Comment

It is well known that cutaneous malignant melanomas are very rare in people of Afro-Caribbean origin. However, as in this patient, when they present they are usually acral lentiginous melanomas, with the palms, soles and subungual regions being favoured sites and associated with poor survival.[7,8] Metastatic cutaneous melanoma to the conjunctiva is also exceedingly rare and is usually not even mentioned in major clinicopathological reviews on ocular metastases.[9] Only three previous cases of ocular metastases from cutaneous melanoma in Afro-Caribbeans have been reported, all of which were to the orbit presenting with proptosis.[2] To our knowledge, this is the first case report of a metastatic melanoma to the conjunctiva in an Afro-Caribbean patient.

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Sir,

Late infection of a 5-fluorouracil enhanced bleb following systemic chemotherapy

Since the introduction of 5-fluorouracil (5-FU) to improve the results of trabeculectomy,[1] concerns have arisen over the risk of delayed-onset bleb infections. The reported incidence following 5-FU usage is between 3.8%[2] and 5.7%.[3] However, a recent retrospective study[4] found no difference in the rates of such infections whether trabeculectomy was performed with or without adjunctive antiproliferative agents. Systemic factors, such as diabetes mellitus and chemo- or radiotherapy for neoplastic disease, may also influence the development of post-operative ocular infections.[5,6]

We present a case of delayed-onset bleb infection affecting a 5-FU enhanced trabeculectomy occurring in a patient shortly after commencing chemotherapy for carcinoma of the lung.

Case report

A 76-year-old non-diabetic man was diagnosed with chronic open angle glaucoma in 1988. He underwent a left trabeculectomy in 1989 and a right trabeculectomy in 1991. The latter failed and a repeat right trabeculectomy was performed in 1995 with peroperative 5-FU. This resulted in good intraocular pressure (IOP) control and stable visual fields on no topical medication, with a shallow bleb in the left eye and a thin-walled bleb in the right.

In July 1997 he was found to have an inoperable squamous cell carcinoma of lung and was commenced on MIC (mitomycin, iphosophosphamide, cisplatinum) chemotherapy. Three days later, his right eye became sore and inflamed with some discharge. After a further 7 days he presented to the Eye Casualty department, where a bleb abscess with some associated anterior chamber activity was found. *Staphylococcus aureus* was isolated from a conjunctival swab. This delayed-onset bleb infection responded to treatment with topical gentamicin and cefuroxime plus systemic ciprofloxacin. A bleb leak developed during the admission but eventually settled. Unfortunately, subsequent bleb failure with loss of IOP control occurred plus increasing nuclear sclerosis. A phacotrabeculectomy (without 5-FU) was performed, 7 months after the bleb infection occurred, via the inferotemporal quadrant with restoration of IOP control and a corrected vision of 6/9.

He subsequently underwent a further five cycles of chemotherapy, but with a 20% reduction in the chemotherapy dosage because of this episode of neutropenic sepsis. Prophylactic topical chloramphenicol was also used during these cycles. No further episodes of bleb infection occurred, until his death in October 1998.

Comment

The adjunctive use of 5-FU has increased the success rate of filtering surgery[1,2,7–9] but relatively high incidences of bleb-related sequelae have been noted.[2–4] A possible explanation for the higher occurrence of late bleb-related infection in these eyes is the toxic effect of 5-FU on the existing activated fibroblasts.[2] Also, with the use of 5-FU

the resulting bleb is thin-walled and cystic, which is a recognised risk factor for late bleb infection.[4,6] In our case, infection occurred only in the thin-walled cystic bleb of the right eye in which 5-FU was used, and not in the functioning bleb of the other eye.

Systemic conditions such as immunosuppression, diabetes mellitus or upper respiratory tract infections may influence the development of ocular infection.[5,6] In our case, neutropenia secondary to bone marrow toxicity following the first cycle of the MIC chemotherapy was temporally associated with the bleb infection.

Short-term prophylactic use of topical antibiotics for patients with thin-walled blebs has been recommended,[6] although it is unknown whether such a regimen does lower the incidence of late bleb-related infections. We used prophylactic topical chloramphenicol as an empirical approach during the subsequent five cycles of chemotherapy, and no further episodes of infection occurred.

Topical short-term antibiotic prophylaxis should be considered in high-risk patients. However, a randomised trial of topical antibiotic prophylaxis is needed to confirm their benefit.

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Sir,

Ophthalmic findings in HIV seropositive Tanzanian patients

It is now estimated that more than 95% of those infected with HIV live in the developing world. Almost 70% of the global total live in sub-Saharan Africa.[1] At Kilimanjaro Christian Medical Centre (KCMC) in Moshi, Northern Tanzania, patients testing positive for HIV infection were examined to assess the spectrum of ophthalmic disease in an HIV-positive population in East Africa.

Clinical cases

Two cases of patients were examined: unreferred patients from the medical wards in the hospital not known to have an eye problem, and patients with an eye complaint. Forty-seven patients were examined, 24 of whom were male. The mean age was 36.9 years. There were 27 in the first group of unreferred ward patients, of whom 25 had AIDS as defined by the 1993 CDC Expanded Surveillance Case Definition for AIDS among Adolescents and Adults.[2] Nineteen had no abnormal ophthalmic findings; 7 had HIV-related retinopathy consisting of cotton wool spots, dot haemorrhages or both. One patient with an encephalitis had papilloedema and a unilateral VIth nerve palsy.

There were 20 patients in the second group of ophthalmic referrals, of whom 10 had AIDS. The most common diagnoses were herpes zoster ophthalmicus, conjunctival squamous cell carcinoma and conjunctival Kaposi's sarcoma. There were several patients with neuro-ophthalmic diagnoses: papilloedema with cortical blindness, homonymous hemianopia, bilateral optic atrophy, retrobulbar optic neuritis. Only two patients had a retinochoroiditis, both of unknown aetiology but not consistent with cytomegalovirus infection.

In the 35 patients with AIDS the most common non-ophthalmic conditions seen were oral and oesophageal candidiasis, HIV-related wasting syndrome with or without diarrhoea or fever, pulmonary tuberculosis, herpes zoster infection, and central nervous system disease from cerebral toxoplasmosis, pyogenic meningitis and HIV-related encephalopathy.

Comment

Availability of HIV testing at the hospital was poor for financial reasons. Testing was biased towards those with a known risk of HIV, particularly those with herpes zoster ophthalmicus or conjunctival squamous cell carcinoma.[3,4] However, there were also many patients throughout the year with the above two diagnoses[5] and conjunctival Kaposi's sarcoma who could not be tested, in whom a diagnosis of HIV was likely.

The spectrum of ophthalmic disease in HIV-positive patients in Africa is different from that in the developed world. Early markers are herpes zoster ophthalmicus, conjunctival squamous cell carcinoma, and lid or conjunctival Kaposi's sarcoma, which were prominent in