may do so by altering the nature of dynamic vitreoretinal traction when posterior vitreous detachment occurs making break formation more likely. Thus the prevention of gel incarceration into the section at the time of cataract surgery, which can be achieved by anterior vitrectomy, may discourage RRD and of course some of the other complications mentioned by the authors.

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References

1. Claoué C, Steel ADMcG. Visual prognosis following accidental vitreous loss during cataract surgery. *Eye* 1993;7:735-9.
2. McHugh D, Wong D, Chignell A, Leaver P, Cooling R. Pseudophakic retinal detachment. *Graefes Arch Clin Exp Ophthalmol* 1991;229:521-5.

Sir,

We are grateful to Mr Anthony Chignell for his comments on our recent paper.¹ We are well aware of his expertise in the field of pseudophakic retinal detachments and have not commented on this particular aspect in our paper since none of our patients had developed a retinal detachment at the time of data analysis. Clearly, it would be ideal to study patients until they are lost to follow-up or until their death in order to ascertain the long-term benefit of cataract extraction when complicated by vitreous loss. Unfortunately, the establishment of the internal market in the National Health Service encourages discharge of patients at the earliest opportunity commensurate with acceptable clinical practice. This means that the long-term follow-up of patients in order to monitor for eventual complication is likely to become increasingly difficult to justify and will have inevitable repercussions in terms of data generation.

We agree entirely with Mr Chignell's final sentence regarding the importance of preventing gel incarceration into the wound at the time of cataract surgery and likewise believe that adequate vitreous toilet following accidental vitreous loss should have a significant beneficial effect on the incidence of subsequent rhegmatogenous retinal detachment.

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References

1. Claoué C, Steele, ADMcG. Visual prognosis following accidental vitreous loss during cataract surgery. *Eye* 1993;7:735-9.

Sir,

Further to McElvanney and Sherriff's Letter to the Journal on 'Uveitis and Skin Tattoos',¹ I feel that emphasis should be placed on the more likely differential diagnoses.

The Koebner phenomenon (isomorphic reaction) describes the tendency for lesions characteristic of a particular disease to develop at sites of skin trauma such as surgical or mechanical trauma.² This phenomenon is well recognised in sarcoidosis and psoriasis, as well as the more common associations of lichen planus and viral warts. Additionally, the granulomata formed in cutaneous sarcoidosis are often indistinguishable from inclusion granulomata varying from cactus spine to zirconium, and this is the reason against tattooing with ink over the site of Kveim testing.³

Therefore in a patient who has uveitis plus a reaction in a coexisting scar, the diagnosis of sarcoidosis must be actively pursued (unless there are psoriatic lesions) because of the possible multi-system ramifications. The designation of 'sensitivity to metallic dye' can be made only by exclusion.

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References

1. McElvanney AM, Sherriff SMM. Uveitis and skin tattoos. *Eye* 1994;8:602-3.
2. Marks R, editor. *Roxburgh's common skin diseases*, 16th ed. Oxford: Oxford Medical, 1993.
3. McKee PH. *Pathology of the skin*. London: Gower Medical, 1989;6.22-6.28.

Sir,

The occurrence of uveitis preceded by swelling of skin tattoos is a recently described association.^{1,2} We would agree with Mr Harvey that patients who present in this manner should be appropriately investigated to exclude an underlying pathological cause for their uveitis; however, it is important to ensure that patients are not over-investigated.

The Koebner phenomenon, a term used to describe skin lesions which develop in recently traumatised skin, was originally described in psor-

iasis, but is also associated with vitiligo, lichen planus and viral warts among other conditions. It may also occur at pressure points and in recent scars, but is not commonly associated with sarcoidosis.^{3,4}

More noteworthy, perhaps, is the occurrence of 'scar sarcoid' in which cutaneous lesions of sarcoidosis have been observed in long-standing scars, often on the knees. Scar sarcoidosis typically presents with purplish-red skin lesions which fade and become brown. It may be observed in the acute eruptive phase of sarcoidosis, following erythema nodosum or in scars following biopsy taken at that time. It may also occur in the later stages of the disease.⁵ The scar, in our patient, had been present for more than 20 years and, unlike the typical appearance of cutaneous sarcoidosis, presented as a greyish swelling which subsequently became crusted in the later stages.

Unfortunately, there are no absolute diagnostic criteria for sarcoidosis and its aetiology remains obscure.⁶ A diagnosis is therefore based on clinical findings, demonstration of non-caseating granulomata on biopsy and the exclusion of other granulomatous diseases. Systemic examination and chest radiograph in our patient proved negative.

Other useful tests include serum angiotensin converting enzyme, lysozyme and calcium metabolism, but are unlikely to be positive in a patient who has sarcoidosis with limited organ involvement. The Kveim test is infrequently performed nowadays, because the sarcoid antigen is not readily available and the test carries the risk of transmitting hepatitis B virus and human immunodeficiency virus to the patient. Its usefulness is also limited by the false positive and false negative results which may occur.⁷

Furthermore, most patients with sarcoidosis do not require treatment, and even those with extensive systemic and immunological abnormalities have only a minimal reduction in long-term survival⁶

Hanada and associates⁸ described a patient who developed uveitis and symptoms similar to systemic sarcoidosis following extensive tattooing. The patient was extensively investigated, and lung specimens

revealed the presence of red tattoo granules on electron microscopy, suggesting that certain tattoo pigments could be responsible for the systemic sarcoidal reaction.

Tattoo granulomata are relatively rare, and in previous years approximately 10 patients were seen annually in the United Kingdom. However, with the recent trend towards body tattooing being regarded as highly fashionable, there may well be an increase in tattoo-related pathology in the future, and uveitis associated with skin tattoos may become a more clearly defined entity.

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References

1. Mansour AM, Chan C-C. Recurrent uveitis preceded by swelling of skin tattoos. *Am J Ophthalmol* 1991; 111:515-6.
2. McElvanney AM, Sherriff SMM. Uveitis and skin tattoos. *Eye* 1994;8:602-3.
3. Champion RH, Burton JL, Ebling FJG, editors. *Textbook of dermatology*. Vol 2. Oxford: Blackwell Scientific, 1993;19:778.
4. Fitzpatrick TB, Eisen AZ, Wolff K, Freedberg IM, Austen KF, editors. *Dermatology in general medicine*. Vol 1. New York: McGraw-Hill, 1993;4:45-6.
5. Champion RH, Burton JL, Ebling FJG, editors. *Textbook of dermatology*. Vol 4. Oxford: Blackwell Scientific, 1993;57:2390-7.
6. Bresnitz EA, Strom BL. Epidemiology of sarcoidosis. *Epidemiol Rev* 1983;5:124-56.
7. Sheppard JD, Nozik RA. Practical diagnostic approach to uveitis. In: Tasman W, Jaeger EA, editors. *Duane's clinical ophthalmology*. Vol 4. Philadelphia: Lippincott, 1994;33:5.
8. Hanada K, Chiyoya S, Katabira Y. Systemic sarcoidal reaction in tattoo. *Clin Exp Dermatol* 1985;10:479-84.

ERRATUM

S. G. Levy, C. M. Kirkness, J. Moss, L. Ficker and A. C. E. McCartney. On the pathology of the iridocorneal-endothelial syndrome: the ultrastructural appearances of 'subtotal-ICE'. *Eye* 1995;9:318-323.

In the Discussion section of this paper the first

sentence of the third paragraph (p. 22, right-hand column, line 5) should read:

Normal endothelial cells were often damaged or necrotic at the boundary zone, suggesting that ICE-cells may have a toxic effect on neighbouring normal endothelial cells.