IgG demonstrating linear deposition of IgG in the basement membrane zone. (b) Imuunofluorecense study of conjunctival biopsy, snap frozen tissue, stained with fluorescein-labelled anti human IgA demonstrating linear deposition of IgA in the basement membrane zone.

azurophilic granules.[3] Previous identification of T cells in vessel walls points towards the pathogenesis being cell mediated.[4] In all, 8–16% of new cases present with ocular involvement[5] but overall orbital pseudotumors and scleral/corneal ulcerations are the most frequent presentations. Tarso-conjuctival disease is an uncommon clinical characteristic most commonly affecting the upper palpebral region,[4] however, classic symblephara and fornix shortening has been described.[4,6]

Clinically MMP is characterised by hyperaemia, acute inflammation, blisters, and ulceration (suggesting active, aggressive disease[1]) with the primary process not affecting the cornea but rather the conjunctiva. Autoantibodies to the basement membrane zone at the epithelial–subepithelial junction of mucous membranes characterise this disease with laminin[7] and integrin[8] proposed as antigens, initiating a type II hypersensitivity reaction in the transmembrane hemidesmosomal area in the lamina lucida leading to subepithelial fibrosis, extensive xerosis and ultimately visual loss.

Both conditions involve the presence of circulating autoantibodies; however, the immunopathogenic mechanisms differ, suggesting that two disease processes are occurring in this patient. Fortunately in this case treatment of both conditions requires potent systemic immunosuppressive therapy but we stress, whenever possible, the importance of a tissue diagnosis.

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SP Shah and G Larkin

Department of Ophthalmology, Kings College Hospital, Denmark Hill, London, UK

Correspondence: SP Shah,
Ophthalmology Department, Kings College Hospital, Denmark Hill, London SE 16, UK
Tel +44 7973 662745;
Fax: +44 207 3285162.
E-mail: shaheen_shah@hotmail.com

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Sir,

Staining of filtering bleb with trypan blue during phacoemulsification

We describe the inadvertent staining of the filtering bleb caused by the use of trypan blue during phacoemulsification in an eye that had previously undergone a trabeculectomy.

Case report

A 28-year-old man with juvenile open-angle glaucoma had undergone trabeculectomy with mitomycin C. The patient presented to us after 6 months with poor vision in his right eye. The patient had a best-corrected visual acuity of 20/200 OD and 20/40 OS. The intraocular pressure (IOP) was 14 mmHg OD and 16 mmHg OS. He had an anterior subcapsular cataract in the right eye (records indicated a shallow anterior chamber in the initial postoperative period), while the left eye lens was clear. Diffuse, elevated, avascular microcystic blebs were noted in both the eyes. The vertical cup-disc diameter ratio was 0.8 : 1 OD and 0.7 : 1 OS.

During cataract surgery, anterior capsular staining was carried out with 0.1 ml of 0.06% trypan blue to enhance the capsule visibility during the capsulorhexis. Staining of the filtering bleb with passage of dye into the bleb was noted. The patient underwent uncomplicated phacoemulsification, followed by implantation of an Acrysof® single piece intraocular lens.

On the first postoperative day, the best-corrected visual acuity was 20/30 OD with an IOP of 14 mmHg. Diffuse staining of the filtering bleb was noted (Figure 1). The staining faded away and was barely visible at 2 weeks follow-up. There was no change in the bleb characteristics as compared to the preoperative status.

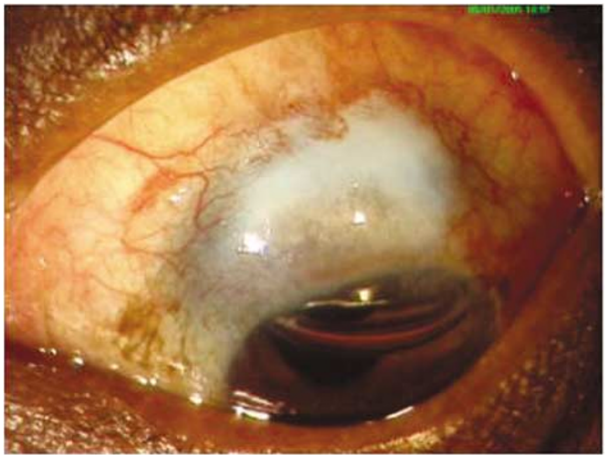

Figure 1 Trypan blue-stained filtering bleb on the first postoperative day after phacoemulsification.

Comments

The present report highlights a benign complication of capsular staining, which is routinely used to aid in the visualization of the anterior capsule during phacoemulsification.[1,2] The surgeon needs to inform the patient preoperatively about the use of the dye and the possibility of transient bleb staining in the postoperative period.

Bleb function may be assessed by slit-lamp examination, by ultrasound biomicroscopy, or indirectly by the control of IOP.[3,4] The inadvertent staining of the bleb as seen in the present case may provide a clue to the adequacy of aqueous drainage through the filter and further studies should be conducted to test this hypothesis.

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T Dada, R Muralidhar and HS Sethi

Dr Rajendra Prasad Centre for Ophthalmic Sciences, All India Institute of Medical Sciences, New Delhi, India