Improvement in his self-image resulting from surgery has contributed to the improvement in his lifestyle and he has managed to abstain from alcohol since his surgery.

Comment

This case is unusual and interesting for several reasons. An intracavernous lesion presented with symptoms of pain and redness in the contralateral eye. Although such a finding has been reported previously[9] it remains difficult to explain, especially in the absence of a demonstrable carotico-cavernous fistula.

The results of conventional vertical muscle transposition surgery are often disappointing.[1–8] Whilst the Foster modification has been adopted widely in North America with encouraging results in both complete sixth nerve palsy and Duane syndrome, it has not gained great popularity in Britain. The addition of lateral fixation sutures to the transposed vertical rectus muscles significantly increases the tonic abducting forces of the transposition without decreasing adduction, by horizontal redirection of the path of the post-equatorial vertical muscle. The pre-operative use of botulinum added little to the procedure and the excellent post-operative improvement in ocular motility has remained long after any therapeutic effect from the injection had disappeared. In retrospect we should have reserved its use for treatment of a possible post-operative undercorrection, as suggested by Foster.[8] Repeated botulinum toxin injected into the left (or right) medial rectus may result in correction of the residual esotropia and remains an option in this case. Foster suggests that an ipsilateral medial rectus recession, even at a later date, should be avoided because of the risk of reduced adduction and possible late overcorrection.[8] We suggest the Foster modification of vertical muscle transposition is a useful technique in selected cases for the surgical management of permanent complete sixth nerve palsy.

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Sir,

The cosmetic improvement of ocular deformities with spectacles

Spectacles were first described during the Middle Ages. Their commonest use is for the correction of refractive errors. A less widely known use is in the optical improvement of cosmetic deformities.

Case report

A 4-year-old boy was born at 27 weeks gestation to non-consanguineous parents. He was subsequently found to have a cosmetically noticeable left microphthalmic eye with an opaque vitreous and cataract (Fig. 1). The right

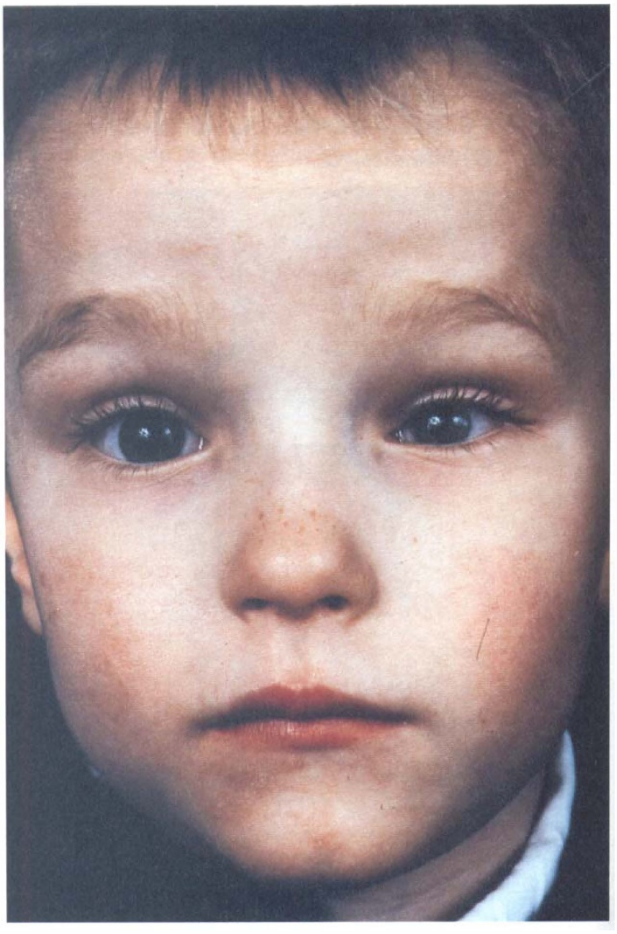

Fig. 1. *The patient's appearance without spectacles, showing noticeable left microphthalmia.*

