Regarding the proposed infection control measures in admitting patients to hospital, the underlying principle is a balance between the infection containment risk and the ophthalmic need for timely care.³ In the midst of SARS infection, a well-planned infection and ophthalmic triage system is mandatory. Our proposal has taken into consideration of these two competing interests. For instance, it is unethical to decline patients from proper ophthalmic care for the sake of infection containment need. There was cancellation but not to a 100% of clinical admission during SARS outbreak. To our knowledge, only a small number of nonurgent or nonessential operations were suspended in most of the eye service teams in Hong Kong. On the other hand, lowering the admission threshold while jeopardizing the infection control is equally unwise. The keys to this dilemma are judicious exercise of one's clinical judgment and close liaison with the hospital infection control team in the implementation of measure. Emergency ophthalmic patients obviously differ from the clinically admitted patients in term of the severity and urgency of their ocular conditions. Emergency eye patients are in need of almost immediate ophthalmic attention such as the acute angle closure glaucoma patients. They have to be admitted the sooner the better. Most of the time, investigation or treatment is instituted swiftly after the admission and owing to the complexity of the ocular problem, these patients are likely to stay at the hospital for a few days. In other words, if the emergency eye patients happen to have been infected by SARS coronaviruses but in incubation period, the risk of a major hospital outbreak should not be understated. Therefore, for emergency eye patients, an early isolation and observation in the infection triage ward are in conformity with the major infection control guidelines.⁴ As for the clinically admitted patients such as those coming for cataract operation, their time of stay inside hospital is comparatively shorter and they carry a lower risk of crossinfection in contrast to the emergency eye patients. Obviously, admitting all patients to the infection triage ward for observation is neither practical nor feasible. Screening by house eye surgeons is a realistic alternate without significant compromise of the infection containment principle.

Dr Lai may have mistaken our suggestions regarding the ophthalmic consultation catered for suspect cases. In order to minimize the period of contact between the suspect cases and other patients in eye clinic, we were advocating seeing the suspect cases at the last time slot and they were strongly advised not to come earlier.³ Arrangement and proper prior notice were given to patients concerned so they the running was very smooth.

As mentioned in our paper, 'Under circumstances such as between cases and immediately following a high-risk

procedure, all health-care workers have to abide by the decontamination process consisting of removal of all potentially contaminated protective wear in proper sequence and putting on clean protective wear...', a proper knowledge and usage of PPE is universally accepted as the bread and butter for infection control.⁵ Dr Lai has simply echoed our point in his letter.

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Sir,
**Uveal malignant melanoma with extrascleral extension,
 treated with plaque radiotherapy**

Previous reports show that uveal melanoma with small extraocular extension can successfully be treated with brachytherapy.^{1,2} There is a case report of a large, posterior extraocular tumour nodule treated satisfactorily with excision, proton beam radiotherapy, and interferon therapy.³ We report a bulky, anterior, extraocular extension, which was excised, thereby allowing the underlying ciliary body melanoma to be treated with brachytherapy.

Case report

We present a 73-year-old man, with an asymptomatic episcleral tumour in the right eye, noticed 6 months before. Systemic enquiry gave a history of carcinoma of the penis in 1995, chronic bronchitis, and transient ischaemic attacks. On examination, the corrected visual acuities were OD 6/6, and OS 6/9. There was a supero-temporal, pigmented, episcleral tumour measuring 12 × 10 mm in diameter, with a thickness of 2 mm (Figure 1). Ultrasonography showed an underlying ciliary body tumour measuring 7.6 × 7.8 mm with a thickness of 3.4 mm. Systemic examination revealed no metastases.

The patient underwent local excision of the episcleral mass together with a surrounding lamella of superficial sclera. A 20 mm Ruthenium plaque was then inserted, which remained in place for 72 h, delivering 100 Gy to a depth of 4.4 mm. Histopathology confirmed the diagnosis of malignant melanoma, which was of mixed cell type. Cytogenetics indicated monosomy 3 and structural rearrangements of chromosome 8q.

Figure 1 Ciliary melanoma with extrascleral extension.

Thirty months post-operatively, the patient showed no local recurrence (Figure 2). Liver MRI scans and liver function tests indicated no metastases. The visual acuity remained 6/6 in the treated eye.

Discussion

Our case is remarkable because seemingly inoperable extraocular extension of a ciliary body melanoma was easily treated without any complications. It is not widely appreciated that even a large epibulbar tumour nodule usually spreads from the eye through only a tiny scleral channel.⁴ This makes it possible to excise the epibulbar tumour *en bloc* with the superficial lamella of surrounding sclera, which is usually of normal thickness.⁵ The intrascleral tumour is cauterised with bipolar diathermy, which is immediately discarded. The scleral lamella can be used as a handle, so that the tumour is not touched with any of the instruments. The intraocular tumour is treated with brachytherapy in the usual manner, according to the size and extent of the lesion. Scleral grafting is not necessary and would be difficult after radiotherapy, which delays healing. The conjunctiva is closed in the standard way.

Another unusual feature of this case was the use of extraocular tumour tissue for cytogenetic studies. The results indicated a high probability of metastatic disease so that the patient was referred to an oncologist for counselling and appropriate systemic management.

To our knowledge, there is no evidence in the literature to suggest that local excision of an extraocular tumour nodule might adversely influence the survival probability. Our impression from the cytogenetic results is that subclinical micrometastases were probably already present in this patient so that the ocular treatment was only palliative.^{6,7} Enucleation would

Figure 2 No signs of complications at 30 months post-operatively.

therefore have been ineffectual at prolonging life, besides causing unnecessary visual loss and mutilation.

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Sir, Use of 18-gauge intravenous catheter needle for frontalis suspension in children with congenital ptosis

We would like to describe a modification of frontalis suspension using an 18-gauge intravenous catheter instead of the Wright needle. It has several advantages:

smaller diameter than the Wright needle and hence less trauma (1.1 vs 2 mm), disposability, and low cost.

Surgical techniques

A Fox¹ pentagon was used with five stab incisions using no. 11 blade, two in the eyelid, two in the superior eyebrow margin, and one in the forehead. The 18-gauge intravenous catheter needle was inserted through the incision sites. A lid guard was placed between the globe and the eyelid to avoid accidental penetration of the eye by the needle. The 2/0 prolene was introduced through the needle lumen to be placed deep to the orbicularis and frontalis muscles (Figures 1 and 2). The sutures were lifted and tied at the forehead incision to achieve the satisfactory lid height and contour. Only the forehead incision needs suturing with 6.0 Vicryl to prevent protrusion of the suture ends.

Figure 1 The tip of 2/0 prolene is introduced through an 18-gauge intravenous catheter needle, which has been passed through the eyelid stab incision.

Figure 2 The 2/0 prolene is passed through the orbicularis when the 18-gauge intravenous catheter needle is withdrawn.