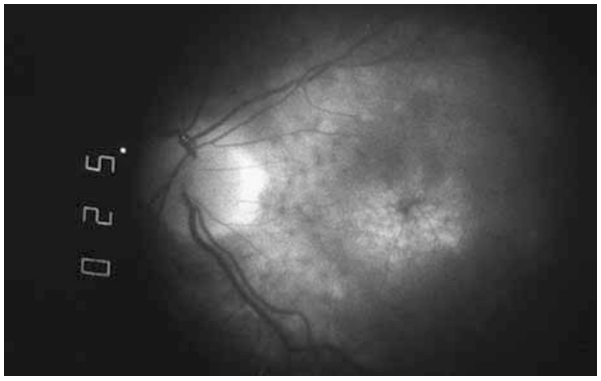

Figure 3 Fluorescein angiography of the left macula at presentation shows cystoid oedema.

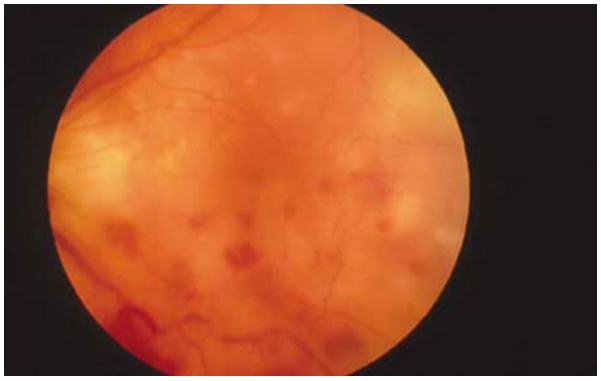

Figure 4 Colour fundus photograph of the left eye 4 months after initial presentation shows new retinal infiltrates and haemorrhages.

The initial diagnosis was multifocal choroiditis and panuveitis. RPR, FTA-ABS, Lyme antibody titres, and Epstein–Barr virus antibody titres were normal. Empirical therapy with acyclovir 600 mg orally four times daily and a subconjunctival injection of triamcinolone acetonide 20 mg in the left eye was given.[2] At 2 months there were no changes.

Four months later, the temporal subretinal lesion of the right eye had resolved and new retinal infiltrates and haemorrhages of the left eye were present (Figure 4). Vitreous biopsy revealed lymphoma. MRI scan revealed no central nervous system lesions, and spinal fluid was normal. Craniospinal irradiation and intrathecal methotrexate were administered. The patient was well for 7 years until fatal relapse developed.

The clinical presentations of primary intraocular lymphoma include subretinal deposits, vitritis, retinitis, infiltrative optic neuropathy, iritis, scleritis, and multiple evanescent white dot syndrome-like appearances.[3] In this case, the clinical picture was compatible with multifocal choroiditis and panuveitis. The subretinal deposit of lymphoma resolved simultaneously with the fellow eye appearance of white retinal infiltrates and haemorrhage, a picture associated with PIOL.[4] Clinicians faced with a picture of multifocal choroiditis and panuveitis in an elderly patient should include primary intraocular lymphoma in the differential diagnosis and consideration of vitreous biopsy given. Early treatment has been associated with improved survival.[5]

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Sir,

Superior oblique myokymia—a case report

Superior oblique myokymia (SOM) is an unusual, eye movement disorder presenting as episodes of oscillopsia and diplopia.

Case report

A 58-year-old lady presented with a 3-year history of 'jumping objects' and 'difficulty in focusing'. Her visual acuity (unaided) was 6/5 in both eyes. Orthoptic assessment revealed slight updrift of right eye on

Figure 1 Cyclotorsional movement-right eye.

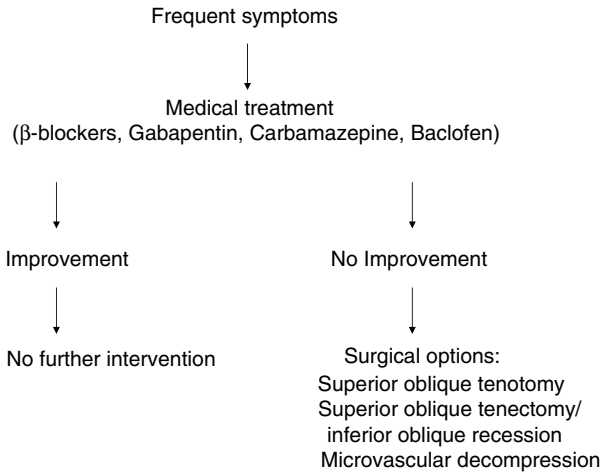

Figure 2 Treatment flow-chart.

levoversion and minimal underaction of the right superior oblique muscle with slight overaction of the inferior rectus. Anterior segment and fundus were unremarkable. Fresnels prism (base down) for right eye was prescribed but symptoms continued to persist.

One year later, she presented with a sensation of her right eye moving like a 'fish in a bowl'! Careful slit-lamp examination with focussed attention to the conjunctival vessels then revealed brief cyclotorsional movements in her right eye (Figure 1). 'Honda Sign' was elicited on pressing the diaphragm of the stethoscope over the closed right eyelid.

Neurological and laboratory investigations including MRI of brain were unremarkable. Diagnosis of SOM was made and treatment with T. Propanolol 20 mg BD was started. Marked improvement in symptoms was noted on 9 months follow-up.

Comment

In 1906 Duane reported the first case with uniocular rotatory nystagmus involving the superior oblique muscle.[1] In 1970 Hoyt and Keane termed SOM as an acquired abnormality in the innervation of the superior oblique muscle causing an episodic oscillation.[1,2] They postulated a trochlear nerve disinhibition as the basis of this abnormality.

