- 4 Wolfe SA. The utility of pericranial flaps. *Ann Plast Surg* 1978; **1**: 147–153.
- 5 Tse DT, Goodwin WJ, Johnson T, Gilberg S, Meldrum M. Use of galeal or pericranial flaps for reconstruction of orbital and eyelid defects. *Arch Ophthalmol* 1997; **115**: 932–937.
- 6 Smith JE, Ducic Y. The versatile extended pericranial flap for closure of skull base defects. *Otolaryngol Head Neck Surg* 2004; **130**: 704–711.
- 7 Parhiscar A, Har-El G. Frontal sinus obliteration with the pericranial flap. *Otolaryngol Head Neck Surg* 2001; **124**: 304–307.
- 8 Hobar PC, Burt JD, Masson JA, Merritt JA, Trawnink R. Pericranial flap correction of superior sulcus depression in the anophthalmic orbit. *J Craniofac Surg* 1999; **10**: 487–490.

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Sir,
Rituximab in IgG4-related inflammatory disease of the orbit and ocular adnexae

The discovery of IgG4 implication in a subtype of previously-idiopathic orbital disease is beginning to change the disease management. In 2002, 'the mainstay of therapy for idiopathic orbital inflammation (was) corticosteroids',¹ with often excellent but unsustainable treatment response. Specific immunomodulatory therapy is now being investigated and early results show promise. Of particular interest is Rituximab (chimaeric monoclonal antibody against B-cell CD20).

The efficacy and safety of Rituximab has been demonstrated for systemic and intraocular inflammatory conditions.^{2,3} Since the submission of a review on adnexal IgG4-related disease,⁴ papers have been published on the use of Rituximab for systemic IgG4-related disease and data are now emerging on the use of Rituximab for IgG4-specific orbital disease.

The first is a case report of a 56-year-old lady with over 30 years of intractable orbital disease presumed to be idiopathic.⁵ Recent interest in IgG4 has led to further serum samples and tissue biopsy (lacrimal gland, extraocular muscles, intraconal fat, and trigeminal nerve) showing levels of IgG4 above the reference range. Six months after commencing, Rituximab proptosis improved, serum IgG4 normalised and orbital disease was deemed dormant.

The second paper is a review of 10 cases with IgG4-related orbital disease unresponsive to oral steroids and disease-modifying antirheumatic drugs (DMARDs).⁶ All patients received two infusions of Rituximab (1000 mg) 15 days apart. Nine of ten patients demonstrated 'striking clinical improvement' after 1 month of starting treatment. The remaining patients'

disease progression was halted, but no clinical improvement was evident. All 10 patients were able to discontinue oral steroid and DMARDs. Four patients required re-treatment at 6 months, with repeatable clinical improvement and serum IgG4 reduction.

Evidence is encouraging but of low scientific value, with no direct comparison to current standard care (prednisolone). Higher-level, prospective and randomised evidence investigating Rituximab against glucocorticoids would be beneficial. However, powering a study for a disease with such heterogenous clinical manifestations and poorly definable outcomes doubtless limits evidence supporting Rituximab to case-series data only.

Conflict of interest

The author declares no conflict of interest.

References

- 1 Jacobs D, Galetta S. Diagnosis and management of orbital pseudotumor. *Curr Opin Ophthalmol* 2002; **13**: 347–351.
- 2 Khosroshahi A, Stone JH. A clinical overview of IgG4-related systemic disease. *Curr Opin Rheum* 2011; **23**: 57–66.
- 3 Taylor SR, Salama AD, Joshi L, Pusey CD, Lightman SL. Rituximab is effective in the treatment of refractory ophthalmic Wegener's granulomatosis. *Arthritis Rheum* 2009; **60**: 1540–1547.
- 4 Lindfield D, Attfield K, McElvanney A. Systemic immunoglobulin G4 (IgG4) disease and idiopathic orbital inflammation; removing 'idiopathic' from the nomenclature? *Eye* 2012; **26**: 623–629.
- 5 Wallace ZS, Khosroshahi A, Jakobiec FA, Deshpande V, Hatton MP, Ritter J *et al.* IgG4-related systemic disease as a cause of 'idiopathic' orbital inflammation including orbital myositis, and trigeminal nerve involvement. *Surv Ophthalmol* 2012; **57**: 26–33.
- 6 Khosroshahi A, Carruthers MN, Deshpande V, Unizony S, Bloch DB, Stone JH. Rituximab for the treatment of IgG4-related disease: lessons from 10 consecutive patients. *Medicine (Baltimore)* 2012; **91**: 57–66.

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Sir,
Subtarsal eyelid examination using an oblique slit lamp mirror in cases of eyelid shortening

We report a novel technique enabling examination of the superior fornix and tarsus in patients in whom the eyelid cannot be everted.

Case report

An 89-year-old man presented to ophthalmic A&E with a painful right eye and foreign body sensation. He had recently had extensive right upper eyelid surgery with full thickness excision of a Merkel Cell tumour at another unit (Figure 1a). A corneal abrasion was found postoperatively in his right eye. To investigate the cause of the abrasion, attempts were made to evert his upper eyelid. However, owing to the horizontal shortening as a consequence of his recent surgery, this was not possible.

