pigmentosa, and ocular trauma, as well as in individuals with no additional risk factors.[2–4] Tsatsos and Eke[5] also reported cataract progression following Nd:YAG LPIs in a Caucasian population with no or insignificant crystalline lens opacities.

It has been suggested that intermittent pupillary block and angle closure could lead to zonular laxity through weakening of the iris and the ciliary body[2,3] and that LPIs could result in zonular damage due to a shock-wave effect.[3,4] The bilaterality and symmetrical location of the zonular dialysis in our patient suggest that the Nd:YAG LPIs disrupted the zonules that may have been already weakened by the previous episodes of intermittent ACG. In addition, the documented slight extension of the initial zonular dialysis beyond the area of the iridotomy sites may have been caused by the shearing force during IOL insertion, as well as by the increased zonular tension because of anterior capsule shrinkage after cataract surgery, as previously suggested in the literature.[6]

To the best of our knowledge, this complication has not been described before. Retrospective and prospective studies on patients similar to the one described here are required to ascertain the risks involved. Nd:YAG LPI may be regarded as an isolated risk factor for structural zonular damage and appropriate precautions should be taken during cataract or other intraocular surgery. The ophthalmic surgeon should always be aware of this possibility and proceed with caution.

Conflict of interest
The authors declare no conflict of interest.

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Sir,

Juvenile xanthogranuloma: an unusual eyelid presentation

Juvenile xanthogranuloma (JXG) is an uncommon dermatological condition rarely linked to systemic manifestations, with predilection for the eyes. We would like to present a case of an unusual eyelid presentation of JXG, which had not been reported previously.

Case report

A 2-year-old baby girl of African extraction presented to the eye clinic with a 6-month history of a slowly enlarging pedunculated spherical left upper eye lid painless tumour that was 6 mm in diameter with a central umbilication (Figure 1). She was otherwise fit and healthy. Ocular examination was otherwise unremarkable. Her mother was concerned that the lesion would get bigger and affect vision. The lesion was surgically removed. Histopathology confirmed the diagnosis of juvenile xanthogranuloma (JXG). In view of the rare possibility that there may be systemic involvement, she was referred to the paediatric medical team for further systemic investigations, which proved negative. Follow-up at 4 months did not show recurrence.

Comment

JXG is frequently a self-limiting dermatological disorder, rarely linked to systemic manifestations.[1] JXG presents with single or multiple yellowish, firm, and slightly raised papulonodular skin lesions, several millimetres in size. This usually occurs in the head and neck region. It also has a predilection for the ocular structures, especially the uveal tract and, occasionally, the orbits and the eyelids.[2–4] The present case was an unusual eyelid presentation, wherein the lesion was atypical (Figure 1). It was the only lesion found. Histopathology confirmed the lesion to be JXG. It is therefore important to recognise an unusual JXG presentation, to perform a full ocular examination, and then to refer the case to the paediatric medical team for a systemic work-up to rule out the unlikely event of latent systemic manifestations.

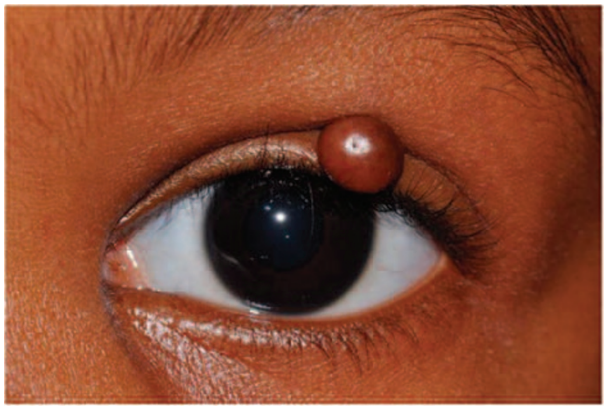

Figure 1 A spherical 6-mm-diameter central umbilicated painless lesion on the left upper eyelid.

