haemorrhage remained unchanged following drainage of the sub-ILM haemorrhage. A macular 'double ring' sign can be a clinical indicator of a sub-ILM and subhyaloid haemorrhage occurring concurrently.

Acknowledgements

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Sir,

Bronchial carcinoid tumour with choroidal metastasis masquerading as ocular tuberculosis

Ocular tuberculosis can have variable clinical manifestations and occasionally masquerade as an intraocular or epibulbar tumour.[1] Diagnosing ocular tuberculosis is difficult and relies on clinical findings, biopsy of the lesion, or polymerase chain reaction of vitreous or aqueous aspirate and presence of systemic disease with a high degree of suspicion in the developing countries.[2]

We present an unusual case of a bronchial carcinoid tumour, with choroidal metastasis masquerading as ocular tuberculosis.

Case report

A 14-year-old boy was referred with a diagnosis of bilateral choroidal tuberculoma with serous retinal detachment (RD). The child had diminution of vision in both eyes since 4 weeks from presentation, with difficulty in breathing. Past records documented BCVA of 5/200 OD and 20/50 OS with bilateral choroidal mass and serous RD. Based on a chest X-ray finding of mediastinal lymphadenopathy, right lower lobe pneumonitis, and a positive Mantoux reaction (18×15 mm), the child was started on antitubercular therapy (isoniazid, rifampicin, ethambutol, and pyrazinamide). As there was deterioration in the systemic and ocular symptoms and signs, the child was referred to us.

The child had a BCVA of light perception OD and 20/50 OS. There was bullous serous RD in the right eye with a large orangish choroidal mass in the superior quadrant, and a choroidal mass in the infero-temoral quadrant in the left eye with surrounding serous RD. (Figure 1a, b). Ocular ultrasonography revealed a solid lesion in both the eyes with medium internal reflectivity without choroidal excavation or orbital shadowing (Figure 1c), and fluorescein angiography demonstrated early hyperfluorescence with late staining (Figure 1d). The size of the choroidal mass was 16*12*5 mm OD and 12*8*4 mm OS. A contrast-enhanced CT scan of the chest and abdomen revealed mediastinal lymphadenopathy with a soft tissue nodule in the bronchus intermedius, collapse of the right lower lobe and multiple hypodense lesions in the liver. (Figure 2) Ultrasound-guided FNAB of the liver nodule showed cells consistent with carcinoid tumour. Although there was no history of facial flushing and diarrhoea, urinary 5-hydroxyindoleacetic acid levels were elevated. The child underwent bronchoscopy-guided tumour resection, and was started on a chemotherapy of 5-Fluorouracil and Streptozocin, with transpupillary thermotherapy (TTT) in both eyes. At the 5-month follow-up, there was a decrease in the tumour

