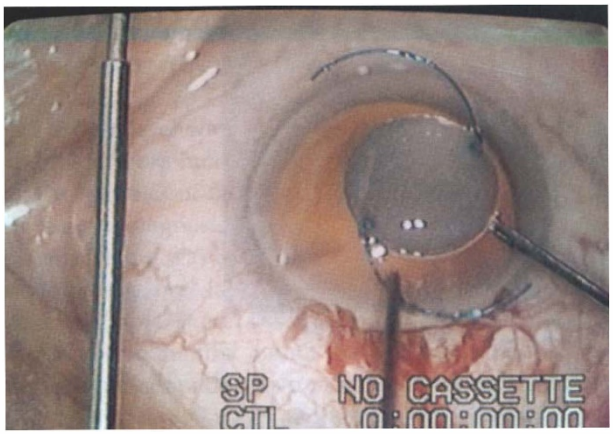

Fig. 1. *Appearance of the intraocular lens at the time of explantation.*

and the optic of the implant was opaque, obscuring the fundal view. The affected implant was found to be milky at explant (Fig. 1) and a 7 mm rigid PMMA lens (Model PS26TB, Allergan) was inserted into the capsular bag (Fig. 2) 4 days after the original procedure. Subsequently the vision has improved to 6/9 in either eye.

Comment

Inspection of the affected intraocular lens (IOL) revealed a white cloudiness over the entire area of the lens body, except for the extreme perimeter and a small area around each haptic. The cloudiness was throughout the whole body of the material and not on the surface. The IOL was returned to the manufacturer who carried out a thorough investigation and produced a full report. The IOL had a high haze level and failed the resolution specification for the implant. The cloudiness did not disappear in distilled water at room temperature, but cleared 15 days later following heating at 50 °C. There were no unusual factors or abnormalities during the manufacturing process of the implant.

The estimated incidence of opacity in other models of silicone implants is 1 in 50 000 of those manufactured. However, only one other case of a cloudy silicone PhacoFlex SI30NB lens has been reported. When explanted, the lens was found to be covered in white deposits and the material of the implant was not opaque.

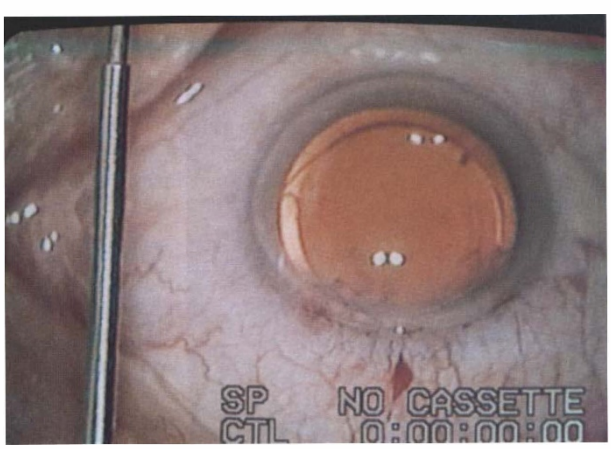

Fig. 2 *Appearance of the intraocular implant immediately following lens exchange.*

Consequently, this case appears to be unique for this model of intraocular implant. In the majority of cases involving other models of implant, the cloudiness is said to reduce with time, but implants are exchanged in about a third of cases. No definitive cause for the problem has been found. In view of the fact that this lens cleared with heating, and in other cases some spontaneous clearing may occur, it may be reasonable to manage cases conservatively for a period before lens exchange is carried out.

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Sir

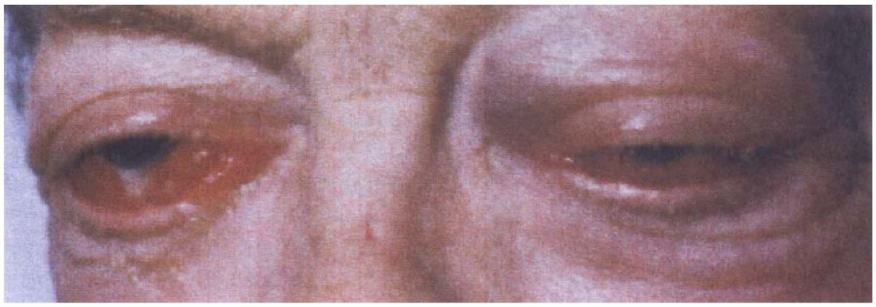
Bilateral retro-orbital plasmacytoma

Orbital involvement by multiple myeloma accounts for less than 1 in 400 cases of malignancy of the eye.[1] Most frequently it presents with proptosis,[2–6] which is more commonly unilateral.[2] We report an unusual case with bilateral orbital involvement plus cutaneous manifestations.

