patients with scleritis develop bilateral disease, 50% of whom have delayed onset in the fellow eye, mostly of the same type of scleritis.⁸ A high index of suspicion may uncover this sight-threatening but treatable condition.

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Sir,
Black or negative flashes in posterior vitreous detachment a transient symptom before lightning flashes commence

Occasionally a patient with medical training will experience the symptoms of a disorder that may provide a unique opportunity to determine the exact nature of the symptom. This has occurred in the past with lightning flashes from posterior vitreous detachment (PVD) because Moore published the findings of his own photopsia in 1947.¹ We describe an ophthalmologist colleague who suffered bilateral PVD with specific symptoms of black flashes for a brief period before the onset of the typical lightning flashes. One of the authors (LW) a 51-year-old female ophthalmologist with −5.5 D right eye and −6.0 D left developed acute PVD in the left eye. The first symptoms she noticed were black coloured flashes in the inferotemporal periphery. These were

momentary, vertically orientated and occurred in a flickering pattern before subsiding and then returning again. After 6 h, they were replaced by white flashes and floaters. She was examined by THW and found to have a PVD with Weis ring. Seven years later, she developed in the right eye a similar pattern of black flashes for 2 h before they were replaced by white flashes and floaters from PVD (confirmed by THW). We suspect that many patients forget or disregard this initial symptom because these flashes are soon replaced by white lightning flashes. Since the presentation by LW, we have on specific questioning found black flashes to be present in other individuals with PVD. The symptom may be due to traction on the axons of the surface of the optic nerve by the vitreous as the PVD process creates the Weis ring thus interrupting the signal from the retina. The fact that the PVD has not yet occurred is suggested by the appearance of floaters and white lightning flashes only after the black flashes have disappeared. Evidence that the PVD process can be traumatic to the optic nerve head can be seen in some patients who develop haemorrhages on the surface of the optic nerve head after PVD.^{2,3} This is the first description of black photopsia in PVD that we are aware of.

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Sir,
Successful surgical treatment of optic disc pit maculopathy

Congenital optic disc pit (ODP) with associated maculopathy is a rare anomaly with unknown pathogenesis. However, since the remarkable observations of Lincoff, it is widely accepted that fluid originating from ODP creates a schisis-like separation of the neuroretina and subsequently breaks through into the subretinal space.¹

We report successful surgical management of this pathology with emphasis on drainage of subretinal fluid.

Figure 1 Fundus photograph shows temporally located optic disc pit with associated maculopathy.

Figure 2 -5 degree 10mm single line time-domain (OCT) through optic nerve head and fovea (asterisk) shows schisis-like separation of the neuroretina (long arrows) and subretinal space (short arrow).

Case report

A 35-year-old woman was referred for left ODP maculopathy with reduced visual acuity to counting finger of 6 months duration. Fundus examination and Optical Coherence Tomography (OCT) confirmed the diagnosis (Figures 1 and 2).

Pars plana vitrectomy (PPV) with induction of vitreous detachment was carried out. Subretinal fluid only was internally drained. Argon endolaser was applied to retinotomy sites only. Internal tamponade was achieved with C3 F8 14%. Ten days face-down posturing was instructed.

Postoperatively, visual acuity improved to 6/18. Macula was flat on biomicroscopy with no recurrence and stable vision after 26 months (Figure 3).

Comment

The unfavourable natural history of this pathology has encouraged ophthalmologists to use a combination of techniques such as PPV, laser photocoagulation to the temporal margin of the optic disc, internal tamponade, macular scleral buckling procedure, and internal drainage of submacular fluid.²⁻⁴ However, the success rate is variable and optimal treatment is controversial.

Figure 3 Post-operative fundus photograph and OCT scan show the recovery of foveal depression and flat looking macula on biomicroscopy. Subfoveal hyporeflectivity (arrow) could be caused by shallow residual subretinal fluid or schisis.

