OA Mahroo[1,2], EA Gavin[2], KM Williams[1,2], E De Smit[2], CJ Hammond[1,2] and DA Morrison[2]

[1]Department of Ophthalmology, King's College London, St Thomas' Hospital, London, UK
[2]Department of Ophthalmology, St Thomas' Hospital, London, UK
E-mail: omar.mahroo@kcl.ac.uk

Eye (2013) **27,** 990–991; doi:10.1038/eye.2013.88; published online 24 May 2013

Sir,

Response to Mahroo *et al*

In response to the comment by Mahroo *et al*.[1] on determining the accuracy of higher cut-off values of light meter readings to determine time spent outdoors *vs* indoors, we have evaluated the accuracy of cut-offs higher than 1000 Lux of 1200 and 1500 Lux.

The Intra Class correlation for the cut-off values of 1200 and 1500 Lux showed higher correlations between the light meter and diary recordings during the week in a school term and school holidays, compared with cut-offs of 800 and 1000 Lux (Table 1).

Thus, we agree with the proposal that the best cut-off value for evaluating outdoor *vs* indoor activities is 1500 Lux instead of 1000 Lux.

Table 1 Intra Class Correlation co-efficients (ICC) for cut-off values of 800, 1000, 1200, and 1500 Lux during the school term and school holidays

Cut-off light intensity (in Lux)	ICC—school term	ICC—school holidays
800	0.1 (−0.13, 0.32)	0.23 (−0.07, 0.49)
1000	0.21 (−0.02, 0.42)	0.28 (−0.02, 0.53)
1200	0.26 (0.03, 0.46)	0.28 (−0.02, 0.53)
1500	0.29 (0.07, 0.49)	0.25 (−0.05, 0.50)

Conflict of interest

The authors declare no conflict of interest.

Reference

1 Mahroo OA, Gavin EA, Williams KM, De Smit E, Hammond CJ, Morrison DA. Potential effect of 'cut-off intensity' on correlation between light meter measurements and time outdoors. *Eye* 2013; **27**(8): 990–991.

R Dharani[1], C-F Lee[2,3], EA Finkelstein[4] and S-M Saw[5]

[1]Department of Optometry/Ophthalmology, SRM Medical College Hospital and Research Centre, SRM University, TamilNadu, India
[2]Department of Biostatistics, Singapore Clinical Research Institute, Singapore
[3]Center for Quantitative Medicine, Office of Clinical Sciences, Duke-NUSGraduate Medical School, Singapore
[4]Saw Swee Hock School of Public Health, National University of Singapore, Singapore
[5]Health Services Research Program, Duke-NUS Graduate Medical School, Singapore

Eye (2013) **27,** 991; doi:10.1038/eye.2013.89; published online 24 May 2013

Sir,

***In vivo* confocal microscopy detects preclinical corneal lattice dystrophy**

Lattice dystrophy of the cornea is caused by the deposition of amyloid in characteristic linear branching patterns in the corneal stroma. *In vivo* laser confocal microscopy (IVCM) images the different layers of the cornea with a resolution of up to 4 microns and has the potential to provide ultra-structural information that may not be visible on slit-lamp examination. The IVCM appearance in lattice dystrophy is well described.[1]

Case report

A 25-year-old male patient was referred to the ophthalmologist by his optician, who noted lattice

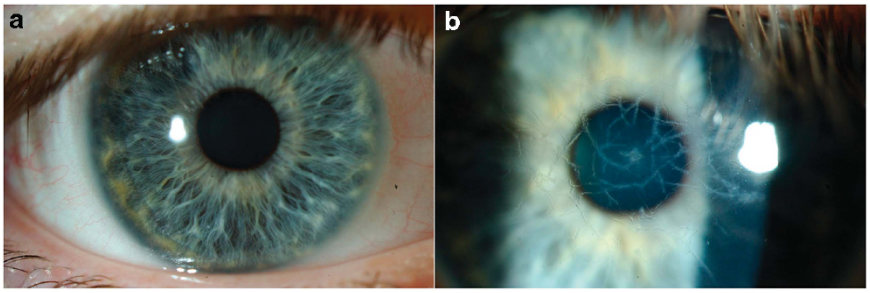

Figure 1 Colour photos of (a) the right eye and (b) left eye.

