Sir,

Screening for suspicious macular lesions using a telemedicine link

We would like to thank Drs Singh and Stewart for their interest and comments on our paper. We agree with them in that screening the whole population over a certain age for AMD would be a time consuming, expensive, and largely fruitless exercise. However, that was not the aim of our study.

We have evaluated the effectiveness of retinal screeners in judging the urgency of referral in patients referred with a suspicious macular lesion. In a population-based scenario, these would be patients referred to the general practitioners (GP) or hospital eye service by optometrists, either following a routine examination or with symptoms. These pictures could then be transmitted to the hospital via a telemedicine link and the urgency of referral determined by trained graders. These pictures would then be graded by ophthalmologists or trained graders as in our model, and not by GP as stated by Singh and Stewart.

It has been clearly established that a delay in treatment adversely affects the clinical outcome.[1] We believe this technique offers significant advantages in decreasing the time from referral to treatment especially with the advent of new treatment modalities for AMD.

Reference

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Sir,

AMD: Should we screen?

We read with keen interest the paper by Jain *et al* describing the successful use of non-stereo digital fundus photographs for screening for AMD.[1] Screening in medicine is defined as a method of detecting disease at a very early stage before it produces any signs or symptoms. In the case of screening for AMD, the aim is to prevent or modify a disease that can cause severe vision loss.

We believe that the authors' efforts are well-intended but do not represent an efficient use of resources. Neovascular AMD causes symptoms—metamorphopsia, blurred vision, or scotomas—that lead the patient to seek ophthalmic care. There is no evidence to suggest that neovascular AMD suitable for treatment, the type of disease state that the authors seek to identify, is asymptomatic in any significant number of patients. This is contrasted with diabetic retinopathy (DR), the condition cited by the authors as a standard for comparison. In the case of DR, patients can have mild nonproliferative DR, clinically significant macular oedema, or even neovascularization and be completely asymptomatic.

In addition, the authors point out that screening for DR is routine in health systems around the world for patients who have an existing or newfound diagnosis of diabetes mellitus. No such strong relationship has been established between AMD and a systemic disorder, thereby making the cohort for screening for AMD a limitless population over the age of 60 or 70 years.[2]

Finally, the individuals screening the photographs in this study were ophthalmic interns who are probably less likely to overlook features of neovascular AMD as compared to general physicians, who have more than just the eye to think about. Findings mentioned by the authors such as a pigment epithelial detachment might be easy for an observer inexperienced in retinal examination to miss. This is noteworthy as the number of false negatives is likely to be higher if the process gets implemented according to the authors' proposal, in which general practitioners (non-ophthalmologists) would interpret the fundus photographs.

In our opinion, self-screening by patients after proper instructions with an Amsler grid to a target population above 45–50 years of age would be more effective in serving the purpose of early recognition and treatment.[3] Until new tests are developed that could determine which dry AMD patients are most likely to progress to the wet form of the disease, self-screening may be the most practical method of detecting early disturbances of vision.

References

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3 Fine AM, Elman MJ, Ebert JE, Prestia PA, Starr JS, Fine SL. Earliest symptoms caused by neovascular membranes in the macula. *Arch Ophthalmol* 1986; **104**(4): 513–514.

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Sir,

Spontaneous globe luxation and floppy eyelid syndrome in a patient with Hashimoto's disease

Spontaneous subluxation of the globe is a rare event. Luxation occurs when the equator of the globe is allowed to protrude anterior to the eyelid aperture. The orbicularis muscle then contracts, causing further anterior displacement and the globe is caught outside the eyelid aperture.[1,2]

Case report

A 46-year-old Indian man complained of eyes spontaneously 'popping out' several times since 3 months.

Both eyes also luxated when the eyelids were spread manually (Figure 1). In the last 3 months, he had gained 12 kg and complained of fatigue. He had a history of gout, treated daily with indometacin. There was no family history of autoimmune disease. The patient smoked about 25 cigarettes per day. Ophthalmic examination showed a visual acuity of 25/25 in both eyes and an intraocular pressure of 22 mmHg right and 23 mmHg left. His upper eyelids were swollen and extremely lax. There was a mild lash droop bilaterally. There was no lid lag nor eyelid retraction. Hertel measurements were 25 mm in both eyes at a base of 90 mm.

A slight exophoria was noted. The ductions were normal in all directions. Slitlamp examination revealed a chronic papillary conjunctivitis. The cornea showed diffuse punctuate keratitis. The anterior chamber was quiet. The fundoscopic examination was normal. Computerized tomography (CT) imaging showed bilateral proptosis, an enlarged orbital fat volume, a normal aspect of the extraocular muscles and a normal, deep bony orbit. (Figure 2)

Laboratory tests revealed a high TSH, a low FT4, a normal T3 and high TPO antibodies, so an autoimmune hypothyrodism (Hashimoto's disease) was diagnosed and treated with levothyroxin. They also revealed a normal value of cortisol, a Cushing's syndrome could be excluded.

Comment

We assume that the combination of exophthalmia and FES caused repetitive spontaneous globe subluxations. The increased orbital fat volume may be explained by the massive and quick weight gain. The association between the FES and globe luxation proves very rare, since it was recently reported in only two case reports.[2,3] In the published cases, there was no history of

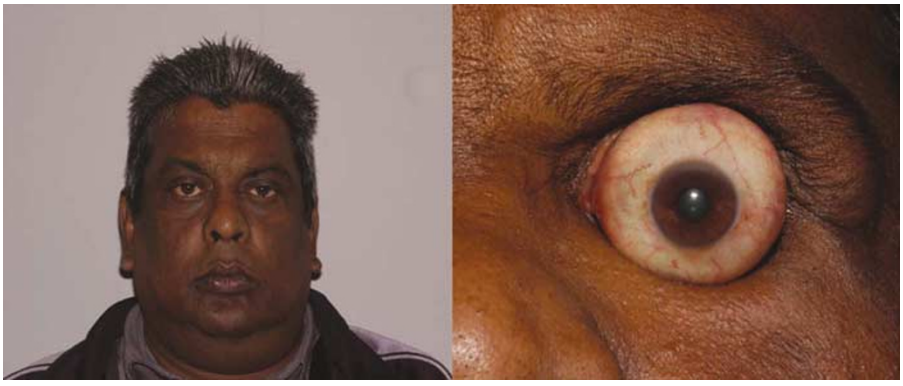

Figure 1 Left. A 46-year-old. Indian male who developed rapid weight gain and the floppy eyelid syndrome secondary to Hashimoto's disease. Right. Subluxation of his left eye.