paresis to mucormycosis infection of the sphenoid sinus that involved the cavernous sinus and resulted in occlusion of the intracavernous internal carotid artery. In contrast, we attributed the conjugate gaze paresis to posterior cerebral artery occlusion that was confirmed angiographically.

We consider that the mechanism of ocular movement disorder in our case may be explained as follows. The conjugate gaze paralysis in the contralateral direction is attributable to the left fronto-pontine pathway lesion at the midbrain level on the left, but the right fronto-pontine pathway from the right frontal eye field to the left pontine paramedian reticular formation is intact, and therefore conjugate horizontal gaze to the left is possible.[8] Total ophthalmoplegia, dilated pupil and ptosis of the eyelid in the left eye are attributable to an ipsilateral third and sixth nerve palsies due to midbrain and ventral pontine lesions. Thus, only adduction of the contralateral eye was preserved. The additional findings, which include hemiplegia and hemihypoesthaesia of contralateral side, are attributable to involvement of the left corticospinal and right spinothalamic tracts in the ipsilateral brain stem and thalamus.[9] Also, because of the left thalamic involvement, all sensory modalities markedly decreased on the right side of the body. The sensory symptoms in the patient's face and decreased corneal reflex suggested that the trigeminothalamic tract was becoming involved.

All these signs in our patient may be explained by posterior cerebral artery occlusion. The paired posterior cerebral arteries supply the occipital cerebral cortex, medial temporal lobes, thalamus and rostral midbrain. Also, extension of the infarction area to the pons in the patient's MRI scans additionally reflects occlusion of the pontine branches of the basilary artery.[9] Since these branches are quite small-calibre arteries, they were not visualised at DSA.

We report this case to emphasise an unusual case of the one-and-a-half syndrome in a patient in whom the only preserved eye movement was adduction.

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Sir,

Late clouding of an acrylic intraocular lens following routine phacoemulsification

Acrylic intraocular lenses (IOLs) are becoming increasingly popular in phacoemulsification surgery. There are different acrylic IOLs and variations in the side-chain components of the acrylate/methacrylate polymer backbone give the lenses different physical and biological properties.[1,2] The advantages of acrylic IOLs include a lower inflammatory response,[3] lower risk of pigmented precipitates[4] and a lower rate of posterior capsule opacification[5] compared with either standard polymethylmethacrylate or silicone lenses. The acrylic lenses are usually foldable, allowing their insertion through a smaller incision.

There have been few complications reported from the use of acrylic IOLs. These include scratches on the lens optic,[6] stress fractures[7] and transient marks[1] during folding, and post-operative glistenings.[8] We report a case of clouding/fogging of a foldable acrylic IOL (SC60B-OUV, Medical Devices Research, FL) made from poly-2-hydroxyethyl methacrylate polymer. This case is unique in that the fogging became apparent only 7 months after surgery and seems permanent.

Case report

A 73-year-old Caucasian woman underwent uneventful phacoemulsification with lens implant in her right eye. Her post-operative recovery was uneventful and vision improved from 6/24 pre-operatively to 6/12 with correction on a Snellen chart. Her past ocular history includes bilateral panretinal photocoagulation for proliferative diabetic retinopathy, mild to moderate dry macular degeneration of both eyes and known left optic atrophy which was long-standing. The left eye also has tractional retinal detachment involving the macular area and hence has poor vision. One year following surgery she complained of worsening vision but her Snellen acuity remained stable. Clinically her IOL was noted to be cloudy centrally, making it appear as though there was a nuclear cataract in the IOL (Fig. 1). The anterior and posterior chambers were quiet with no inflammatory cells or blood. Four months prior to this the visual axis was recorded as clear. A short course of prednisolone 0.5% drops was prescribed but made no difference to the cloudy appearance of the IOL. By the following month, the cloudiness increased and retinoscopy became more

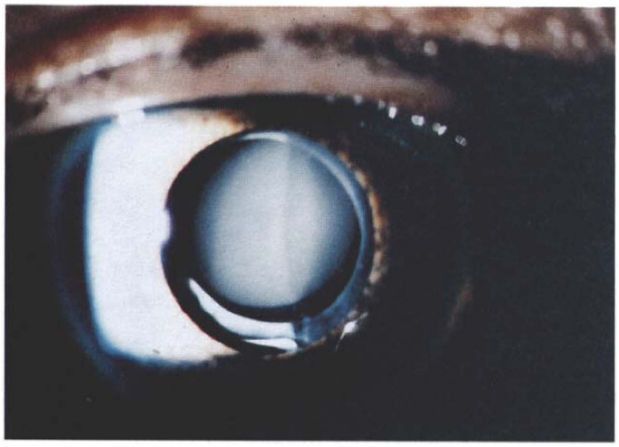

Fig. 1. *Photograph showing the central cloudiness of the intraocular lens.*

difficult. Her vision dropped to 6/18 corrected. We are considering exchanging the IOL as she is significantly affected by the drop in vision. However, she has significant corneal guttata in that right eye.

Comment

Clinically insignificant glistenings on acrylic IOLs have been described a week following surgery or after 48 h in laboratory conditions.[8] Temperature fluctuations were linked to these findings and the glistenings were thought to be due to microvacuole formation within the lens polymer as the temperature exceeded the glass transition temperature. Water from the anterior chamber was then able to enter these vacuoles and cause the glistenings, due to the different refractive indices of water and the lens polymer. These glistenings disappeared when the IOLs were dehydrated/dried.[8]

Fogging of excessively warmed AcrySof IOLs has been reported when the lenses were unfolded in the eye. When explanted they became clear again, presumably due to drying.[9] The IOL in this case was kept at room temperature and not pre-warmed. Condensations on acrylic[10] and silicone[11] IOLs have been noted after vitrectomy and air-fluid exchange, but these only occur on posterior surfaces of IOLs. As far as we are aware there has been no such reported clouding of an IOL this long after routine phacoemulsification surgery.

The ideal management of any foggy IOL is removal at the time of primary surgery, but in this case the fogging only became apparent about 7 months post-operatively. This incident has been reported to the distributor and the Medical Devices Agency. We speculate whether this was a problem in design/manufacture and whether temperature fluctuations that occur daily in the human body can cause this. We are not aware of another published report of this problem although a significant number of these lenses have been implanted. We recommend caution in the use of IOLs made from poly-2-hydroxyethyl methacrylate and that patients with such implants should be followed up for longer than usual.

We would like to thank Mike Geall, Leeds General Infirmary, for the photograph.

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Sir,

Familial intermediate uveitis: a case report of two brothers

Intermediate uveitis (IU) is a well-recognised chronic ocular inflammation characterised by an inflammatory aggregate at the inferior vitreous base, pars plana and peripheral retina. The aetiology of the condition remains obscure, but there is some indirect evidence that autoimmunity plays a role. We present two brothers with IU, together with the results of their HLA typing and that of their immediate family.