Conflict of interest
The authors declare no conflict of interest.

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Sir,
Bilateral retinoschisis in a 2-year-old following a three-storey fall

Intraocular haemorrhages, traumatic retinoschisis, and retinal folds are of prime diagnostic importance in children because of their correlation with abusive head trauma (AHT). We report a case of a previously well 2-year-old with bilateral macular retinoschisis as a result of head trauma sustained in a fall of 11 m onto concrete.

Case report
A 24-month-old girl was transferred to our facility following an unwitnessed fall of 11 m onto concrete, from a window in the family's third floor apartment. Her initial Glasgow Coma Score was 4; she had decorticate posturing and a fixed, dilated right pupil. She was intubated, sedated, paralysed, and given intravenous mannitol.

Computed tomography of the brain (Figure 1) showed multiple skull fractures, acute right subdural haematoma (SDH), and cerebral oedema. She underwent decompressive craniotomy and evacuation of SDH. Intraoperatively, there was also evidence of subarachnoid haemorrhage. Postoperatively, her intracranial pressure fluctuated between 20 and 52 mm Hg. Coagulation studies remained normal.

Dilated indirect ophthalmoscopy by a paediatric ophthalmologist on day 9 revealed bilateral preretinal, intraretinal, and subretinal haemorrhages and bilateral macular retinoschisis (Figures 2 and 3). The schisis cavity in the right eye showed a possible elevated retinal fold at the inferior edge (Figure 2).

Despite maximal therapy there was no improvement, and treatment was withdrawn on day 11. No post-mortem examination was conducted after consultation with the State Coroner. Police investigation concluded that the injury was an accident.

Comment
Previous studies[1,2] have found IOH to be rare, mild, and generally unilateral in accidental head injury. Until recently, retinoschisis and retinal folds were considered specific for AHT. They have only otherwise been reported in static crush head injuries.[3–5] In an autopsy series of motor vehicle crashes,[6] three of the ten cases had unilateral retinal folds and five patients had sub-internal limiting membrane haemorrhages, although these were not referred to as traumatic retinoschisis.

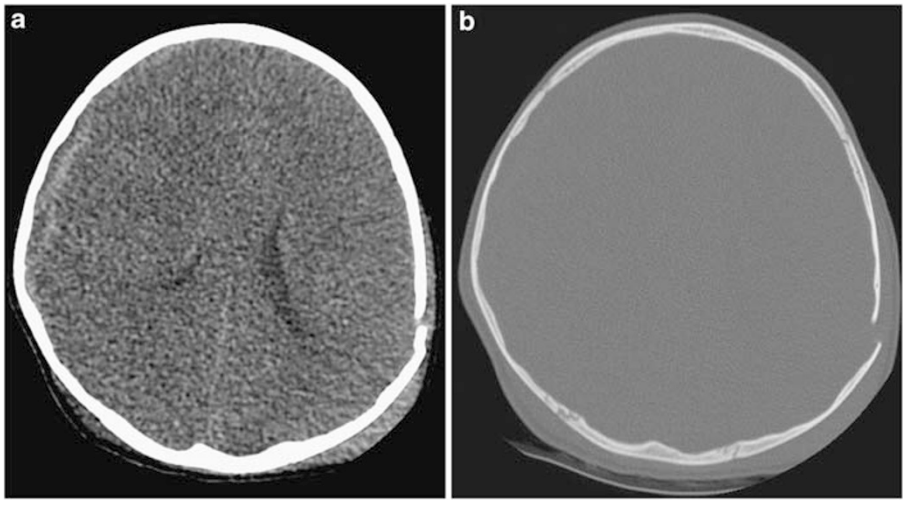

Figure 1 Computed tomography scan performed on day 1 of admission at the local hospital. (a) There is evidence of acute right SDH measuring 7 mm in width, midline shift, dilatation of the left lateral ventricle, and widespread cerebral oedema. (b) Bone windows showing the large left parietal fracture.