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Eye (2013) **27,** 1424–1425; doi:10.1038/eye.2013.199; published online 20 September 2013

Sir,

Amlodipine as a cause of mucous membrane pemphigoid: first report of amlodipine as a causative agent in MMP

Cicatricial Pemphigoid is an autoimmune sub-epithelial blistering disease, which affects skin and mucous membranes. It is characterised by depositions of IgG and C3 at the lamina lucida of epithelial basement membrane.[1] Several medications, including topical glaucoma medications, are implicated in the aetiology of pseudo-pemphigoid, in which ocular manifestations are similar but histology not diagnostic.[2] Lisinopril, atenolol, and spironolactone have been implicated in causing drug reactions mimicking mucous membrane pemphigoid.[3] Amlodipine, used for the treatment of hypertension, has been known to cause linear IgA dermatosis[4] as well as bullous pemphigoid,[5] but has not been previously linked to ocular pseudo-pemphigoid.

Case report

We present the case of a 78-year-old Caucasian gentleman referred with suspected mucous membrane pemphigoid. He was on topical tafluprost to both eyes as treatment for low pressure glaucoma. Systemic medications consisted of amlodipine, atenolol, and simvastatin. Clinical features included shortening of the lower fornices of both eyes and marked symblepharon. Immunofluorecence studies of the conjunctival biopsy showed scattered intercellular IgG positivity alone in the epithelium, suggestive of either paraneoplastic or drug-induced pemphigus. Biopsies from inflammed skin plaques and normal-looking adjacent skin revealed weakly positive linear IgA and IgG deposition and granular arrangement of C3 at the basement membrane. The skin histology was thought to be consistent with Lupus, drug-related disease, or possible eczema. The patient was started on topical and a tapering course of systemic steroids. Examination and investigation excluded occult malignancy. As the clinical picture was one of mucus membrane pemphigoid, a review of treatment was undertaken. Amlodipine was stopped, as this was the most recently started antihypertensive and closest temporally to the start of symptoms. Alternative treatment for hypertension has been instituted. Within 6 months of stopping Amlodipine and after 18 months of progressive deterioration, the eyes settled with no sign of activity or progression. The patient is now off all ocular treatment apart from tafluprost for glaucoma.

Comment

Pseudo-pemphigoid associated with topical glaucoma medications is not associated with skin lesions, making tafluprost an unlikely candidate. Oral medications for hypertension and angina are rarely associated with ulcerative disease. However, it is important to bear the association in mind when faced with such a patient. The disease process may arrest on withdrawal of precipitating medication but this is not always the case. This case highlights the importance of enquiring about systemic medication and reporting these rare associations.

Conflict of interest

The authors declare no conflict of interest.

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Eye (2013) **27,** 1425; doi:10.1038/eye.2013.197; published online 6 September 2013

Sir,

National survey of progressive symptomatic retinal detachment complicating retinoschisis in the United Kingdom

Progressive symptomatic retinal detachment complicating degenerative retinoschisis (PSRDR) is rare, and no uniform consensus exists regarding the optimal management of PSRDR.[1,2] The surgical outcomes appear to be inferior compared with those of rhegmatogenous retinal detachment (RD).[3–5] Between September and November 2012, we conducted an anonymous, online survey of PSRDR management with members of the British and Eire Association of Vitreoretinal Surgeons to

obtain a contemporary snapshot of the clinical management and surgical approaches.

The survey explored five clinical scenarios: Scenario 1. How do you manage a retinoschisis with a localised, asymptomatic macula-on retinal detachment? Scenario 2. What is your surgical approach for PSRDR in the presence of a significant cataract? Scenario 3. What is your approach for a PSRDR with an anterior outer leaf break (OLB)? Scenario 4. What is your approach for a PSRDR with an OLB posterior to the equator? Scenario 5. What is your approach for a PSRDR complicated by grade B or grade C proliferative vitreoretinopathy (PVR)? Eight-four completed responses were received, including consultant vitreoretinal surgeons (77.4%), and VR fellows/specialists (14.3%). The reported annual vitrectomy surgery caseload was 101–300 in 64.3% ($n=54$) and 301–500 in 25% ($n=21$). The majority (57.1%, $n=48$) of surgeons undertake 6–20 scleral buckle procedures annually. The numbers of PSRDR cases managed annually were as follows: 0 cases (8%); 1 case (30%); 2 cases (30%); 3 cases (20%); 4 cases (7%); and 5 cases (5%).

