

We hope that dissemination of this information to a wider, general ophthalmic audience will improve the prophylactic management of recurrent Herpetic Eye Disease.

This study received funds from Bausch and Lomb. Some results of this study were presented as a poster at the Royal College of Ophthalmologists meeting, Birmingham, May 2007 and the European Association for Vision and Eye Research meeting, Vilamoura, October 2006.

## References

- 1 List of Consultant Ophthalmic Surgeons obtained from the Royal College of Ophthalmologists in February 2006.
- 2 The Herpetic Eye Disease Study Group: the epithelial keratitis trial. A controlled trial of oral acyclovir for the prevention of stromal keratitis or iritis in patients with herpes simplex virus epithelial keratitis. *Arch Ophthalmol* 1997; **115**: 703–712.
- 3 Wilhelmus KR, Gee L, Hauck WW, Kurinij N, Dawson CR, Jones DB, *et al.*, Herpetic Eye Disease Study. A controlled trial of topical corticosteroids for herpes simplex stromal keratitis. *Ophthalmology* 1994; **101**: 1883–1896.
- 4 Barron BA, Gee L, Hauck WW, Kurinij N, Dawson CR, Jones DB, *et al.*, Herpetic Eye Disease study. A controlled trial of oral acyclovir for herpes simplex stromal keratitis. *Ophthalmology* 1994; **101**: 1871–1882.
- 5 The Herpetic Eye Disease Study Group. Acyclovir for the prevention of recurrent herpes simplex virus eye disease. *N Engl J Med* 1998; **339**: 300–306.

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## Sir, Herpes zoster ophthalmicus complicated by incomplete ophthalmoplegia and a neurotrophic ulcer

We read with interest the article by Drew *et al.*,<sup>1</sup> and would like to comment on the authors' clinical management and conclusions.

In this patient, the authors elected not to investigate further for immunodeficiency. This is a fair approach in developed countries for healthy children with a sentinel herpes zoster ophthalmicus (HZO) event, as most do not have immunodeficiency or malignancy. However, in India and Africa, where human immunodeficiency virus (HIV) infection is epidemic, the first presentation of herpes zoster may be an indicator of HIV infection.<sup>2,3</sup> We would like to clarify this patient's background and whether HIV status was assessed, as this would be of clinical importance if she had originated from the Indian subcontinent.<sup>2</sup> Furthermore, adult patients with HZO-associated ophthalmoplegia were significant for HIV

infection.<sup>4</sup> HZO was the initial clinical manifestation in some cases, suggesting that reliance on clinical 'stigmata' of immunodeficiency as a guide to testing may be unreliable. None of the children reported with HZO-associated ophthalmoplegia had been tested for HIV, and therefore, the likelihood of underlying immunodeficiency in this condition is still unknown.

The authors mentioned that this patient received acyclovir and prednisolone to 'hasten resolution of her cranial nerve palsies'. Although early acyclovir treatment is effective for reduction of the duration of rash, incidence of pseudodendritic and immune stromal keratopathy and incidence and severity of postherpetic neuralgia, there is little evidence for its role in improving outcomes in HZO-associated ophthalmoplegia.<sup>5</sup> Likewise, there is little consensus on the efficacy of steroids. Good recovery of ophthalmoplegia and ptosis in both adults and children possibly reflects an intrinsic disease course towards resolution even without treatment. The rarity of paediatric zoster has prevented the conduct of prospective studies evaluating treatment options; however, we recognise that acyclovir and steroid administration is common in clinical practice.

Despite improvement in ophthalmoplegia and ptosis, mydriasis persisted. This has been consistently observed in patients with HZO and pupil dilation.<sup>3,4</sup> We hypothesise that orbital inflammation may have a relatively greater impact on the smaller parasympathetic C fibres to the sphincter pupillae than on the larger Aδ motor fibres innervating the extraocular muscles. Mydriasis should be recognised as an important neuro-ophthalmic sequelae of HZO.

## References

- 1 Drew B, Ibrahim K, Reddy MA. Herpes zoster ophthalmicus complicated by incomplete ophthalmoplegia and a neurotrophic ulcer. *Eye*, 3 October 2008 [E-pub ahead of print].
- 2 Feder Jr HM, Gnann Jr JW, Whitley RJ. Herpes zoster. *N Engl J Med* 2003; **348**: 2044–2045.
- 3 Pandey N, Chandrakar AK, Adile SL, Garg ML, Patel S. Human-immunodeficiency virus infection in a child presenting as herpes zoster ophthalmicus. *J Indian Med Assoc* 2007; **105**: 216–217.
- 4 Delengocky T, Bui CM. Complete ophthalmoplegia with pupillary involvement as a initial clinical presentation of herpes zoster ophthalmicus. *J Am Osteopath Assoc* 2008; **108**: 615–621.
- 5 Pavan-Langston D. Herpes zoster antivirals and pain management. *Ophthalmology* 2008; **115**: S13–S20.

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