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Sir,

Peripapillary subretinal neovascular complex complicating papillitis

Peripapillary subretinal neovascular membrane in a young patient is commonly associated with high myopia, angioid streaks, choroidal rupture, presumed ocular histoplasmosis, toxoplasmosis, disc drusen and coloboma. We report an unusual case of peripapillary subretinal neovascular membrane extending subfoveally following an attack of papillitis and not associated with pre-existing ocular pathology.

Case report

An 18-year-old Caucasian woman presented with a 1 week history of rapidly worsening vision in her left eye. Apart from moderate hypermetropia there was no ocular or medical history of note. On examination her visual acuity was 6/4 in the right eye and 6/60 in the left eye. There was a left-sided relative afferent pupillary defect. The left fundus examination showed papillitis with swelling of the temporal disc and adjacent retina. MRI of the brain and the orbits revealed no abnormalities. She was treated with a 1 week course of oral prednisolone.

Three weeks later visual acuity was still 6/60 in the left eye and the afferent pupillary defect remained. Fundus examination now revealed exudation and serous detachment of the retina extending from the disc and involving the fovea (Fig. 1). There was no evidence of chorioretinal scarring or other inflammatory changes in the eye. Fundus fluorescein angiography confirmed the presence of a subretinal neovascular membrane (Fig. 2).

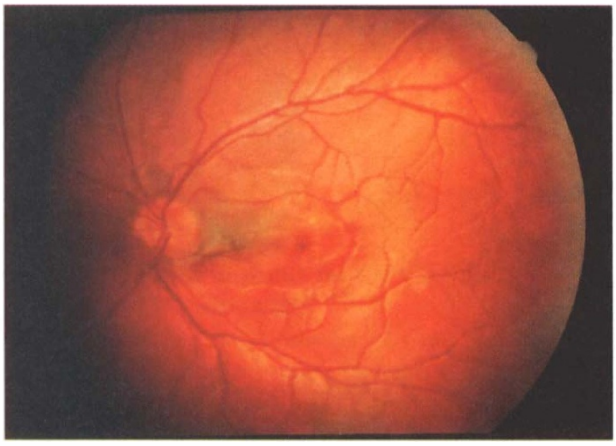

Fig. 1. *Fundus photograph showing exudation and serous detachment of retina of the peripapillary area extending to the fovea.*

She was referred to a Vitreoretinal Unit for management, where she underwent surgical excision of the membrane, some 6 months from the time of presentation. Post-operatively her vision in this eye has improved to 6/36 and fluorescein angiography has not shown a recurrence of the membrane to date.

Comment

Papillitis is a disc swelling caused by local or contiguous inflammatory processes near the optic nerve head. Giuffre *et al.*[1] have reported a case of extensive subretinal neovascular membrane in the papillomacular area following anterior ischaemic optic neuropathy. There are 7 reported cases of peripapillary and subfoveal subretinal neovascular membranes associated with papilloedema from pseudotumor cerebri.[2–8] We could not find any similar case reported following papillitis. Lopez and Green[9] in 1992 defined peripapillary subretinal neovascular membrane as a collection of new vessels anywhere between the inner collagenous layer of Bruch's membrane and the outer aspect of the sensory retina, any portion of which is located within one disc diameter of the margin of the optic nerve head. A variety of congenital and acquired optic nerve lesions have been

