Sir,
A reminder that temporal arteritis is not necessarily giant cell arteritis

Arteritis affecting the temporal arteries may be the initial presentation of a widespread systemic vasculitis affecting multiple organ systems and requiring immunosuppressants other than corticosteroids to induce remission.

Case report

A 59-year-old woman presented to the eye department with a 1-day history of sudden decline in vision in the left eye. Associated symptoms were a 1-month history of intermittent frontal headache, jaw claudication, weight loss, and 'lumpy' areas on her temples. Best-corrected visual acuity was Snellen 6/6 right eye and 6/36 left eye. On examination, the left optic nerve head was swollen and the left temporal artery was tender and non-pulsatile. ESR was >100 mm/h and CRP was 195 mg/l. A diagnosis of temporal arteritis was made and corticosteroid treatment commenced.

Subsequently, a temporal artery biopsy confirmed arteritis but with features atypical for giant cell arteritis, namely a predominantly eosinophilic infiltrate (Figure 1a), a paucity of giant cells and fibrinoid necrosis (Figure 1b). Because of these features, she was referred to a rheumatologist. Further investigation revealed peripheral nerve involvement, livido reticularis, mild renal impairment (creatinine 102 µmol/l), and positive pANCA anti-MPO antibodies. A diagnosis of microscopic polyangiitis was made by the rheumatologist, who subsequently took over management. Combined treatment with corticosteroids and cyclophosphamide was commenced to induce remission.

Comment

It is common for the ophthalmologist to be referred suspected cases of temporal arteritis. It is also common

for patients to be treated presumptively with corticosteroids on the basis of a raised ESR and symptoms alone. Published good rheumatologic practice for the management of vasculitis advocates biopsy of affected tissue to classify the vasculitis and choose a treatment regimen.¹ The often quoted American College of Rheumatology diagnostic criteria for temporal arteritis have a false-positive rate of 7.8%.² We suggest that patients with the clinical diagnosis of temporal arteritis should undergo temporal artery biopsy to confirm the histological diagnosis of giant cell arteritis. If the biopsy shows atypical features, they should undergo investigation into the possibility of systemic vasculitis, which ideally should be undertaken by a rheumatologist. There have been other reports of ANCA-associated small vessel vasculitis affecting larger vessels.^{3–5} In our case without the biopsy findings, the presence of systemic vasculitis with renal impairment could have been missed and the treatment regimen would have been inadequate to induce remission.

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Figure 1 Haematoxylin- and eosin-stained sections of temporal artery biopsy. (a) Inflammatory infiltrate of temporal artery, including many eosinophils (arrows). (b) Area of fibrinoid necrosis in temporal artery (arrowhead).

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Sir, Unusual corneal foreign body

Many types of foreign bodies can enter the cornea.¹ We report an unusual case of a corneal foreign body that migrated through the corneal epithelium and stroma. The foreign body was a fragment of the patient's own hair that had migrated from the limbus to the paracentral cornea 6 weeks after a haircut.

Case report

A 27-year-old female patient was referred by her optician to the casualty department of Moorfields Eye Hospital for corneal opacity in her right eye. It had never been noticed before and there was no history of trauma to the eye.

Her best-corrected visual acuity was 6/5 in both eyes. Slit-lamp examination revealed a foreign body embedded in the stroma of the right cornea, surrounded by a very thin stromal reaction and an intact overlying epithelium. A stromal track of the moving foreign body was also noticed (Figure 1). The foreign body looked like a fragment of hair. Direct questioning revealed a haircut a few weeks before visiting her optician.

The foreign body was removed under topical anaesthesia and was recognised as the patient's own hair. At follow-up the cornea was clear with no signs of stromal scarring.

Comment

Hair usually penetrates deeply into the cornea and anterior segment, and once embedded can migrate or advance deeper into the cornea.¹ Although various theories have been proposed, the exact mechanism by which hair migrates or advances into the deeper layers of the cornea is not known.² The mechanism may vary depending upon the nature of the hair and the individual's immune

Figure 1 Astromal track of the moving foreign body.

response.² In principle, it is necessary to remove the foreign body adequately and identify it.³

We highlight this case because the corneal foreign body caused no symptom to the patient but caused corneal scarring. It entered the eye at the limbus and migrated in a centripetal fashion to the paracentral cornea. It would eventually have compromised the vision if the foreign body had migrated further into the central visual axis.

We are unaware of any similar report where a patient's own hair has been embedded in the cornea.

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Sir, Premacular subhyaloid haemorrhage in Eales' disease managed with Nd:YAG laser

Eales' disease is an idiopathic inflammatory obliterative vasculopathy.¹ We describe a case of premacular subhyaloid haemorrhage in Eales' disease managed with Nd:YAG laser posterior hyaloidotomy. We are unaware of such finding in world literature.