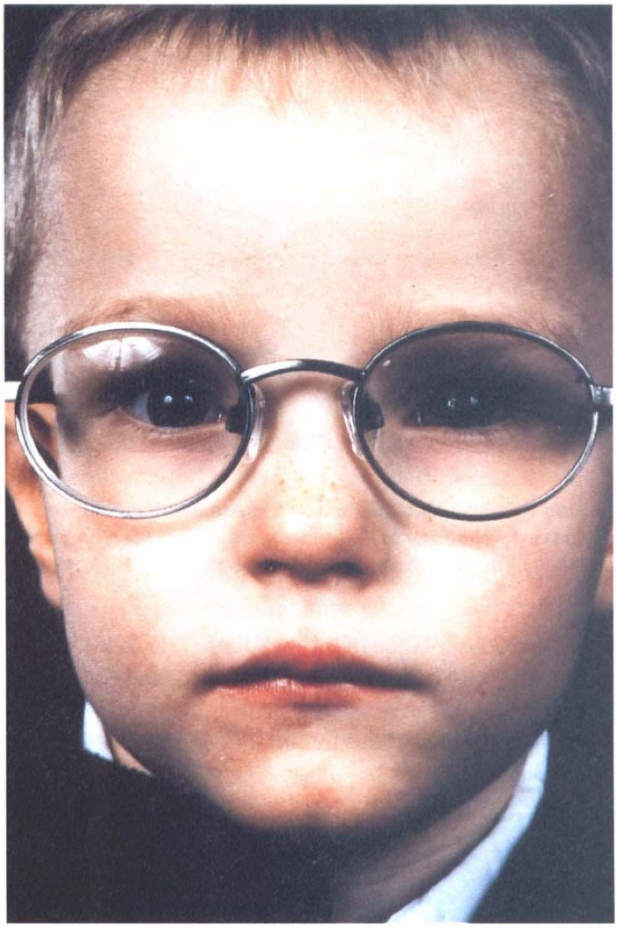

Fig. 2. *Spectacles with an appropriate prescription make the two eyes appear symmetrical in size.*

eye appeared unaffected. The microphthalmos may have been idiopathic but in view of the prematurity and the subsequent finding of a myopic fellow eye, retinopathy of prematurity was considered a possibility.

At the age of 2 years his right eye was highly myopic and had a visual acuity of 6/9 with a correction of −5.00 DS/+1.00 DC×90. The left eye had no perception of light. A prescription of +5.00 DS was given for this eye, which served as a counterbalance for the right lens and also had the effect of magnifying the microphthalmic eye to observers. The patient's eyes hence appeared symmetrical in size (Fig. 2).

Comment

The eyes are commonly judged to be the most prominent facial feature. This is particularly true for those wearing spectacles[1] and so can attract attention to any abnormalities of the eyes. It is thus desirable to strive for a good cosmetic appearance in such cases. The use of optical methods to improve cosmesis, particularly after orbital or facial reconstructive surgery, is well known to ocular prosthetists but little is written about it in the ophthalmic literature. Mittelviefhaus[2] has previously described cases in which the use of prismatic, hyperopic or myopic lenses improved the appearance of abnormal non-seeing eyes.

If the usual balance lens of −5.00 DS had been given to our patient, the cosmetic appearance would have been considerably worse. This case demonstrates how patients with deformities of the orbit or globe can benefit cosmetically if appropriate lenses are fitted in front of an ambylopic or blind eye.

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Sir,

Massive subretinal haemorrhage associated with central serous chorioretinopathy

Central serous chorioretinopathy (CSCR) is an exudative macular disease occurring in young healthy individuals commonly associated with serous pigment epithelial detachment. In most cases, CSCR is self-limiting and the majority of patients have excellent visual outcome. Some patients may develop persistent loss of vision due to irreversible damage to retinal pigment epithelium. Massive subretinal haemorrhage following CSCR is extremely rare.[1] We report a patient with a history of CSCR who developed massive submacular haemorrhage 5 years later.

Case report

A 48-year-old healthy Chinese woman presented with a 2 week history of a sudden drop in right eye vision. She had a history of CSCR in the right eye 5 years previously and was treated with focal laser in another institution (Fig. 1a). The vision in both eyes remained normal until this episode. On examination, visual acuity was light perception and 20/30 over the right and left eye, respectively. Anterior segment and intraocular pressure were normal bilaterally. Fundus examination of the right eye revealed an extensive subretinal pigment epithelial (RPE) and choroidal haemorrhage with a few superimposed subretinal haemorrhages. The lesion involved almost the complete temporal half of the retina (Fig. 1b). Contact lens biomicroscopy of the left macula showed small serous RPE detachments with surrounding RPE changes temporal to the foveola (Fig. 2a). Fundus fluorescein angiography (FFA) revealed only blocked fluorescent in the right eye and small punctate hyperfluorescent RPE window defects with mild leakage in the left eye (Fig. 2b). Indocyanine green angiography