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.

References

1 Sakai T, Shikishima K, Mizobuchi T, Yoshida M, Kitahara K. Bilateral tonic pupils associated with neurosyphilis. *Jpn J Ophthalmol* 2003; **47**(4): 368–371.
2 Faroozan R, Buono L, Savino P, Sergolt R. Tonis pupils from giant cell arteritis. *Br J Ophthalmol* 2003; **87**(4): 510–512.
3 Lee AG, Brazis PW. Clinical pathways in neuroophthalmology. *Thieme* 1998; **1**: 362–364.
4 Wabbels BK, Efflienh H, Lorenz B, Kelling G. Bilateral paraneoplastic manifestation of small cell lung carcinoma. *Ophthalmologica* 2004; **218**(2): 141–143.
5 Thompson HS. Adie's syndrome: some new observations. *Trans Am Ophthalmol Soc* 1977; **75**: 587–626.
6 Anzai T, Uematsu D, Takahashi K, Katayama T. Guillain-Barre syndrome with bilateral tonic pupils. *Intern Med* 1994; **33**(4): 248–251.
7 Becker V, Sturmer J. Granuloma of the pancreas. *Leber Magen Darm* 1987; **19**(4): 198–207.

KGH Bailey and TRG Poole

Frimley Park Hospital, Portsmouth Rd, Frimley, Camberley, Surrey GU16 7UJ, UK

Correspondence: KGH Bailey,
Tel: +44 1276 604604;
Fax: +44 1276 604149.
E-mail: kevinghbailey@ntlworld.com

Eye (2006) **20,** 958–959. doi:10.1038/sj.eye.6702067;
published online 5 August 2005

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.

