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CORRESPONDENCE

Sir,

Cryptococcal-related exudative retinal detachment

Cryptococcosis is a common fungal infection in immunocompromized individuals. Frequent sites of involvement include the central nervous system, lung, skin, and eyes. We describe an unusual case of bilateral exudative retinal detachment in a HIV patient with cryptococcal meningitis.

Case report

A 43-year old HIV-positive Chinese man was referred to the ophthalmology department for right-sided blurring of vision for 3 weeks, associated with headache and neck stiffness. He was on HAART (lamivudine, nevirapine, and stavudine), with trimethoprim/sulphamethoxazole, clarithromycin, and ethambutol for *Mycobacterium avium* complex infection. His CD4 count was 104 cells/mm^3. Visual acuity was 6/24 in the right eye and 6/6 in the left, with normal intraocular pressures and no sign of anterior chamber inflammation. Dilated fundal examination revealed bilateral exudative detachments with involvement of the right macula but no vitritis (Figures 1a and b) corroborated on OCT imaging (Figures 2a and b). Systemically, meningitis was suspected and confirmed on MRI imaging of the brain showing increased leptomeningeal enhancement. Lumbar puncture showed opening pressures of 33.5 mm H_2O; with CSF stains, cultures, and serology positive for *Cryptococcal neoformans*. Investigations for other pathogens including CMV, EBV, HSV, VZV, Toxoplasma, and *Mycobacterium tuberculosis* were negative. He was initiated on amphotericin B and flucytosine, followed by fluconazole. The exudative detachments subsequently resolved with a residual pigment epithelial detachment over the right macula (Figures 3a and b). In view of his systemic findings and response to treatment, a diagnosis of cryptococcal-related exudative retinal detachment was made retrospectively.

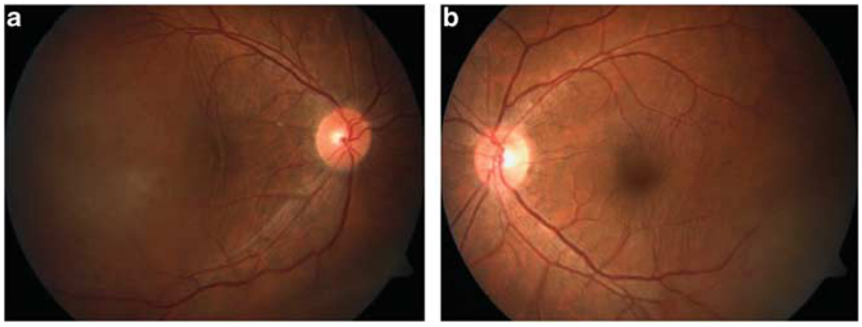

Figure 1 (a, b) Exudative retinal detachment at presentation.

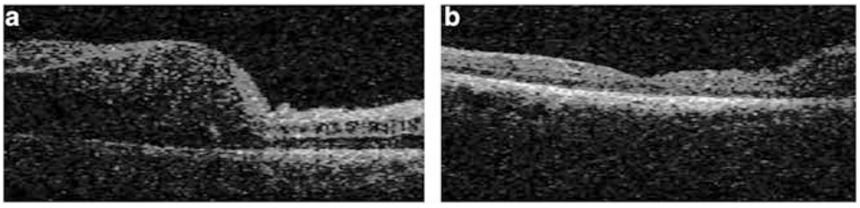

Figure 2 (a, b) Exudative retinal detachment at presentation with corresponding OCT.

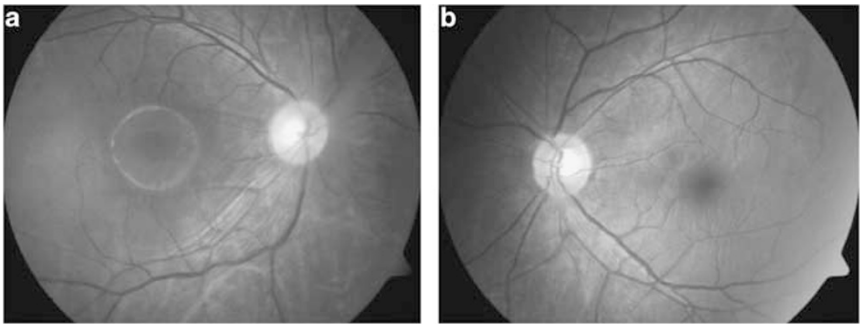

Figure 3 (a, b) Final resolution of exudative retinal detachment with residual pigment epithelial detachment over the right macula.