In 1983 Bringewald suggested that it resulted from vascular compression of the trochlear nerve.[3]

Aetiology is still unclear, but many factors are found to aggravate these symptoms such as stress, lack of sleep, fatigue, alcohol, etc. It is usually not associated with any underlying systemic disease. However, cases have been identified after fourth nerve palsy[4], mild head trauma, brainstem stroke in association with posterior fossa mass, dural arterio-venous fistula, astrocytoma in the region of trochlear nerves, and multiple sclerosis.[3]

Patients complain of vague visual disturbances. On careful slit-lamp examination, low-amplitude cyclo-torsional ocular movements are seen occurring at a very rapid pace (Figure 1).[5]

One can elicit 'Honda sign' by placing the stethoscope over the oscillating eye. A distinctive noise that sounds like a motorbike revving is heard. This is due to the rapid movement of the superior oblique tendon back and forth through the trochlea. For an unknown reason, right sided SOM appears to be more frequent than left.[1]

Various treatment modalities suggested are summarised in Figure 2.[6] These treatment options may not be very effective giving rise to unacceptable side effects; but most patients require only reassurance regarding the benign nature of the condition.[7]

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Sir,

Wegener's granulomatosis masquerading as upper lid chalazion

A 79-year-old gentleman presented with a left upper lid lump clinically typical of a chalazion. Incision and curettage was performed twice, and each time followed by recurrence. The second time, the lid lesion had grown to a very large size and filled 3/4 of the upper lid and produced a considerable ptosis (Figure 1a). The lesion was incised via a skin incision and curettings were sent for histology together with a tarsal plate biopsy. The histology showed extensive tissue necrosis associated with a heavy eosinophil infiltrate (Figure 1b). Neither active vasculitis nor granulomatous inflammation was identified, but the appearances were considered to reflect tissue involvement in Wegener's granulomatosis (WG), particularly in view of similar findings in a previous prostatic biopsy. Relevantly, the past medical history included previously active WG, which presented as prostatic enlargement. Circulating anti-neutrophil cytoplasmic antibody (cANCA) was high, but there was no other evidence of clinically active WG elsewhere in the body. The patient was commenced on 30 mg prednisolone and azathioprine. With continuing systemic immunosuppression, over the next 4 months, complete resolution of the lesion followed (Figure 1c).

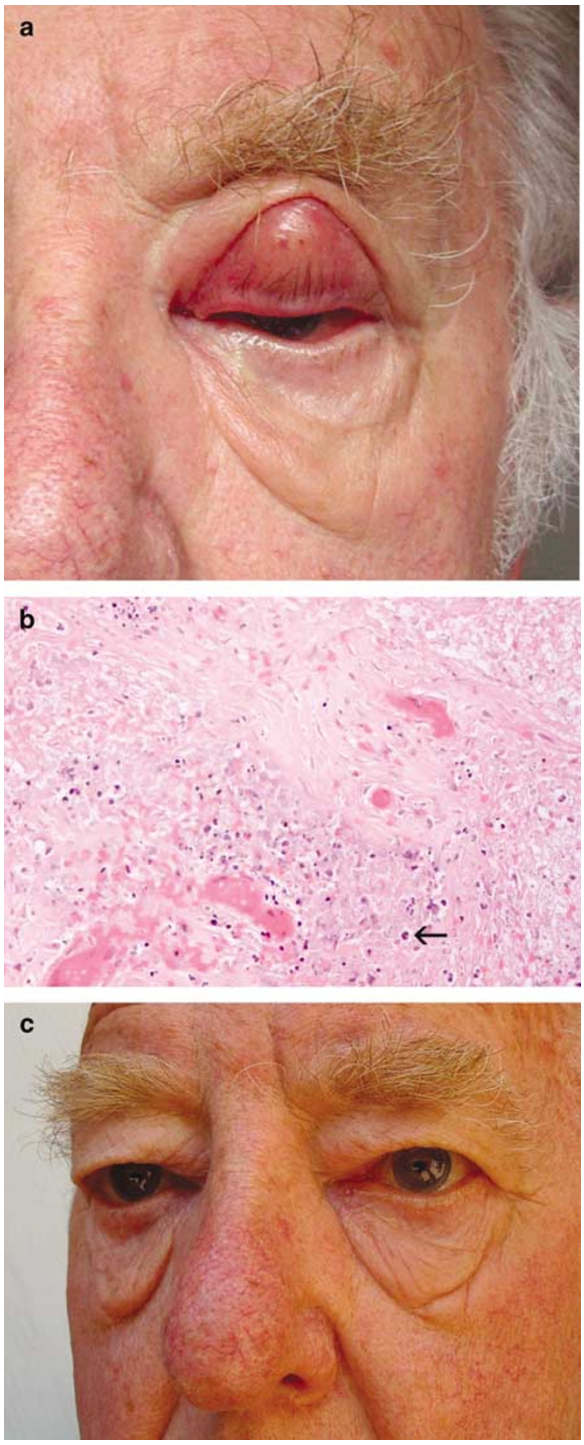

Figure 1 (a) Large left upper lid mass causing secondary ptosis. (b) Histology from tarsal plate biopsy, showing an area of stromal necrosis associated with eosinophilic polymorphs (arrow). (c) Complete resolution of left upper lid lesion.

Comment

Chalazion is the most common inflammatory lesion of the eyelid,[1] but can occasionally be clinically confused