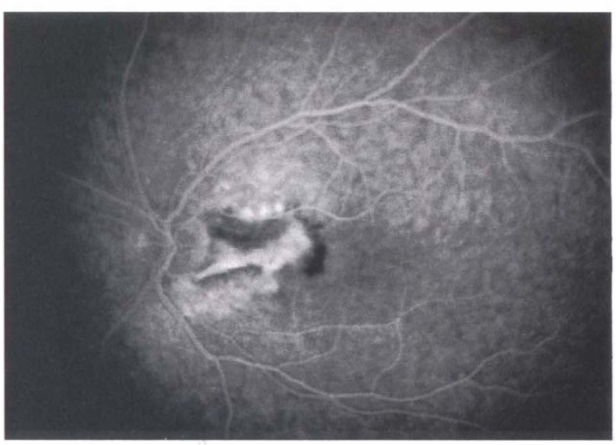

Fig. 2. *Fluorescein angiogram showing the subretinal neovascular membrane.*

reported to be associated with peripapillary subretinal neovascularisation. These include morning glory disc syndrome, optic nerve drusen, optic nerve pits, pseudotumor cerebri, retinochoroidal colobomas and tilted disc syndrome. The exact pathogenic association of disc swelling with subretinal neovascularisation is still unclear. Morse *et al*.[5] suggested two plausible factors for its occurrence in papilloedema, the first being an anatomical dehiscence due to physical deformation of peripapillary tissue creating a pathway for ingrowth of new vessels, and the second, hypoxia caused by axonal swelling leading to impaired vascular perfusion of the tissues and hence neovascularisation. It appears, from our case, that this might also apply to the inflammatory swelling of the disc.

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Sir,

Endogenous fungal endophthalmitis caused by *Paecilomyces variotii*

With the increasing use of antibiotics, indwelling catheters and immunosuppressive agents, the incidence of endogenous fungal endophthalmitis has been increasing over the past few decades.[1] While endogenous fungal endophthalmitis is an infrequent complication of systemic mycoses, it is typically found in patients who have risk factors such as systemic debilitating disease, malignancy, long-term intravenous treatment with or without antibiotics, hyperalimentation, recent systemic surgery or trauma, indwelling bladder catheters, immunosuppression, and intravenous drug abuse.[2] The condition seldom occurs in healthy immunocompetent individuals. *Candida*, *Aspergillus*, *Coccidioides*, *Cryptococcus* and *Blastomyces* are the more commonly encountered causative agents.[2]

Paecilomyces endophthalmitis is very rare, and to our knowledge, endogenous fungal endophthalmitis caused by *P. variotii* has not been reported in the literature. We report herein such a case in a young woman who had a background of acute myeloid leukaemia.

Case report

A 23-year-old woman was referred to us in June 1996 with a 1 day history of blurring of vision in the left eye. She had had acute myeloid leukaemia diagnosed in 1995, and was in complete remission after induction chemotherapy. The last dose of consolidation chemotherapy with cytarabine was given 2 weeks before the present illness. Her eye symptoms were preceded by a 3 day history of general malaise, fever, chills and rigors. Her general condition deteriorated rapidly and the conscious level fluctuated from poor to fair. Her past ocular history was unremarkable with normal vision in both eyes.

On examination, visual acuity was finger counting and 20/20 in her left and right eyes respectively. Slit-lamp examination of the left eye revealed a moderate amount of ciliary injection. The cornea was clear but there were some scattered non-pigmented keratic precipitates, 3+ cells and 4+ flare in the anterior chamber. There was also an organised mass about 5 mm in diameter adhering to the anterior lens surface (Fig. 1). Some posterior synechiae were also present but the crystalline lens appeared otherwise to be clear. Moderate vitreous haze was present and the posterior pole of the

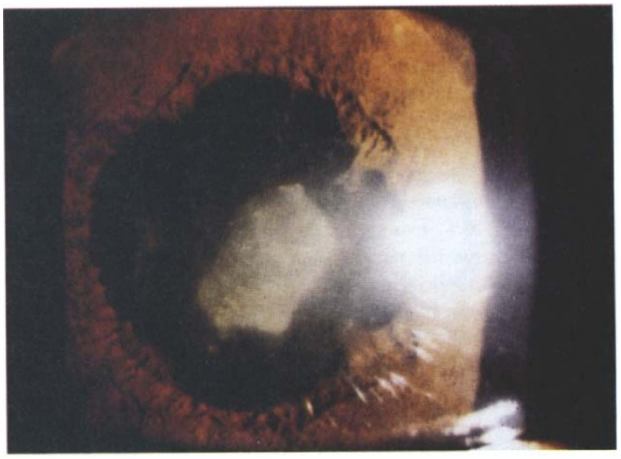

Fig. 1. *Slit lamp photograph showing some posterior synechiae and an organised mass in the anterior chamber.*