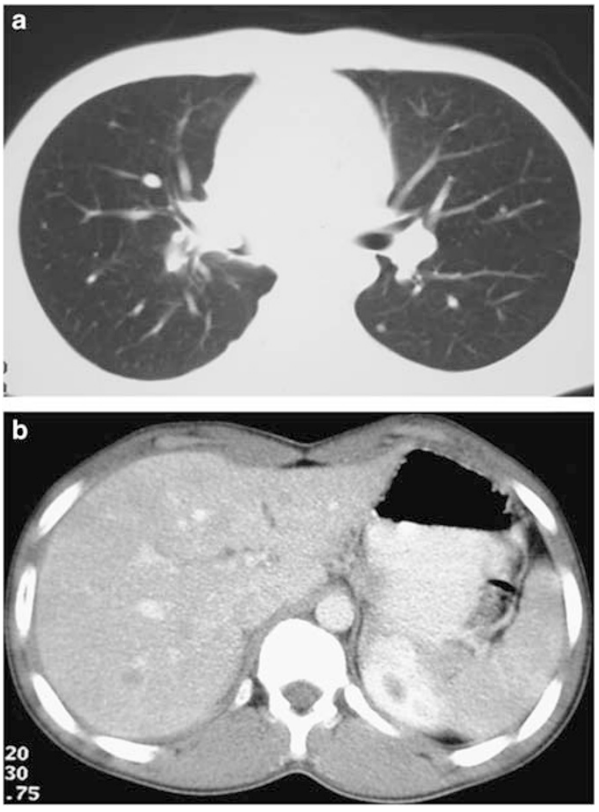

Figure 2 (a) Contrast-enhanced CT scan of the chest showing mediastinal lymphadenopathy with a soft tissue nodule in the bronchus intermedius. (b) Contrast-enhanced CT scan of the abdomen showing multiple hypodense lesions in the liver.

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

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None of the authors have any proprietary interests in the manuscript

Eye (2006) **20,** 1101–1103. doi:10.1038/sj.eye.6702139; published online 4 November 2005

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

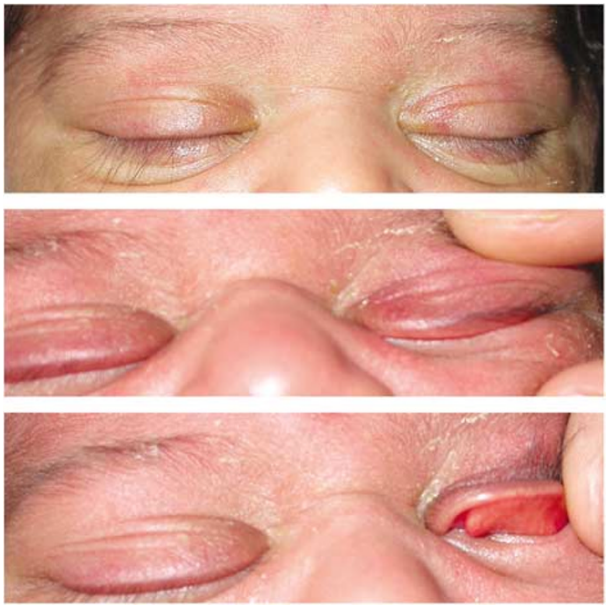

Figure 1 A newborn neonate with bilateral eyelid imbrication syndrome. Large and elongated upper lids/tarsal plates overlapped the lower lid margins by over 1 mm. The upper eyelids were 'floppy' and could be everted with minimal effort or did so spontaneously with forceful orbicularis oculi contraction.

birth were unremarkable apart from minimal olighydramnios noted at 20 weeks gestation. Ocular examination of the child asleep showed elongated upper lids and tarsal plates overlapping the lower lid margins by more than 1 mm (Figure 1). Horizontal and mid-point vertical dimensions of the upper lids were 25 and 8 mm respectively. In addition, the upper eyelids were 'floppy' and could be everted with minimal effort or did so spontaneously with forceful orbicularis oculi contraction. The subtarsal conjunctiva showed minimal hyperaemia and few papillae. Conjunctival swabs showed no microbial growth. The patient was managed with topical lubricants and antibiotic prophylaxis. At 2 months postpartum there was marked improvement in lid position with reduced overriding and absence of spontaneous eversion.

Comment

Eyelid imbrication is typically acquired in adults over the age of 40, with only one previous report of the condition in a neonate.[1,2] Here we describe a second congenital case, which in addition displayed spontaneous upper lid eversion on forceful contraction of orbicularis oculi. This striking feature is reminiscent of floppy lid syndrome, and was notably absent from the case reported by Rumelt *et al*.[1] In both cases of congenital imbrication, natural resolution occurs with apparent tightening of the upper canthal ligaments. Congenital eyelid imbrication syndrome is thus an unusual, apparently isolated and transient eyelid abnormality, which resolves within the first few months of age. Surgical management of this condition is not required.

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Eye (2006) **20,** 1103–1104. doi:10.1038/sj.eye.6702141; published online 24 March 2006

Sir,

Expanding role of local anaesthesia in vitreoretinal surgery

We read with interest the above analysis of local anaesthetic (LA) usage for vitreoretinal (VR) surgery in Southampton and wish to make several comments. The paper describes a 20.2% sedation rate (35.9% in ages under 35 years). A retrospective database analysis of our last 500 VR cases from mid-2003 shows 380(76%) performed under LA without an anaesthetist present, 55(11%) with an anaesthetist present, and 70(14%) under general anaesthetic. Our LA method is an 8 ml 50 : 50 mix of lignocaine 2% and bupivocaine 0.5% administered with a blunt cannula into the subtenon space. We have found this to provide excellent analgesia and akinesia without any need for sedation. This also reduces the risk