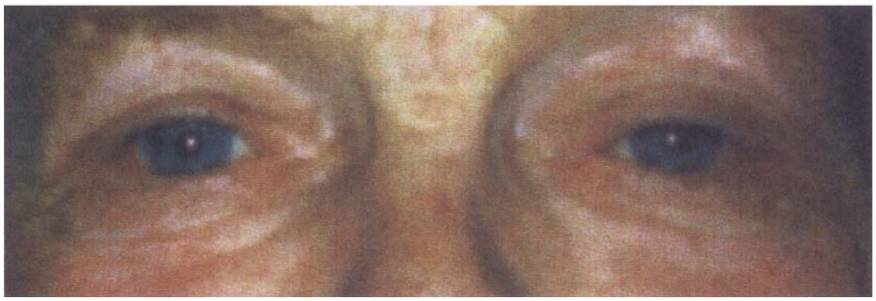
Case report

A 75-year-old man presented in January 1998 with a 7 day history of bilateral swelling of his eyelids. He had had discomfort and intermittent diplopia since December that had become constant over the preceding week. He was a type II diabetic and was diagnosed with IgA myeloma in December 1996, when he presented with increasing shortness of breath. He was noted to be anaemic with an IgA level of 64.8 IU, and IgA light chain. The plasma cell proliferation was confirmed by bone marrow biopsy. Treatment consisted of plasmapheresis and adriamycin, carmustine, cyclophosphamide and melphalan (ABCM) chemotherapy. Following treatment he remained in remission (plateau phase) until January 1998. His last IgA taken in December 1997 was 4.5 IU (normal range 1.25–4.25 IU).

On examination corrected visual acuity was 6/9 right and 6/12 left. He had proptosis of 25 mm right and 23 mm left, but there was no lid lag or retraction. Severe restriction of all eye movements was noted. There was bilateral chemosis and conjunctival injection (Fig. 1a).



(a)



(b)

Fig. 1. *(a) Prior to treatment there is bilateral chemosis and proptosis. (b) After treatment.*

Fundoscopy was unremarkable. Multiple subcutaneous nodules were seen on both forearms. These were 4–8 cm in diameter, firm and mobile.

Orbital computed tomography showed soft tissue material within the orbital cone surrounding the optic nerve but separate from the extraocular muscles (Fig. 2).

