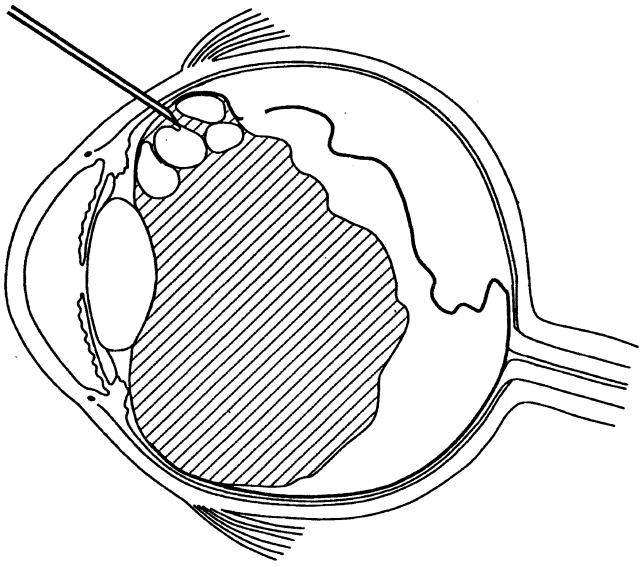

Fig. 1.

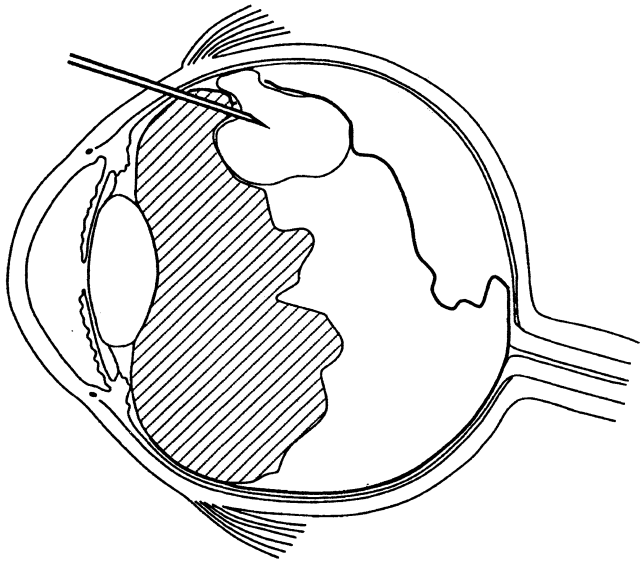

Fig. 2.

because the PHM is tough, inelastic and usually highly mobile, penetrating it with a needle tip to gain access to the retrohyaloid/preretinal space is quite difficult, as testified by attempts to sample subretinal fluid in this way prior to vitrectomy.

It follows that patients with an attached PHM and round holes have a negligible risk of subretinal gas. Those at greatest risk are: (1) patients in whom the PHM is shortened, e.g. by incarceration, so that its mobility is lost and perforation made easier; (2) patients who have an incomplete posterior vitreous detachment with a large defect in the PHM allowing gas bubbles through. These patients can still be managed safely with gas provided the retina is first flattened to close the break using the correct surgical D-ACE sequence as described by Gilbert and McLeod,[4] avoiding pneumoretinopexy.

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Sir,

We were very interested to read the paper by Sadiq and Downes[1] on dysversion of lateral eyelashes in children. They described four cases where this new diagnosis was made for recurrent red, sore, watery eyes in young boys. We would like to support this new diagnosis by reporting three further similar cases in young girls and discuss the implications for management.

Case 1

A 4-year-old girl attended her general practitioner with a history of recurrent episodes of a sticky, watery left eye. She was noted to have some ingrowing eyelashes at the lateral end of the left upper lid and was referred to the eye clinic for further management. The ophthalmologist confirmed the finding of misdirected lashes at the lateral aspect of the left upper lid which were subsequently treated with electrolysis under general anaesthetic (GA). This resulted in the resolution of symptoms for 3 years until she re-presented with similar problems in the right eye. On examination she was noted to have dysversion of the lateral lashes of the right upper lid, and was treated again with electrolysis under GA. Six months later she remains symptom free.

