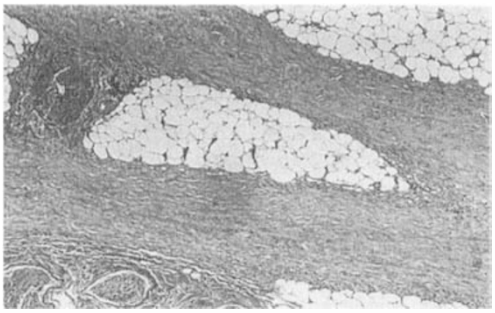

Fig. 3. *Skin biopsy showing thickening of fascial planes and interlobular septae of subcutaneous fat with homogenisation of collagen bundles. H & E×125.*

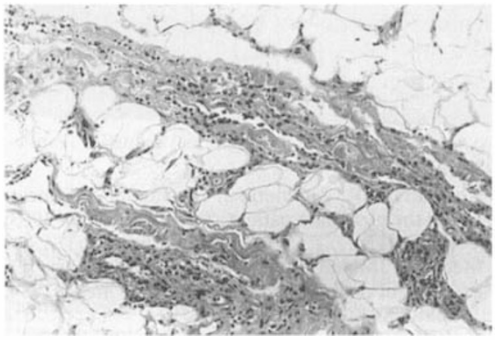

Fig. 4. *Skin biopsy showing inflammatory cells (predominantly lymphocytes and plasma cells) within the interlobular septae of subcutaneous fat. H & E×250.*

appearance, eosinophilia, raised ESR and the skin biopsy, a diagnosis of eosinophilic fasciitis was made.

The aplastic anaemia failed to respond to increased doses of steroid, antilymphocyte globulin, oxymetholone or plasmapheresis. She died in July 1986 of fungal pneumonia and post-mortem examination revealed disseminated infection with Zygomycetes.

Discussion

Many cases of eosinophilic fasciitis with multisystem presentation have been described.[2,3] However, no case has previously been described with ocular involvement. The diagnosis of eosinophilic fasciitis was somewhat delayed in this patient, as a result of the unusual presentation. Clear clinical, biochemical and pathological evidence substantiate the diagnosis. Autoimmune phenomena may account for the development of aplastic anaemia which has previously been reported in eosinophilic fasciitis.[4] The severe conjunctival chemosis with which this patient presented was the first manifestation of the generalised oedema which occurred some 14 months later. It occurred in the absence of any other ocular pathology or hypoproteinaemia and was resistant to usual treatments. It resolved rapidly and completely after administration of systemic corticosteroids.

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Sir,

Glaucoma: Ignorance and Apathy

I have interviewed 146 consecutive patients with chronic open angle glaucoma attending a general ophthalmology clinic in Norwich to assess their understanding of the disease and its treatment, and whether they would like to know more. A standardised questionnaire was used for each patient. New patients were excluded. The key question (a) "What is glaucoma" was awarded four marks for understanding of pressure, visual field loss, optic nerve compromise, and chronicity although considerable paraphrasing and flexibility of question and response was allowed. For example "Its something pressing inside my eyes which will eventually restrict my sight" would score four marks.

One patient declined to take part. The remaining 145 patients were 31 to 88 years old (mean 73). Results were analysed using the Chi-squared test.

There was a remarkably poor understand-

ing of glaucoma: 6% did not know they had the condition and 46% scored zero for the question "What is glaucoma." Only 5% gave a completely correct answer to this question. The mean score declined in a steady fashion with age (Fig. 1). The score was unrelated to duration of disease but was higher in those with affected relatives ($p<0.01$).

Understanding of the treatment was better: 57% knew that glaucoma could be effectively treated, 76% understood what would happen without treatment and 49% knew that treatment should be lifelong, however, 41% erroneously believed that their sight would be improved by treatment. Thirty per cent gave correct responses to all of these. It was alarming to find that only 12 of 39 patients who had undergone surgery had any understanding of trabeculectomy and 44% thought this carried no risk!

The familial nature of glaucoma was appreciated by 42%, and as expected this awareness was more frequent in those with affected relatives, ($p<0.001$).

The most revealing question concerned desire to know more about glaucoma and 67% said they did not want to learn more. Those who had scored least to the 'key' question 'What is glaucoma' were less likely to want more information; those who already knew the most wanted to learn more ($p<0.001$). Such apathy was not more frequent in older patients.

In summary, there is an astonishing lack of knowledge in glaucoma patients. Few comparisons are available but patients in Leicester[1] and Southampton[2] gave broadly comparable results. Many seem to be adopting a 'head in the sand' attitude which presents considerable difficulty if the basic hope that improved understanding leads to better compliance is true, however it is notable that in one large study a well organised education programme failed to increase medication compliance in benign hypertension.[3] Nevertheless the average glaucoma patient has a woeful ignorance of the disease and efforts should certainly be made to improve this, although this study suggests that such well meaning attempts may not be universally welcomed.

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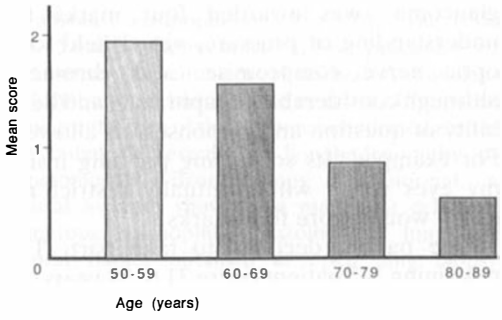

Fig. 1. *Mean score for question (a) according to age of patient.*

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Sir,

Skin signs during giant cell arteritis, (GCA), varying from redness of the temples to frank gangrene of the scalp, occur infrequently.[1] Most reported cases of the skin manifestations of GCA have been in dermatological journals.

Having recently examined five patients where these skin signs were of diagnostic importance, two are briefly described to bring this sign to the attention of ophthalmologists.

Case 1

A male, aged 64, presented with sudden loss of right vision. Two weeks earlier he had developed a painful, rash on the temples.

Visual acuity was light perception right and 6/9 Snellen left. There was right anterior ischaemic