By distracting the eyelid away from the globe and placing the detached slit lamp oblique mirror (Figure 2a) under the eyelid margin, the tarsus and superior fornix could be easily seen (Figure 1b). Using this technique, we were able to identify a Vicryl suture within the tarsal wound (Figures 1b and c), which was also easily removed with the aid of mirror (Figure 1d). The patient was treated with chloramphenicol ointment and the corneal abrasion resolved within 1 week.

Comment

In cases of a corneal abrasion, inverting the upper eyelid to exclude a foreign body is an essential step of the ocular examination.¹ However, everting the eyelid may be difficult in cases of previous surgery or in the presence of a cicatricial disease such as ocular cicatricial pemphigoid. In certain circumstances, eversion of the upper eyelid may also be contraindicated after eyelid surgery owing to the risk of disrupting the wound. In such cases, the oblique mirror from the slit lamp is a useful alternative to examine the superior fornix and tarsal surface.

We advise cleaning and disinfecting the mirror using the same standard methods as used for other ophthalmic instruments such as a three-mirror contact lens.

Figure 2 The oblique slit lamp mirror.

Figure 1 (a) Photograph of the right upper eyelid following resection of a Merkel Cell tumour and subsequent reconstruction illustrating a horizontally shortened eyelid, which could not be everted. (b, c) The oblique slit lamp mirror placed under the upper eyelid margin to highlight the fluorescein-stained suture that had caused the corneal abrasion. (d) The suture is removed visualised indirectly with the slit lamp mirror.

Previous reports have described the use of a nasopharyngeal or a dental mirror as a useful aid in similar situations,^{2,3} these are however not readily available in most eye departments.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Ehlers JP, Shah CP. Wills Eye Institute. *The Wills Eye Manual: Office and Emergency Room Diagnosis and Treatment of Eye Disease*. 5th edn. Lippincott Williams and Wilkins, 2010.
- 2 Bardenstein DS. A novel method for examination of the inner eyelid. *Invest Ophthalmol Vis Sci* 2003; **44**: U421.
- 3 Weinstein GS. Use of dental mirror for postoperative eyelid examination. *Arch Ophthalmol* 1987; **105**(6): 747.

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Sir, More on a patient-centric approach in the anti-VEGF therapy

We read the article by Brand¹ with interest; however, we believe that the role of bevacizumab was underestimated in the patient-centric approach of retinal vascular diseases treatment. In fact, although bevacizumab has not been authorised by any Health Authority worldwide, its off-label use for a variety of chorioretinal disorders has gained global acceptance, and now it is the most commonly used anti-VEGF drug all over the world. Its lower cost of treatment, approximately \$40 per dose compared with approximately \$2000 per dose for ranibizumab, largely explains its more frequent widespread use over the latter.² Paradoxically, despite the increasing number of indications and patients under anti-VEGF treatment, the price of ranibizumab has barely declined. Moreover, although the content of a single-dose vial of ranibizumab is two to three times larger than that needed for single use, due to the dead space in the tuberculin syringe, a significant portion of the drug is unused and wasted.

Similarly, the 2-year CATT study³ results have recently reported the non-inferiority of bevacizumab as compared with ranibizumab, providing the first-level 1 evidence for the use of bevacizumab in most people with neovascular AMD who will never have the opportunity to receive ranibizumab because of cost. This is particularly the case for developing countries, in which the high unit cost of ranibizumab over bevacizumab has limited its use

after licensing.⁴ The real dilemma in these countries is not between ranibizumab and bevacizumab, but between bevacizumab and no treatment. There, people cannot afford the treatment and, in this perspective, bevacizumab seems to be a miracle drug. Therefore, it seems that regulators in certain countries should be forced to reconsider their policies that make it illegal to use drugs off-label, particularly when so many of their citizens cannot afford ranibizumab.⁵ With primary-care trusts under financial pressure, an increasing number are considering, allowing ophthalmologists to use the cheaper bevacizumab for certain ocular conditions. This low-cost alternative to ranibizumab would have a rapid impact of reducing incident global blindness, and is certainly an important alternative in the patient-centric approach of retinal vascular diseases treatment.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Brand CS. Management of retinal vascular diseases: a patient-centric approach. *Eye* 2012; **26**(Suppl 2): S1–S16.
- 2 Gonzalez S, Rosenfeld PJ, Stewart MW, Brown J, Murphy SP. Avastin doesn't blind people, people blind people. *Am J Ophthalmol* 2012; **153**: 196–203.
- 3 Martin DF, Maguire MG, Fine SL, Ying GS, Jaffe GJ, Grunwald JE *et al.* Ranibizumab and bevacizumab for treatment of neovascular age-related macular degeneration: two-year results. *Ophthalmology* 2012; **119**: 1388–1398.
- 4 Tufail A, Patel PJ, Egan C, Hykin P, da Cruz L, Gregor Z *et al.* Bevacizumab for neovascular age related macular degeneration (ABC Trial): multicentre randomised double masked study. *BMJ* 2010; **340**: c2459.
- 5 Rosenfeld PJ. Bevacizumab versus ranibizumab for AMD. *N Engl J Med* 2011; **364**: 1966–1967.

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Sir, Ciliary-body adenoma of the non-pigmented epithelium with rubeosis iridis treated with plaque brachytherapy and bevacizumab

Ciliary-body adenoma of the non-pigmented epithelium (NPCE adenoma) is a rare, benign tumour that can cause cataract¹ and recurrent iridocyclitis,² but, to our knowledge, has not been reported to cause rubeosis iridis.