Sir,

I read with interest the article 'Primary orbital Ewing's sarcoma: report of a case and review of the literature' by Dennis S.C. Lam *et al.* (*Eye* 1999;13:38–42), and wish to comment on it. The authors entitled the article 'primary orbital Ewing's sarcoma' in spite of the fact that it is clear from the CT scan that there is involvement of the ethmoid sinuses bilaterally as well as the floor of the anterior cranial fossa and orbit. Since the bones do not appear to be significantly eroded in the roof of the orbit, it is my assumption that this lesion was in fact of primary origin from the nasal sinuses, which has extended bilaterally into the orbits and to the intracranial cavity through the very thin bones of the ethmoids. It would be hard to call it a bilateral primary that had invaded the other way, in view of the fact that the bony structures appear relatively intact. In addition to this, the authors themselves mention that the lesion was biopsied from the nasal sinuses. I would certainly have classified this as a secondary tumour of the orbit arising from the nasal sinuses.

In addition, I would like to correct the statistics that the authors have offered in so far as they mention seven cases reported in the literature. I have reported two in the past, and they should be included in their survey. Both of them occurred in young children and both involved the sinus and orbit. They have gone on to successful cure of their disease through combined chemotherapy and radiotherapy with a follow-up of 17 years and 10 years each.

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Sir,

We are grateful to Professor J. Rootman for his interest and comments on our paper.[1] We failed to include the two cases described in his textbook[2] in our original report as we could not find them through the computerised literature search utilising the database of Medscape Medline. We would have included these cases should we have known about them since they would have enabled us to have a more complete picture of orbital Ewing's sarcoma.

A very important point of our article is the non-surgical approach in the management of orbital Ewing's sarcoma.[1] Both of Professor Rootman's cases, like ours, also had excellent outcome after combined chemotherapy and radiation therapy. Since the publication of our article, Choi *et al.*[3] have reported another case of primary orbital Ewing's sarcoma successfully treated with combined chemotherapy and radiation therapy. This additional information further establishes the effectiveness of combined chemotherapy and radiation therapy in the management of orbital Ewing's sarcoma. This is encouraging, since patients with orbital Ewing's sarcoma can have a good prognosis while avoiding extensive surgery, which often results in significant morbidity including mutilating cosmetic effects.

With regards to the origin of the tumour in our patient, Professor Rootman is of the opinion that it is more likely to have originated from the nasal sinuses as the orbital roof did not appear to be eroded. This is certainly a possibility. However, there have been reported cases of primary Ewing's sarcoma of the orbit in which the orbital roof was intact.[4] Therefore, in our patient, even though there was no orbital roof erosion, the tumour could still have arisen from the orbits, with extension involving the ethmoidal sinuses and anterior cranial fossa.

References

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Sir,

I read with interest the article by Tanner *et al.* on posterior sub-Tenon's triamcinolone injections in the treatment of uveitis,[1] but I wonder whether sub-Tenon injection is indeed sub-Tenon. Indeed the authors were unable to locate the repository drug with the B-scanner and claim the drug used was 'echolucent'; but they also failed to find echo-free sub-Tenon's space occupied by the drug, or the echo-opaque fascia of Tenon.

The fascia bulbi (capsule of Tenon) posteriorly around the optic nerve is pierced by the ciliary vessels and nerves, and becomes very thin; it can be traced only with difficulty to the dural sheath of the optic nerve.[2] Crossing the episcleral space and attaching the fascial sheath to the sclera are numerous delicate bands of connective tissue.[3]

As illustrated in Fig. 1, where actual dimensions of eye globe and 25G needle (5 8 inch, 16 mm) used have been respected, with a straight needle it is not possible to remain in a spherical sub-Tenon space using the method discussed by Tanner. As the needle is advanced up to its hub while keeping it firmly against the globe, its tip moves at least 7 mm away from the posterior curvature of the eye; alternatively keeping the tip of the needle adjacent to the posterior surface

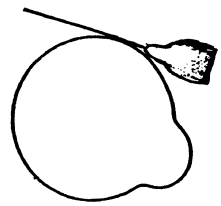

Fig. 1. *A 25G needle ($^5/_8$ inch, 16 mm) on a 24 mm axial-diameter globe.*