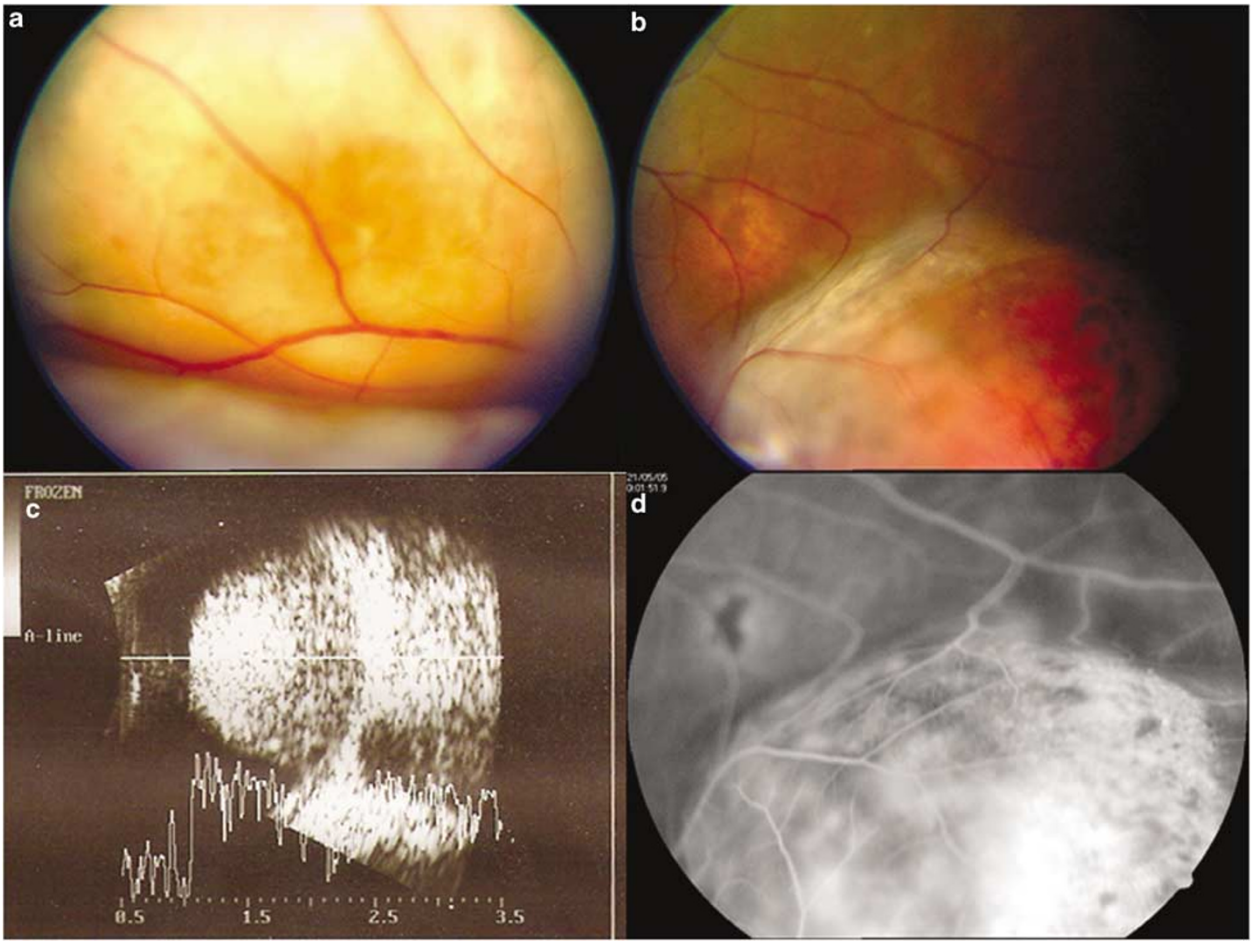

Figure 1 (a) Fundus photograph of the right eye, with bullous serous retinal detachment (RD) and a large orangish choroidal mass in the superior quadrant. (b) Fundus photograph of the left eye with choroidal mass in the infero-temoral quadrant with surrounding serous RD. (c) Ocular ultrasonography A and B scan showing a solid lesion with medium internal reflectivity without choroidal excavation or orbital shadowing. (d) Fluorescein angiography demonstrating early hyperfluorescence with late staining in the left eye.

size (8*6*2 mm OD and 5*3*1.5 mm OS) and serous RD in both the eyes with a BCVA of 20/200 OD and 20/40 OS, and the child was systemically stable.

Comment

Carcinoid tumours arise from neuroendocrine tissue, mostly from the bronchial or gastrointestinal tract, with choroidal metastasis usually originating from bronchial carcinoid tumours.[3,4] The most common site of metastasis is the liver, although a uveal metastatic carcinoid can be the initial finding of the systemic disease. Establishing the correct diagnosis of such choroidal tumours can be challenging, and often results in misdiagnosis. In our case also, keeping in mind the endemic status, a positive tuberculin test and chest findings, the child was started on antitubercular chemotherapy. Possibly, a more thorough systemic evaluation of the patient with ultrasonography and CT scan could have led to a diagnosis of choroidal metastasis.

In view of the large choroidal metastasis, serous RD and liver metastasis, a combination of local resection, chemotherapy, and TTT was performed. Combination is considered to be an active regimen of therapy when chemotherapy is judged to be an option for selected patients with carcinoid tumours with improved survival with a combination of 5-Fluorouracil and Streptozocin.[5] The advantages of transpupillary thermotherapy are the low cost of treatment, low lateral spread of heat into adjacent tissues and optimal tissue penetration, with low absorption by clear ocular media.[6] It is possible that the choroidal tumours responded to chemotherapy rather than TTT in the present case.

To conclude, although tuberculosis is very common in the developing countries, with a high index of suspicion,

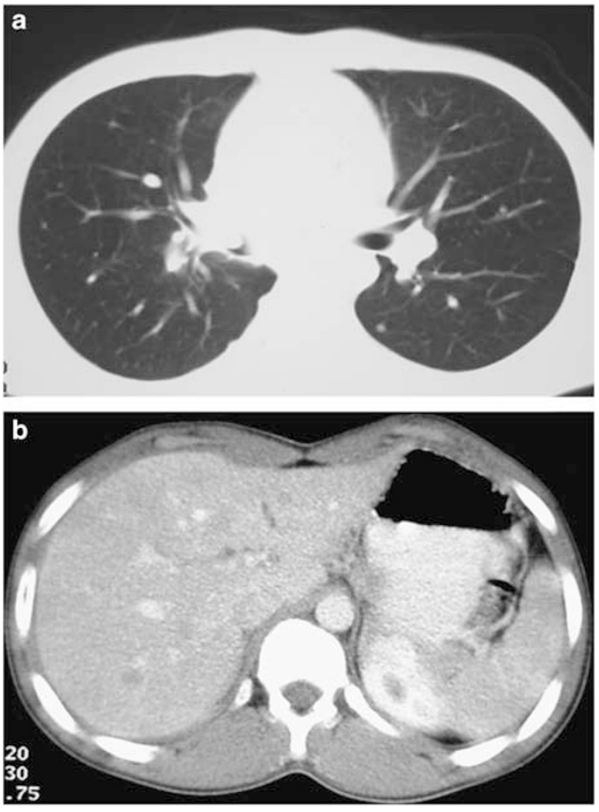

Figure 2 (a) Contrast-enhanced CT scan of the chest showing mediastinal lymphadenopathy with a soft tissue nodule in the bronchus intermedius. (b) Contrast-enhanced CT scan of the abdomen showing multiple hypodense lesions in the liver.

ophthalmologists must perform a complete systemic workup to rule out life-threatening choroidal metastasis even in the adolescent age group.

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Sir,

Congenital eyelid imbrication syndrome

Eyelid imbrication syndrome is a rare cause of congenital eyelid malposition characterised by overriding of the upper eyelids on the lower lids.[1] In the adult, eyelid imbrication is usually associated with floppy eyelid syndrome, and is managed by surgical tightening of the upper lid.[2] In children, eyelid imbrication is extremely rare with only a single previously reported congenital case.[1] Here, we describe a second case of congenital eyelid imbrication in an otherwise healthy neonate presenting with overriding upper lids on eyelid closure and also spontaneous upper lid eversion.

Case report

A full-term newborn male of Indian origin was referred 48 h postpartum with sticky eyes and apparent 'entropion' of both lower eyelids. The pregnancy and