

reported. To our knowledge, this is the first report of LCH causing uveitis masquerade syndrome. Only 1–4% of LCH patients develop intracerebral infiltration not extending from bone, usually with widespread disease and 5 years after diagnosis.⁷ Only 7 cases of positive CSF are reported,⁸ usually with meningeal infiltration. CSF involvement in this patient probably reflects brain infiltration, since meninges were normal on imaging. This case demonstrates unusual manifestations of LCH in the adult eye.

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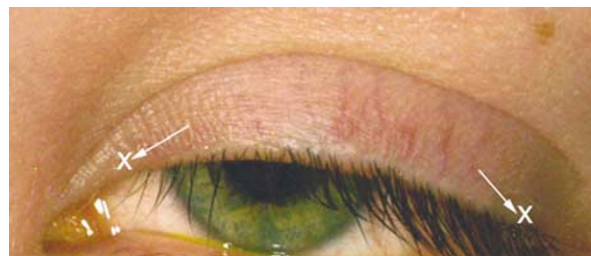


Figure 1 Injection sites for botulinum toxin are marked 'X'. The syringe is orientated to point in the directions of the arrows.

Thirty-five years ago, Mackie had shown that contraction of the orbital portion of the orbicularis muscle stopped Bell's phenomenon.¹ Normal blinking involves only the palpebral portion of the orbicularis muscle and is accompanied by Bell's phenomenon. He presumed that orbital orbicularis action prevented Bell's phenomenon during rapid eye movements in sleep and induced corneal erosion.

Using a modification of Mackie's method, in which I inject into the upper eyelid Riolan's muscle, I have successfully treated eight cases of recalcitrant recurrent corneal epithelial erosions without noticeably altering the eyelid position. The intention is to reduce horizontal tension in the lid, on the basis that shearing between the lid and the ocular surface in combination with overnight reduction in tear secretion, and thus lubrication, is contributory.

I make two injections, each of 4 IU of BotoxTM or 12 IU of DysportTM, just above the upper-lid margin near the medial and lateral canthi (Figure 1). The choice of injection site was inspired by Mackie's paper on Riolan's muscle.²

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Sir,
Reply to Ramamurthi and Rahman
The authors incorrectly cite Ian Mackie's paper (reference 41). Mackie did not advocate the induction of ptosis with botulinum toxin for the treatment of recurrent corneal erosions.

His method was to reduce the action of the orbital part of the orbicularis muscle by injecting it with botulinum toxin.

Sir,
Intravitreal triamcinolone and bevacizumab combination therapy for macular edema due to central retinal vein occlusion refractory to either treatment alone

A review of the literature showed no published cases using a combination of intravitreal triamcinolone and anti-VEGF agents for macular edema due to central retinal vein occlusion (CRVO). We present a case