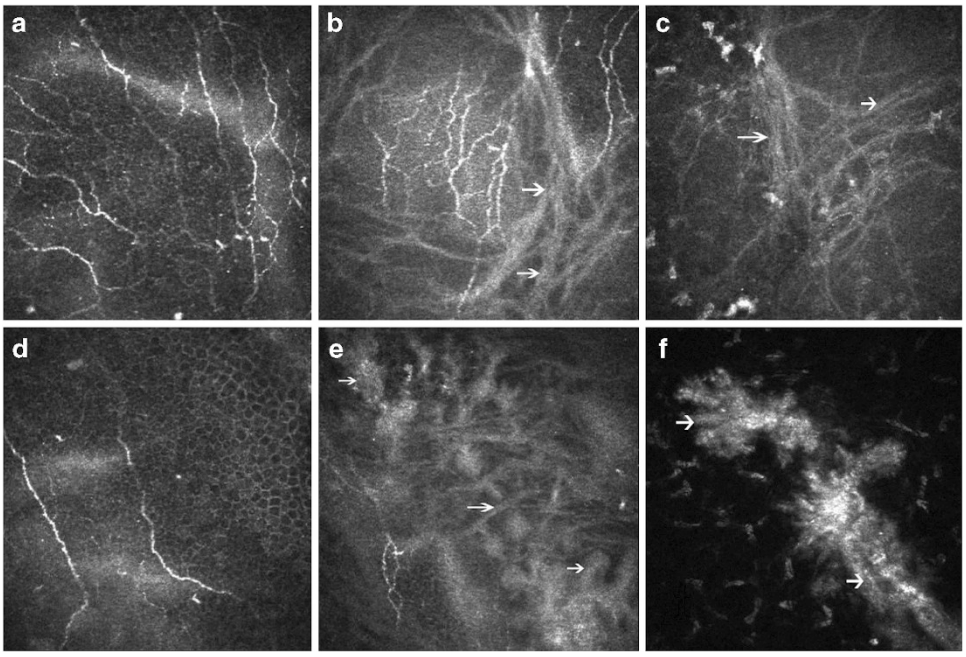

Figure 2 *In-vivo* confocal microscopy images of the (a–c) right eye and (d–f) left eye.

changes in the left eye. The patient was asymptomatic and did not have symptoms of photophobia, recurrent erosions, or reduced vision. He did not have a family history of corneal dystrophies and did not have any systemic illnesses. His best corrected visual acuity was 6/5 in the right eye and 6/9 in the left eye. Slit lamp examination of the cornea revealed lattice dystrophy in his left eye (Figure 1b), but no abnormalities in the right eye (Figure 1a). He had normal corneal sensation and an intact corneal epithelium. The reminder of the eye examination was normal. Both eyes were examined using IVCM.

IVCM was performed with the Heidelberg Retinal Tomograph Rostock Cornea Module (Heidelberg Engineering GmbH, Heidelberg, Germany). The linear branching hyper-reflective deposits were seen in both eyes. The left eye had larger and more intense deposits with blurred margins (Figures 2d–f), whereas the right eye had less intense thinner lattice-shaped branching hyper-reflective deposits with more defined margins (Figures 2a–c).

Comment

Lattice corneal dystrophy is usually a bilateral condition that is commonly asymmetric. Rarely, it has been reported to occur unilaterally. In our patient, the clinical diagnosis of lattice corneal dystrophy in the left eye was supported by the IVCM findings. In the right eye, the most plausible explanation for the IVCM findings is that of preclinical amyloid deposition (not seen on slit-lamp examination).

As far as we are aware, IVCM has previously not been reported to show changes suggestive of lattice dystrophy in a clinically unaffected eye.

Conflict of interest

The authors declare no conflict of interest.

Reference

1 Kobayashi A, Fujiki K, Fujimaki T, Murakami A, Sugiyama K. *In vivo* laser confocal microscopic findings of corneal stromal dystrophies. *Arch Ophthalmol* 2007; **125**: 1168–1173.

A Kailasanathan and S Maharajan

Queens Medical Centre, Department of Ophthalmology, Nottingham, UK
E-mail: senthil.maharajan@nuh.nhs.uk

Eye (2013) **27,** 991–992; doi:10.1038/eye.2013.80; published online 3 May 2013

Sir,

Aplasia cutis congenita of eyelid: case report

Aplasia cutis congenita (ACC) is a rare, congenital defect of the skin, which mostly affects the scalp and the trunk. The main complications include bleeding and infection. We present a rare case of ACC that involved solely the eyelid and confirms the effectiveness of conservative therapy.

Case report

A Chinese female neonate was referred to us because of skin and lash defect in the upper eyelid with a granulation tissue at the base at birth (Figure 1a). She was a full-term otherwise healthy baby delivered by