Case 2

A 4-year-old girl was referred to the eye clinic with a history of recurrent red, sticky eyes. There had been a variable response to treatment with topical antibiotics. On examination, several misdirected eyelashes were seen at the lateral aspects of both upper

lids. The lashes were long and fine, arising from the correct position, but curved and trapped in the conjunctival fornices. Otherwise, the eyelid positions were normal and there was no ocular abnormality. She underwent electrolysis of the offending eyelashes under GA which led to resolution of symptoms without any recurrence.

Case 3

An 8-year-old girl was referred to the eye clinic with a long-standing history of irritable eyes due to ingrowing eyelashes. Epilation of the offending lashes prior to referral invariably led to recurrence of symptoms after a short symptom-free period. Ophthalmic examination revealed dysverted lashes at the lateral ends of both upper lids, trapped under the lid margin. There was no evidence of lid malpositioning, trichiasis or other ocular pathology. She underwent electrolysis of the offending eyelashes under GA, but on examination a month later was noted to have some remaining misdirected lashes on the right side. However, when she was admitted for further electrolysis 3 months later, despite persistent occasional irritation of the right eye, no dysverted lashes were seen and the procedure was cancelled. She remained relatively symptom free for 6 months when she was again noted to have obvious misdirected eyelashes at the temporal aspect of the right upper lid. These were subsequently treated with electrolysis which led to resolution of symptoms and no recurrence within the following 5 months.

Discussion

We agree with Sadiq and Downes[1] that dysversion of the lateral eyelashes is a cause of recurrent sore, red, watery, sticky eyes in children. Our three cases support their findings, but demonstrate that this condition may occur in both girls and boys. We also found the lateral lash dysversion syndrome to be bilateral, although our first case suggests that initial presentation may be unilateral. Our third case demonstrates the ease with which it is possible to overlook this condition, as dysverted lashes may spontaneously reposition leading to temporary resolution of symptoms. Finally, although our cases were successfully treated with electrolysis, we would agree with Sadiq and Downes that manual repositioning of the dysverted eyelashes may be preferable as it prevents the need for surgery and a general anaesthetic.

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Reference

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Sir,

We read with interest the paper entitled 'Primary ocular relapse in acute lymphoblastic leukaemia' by MacLean *et al.*[1] They presented four cases of isolated anterior segment relapse in acute lymphoblastic leukaemia (ALL) occurring within 2 months of stopping therapy. Ocular signs responded well to radiotherapy; however, three patients subsequently died from haematological relapse. Anterior segment relapse, presenting soon after maintenance treatment has been completed, has been upheld by previous reports.[2–4] Anterior segment relapse is not commonly associated with concurrent central nervous system (CNS) involvement,[3,4] but there seems to be a high risk of bone marrow relapse.[2] However, CNS involvement is frequently associated with posterior segment relapse.[5]

A recent report described posterior segment relapse in a 12-year-old boy who had been treated in accordance with the recent UKALL protocol, which did not include cranial irradiation.[6] He developed leukaemic infiltration in the left eye while on maintenance chemotherapy 7 months after diagnosis. CNS relapse was confirmed on lumbar puncture. Radiotherapy resulted in initial resolution, but death occurred 11 months after the first ocular presentation.

Ocular relapse in ALL carries a poor prognosis for life and requires immediate treatment with high-dose radiotherapy. A multicentre study of leukaemic ophthalmopathy[5] suggested that doses of 20 Gy may be ineffective against ocular leukaemia and that doses of 30 Gy or more may be necessary to eradicate ocular leukaemic cells. Indeed, 5 of their 6 patients treated with chemotherapy and radiotherapy to the eye at doses of 20–30 Gy achieved ocular remission. However, only 2 of 4 patients treated with chemotherapy and radiotherapy at doses of 10–20 Gy achieved ocular remission. It has also been proposed that for cases of recurrent ocular relapse where the eye is the sole sanctuary site, enucleation may be considered.[5]

We agree with MacLean *et al.* that awareness of leukaemic relapse, particularly in those patients recently coming off chemotherapy, should aid early diagnosis and instigation of treatment. It is important that all cases of ocular leukaemic relapse are carefully monitored in order to fully evaluate the current treatment protocols.