Laser photocoagulation alone to the temporal margin of the disc does not generally yield promising results.⁵ The reason could be that laser energy that is absorbed by retinal pigment epithelium creates a deep scar, while the primary pathology is more superficial.⁶ It can also be destructive to the important structures adjacent to the disc.

Tangential vitreous traction is thought to be important in the pathogenesis. Vitrectomy with removal of posterior hyaloid combined with internal compression with or without laser treatment has successfully reattached the macula in several reports but has usually required a few months before complete disappearance of fluid.^{7,8}

The viscous nature of the fluid prompted the surgeon (PES) to attempt active internal drainage of subretinal fluid intraoperatively, which resulted in faster visual recovery in this patient. This is the first report that demonstrates inducing PVD with drainage of subretinal fluid could be as effective as applying laser to the temporal margin of the disc without its associated complications.

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Sir,
Exposure to verteporfin and bevacizumab therapy for choroidal neovascularization secondary to punctate inner choroidopathy during pregnancy

A pregnant woman diagnosed with choroidal neovascularization (CNV) secondary to punctate inner choroidopathy was treated with verteporfin and bevacizumab, without fetal side effects.

A 24-year-old healthy myope presented with blurred vision in her right eye, with a visual acuity (VA) of 20/40 in the right eye and 20/25 in the left. Fundusoscopic findings revealed peripapillary chorioretinal plaques bilaterally, and an elevated grey subfoveal lesion RE. Fluorescein angiography confirmed right eye CNV and multiple punctate peripapillary and midperipheral hyperfluorescences.

After explaining the treatment options, she underwent PDT. Twelve days later, we were informed that β HCG levels and an ultrasound were consistent with a fourth week pregnancy, indicating exposure to PDT 1- to 2-week postconception. The patient was informed of possible risks related to her drug exposure.

Subsequently, right eye VA decreased to 20/70, and a thickened CNV was evident on FA with subfoveal fluid on OCT. After discussing treatment options, she underwent intravitreal injection of 1.25 mg bevacizumab (Avastin, Genentech, San Francisco, CA, USA) 3-month postconception. VA improved to 20/30, the macular lesion became a small atrophic scar, with stable OCT scans and VA throughout follow-up, until 3-month postpartum.

The pregnancy continued under observation. Two fetal ultrasounds were normal, and she delivered a healthy infant at term, without congenital anomalies then or at a 3-month follow-up examination.

A teratogenic effect of verteporfin exposure was found in rat fetuses at 40–125 times the human dose.¹ The risk of fetal exposure to activated verteporfin is smaller, and it is also not exposed to activating light. De Santis *et al*² reported verteporfin exposure in the first week postconception in a woman who had a healthy child.

Systemic bevacizumab is teratogenic in rabbits in doses twice the recommended intravenous human dose.¹ Our patient was exposed to intravitreal bevacizumab during the second trimester. Data from Genentech

concerning ranibizumab (~50 kD) revealed unmeasurable serum concentrations following intravitreal administration. This is expected to be even lower for the higher molecular weight bevacizumab. Nevertheless, minimal systemic absorption should be suspected, and although the drug could not cross the placenta barrier due to its high molecular weight (~149 kD), a theoretical effect on placental vasculature was kept in mind.³

Although exposed to verteporfin and bevacizumab, our patient and the fetus had no side effects. Obviously, verteporfin or bevacizumab treatment should be used with caution during pregnancy.

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Sir,
Fat-forming variant of solitary fibrous tumour of the orbit: the entity previously known as lipomatous haemangiopericytoma

The fat-forming variant of solitary fibrous tumour (SFT) previously known as lipomatous haemangiopericytoma is a distinctive soft tissue tumour composed of haemangiopericytoma-like areas interspersed with mature adipose tissue. Around 40 cases have been reported in the literature.¹ These tumours usually occur in deep soft tissue and only three orbital cases have been described.^{1–3}

Case report

A 49-year-old woman presented with acute left eye pain, epiphora, and proptosis. There was a history of thyroid eye disease and bilateral proptosis that had required orbital decompression and low-dose radiotherapy 6 years previously.