Comment

Ocular cryptococcosis often manifests as a consequence of systemic disease. However, isolated ocular involvement may present as choroiditis and endophthalmitis from hematogenous spread, or ophthalmoplegia and papilloedema secondary to raised intracranial pressure or direct infiltration of the optic nerve.[1] Cryptococcal endophthalmitis itself is a rare disease; fewer than 20 cases worldwide, including 5 in AIDS-related cases have been reported (none of these patients regained normal vision).

Despite being well documented in animals (especially cats),[2] cryptococcal-related exudative detachment has only been reported in cases of endophthalmitis.[3] Our case is unique as there was only evidence of cryptococcal meningitis and absence of concomitant endophthalmitis. Exudative retinal detachment in HIV patients are more commonly related to CMV infection,[4] immune recovery uveitis, acute retinal necrosis,[5] and progressive outer retinal necrosis.[6] We report an unusual case of exudative detachment secondary to cryptococcal infection that responded to systemic anti-fungal therapy.

Conflict of interest

The authors declare no conflict of interest.

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J Chen[1], C Chai[1] and SC Teoh[2]

[1]Department of Ophthalmology, Tan Tock Seng Hospital, Singapore
[2]Vitreo-retina and Uveitis Service, Department of Ophthalmology, Tan Tock Seng Hospital, Singapore
E-mail: chenjianping86@gmail.com

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Sir,

Angle closure glaucoma associated with ectopia lentis in a patient with Sturge-Weber syndrome

Sturge-Weber syndrome (SWS) is a rare, sporadic phakomatosis characterized by cutaneous facial angioma, leptomeningeal angioma, and ocular manifestations.[1] We report a case of ectopia lentis associated with angle closure glaucoma (ACG) and pigment dispersion, ipsilateral to the angioma in a patient with SWS.

Case report

A 45-year-old woman with SWS was referred for blurred vision OS and left-sided headaches. The visual acuities were 20/20 OD and 20/25 OS with a 2-D myopic shift OS, and intraocular pressure (IOP) was 15 mm Hg OD, and 30 mm Hg OS ipsilateral to the SWS lesion, which extended from the left upper eyelid to the vertex, with minimal conjunctival involvement. Gonioscopy was open OD, but mostly closed OS. Laser iridotomy OS deepened the anterior chamber (AC), with IOP 15 mm Hg 1 week later. However, the AC remained shallow and the patient underwent further evaluation. At that time the IOP was 26 mm Hg OS. Gonioscopy remained narrower OS with heavy pigment, but without synechiae; neither Krukenberg spindle nor iris transillumination defects were present. Dilated examination revealed temporal and anterior subluxation of the left lens (Figure 1); no pigment was seen on the few visible zonules. The cup : disc ratio was 0.3 OD and 0.7 OS. No choroidal hemangioma was seen OS, and ultrasound biomicroscopy OS was normal. She was 6-feet tall with normal mentation; echocardiogram, chest X-ray, and electrocardiogram revealed no evidence of Marfan disease. There was no history of trauma.

The patient underwent pars plana lensectomy/vitrectomy OS. At 28 months post-operatively, the

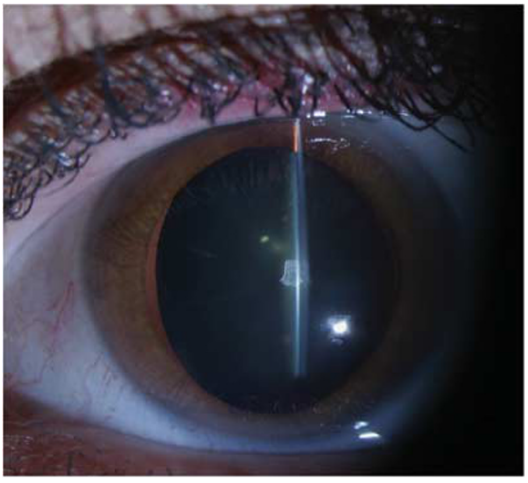

Figure 1 Slit-lamp biomicroscopy. Dilated left eye demonstrating temporal subluxation of the crystalline lens (red reflex visible nasal to lens).