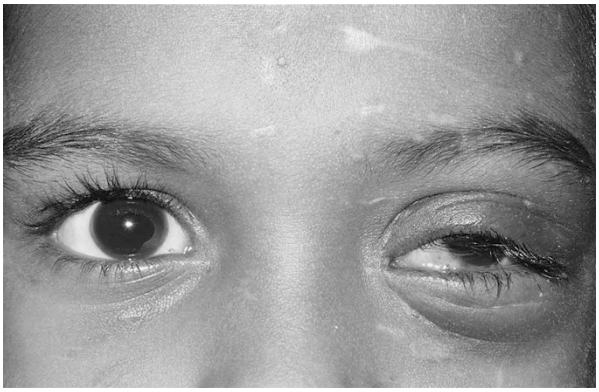

Figure 2 Clinical photograph after treatment.

tomography scan showed diffuse inflammation of the left orbit. Paranasal sinuses and brain study were normal. Based on these findings the diagnosis of orbital cellulitis secondary to self-inflicted periocular injury was made.

Clinical improvement was noted after 48 h of intravenous antibiotics (Figure 2).[1] Psychiatric evaluation revealed attention deficit/hyperactivity disorder (ADHD) with night terrors. The child was prescribed Methylphenidate and Clonazepam for his ADHD and parasomnia, respectively. He was advised to wear gloves during sleep.

Currently, at 9 years of age, he is not using either medications or gloves. He has not had any episodes of self-injury for the past 2 years.

Comment

Parasomnias, defined as undesirable behavioral events during sleep, for example, nightmares, sleep terrors, and sleep walking, are common in the general population. Disorders of arousal, like sleep terrors, are the most common parasomnia seen in boys aged 5–7 years.[2]

The child may sit up, scream, and appear frightened, with increased pulse and respiratory rates and sweating. For most children, treatment is not necessary. Adhering to good sleep routines will usually reduce the frequency of events.[3] If sleep terrors cause an injury, parents/guardians need to be educated about creating a safe environment for the child.[4] The etiology of orbital cellulitis in the pediatric age group is varied, ethmoid sinusitis being the commonest.[5] To our knowledge, this is the first reported case of orbital cellulitis secondary to self-inflicted trauma due to parasomnia in a child. However, in any case of trauma in a child, non-accidental injuries should be ruled out. In case of parasomnia, it is important to prevent further episodes by psychotherapy and protective measures.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Central corneal haze after wedge resection following penetrating keratoplasty and photorefractive keratectomy

Arcuate keratotomy is a common procedure after keratoplasty, but can induce central corneal haze in eyes with a history of PRK. Herein, we report on a patient with the history of uncomplicated penetrating corneal transplantation with uncomplicated PRK, who developed central corneal haze 6 months after wedge resection.[1]

Case report

A 34-year-old man with keratotconus underwent penetrating keratoplasty in the right eye in 1993 and arcuate keratotomies (AK) for high astigmatism in 2000. A PRK for a refraction of $-1.0\times-2.0/140^{\circ}$ without mitomycine C (MMC) was done in 2005.

Postoperative course was uncomplicated including a clear cornea and uncorrected distance visual acuity (UDVA) was 0.2 logMAR 6 months after PRK. The patient's vision decreased 5 years later again due to inferior corneal steepening and wedge resection (two opposite 60° AK in the 6.0-mm central optical zone with six compression sutures using 10-0 nylon) was performed to treat irregular astigmatism.

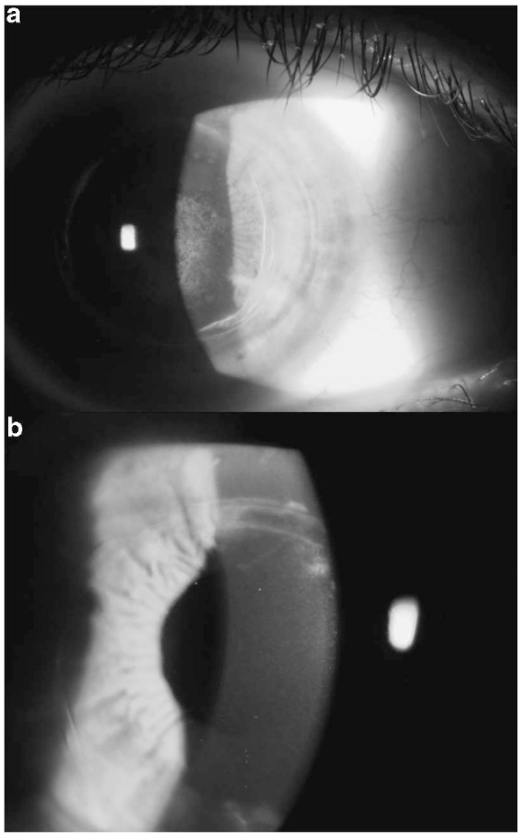

Figure 1 (a) Severe corneal haze of the patient 9 months after wedge resection. (b) The same cornea 18 months after a single application of MMC to the scarred area.

The cornea developed severe central haze with decrease of vision to 2.0 logMAR with a refraction of $-1.0 \approx -2.5/180$ 6 months later (Figure 1a).

MMC 0.02% was applied therefore as a therapeutic option for 45 s on a sponge after epithelial removal.[2] Haze disappeared 4 months later and UDVA increased to 0.2 logMAR. The cornea remained clear for the follow-up period of 21 months (Figure 1b).

Comments

Haze formation is possible in the central cornea after incisional surgery in eyes with a history of PRK, even if the cornea was clear.

However, lamellar transplantation has been described as therapeutic option for visual recovery in such cases,[3] but this case shows that a single topical application of MMC 0.02% for 45 s is a suitable treatment option and the cornea remained clear for the entire postoperative follow-up period of 21 months.

Incisional surgery is a risk factor for eyes with a history of PRK, but MMC 0.02% application is a useful therapeutic option for the removal of corneal haze.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Intra-lesional interferon injection for recurrent conjunctival MALT lymphoma

Conjunctival mucosa-associated lymphoid tissue (MALT) lymphomas are localized low-grade extra-nodal tumours that are managed with radiotherapy, cryotherapy, surgical excision, or even observation.

Intra-lesional interferon injection for conjunctival lymphomas was first cited as early as 1996 by Cellini *et al*;[1] its successful use has been reported since then.[2,3] We report a case where its use has been invaluable in a patient with recurrent conjunctival MALT lymphoma following external beam radiation.

Case report

A 55-year-old woman presented with a 2-week history of red watery right eye and swelling of her right lower lid. On examination, she had a salmon pink mass in the right inferior bulbar conjunctiva (Figure 1a). The rest of the ocular examination was normal. Conjunctival biopsy confirmed this to be an extra-nodal marginal-zone MALT-type lymphoma. The patient was treated with external beam radiation (24 Gy in 12 fractions) to the right inferior conjunctiva with complete regression of the lymphoma.

At 10 months post radiotherapy, she was noted to have a similar pink lesion in the right superior bulbar conjunctiva (Figure 1b). A biopsy confirmed recurrent MALT lymphoma (Figure 1c).

Owing to recent external beam radiotherapy it was felt inappropriate to re-treat her with the same modality and she was treated with intra-lesional interferon injection.

She received a 4-week course of 3 times a week intra-lesional injections of 1.5 mega-units in 0.25 ml of Interferon α2A, with complete regression of the lesion.

She remains disease free at 10 months follow-up.