

deposition or other signs of Terrien's degeneration, Mooren's ulcer, or systemic autoimmune disease. The absence of senile arcus and juxtalimbal corneal thinning also ruled out senile marginal degeneration. However, the patient was young and without ptosis and there was a real corneal thinning, so ptosis induced superior keratoconus like topographic appearance was unlikely.

References

- 1 Auffarth GU, Wang L, Volcker HE. Keratoconus evaluation using the orbscan topography system. *J Cataract Refract Surg* 2000; **26**: 222–228.
- 2 Cameron JA, Mahmood MA. Superior corneal thinning with pellucid marginal corneal degeneration. *Am J Ophthalmol* 1990; **109**: 486–487.
- 3 Taglia DP, Sugar J. Superior pellucid marginal corneal degeneration with hydrops. *Arch Ophthalmol* 1997; **115**: 274–275.
- 4 Bower KS, Dhaliwal DK, Barnhorst DA, Warnicke J. Pellucid marginal degeneration with superior corneal thinning. *Cornea* 1997; **16**: 483–485.
- 5 Kayazawa F, Nishimura K, Kodama Y, Tsuji T, Itoi M. Keratoconus with pellucid marginal corneal degeneration. *Arch Ophthalmol* 1984; **102**: 895–896.

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Sir,
Furuncular myiasis of the face caused by larva of the Tumbu fly (*Cordylobia anthropophaga*)

Myiasis is the infestation of any part of the body by fly larvae, and furuncular lesions may result when the skin is affected. We report a patient with furuncular myiasis of the face, who was initially misdiagnosed as dacryocystitis.

Case report

A 39-year-old caucasian man presented to the emergency department with a 5-day history of swelling and redness under his left eye. This had started from a small red spot, and was associated with a dull ache and watering by the time of presentation.

There was no history of systemic malaise, trauma, or bites. He had just returned from travelling in Angola, and it was before returning to the UK that he first noticed the red spot. He was diagnosed with dacryocystitis in the emergency department, and referred for incision and drainage of the presumed abscess. He was afebrile, and in the middle of the indurated area there was a white central plug oozing a clear discharge. After infusing 2% lidocaine (lignocaine) with adrenaline (1:80 000) a live and mobile larva was removed in its entirety from the central pore; it was later identified as *Cordylobia anthropophaga* (Figures 1 and 2). Further similar lesions were subsequently found on his right thigh and left buttock.

Comment

C. anthropophaga (also known variably as Tumbu fly, Mango fly or Ver du Cavor) is endemic in tropical Africa.¹ The female fly lays its eggs in soil (usually sandy soil contaminated by faeces or urine) or on wet clothes, from which primary larvae emerge after about 2 days. These are able to penetrate unbroken human or animal skin and then develop into secondary and subsequently tertiary larvae within the dermis. While developing they maintain a breathing pore in the skin through which they emerge when fully mature. At this stage, they may be up to 1.5 cm in length. Having dropped out of the breathing pore, they pupate to form the adult fly.



Figure 1 After infusing 2% lidocaine with adrenaline (1:80 000), the head of the larva became evident through the central pore.



Figure 2 The extracted Tumbu fly larva.

Infestation of humans in areas where the fly is endemic is not uncommon, but the lesions are usually on nonexposed parts of the body. The larvae need air to develop and so asphyxiation is an effective, although slow, treatment. Paraffin, petroleum jelly, or sticking plasters have been used to occlude the central pore.² Toxic agents (eg insecticide) may also be applied, or the larvae can be extracted taking care to remove it in one piece. Complications of the infestation are unusual, although rupture may lead to a severe inflammatory response.³

Basic sanitation helps to prevent infestations, by covering or removing areas of soil contaminated with urine or faeces. Ironing of clothes or bedding that has been dried outside is also believed to help by killing eggs within the fabrics.

Other flies that cause furuncular myiasis include *Cordylobia rhodaini* (Lund fly) and *Dermatobia hominis* (Human Botfly), which are found in tropical Africa and southern America, respectively. Cutaneous myiasis of any cause is uncommon in the UK and infestations on the face are even more unusual. They may be confused with other causes of abscess, but larval infestations should be considered in patients returning from endemic areas.

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References

- 1 Veraldi S, Brusasco A, Suss L. Cutaneous myiasis caused by larvae of *Cordylobia anthropophaga* (Blanchard). *Int J Dermatol* 1993; **32**: 184–187.
- 2 Oliver PR. Tackling tumbu fly larvae. *Lancet* 1985; **ii**: 37.
- 3 Nunn P. Tangling with tumbu larvae. *Lancet* 1994; **343**: 676.

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Sir,

Pseudophakic cystoid macular oedema: 30 months after latanoprost challenge

Latanoprost-induced cystoid macular oedema (CMO) is well documented, and stopping the drops before or after cataract surgery has been used to reduce this risk.¹ What is not clear is whether cataract surgery can increase the risk of prostaglandin-induced CMO, following recovery from cataract surgery. In this context, we report a case of latanoprost-induced CMO developing 30 months after an uneventful cataract surgery.

Case report

An 83-year-old male patient with primary open-angle glaucoma on latanoprost (0.005%) and brinzolamide (1%) eye drops in both eyes underwent phacoemulsification with posterior chamber intraocular lens implanted in the left eye and achieved best-corrected visual acuity of 6/6. Latanoprost eye drops were continued before and after the surgery. After 3 months, the visual acuity in the operated eye dropped to 6/18 and cystoid macular oedema (CMO) was seen clinically. He was in good general health and did not suffer from diabetes mellitus. Latanoprost drops were immediately withdrawn and subtenon's triamcinolone injection was administered.