associated inflammation is not able to induce hepatic synthesis of CRP and is associated with a limited local and subclinical inflammatory reaction in involved tissues.

Conflict of interest

The authors declare no conflict of interest.

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Sir, Congenital glaucoma: still a clinical challenge

It was with interest that I read the article on the results of combined trabeculotomy and trabeculectomy in Ghana published recently in your journal.¹ Congenital glaucoma is a clinical challenge for any ophthalmologist, and requires a long-term commitment toward these patients with extended care for rehabilitating these children.^{2,3} Hence, this article holds importance in serving as a baseline for the entire West African region, which is important to decide management strategies to cope with childhood blindness in that place.

The authors have correctly pointed out that their poor 1 year success of 44% may be due to severe disease at presentation, racial and genetic influences, and also non-use of mitomycin-C.^{2–4} Yet, it was surprising that 63% of the children had diffuse avascular blebs, which raises the question of how many persons graded the blebs and evaluated the patients postoperatively. The authors state that three patients had normal intraocular pressure

(IOP); one on medication and two others with IOP taken under anesthesia. Yet, the cutoff for surgical success has been taken as 21 mm Hg. It is not clear whether this the cutoff has been maintained for infants examined under anesthesia, which would be inappropriate, taking into consideration the lowering of IOP in deeper planes of anesthesia.

Visual rehabilitation is an important aspect of childhood glaucoma, a dimension that has been totally ignored in this article. It would be worthwhile if the authors include information on the visual acuity obtained postoperatively in at least some patients and the reason for poor vision, such as Haab striae, refractive errors, amblyopia, or others.

Although we understand the non-availability of Perkins tonometer at all times in the operating room, it is advisable to exclude IOP readings taken with Schiotz, as that might give erroneous results in children with corneal edema and buphthalmic eyes.

Studies such as these highlight the challenges faced while treating childhood glaucoma. Consideration of these points has to be kept in mind when we analyze the surgical outcomes in these patients.

Conflict of interest

The author declares no conflict of interest.

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Sir, Response to Dr Rao

We would like to thank Dr A Rao¹ for the comments and questions raised regarding the article 'Combined trabeculotomy and trabeculectomy: outcome for primary congenital glaucoma in a West African population'.² As she rightly pointed out, our article highlights some of the challenges in the care of children with congenital glaucoma in the developing world. We would want to respond to some of the concerns raised in her letter.

It is worth noting that the overall success at the last follow-up for the patients was 79%. It is the probability of success that falls from 66% at 9 months to below 45% at 1 year and beyond. The finding of 63% of the blebs being functional at the last follow up is therefore consistent with the overall success rate. The definition of a well-functioning bleb used was one that is elevated (low to moderately) and diffuse, without any restricting scar, and relatively avascular. The postoperative assessment was done by the same ophthalmologist to ensure consistency.

The intraocular pressures of the infants were usually measured at the initial phase of halothane inhalation 1–1.5% when the patients were just sedated. The intraocular pressures of the two eyes determined during the deep phase of anaesthesia were all done preoperatively, and, therefore admittedly, contributed to a relatively lower mean (30.3 ± 8.8) than expected. However, all postoperative measurements were done at the initial phase of halothane inhalation 1–1.5% when the patients were just sedated except two eyes that had the measurements done using Pulsair non-contact tonometer without anaesthesia and in the office setting, but their results were normal.

We appreciate the suggestion to exclude intraocular pressures readings taken with Schiøtz tonometer in our analysis due to errors associated with its use. However, Schiøtz tonometer was the only tool available to us for a period when the Perkins tonometer was faulty. Presently, Schiøtz tonometer is no longer in use at our centre.

As regards the visual outcome using visual acuity, as indicated in our study, there was paucity of data on postoperative visual acuity and refraction at the last follow-up to make any meaningful statistical analysis. This we acknowledged as a limitation.

Conflict of interest

The authors declare no conflict of interest.

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Sir, Long-term survival in a case of bilateral diffuse uveal melanocytic proliferation

Bilateral diffuse uveal melanocytic proliferation (BDUMP) is a paraneoplastic syndrome described by Machemer¹ in 1966, in which an underlying tumor causes diffuse bilateral proliferation of melanocytes in the uvea. Gass *et al.*² later described five cardinal signs related to BDUMP: multiple red patches at the level of the RPE, corresponding early hyperfluorescence of these patches on fluorescein angiography, development of multiple pigmented and non-pigmented uveal melanocytic tumors with diffuse thickening of the uveal track, exudative retinal detachment, and rapidly progressive cataracts. Patients affected by BDUMP have a short life expectancy.² We, however, report a case of BDUMP, which illustrates that long-term survival can occur despite multiple metastases.

Case report

A 62-year-old man was referred for cataract surgery to both eyes. At presentation, his right visual acuity was 0.40 logMAR and left visual acuity was 0.80 logMAR. He had a past medical history of transitional cell carcinoma of the bladder, with multiple metastases treated with surgical excision and chemotherapy. At preoperative review, his vision decreased to hand movements OD and counting fingers OS due to rapid progression of the cataracts. Postoperative examination revealed BDUMP (Figure 1). Further investigation discovered new metastases. Four years later, his visual acuity is 0.12 logMAR OD and 0.0 logMAR OS and some of the choroidal lesions have reduced in size.

Figure 1 (a) Right fundus colour photograph at the time of the diagnosis showing myelinated fibers at the optic disc, two flat uveal pigmented lesions and one not pigmented in the superior nasal quadrant. (b) same quadrant, 4 years from the diagnosis with the same uveal lesions reduced in size. (c) left fundus colour photograph of the supero-temporal quadrant showing four flat pigmented uveal lesions, which decreased in size (d) 4 years after the diagnosis of bilateral diffuse uveal melanocytic proliferation.