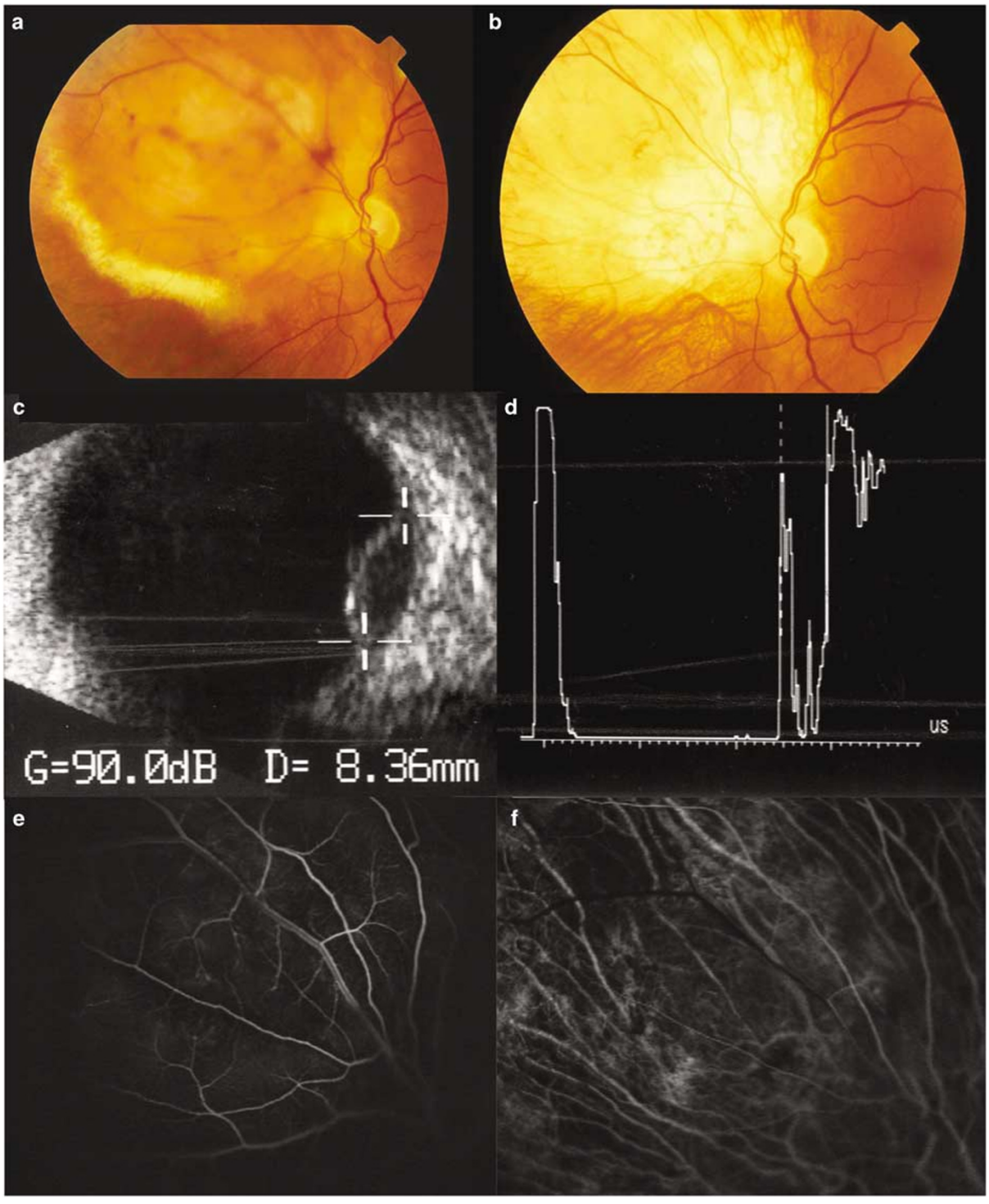

Figure 1 (a) Coloured fundus photograph on presentation, showing the raised lesion with hemorrhage and serous retinal detachment. (b) Coloured fundus photograph 12 months after initial presentation, showing resolution of the melanoma with residual chorioretinal degeneration. (c) B-scan ultrasound at presentation, showing a choroidal lesion with acoustic hollowness. (d) A scan at presentation, showing low internal reflectivity. (e) FFA at presentation, showing masking and intrinsic vascularity in the lesion. (f) FFA at 12 months, showing chorioretinal atrophy (window defect).

This was followed by regression of the melanoma other than a small central nodule. Over the next 4 months, the lesion regressed slowly. At 1 year after the initial presentation, it had regressed to a small melanoma ($1 \times 1 \times 1\,mm^3$) with chorioretinal scarring around (Figure 1b). FFA at this stage showed chorioretinal atrophy (window defect) with underlying choroidal vessels, with the absence of intrinsic vascularity (Figure 1f).

The patient has been followed up in the eye clinic for the last 3 years, with no recurrence of the choroidal melanoma.

Discussion

Spontaneous regression of choroidal melanomas is quite rare.[1] It has been well documented with several other tumours, including cutaneous melanomas.[2] Most tumours that undergo either partial or complete[3] spontaneous regression eventually recur.[2] Complete resolution of one melanoma with a new tumour in the same eye has also been reported.[6] In cases of cutaneous melanomas, regression is associated with depigmentation clinically and degenerative tumour cells with inflammatory cells histologically.[4]

Shields *et al*[5] have reported three cases of incomplete spontaneous regression of choroidal melanomas in more than 8000 patients, with choroidal melanoma with all of them needing further management.

The possible mechanism of regression of tumours is not certain. The possibilities include hormonal influences, immunological factors, tumour cell necrosis, and inhibition of angiogenesis.[2]

In our case, at initial presentation choroidal metastasis was considered as a differential diagnosis, but the diagnosis was changed to melanoma based on the A and B scan appearance, fundus fluorescein angiography, and the absence of a systemic primary. Inflammatory aetiology was less likely as there was no vitreous activity, with the absence of any signs of inflammation in the contralateral eye. Choroidal excavation was absent, though this may be difficult to demonstrate in small melanomas.

This case illustrates an uncommon presentation of a small choroidal melanoma where the tumour regressed on observation over a 12-month period, with no recurrence of the tumour.

References

1 Lambert SR, Char DH, Howes Jr E, Crawford JB, Wells J. Spontaneous regression of a choroidal melanoma. *Arch Ophthalmol* 1986; **104**(5): 732–734.

2 Challis GB, Stam HJ. The spontaneous regression of cancer: a review of cases from 1900 to 1987. *Acta Oncology* 1990; **29**: 545–549.

3 Williams DF, Mieler WF, Lewandowski M. Resolution of an apparent choroidal melanoma. *Retina* 1989; **9**(2): 131–135.

4 Nathanson L. Spontaneous regression of malignant melanoma: a review of literature on incidence, clinical features and possible mechanisms. *Natl Cancer Inst Monogr* 1976; **44**: 67–76.

5 Shields CL, Shields JA, Santos MC, Gunduz K, Singh AD, Othmane I. Incomplete spontaneous regression of choroidal melanoma associated with inflammation. *Arch Ophthalmol* 1999; **117**(9): 1245–1247.

6 Holck DE, Dutton JJ, Pendergast SD, Klintworth GK. Double choroidal malignant melanoma in an eye with apparent clinical regression. *Surv Ophthalmol* 1998; **42**(5): 441–448.

A Jain, M Gupta, PA Rundle and IG Rennie

Department of Ophthalmology, Royal Hallamshire Hospital, Sheffield, UK

Correspondence: M Gupta,
Department of Ophthalmology,
Royal Hallamshire Hospital,
Glossop Road, Sheffield S10 2JF, UK
Tel: +44 11 42711900;
Fax: +44 11 42713747.
E-mail: mohiteye@yahoo.co.uk

Eye (2006) **20,** 959–961. doi:10.1038/sj.eye.6702071;
published online 5 August 2005

Sir,

Smouldering ROP

This letter reports an interesting variation of the abnormal vascularization, that is characteristic of the retinopathy of prematurity (ROP). A male infant of birth weight 1700 g and gestational age 34 weeks born after a normal delivery and given oxygen for a day, was screened for ROP at 37 weeks postconceptional age. On examination, the retinal vascularization stopped short at $\frac{1}{2}$ disc diameter from the nasal ora serrata and 4 disc diameters from the temporal ora serrata in both the eyes. Examination of the right eye revealed an area of preretinal haemorrhage (Figure 1a) with a new vessel in the superotemporal quadrant in zone I close to the arcade. There was questionable plus disease. Examination of the left eye showed mild plus disease with few small superficial haemorrhages in the