In scenario 1, 15% surgeons monitor patients with serial imaging. Laser barrage treatment was undertaken by 17% of surgeons, with 10% opting for vitrectomy. The remainder of respondents would observe the patients in the outpatients clinic using slitlamp biomicroscopy without any imaging. For scenario 2, 80% would undertake combined phacoemulsification and vitrectomy surgery and 8% combined vitrectomy with lensectomy. Regarding refractive choice, 58% surgeons place a posterior chamber lens implant and 4% leave the patient aphakic. Unfortunately, 38% of surgeons did not complete their refractive choice, and the authors can only tentatively presume that a posterior chamber lens implant was placed following phacoemulsification surgery.

In scenario 3, 31% undertake cryotherapy and scleral buckle surgery, with external drainage in 5%. The remainder of surgeons elect to perform vitrectomy with retinopexy; 47% vitrectomy with gas, of which schisis deroofing/retinotomy is done in 20%; vitrectomy with oil is undertaken in 14%, combined with schisis deroofing/retinotomy in 7%; and vitrectomy with scleral buckle surgery is undertaken by 6% of surgeons. In scenario 4, all surgeons perform vitrectomy with retinopexy. In 70% surgeons, the preferred approach is vitrectomy with gas, of which schisis deroofing/retinotomy is performed by 28%. Vitrectomy with oil is the preferred choice for 26%, with combined vitrectomy with scleral buckle surgery in 3%. In scenario 5, primary vitrectomy surgery is undertaken. The majority use oil tamponade (64%) with schisis retinectomy performed by 23%; and gas tamponade by 16% with 4% employing retinectomy. The remainder of surgeons perform combined vitrectomy with scleral buckle surgery, with gas in 6%, oil in 14%, and retinectomy plus oil in 7%. Across all groups for PSRDR, the overall success rate from primary surgery was difficult to interpret. This survey is not a valid method to estimate the results/success rates of the various treatment options, as each surgeon would be dealing with very few cases and recall bias can significantly alter the true outcome estimates.

This survey highlighted the current variation in the management of PSRDR for specific clinical scenarios. The self-reported success rates for surgeons within the BEAVRS group for primary surgical intervention was not reliable, as this survey is based on individual surgeon recall of a rare surgical case(s). Grigoropoulous and co-workers[3] report that PSRDR associated with anterior OLBs have better outcomes than those with posterior OLBs, and PSRDR with PVR have poorer outcomes. Optimal surgical management continues to be the subject of ongoing debate at a national level within the vitreoretinal surgical community.

The contemporary variation in clinical management and surgical approaches for this condition is highlighted by our survey. There is a lack of contemporary epidemiological data for PSRDR, and further studies are required. In the era of revalidation and benchmarking of surgical outcomes in the United Kingdom, the authors will be conducting a prospective multicentre study of PSRDR within the United Kingdom in association with the British Ophthalmic Surveillance Unit.

Conflict of interest

The authors declare no conflict of interest.

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Eye (2013) **27,** 1425–1426; doi:10.1038/eye.2013.230; published online 18 October 2013

Sir,

Intravitreal injections, antibiotics and endophthalmitis

The article by Lyall *et al*[1] entitled 'Post-intravitreal anti-VEGF endophthalmitis in the United Kingdom: incidence, features, risk factors, and outcomes' is timely, given current efforts to minimize the risk of endophthalmitis following intravitreal injections. We take great interest in this topic, and support the authors' efforts to identify risk factors for endophthalmitis.