preoperative counselling, especially in those who participate in sports with a high risk of ocular injury.

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Sir,

Eccentric macular hole formation associated with macular hole surgery

Eccentric macular hole formation has been recently described as a complication of macular hole surgery. We have also experienced this complication following epiretinal membrane peeling surgery, suggesting that the development of this entity reflects is related to generic surgical trauma occurring at the posterior pole.

Case report

Rubinstein *et al*[1] describe an interesting complication following macular hole surgery, namely the development of an eccentric macular hole. They speculate that the hole develops as a consequence of operative trauma, mostly likely as the result of elevation of the ILM. They note that the four cases in their series had stable outcomes and did not require further intervention.

We have noted a similar complication following epiretinal membrane peeling and found the risk appears higher in eyes operated on by vitreoretinal fellows and have called this

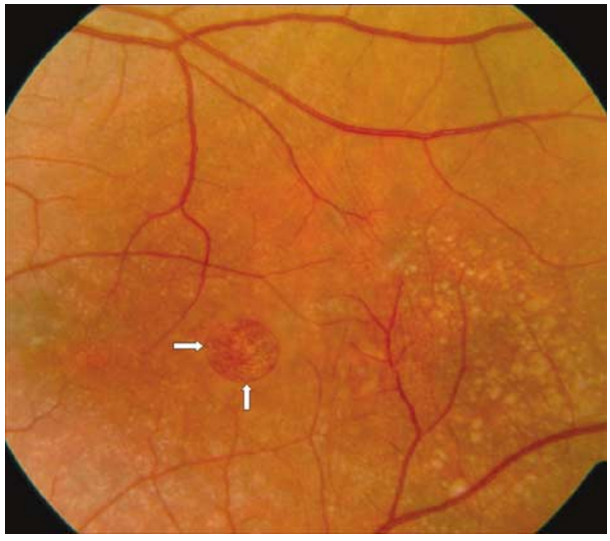

Figure 1 Full thickness macular defect following epiretinal membrane peel.

syndrome 'fellow eye syndrome'. We too believe this complication arises as a result of surgical trauma. The patients in our series did not have fluid–air exchange and vital dyes were not used, suggesting that the injury results from excessive manipulation of the epiretinal membrane.

In our series of four eyes, one patient developed two distinct full-thickness eccentric macular defects. Another two eyes developed macular defects in the presence of extensive drusen, suggesting that outer retinal degenerative changes may increase the risk of eccentric macular hole formation (Figure 1).

Comment

We agree with Rubinstein that both the anatomical and functional prognosis is excellent and the patients in our series remained asymptomatic.

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Sir,

Hypotony as a presentation of giant cell arteritis

Giant cell arteritis (GCA) can cause blindness and rarely death. A clinical diagnosis is confirmed with biochemical tests and temporal artery biopsy.[1] Sometimes the manifestations of GCA are subtle; this case demonstrates an unusual presentation of GCA.

Case report

A 60-year-old male presented complaining of a dark patch in the vision of the left eye; on questioning, he described generalised muscular pain and stiffness for 18 months, jaw claudication, headache, appetite, and weight loss. He had no past medical history of note and was being investigated for anaemia and dysphagia.

Best visual acuity was 6/9 in both eyes. He had a mild left relative afferent pupil defect, Ishihara colour vision scored 17/17 right eye and 1/17 left eye, and visual fields showed a small left inferotemporal scotoma. A left-sided sixth nerve palsy and 2 mm ptosis with normal levator function were present. Both temporal arteries were non-tender but also non-pulsatile and nodular.

Anterior segments were normal; however, intraocular pressures were 5 mmHg in the right eye and 3 mmHg in the left eye. Fundoscopy revealed a cotton wool spot superonasal to the fovea corresponding with the scotoma, but was otherwise normal.

Erythrocyte sedimentation rate, C-reactive protein, and platelet count were all significantly raised. A diagnosis of GCA was made and a temporal artery biopsy performed that day was typical for GCA (Figure 1). The patient was given high-dose intravenous methylprednisolone for 3 days followed by oral prednisolone.

All symptoms resolved within a few days of initiating treatment and all signs of orbital, ocular, and generalised ischaemia resolved within 2 months. Other investigations for vasculitic disorders were normal.

Comment

GCA is an inflammatory disease of large and medium sized arteries of the thorax, head, and neck, and it usually has a typical presentation.[2]

This case highlights some interesting points:

1. The patient had a positive scotoma, which corresponded with the cotton wool spot. This suggests that the patient had significant retinal ischaemia as well as optic nerve ischaemia (indicated by the RAPD).
2. There was evidence of generalised ischaemia of the orbits, a rarer manifestation of GCA.[3,4]
3. The patient had ocular hypotony, probably caused by reduced production of aqueous humour,[5] and a cotton wool spot: both indicate ocular ischaemia.
4. The average age of patients with GCA is 77.6 years,[2] this patient was aged 58 when symptoms started.

In conclusion, any patient presenting with a suspicious history and signs of ocular or orbital ischaemia should be