In our patient, the retinal fold did not involve the fovea; however, it distorted the macular (Figure 1) area causing metamorphopsia and decreased VA. As the indentation of the buckle diminished in height within the next months, the retina gradually unfolded and VA was completely restored.

Our case illustrates the rare but possible occurrence of arcuate retinal folds, which could compromise the results of successful retinal reattachment surgery. We postulate that in our case, the formation of the retinal fold might have been prevented if the air was injected after the drainage of SRF and a gentler buckle was placed when the retina was more or less completely reattached. It could be also postulated that in cases where permanent indentation is not necessary, the removal of the circumferential buckle might be an option for the treatment of symptomatic arcuate retinal folds, as in our patient, the retinal fold regressed when the buckle indentation diminished in height.

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Sir,

Retinal artery occlusion associated with a patent foramen ovale

Systemic disease is usually responsible for retinal ischaemic events in patients under 30 years of age. We report the case of a young man with retinal artery occlusion (RAO) secondary to patent foramen ovale (PFO).

Case report

A healthy 17-year-old African-American male presented with sudden, painless loss of vision in his right eye while playing basketball. He denied associated symptoms of headache, pain, or visual disturbance, as well as a history of sickle cell disease or trait, or recreational drug abuse. An examination revealed a visual acuity of hand motions in the affected eye. The fundus had macular pallor and a cherry-red spot in the fovea (Figure 1). Fluorescein angiography was consistent with a RAO (Figures 2 and 3). An optical coherence tomography showed macular edema of 503 μm. The haemotological/infectious work-up, including transthoracic echocardiogram (TTE), was negative. However, a trans-oesophageal echocardiogram (TEE) showed a PFO. The patient underwent a successful percutaneous femoral catheterization to close the defect.

Comment

A PFO has been a reported finding in young patients presenting with RAO without risk factors for such an event.[1] Autopsy studies report the incidence of PFO to be 17–35% in the general population.[2] The association between PFO and embolism has been reported in young adults.[3] The source for the emboli is often not found, but is usually attributed to occult thrombosis. Nakagawa *et al*[4] reported a case of RAO in a patient with PFO and deep venous thrombosis. Our patient's history is significant for engagement in the basketball game at the onset of symptoms. This exertion, coupled with a sub-clinical thrombosis, may have resulted in the paradoxical RAO.

Chen *et al*[2] reported a fourfold increased incidence of PFO in patients with ischaemic events compared with that in controls, and a greatly increased sensitivity for

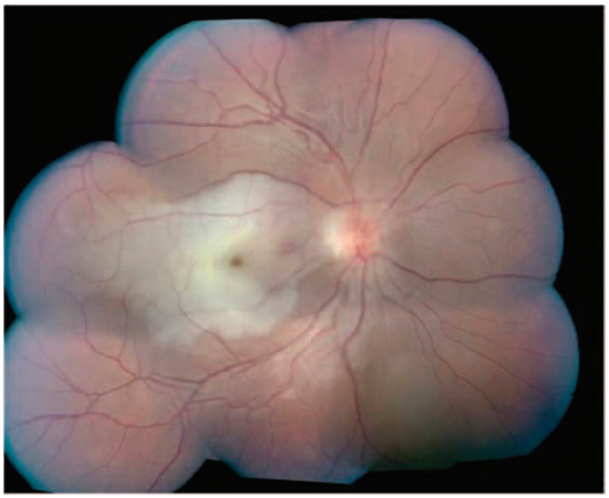

Figure 1 Right eye with inner retinal ischaemic whitening in the area supplied by the temporal retinal artery.

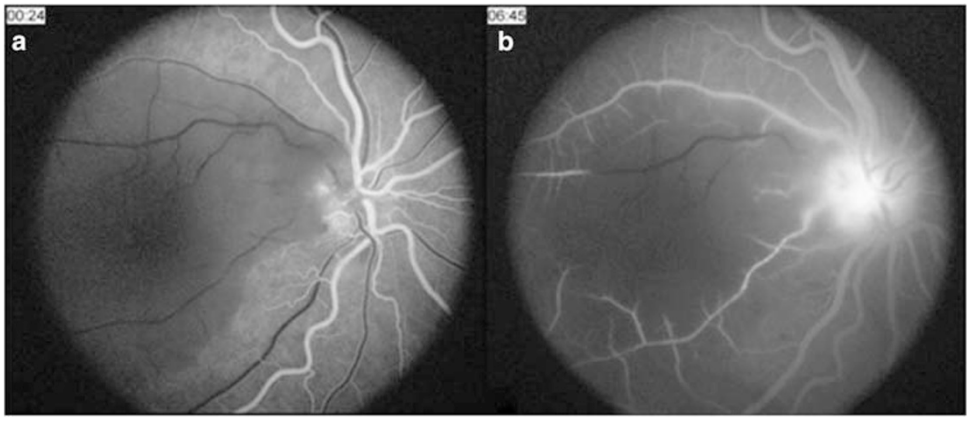

Figure 2 Corresponding fluorescein angiogram with (a) early and (b) late images, showing non-filling of the temporal artery and a corresponding hypofluorescence from non-perfusion of the area supplied by the artery.

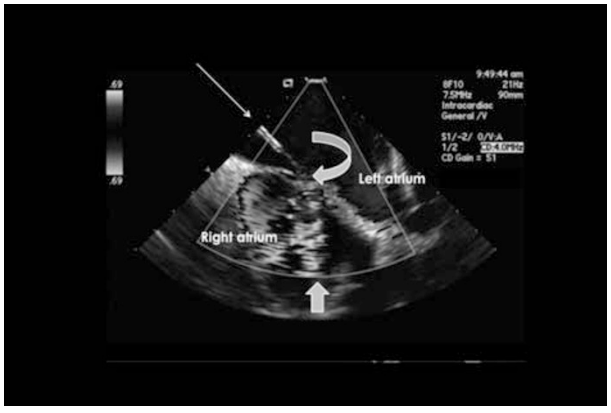

Figure 3 Intra-operative trans-oesophageal echography showing percutaneous femoral catheter (thin arrow) in the right atrium and the closure of the defect (curved arrow). The thick arrow indicates flow towards the defect.

detecting PFO with TEE when compared with TTE. Kramer *et al*[5] found TEE to have a higher yield than TTE in the evaluation of patients with RAO. As PFOs are usually asymptomatic, for younger patients presenting with a RAO and in whom the TTE and the corresponding work-up have been negative, a TEE is a more sensitive means of diagnosis.

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Sir,

Intravitreal bevacizumab as an adjunct in a patient with presumed vascularised choroidal tubercular granuloma

We report an interesting case of presumed vascularised choroidal tubercular granuloma successfully treated with 3 intravitreal injections of bevacizumab (Avastin).

Case report

A 41-year-old man on treatment with a four-drug regimen of antitubercular therapy (ATT), since 6 months