therefore, when given at a dose of 65 mg/kg (in children less than 20 kg) or 130 mg (in children more than 20 kg), has been shown to cause a small but significant improvement in visual acuity as demonstrated by visual evoked potentials. However, long-term results are awaited.

In the present case, the visual acuity and retinopathy remained clinically stable over a follow-up period of 5 years. However, repeat electrophysiological testing could only exclude the progression. This report thus supports the earlier claims that dietary supplementation along with addition of DHA helps in stabilisation of the retinopathy.

We are very grateful to Mr D. Brosanhan for providing us with the details of this interesting case.

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Sir,

Spontaneous reattachment of retinal detachment in a highly myopic eye with a macular hole

Spontaneous resolution of idiopathic senile macular holes with foveal detachment has rarely been observed in non-myopic eyes.[1,2] Bonnet and Semiglia[3] reported a similar finding in three severely myopic eyes in the French literature. They concluded that such detachments were likely to be tractional rather than rhegmatogenous secondary to a macular hole. We would like to report a case of spontaneous reattachment of retinal detachment in a highly myopic eye with a macular hole. The retinal detachment is probably a combined tractional and rhegmatogenous type.

Case report

A 65-year-old Chinese woman with bilateral severe myopia of –20.00 DS was referred to our vitreoretinal unit with a 5 day history of a sudden increase in a central scotoma of the right eye. Her best-corrected visual acuity was 20/200 and 2/200 over the right and left eye, respectively. Slit-lamp examination revealed aphakia in the right eye and pseudophakia in the left eye. Intraocular pressure and the anterior segment were normal. Fundoscopy showed bilateral myopic chorioretinal degeneration of the macula with the presence of posterior staphyloma, which extended up to the temporal arcades and the nasal edge of the disc. Additionally, there was a convex-shaped retinal detachment over the superior two-thirds of the right macula. Contact lens biomicroscopy of the right macula revealed a full-thickness macular hole of size 200 μm, which was surrounded by a thin epiretinal membrane. Axial length was 32.58 mm and 30.40 mm over the right and left eye, respectively. After detailed explanation, she refused operation at that juncture. Four weeks later, the staphylomatous retinal detachment was flattened and the macular hole was not visible. The epiretinal membrane was separated into the vitreous cavity, with a central round defect corresponding to the original macular hole. Her visual acuity remained at 20/200 but she admitted a decrease in size of the central scotoma. Six months later, her condition remained stable.

Comment

In a study by Morita *et al.*[4] the risk of macular hole causing rhegmatogenous retinal detachment was significantly increased in eyes with high myopia, posterior staphyloma and chorioretinal atrophy. However, contrary to their report, we have illustrated a rare case of spontaneous flattening of macular detachment in an eye with all these risk factors. We hypothesise that the detachment in our patient is a combined tractional and rhegmatogenous type. The rhegmatogenous component is apparent, as the detachment is convex towards the pupil with the presence of a macular hole. Epimacular membrane is responsible for the tractional component. Although the

retinal pigment epithelium is unhealthy in a myopic atrophic area, it may still be able to pump away the non-bullous subretinal fluid, especially when the macular hole is small and once the epimacular membrane has separated spontaneously relieving the traction.

As the natural history of retinal detachment secondary to macular hole in severely myopic eyes is not well defined, we have to exercise caution when considering vitreoretinal surgery for this group of patients, as they are prone to risks such as expulsive suprachoroidal haemorrhage and an unfavourable visual outcome.

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Sir,

Central retinal vein occlusion complicating treatment with intravenous immunoglobulin

Intravenous immunoglobulin therapy is increasingly used in neurological practice. We describe a case where the use of immunoglobulin therapy may have contributed to the development of visual impairment secondary to central retinal vein occlusion (CRVO).

Case report

A 40-year-old woman with a diagnosis of chronic inflammatory demyelinating polyneuropathy, according to the criteria of Dyck and Prineas,[1] was initially treated with high-dose oral prednisolone therapy. However, due to progression of disease she was admitted to the neurology unit for treatment with pooled intravenous immunoglobulin (IVIg) 400 mg/kg daily for 5 days. A good clinical response was seen and she was discharged home on a combination of prednisolone and azathioprine therapy and followed up in the outpatient clinic. Treatment with monthly day case IVIg 400 mg/kg, in addition to oral maintenance immunosuppression, was commenced 2 months later.

On attendance for the second infusion the patient complained of two episodes of transient partial visual field loss affecting initially the left eye, 1 week after IVIg treatment, and then the right eye, 4 weeks after IVIg treatment. Visual field testing was normal to confrontation, and visual acuity was 6/6 corrected bilaterally. Fundoscopy revealed a small cholesterol embolus in the upper-outer quadrant of the right eye. General examination revealed no stigmata of hypercholesterolaemia, blood pressure was 140/80 mmHg, pulse rate 68 beats/min and regular, heart sounds were normal and no neck bruits were detectable. The patient is a non-smoker and has no family history of vascular disease. Full blood count, urea and electrolytes, thyroid and liver function tests and serum glucose measurements were all within normal limits. Plasma viscosity was slightly elevated at 1.78 with a normal electrophoretic profile, negative skeletal survey and Bence-Jones protein negative. Serum cholesterol was evaluated at 6.5 mmol/l. Carotid Doppler studies demonstrated bilateral low-grade disease with less than 30% stenosis of the internal carotids. The echocardiogram was entirely normal. The patient was given advice regarding a cholesterol-lowering diet and commenced on aspirin 75 mg once daily.

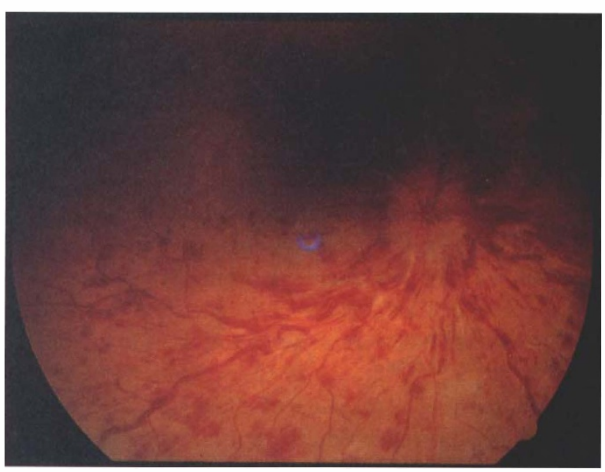

Fig. 1. *Photograph of the right fundus confirming the typical changes of central retinal vein occlusion (CRVO) with disc swelling in conjunction with extensive retinal haemorrhage and cotton wool spots.*