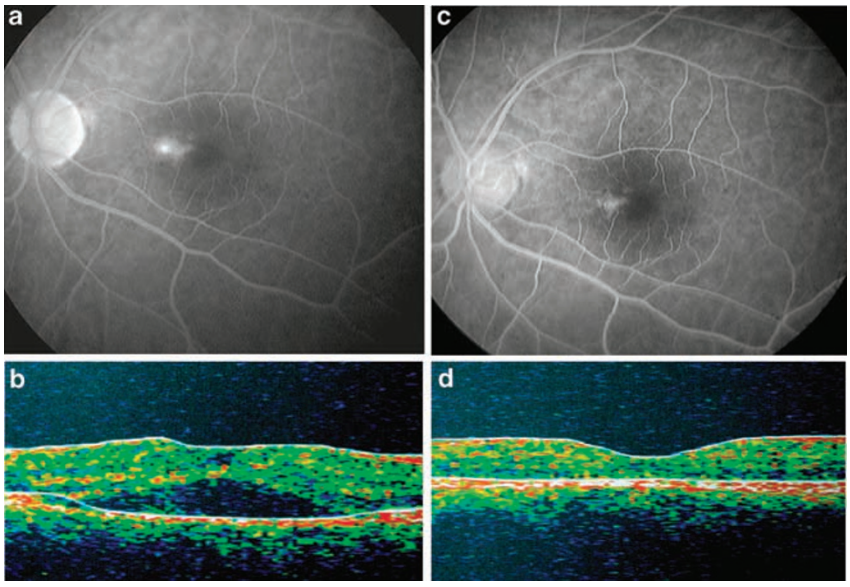

Figure 1 (a) Late-phase FA before treatment showing a focal leak at the level of the RPE. (b) Vertical-line optical coherence tomography (OCT) before treatment showing subfoveal neurosensory detachment. (c) Late-phase FA after treatment showing mottled hyperfluorescence without focal leakage. (d) Vertical-line OCT after treatment showing resolution of retinal detachment.

Comment

Persistent subretinal fluid in chronic CSC can produce severe and irreversible visual loss. Laser photocoagulation[5] and photodynamic therapy with verteporfin[6,7] have both been demonstrated to be effective in resolution of subretinal fluid. In our patient, we demonstrated that intravitreal bevacizumab can terminate RPE leaking and prompt resolution of subretinal fluid, which can be associated with rapidly improving vision and remain stable for 6 months. Although the exact mechanism of bevacizumab in chronic CSC is unknown, it may be due to the effect of antimicrovascular permeability.[8]

Of course, one case report does not prove the efficacy of intravitreal bevacizumab in chronic CSC. However, intravitreal bevacizumab may provide another treatment option for patients with chronic CSC. Further studies with greater number of eyes and longer follow-up are necessary to determine its value in these patients.

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Sir,

Clinicopathologic correlation of a subconjunctival foreign body using ultrasound biomicroscopy and anterior segment ocular coherence tomography

Foreign body (FB) conjunctival granulomas are uncommon. Useful information regarding their nature may be provided by ultrasound biomicroscopy (UBM).[1] The value of anterior segment ocular coherence tomography (AS-OCT) remains uninvestigated. We report a case of a symptomatic FB conjunctival granuloma over a Molteno implant in a patient with uveitic glaucoma. We compared UBM and AS-OCT findings and correlated these with the histological analysis.

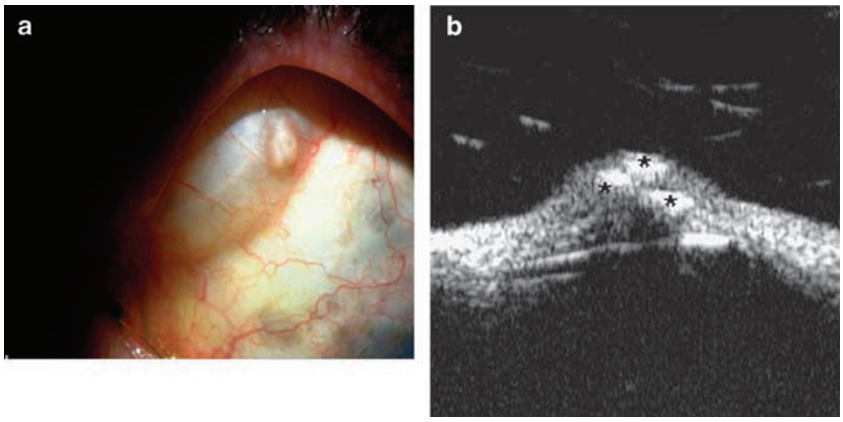

Figure 1 (a) Anterior segment photograph reveals elevated nodule on the bulbar conjunctiva above the glaucoma implant plate. (b) Ultrasound biomicroscopy shows an elevated nodule above the plate with echo dense structures (asterisk).

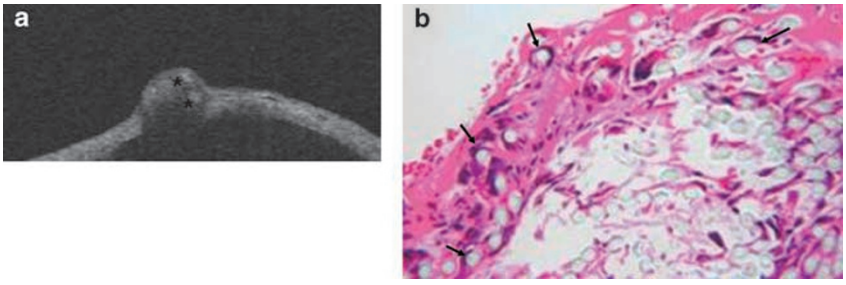

Figure 2 (a) Optical coherence topography shows an elevated lesion above the plate with hyper-reflective deposits (asterisk). (b) Histology (H&E) showing chronic granulomatous inflammation and birefringent suture material (arrows).

