made. The signs and symptoms resolved within the next two days. No evidence of trichisis or distichiasis was observed in either eye.

Comment

Unusual location of cilia, which have settled after falling out of their follicles or have misdirected during their growth, may cause diagnostic difficulty unless carefully looked for. The likely mechanism relates to mechanical factors like rubbing or negative pressure produced by blinking. The latter has been suggested to explain the strange occurrence of cilia in the lacrimal puncta.[2] Gutteridge *et al*[3] in their series of four patients reported one case of lash in the meibomian gland orifice. Agarwal *et al*[4] observed two symptomatic cases with cilia embedded in the meibomian gland orifice. In the present case preoperative trimming of cilia along with the mechanical action of cleaning the lid margin may have resulted in the cilia firmly embedding in the gland orifice.

The normal lash must be differentiated from distichiasis where the lashes are shorter, thinner, and less pigmented.[3] Our patient had a single lash which resembled normal cilia. But here the tip of the cilium was inside the meibomian gland tract and the trimmed end was projecting out. Careful slit-lamp examination to rule out any lid margin abnormality should be a part of the preoperative examination.

Although such cases have been reported in the literature before, we would like to highlight the fact that a cilium lodged in the meibomian gland can mimic the symptoms of endophthalmitis and should carefully be looked for in postoperative cases of phacoemulsification which present with unusual symptoms of pain and foreign body sensation where intraocular examination is normal. Trimming of eyelid cilia should preferably be avoided preoperatively.

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Sir,

A case of bilateral Adie's pupil following acute pancreatitis

We report a case of bilateral Adie's pupil with bilateral facial nerve palsy, following acute pancreatitis, which has not been previously reported.

Case report

A 41-year-old in-patient with gallstone pancreatitis was referred to ophthalmology with blurred vision and red eyes. On examination he had bilateral acute anterior uveitis. He was started on G.dexamethasone 0.1% and G.cyclopentolate 1% for both eyes. Overnight he developed bilateral facial nerve palsies, and was further investigated for sarcoid by MRI, lumbar puncture, CXR and CT thorax, and serum/CSF ACE. These results were negative, as were investigations for Lyme disease and syphilis. The patient was later discharged, but was readmitted with a recurrence of pancreatitis. On review his facial nerve palsies had improved. VA was 6/5 bilaterally; pupils were dilated with no reaction to light but a slow accommodation response. After 4 weeks, the patient's facial nerve palsies had completely resolved. VA was 6/6 bilaterally, his right pupil was 6.5 mm and unresponsive to light. His left pupil was 6.2 mm with a sluggish light response and segmental vermiform iris movement. Pilocarpine 0.125% was instilled into both eyes and the pupils rechecked after 25 min. Both pupils had constricted significantly, and the patient reported an improvement in near vision. In the absence of other pathology, a diagnosis of bilateral Adie's pupil was made.

Comment

Reported causes of Adie's pupil include infection,[1] inflammation,[2] ischaemia, anaesthesia, toxicity,

neuropathy,[3] tumours,[4] and trauma.[5] In this case the bilateral Adie's pupil developed with bilateral facial nerve palsies. Such palsies may be a result of sarcoidosis, Guillain-Barré syndrome, Lyme disease, syphilis, Epstein–Barr infection, malignancy, or leprosy. The most likely link between pancreatitis, bilateral facial nerve palsies and Adie's pupil is sarcoidosis, although in this case tests were negative. A less likely possibility is Guillain-Barré of the cranial nerves (polyneuritis cranialis[6]), although CSF protein was normal and the patient denied autonomic symptoms. A third possibility is syphilis[7] but again, investigations were normal.

No direct link has been reported between a facial nerve palsy and Adie's pupil. There are, however, a number of viruses known to cause one or the other. We postulate that there could be an underlying viral aetiology linking all three conditions. Although, at first glance, the pancreatitis seems to be due to gallstones, it may be exacerbated by infection with an enterovirus, mumps virus, cytomegalovirus or herpes simplex virus. Enteroviruses, particularly, are well known for their manifestations in the alimentary canal and the central nervous system.

In this case the patient was not investigated for a viral infection, but it highlights the need to consider viral causes for unusual presentations of common problems.

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Sir,

Spontaneous regression of choroidal melanoma

A case of spontaneous regression of the melanoma is presented.

Case report

A 56-year-old female was referred to Ocular Oncology service, complaining of photopsiae in the left eye for 4 months. She had no significant past ocular or systemic problems. On examination, her visual acuity was 6/6 in both eyes. Anterior segment examination and intraocular pressure were normal in both eyes. Fundus examination was normal in the right eye. In the left eye, there was an amelanotic lesion $9 \times 9 \times 3.7\,mm^3$ superonasal to disc. There was overlying serous detachment and some superficial haemorrhages (Figure 1a). She was previously seen in the referring hospital 8 years ago, and the fundus was normal in her left eye at that time.

Fundus flourescein angiography (FFA) showed intrinsic vascularity in the lesion (Figure 1e). The B-scan was showing dome-shaped lesion with acoustic hollowness and absence of choroidal excavation (Figure 1c), with low-medium internal reflectivity on A-scan (Figure 1d) and intrinsic vascularity. A provisional diagnosis of choroidal melanoma or choroidal metastasis was made and she was extensively investigated for primary lesion. FBC, LFT including gamma GT, mammography, and X-ray of the chest were normal. CT thorax was showing a small nodule in the left lobe of the thyroid, but there was absence of lymphadenopathy. A fine-needle aspiration biopsy of the lesion confirmed that it was benign. CT abdomen was showing gall stones and a small cyst in the right ovary. The diagnosis at this stage was changed to a choroidal melanoma. Plaque radiotherapy was considered as a treatment option at this stage, but as it would compromise the vision the patient decided to wait till there was definite evidence of growth.

It was decided to observe the lesion and the patient was reviewed closely in the eye clinic; 8 months after her initial visit the exudation started resolving, with decrease in the size of the lesion confirmed on B scan ultrasound.