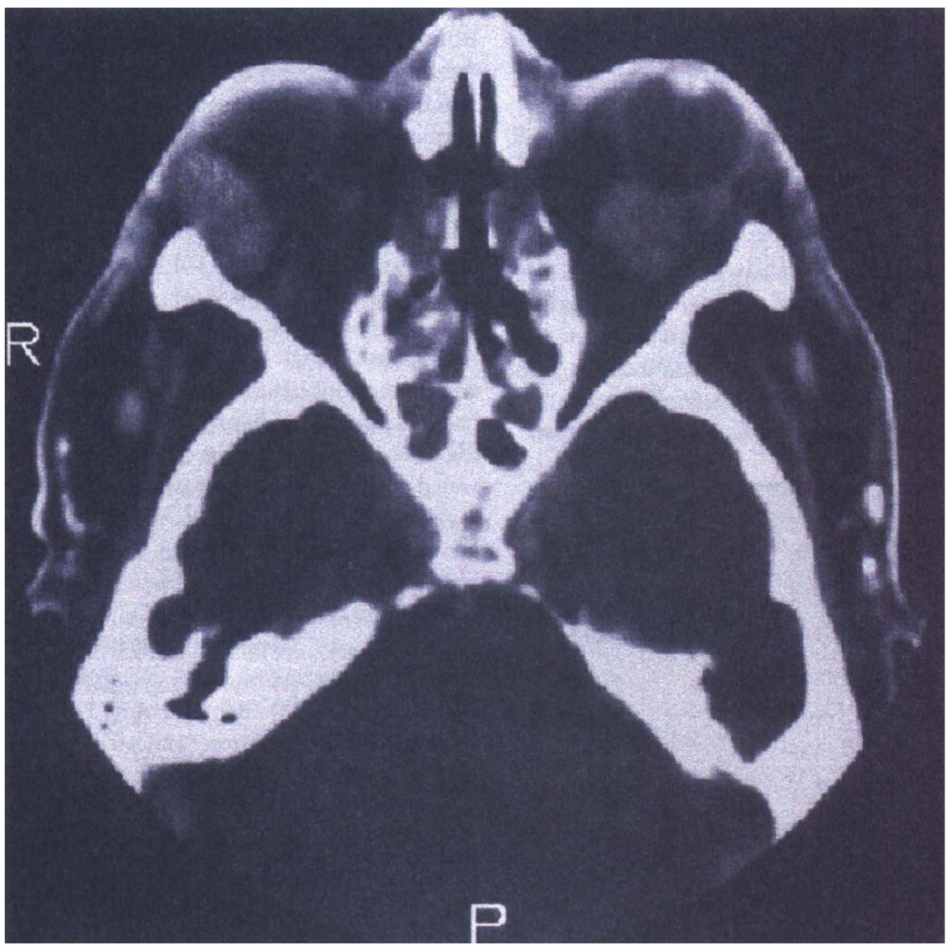


Fig. 2. *CT scan showing retro-orbital masses and normal extraocular muscles.*

There was minimal enhancement with contrast and no bony erosions. The extraocular muscles appeared normal.

His IgA level was repeated and found to be elevated and his thyroid function tests were normal.

On the basis of the past history and the above findings, a diagnosis of retro-orbital deposits of plasmacytoma was made. Treatment consisted of orbital radiotherapy, oral steroids and a further course of ABCM chemotherapy. There was an initial deterioration of vision within the first month that was attributed to exposure keratopathy. Two months following treatment his vision was 6/9, right and left, and the proptosis improved to 20 mm.

Comment

Multiple myeloma is a malignant proliferation of plasma cells which produces diffuse bone marrow infiltration and focal osteolytic deposits.[7] Proliferation of malignant plasma cells may occur as a localised deposit in the bone marrow, as a medullary plasmacytoma. However, if the deposit occurs outside the bone marrow it is termed an extramedullary plasmacytoma. Extraskeletal spread of multiple myeloma most frequently occurs in the spleen, liver, lymph nodes and kidneys.[8]

Orbital manifestations of multiple myeloma are rare.[2,4–6,9] In 1981, a review of the worldwide literature revealed 50 cases.[3] Bilateral orbital involvement is the rarest subgroup, with only four cited references in the literature.[4,10–12]

The disease can affect the orbit in a number of ways. Most commonly, it presents with unilateral proptosis without pain.[2,5,6] Although orbital involvement is rare, when it does occur it may be the initial presentation of the systemic disease in up to 75% of cases.[9]

The prognosis and treatment regimes for solitary plasmacytoma and multiple myeloma differ.[5] Therefore it is important to distinguish between them. Solitary plasmacytoma requires only localised treatment and it carries a better prognosis, with a mean survival rate of 8.3 years compared with 20 months for multiple myeloma.[6]

Interestingly this case of recurrence of myeloma was not limited to the orbits but at the time of diagnosis the cutaneous infiltration was also noted. This is a rare phenomenon, with only 60 cases recorded in the literature in 1978.[13] Generally, the onset of the cutaneous plasmacytoma also proves to be a bad prognostic sign, with 50% mortality at 6 months.[13]

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Sir

Infectious crystalline keratopathy after stitch removal in a lamellar corneal graft

Infectious crystalline keratopathy (ICK) is a rare corneal infection in which the infecting organism, often bacterial commensals found in the normal conjunctival flora, propagates without ulceration between the lamellae of the corneal stroma.[1] We describe a case of ICK which was observed to spread from a suture track immediately following the removal of the corneal suture, despite the use of prophylactic chloramphenicol. This is the first case to our knowledge where ICK has occurred in a lamellar corneal graft.

Case report

A 68-year-old woman was admitted from the orthopaedic ward of an affiliated hospital suffering from a central corneal perforation in the right eye resulting in a flat anterior chamber. The left eye had a central descemetocoele which was very slightly Seidel positive.

She had severe rheumatoid arthritis and was recovering from a left knee replacement. She did not have a history of rheumatoid eye disease.