Case report

A 61-year-old woman, who had undergone multiple ocular surgeries including trabeculectomy, double-plate Molteno Implant, and penetrating keratoplasty, complained of tearing, and FB sensation OS. Slit-lamp biomicroscopy revealed a functional two-plate Molteno implant superiorly with a 2×2 mm round nodular white lesion, 12 mm from the limbus over the nasal plate (Figure 1a). Ultrasound biomicroscopy (Model P40; Paradigm Medical Industries Inc.) revealed an elevated, thickened conjunctiva, and multiple scattered, hyperechogenic deposits over the plate with posterior faint shadowing similar in intensity to the hypoechogenic subconjunctival filtering area (Figure 1b). High speed AS-OCT (Heidelberg Engineering Inc.) revealed similar scattered hyper-reflective less-demarcated deposits over the plate (Figure 2a).

Histological analysis (H&E) showed multi-stranded birefringent suture material surrounded by granulomatous inflammation and fibrosis. No calcification was evident (Figure 2b).

Comment

Conjunctival FB granulomas are uncommon and rarely related to surgery. Imbedded cilia, insect wings, and synthetic fibres are most commonly reported when histology is performed.[2–4] Suture granulomas are seen commonly after strabismus surgery. Both UBM and AS-OCT can detect cystic structures in the conjunctiva and eyelids.[5] Imaging with both modalities in our patient, excluded cystic changes and correlated well with the histological findings, where the multiple hyper-reflective deposits corresponded to embedded suture material. The intensity of hyper-reflectivity was similar, but not typical to that of calcification. Although UBM and AS-OCT are helpful in imaging FB conjunctival granulomas, histological analysis, however, remains the definitive diagnostic modality.

Acknowledgements

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Sir,

Pain response and follow-up of patients undergoing panretinal laser photocoagulation (PRP) with reduced exposure times

I read with interest the paper by Al-Hussainy *et al*.[1] In their paper, the authors concluded that reducing the exposure time and increasing the laser power while performing PRP can reduce pain significantly without compromising the long-term results of the treatment.

It has been our experience that using scatter retinal laser application with shorter duration setting, as described by the author, yields uneven and much smaller sized scars than the traditionally used longer duration laser setting (the scars have less than intended treatment spot size and with larger untreated retina in between). This can be explained by both insufficient time available for heat conduction into surrounding tissue to cause thermal damage and the Gaussian distribution of the energy across laser beam.[2] Additionally, it can be calculated from data provided by the authors that with reduced exposure setting, the mean laser energy necessary to achieve visible retinal reaction was much less ($0.02\,\text{ms} \times 489\,\text{mW} = 9.78\,\text{mJ}$ *vs* $0.1\,\text{ms} \times 178\,\text{mW} = 17.8\,\text{mJ}$) and, hence, expectedly lesser associated tissue damage and subsequent scaring.

Although the immediate visible retinal burns were apparently similar, the authors failed to mention the difference in the scar appearances between the groups in their study. In our experience, spaced smaller retinal scars produced by shorter duration laser setting are usually indicative of inadequate treatment and necessitates further laser application to control the proliferative process.

As the end point of their study has not been clarified, it is difficult to gain any knowledge regarding the time scale as well as the number of the sessions that were required to achieve regression of neovasculrization in their series and conclude effectiveness of their setting, compared with any published data.

Finally, their treatment setting using Volks lens, 300-μm spot size and high power requirement (mean 0.47 W, no SD was mentioned) is likely to breach laser safety to the anterior segment, where the laser energy fluence is much higher than the retinal plane due to smaller laser beam size at the corneal plane.[3]

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Sir,

Functioning avascular retinae—a report of two siblings

Complete absence of retinal vasculature is extremely rare; to date there have been four such reports published.[1,2] It has been previously assumed that such an anomaly necessarily involves a complete lack of vision. We present two siblings who, despite having complete retinal vessel absence, have useful vision. To the best of the authors' knowledge, these are the first avascular, seeing retinae to be described.

Case report

Two sisters, aged three and five (AA, SA) of consanguineous parents, presented with poorly controlled congenital glaucoma. AA had a right phthisical eye following previous surgery and uncontrolled glaucoma in the left. She demonstrated a degraded electroretinogram (ERG) in the right eye (Figure 1); no responses were obtained from the phthisical left eye. No consistent visual-evoked potentials (VEP) were recorded, though she had her eyes closed. AA had a right vitreolensectomy with control of glaucoma with combined dorzolamide and timolol, and bimatoprost. SA had uncontrolled glaucoma and dense cataract on the right with moderately controlled glaucoma in the fellow eye. She demonstrated normal ERGs in the right eye but no consistent responses in the left. Flash VEPs were recorded from both eyes (Figure 1). SA underwent combined left trabeculectomy and trabeculotomy with mitomycin C, with subsequent lensectomy. The right eye glaucoma was controlled topically as for AA. Both children had microspherophakia with marked iris hypoplasia and