

References

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Sir,

Another Disappearing Bullet

A 13-year-old boy who had been shot in the face with an air gun from a distance of 3 m presented to the ophthalmology department. Examination revealed unaided visual acuities of 6/6 right and 6/24 left. The left upper lid was markedly swollen and bruised with a closed 0.5 cm skin laceration just below the eyebrow centrally. On slit lamp examination the conjunctiva was bruised superiorly, but the cornea and sclera were intact. There was also micro-

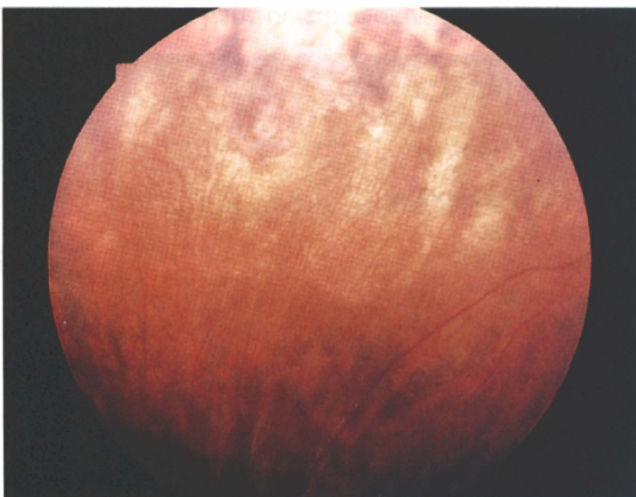
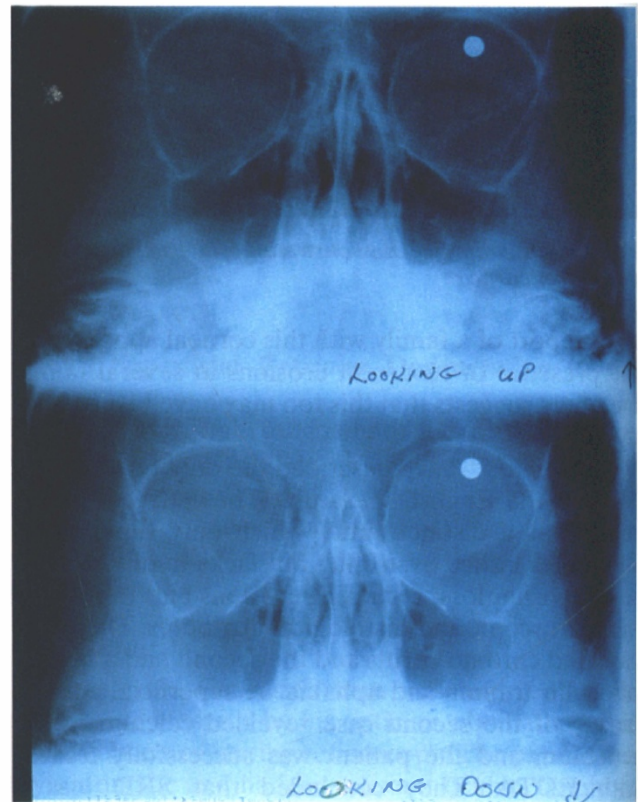


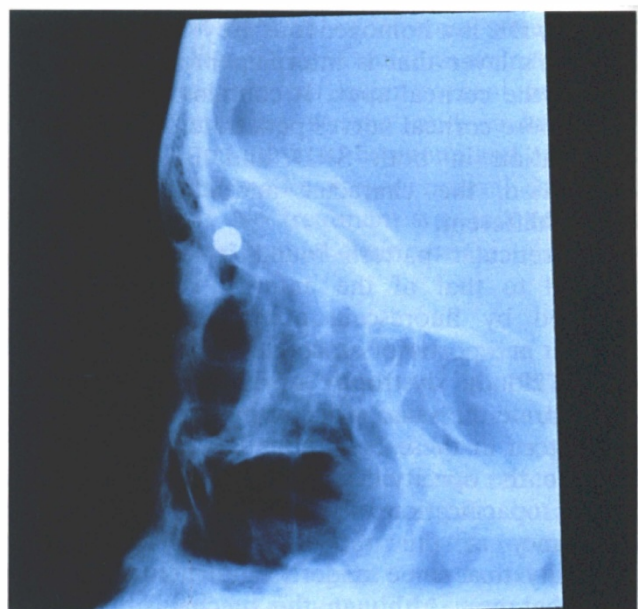
Fig. 1. *Commotio retinae superiorly in the left eye.*

hyphaema with no iris injury. Fundoscopy after dilatation showed moderate intragel haemorrhage inferiorly and commotio retinae superiorly (Fig. 1). Orbital radiographs showed an air gun pellet located anteriorly in the left upper orbit (Fig. 2) rather than in the eye, as there was no shift in its position with a shift in the direction of gaze.

The boy was admitted for observation and bed



(a)



(b)

Fig. 2. *Anteroposterior (a) and lateral (b) radiographs showing the pellet anteriorly located in the left upper orbit.*

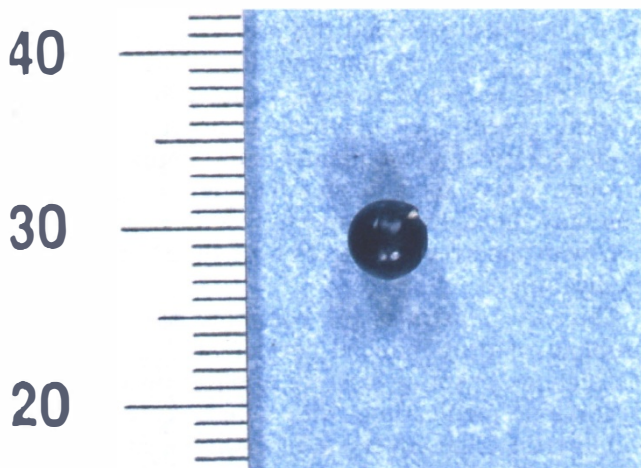


Fig. 3. Retrieved air gun pellet alongside a millimetre scale.

rest, and was given analgesia for pain. On the following day during eversion of the upper lid, an air gun pellet fell from the superior fornix onto the floor. Although this was initially not detected by the examining doctor, the attending nurse fortunately saw the pellet fall and promptly retrieved it (Fig. 3).

The patient was then discharged but kept under close ophthalmic observation. Five weeks later there was complete resolution of the vitreous haemorrhage with a flat retina and an unaided visual acuity of 6/5.

Discussion

Having been shot from such close range, this youngster was undoubtedly fortunate not to have sustained a more severe injury. We assume that the pellet took the following course: it perforated the left upper lid, ricocheted from the upper part of the globe, and lodged in the upper fornix, which subsequently became oedematous. It follows that, once the oedema started to resolve, the foreign body became dislodged and, helped by mechanical eversion, fell out under its own weight.

The localisation of an intraorbital foreign body is sometimes difficult and requires careful examination of the orbit and globe. Radiological imaging techniques such as plain radiography, ultrasound, CT and MRI (useful where wooden foreign bodies are suspected) are therefore employed accordingly. In this case, the anterior location of the pellet on radiography and good visualisation of the posterior segment of the left eye led to the conclusion that the pellet was not intraocular, hence the conservative management.

This case is very similar to that described by Votruba.¹

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Sir, Skin Depigmentation Associated with Ophthalmic Medication

Periorbital skin is often exposed to ophthalmic medications intended for disorders of the eye or its adnexae. Adverse effects include contact dermatitis and allergic reactions. A case of depigmentation of lid skin following incorrect application of an ophthalmic medication is reported.

Case Report

A 73-year-old West Indian man presented to the eye department with a 2 week history of lid skin depigmentation which came on 5 days after starting treatment with Fucithalamic (Leo) eyedrops for bacterial conjunctivitis. Further questioning established that the medication was rubbed onto lid skin rather than being instilled in the lower conjunctival sac. He was found to have two asymmetric and inflamed depigmented patches involving the skin of lower lids, measuring 3.5×1.5 cm on the right and 2×1 cm on the left (Fig. 1). The lesions did not change in size after the medication was stopped. Direct questioning excluded previous skin condition, known allergies and family history of skin disease. There was no evidence of autoimmune conditions or depigmentation affecting other parts of the body.



Fig. 1. Lower lid skin depigmentation following incorrect application of Fucithalamic.