Figure 1 Photographs of right eye (A), left eye (B) and reverse transcriptase-polymerase chain reaction (RT-PCR) (C). Right eye is seen to be normal (A). Marked conjunctival hyperaemia is seen in the left eye (B). Rubella virus mRNA detected by using RT-PCR from the scrapings of the lower conjunctiva of the left eye (C). lane 1 (Sa) samples collected from the patient; lane 2 (pc), positive control (American Type Culture Collection (ATCC) VR-553); lane 3 (nc), negative control (distilled water for injections; Ohtsuka Pharmaceutical, Tokyo, Japan).

Figure 1 (A) A 73-year-old man with bilateral upper eyelid ectropion. The everted tarsal conjunctiva are inflamed and thickened. (B) Severe blepharospasm is seen on clinical examination. (C) One week after injection of botulinum A toxin, the bilateral ectropion and blepharospasm of the upper eyelid show marked improvement. Reproduced with permission.

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Bilateral upper eyelid ectropion associated with blepharospasm

An unusual case of bilateral upper eyelid ectropion thought to be caused by blepharospasm is described. Botulinum A toxin injection yielded a good clinical response. A

hypothesis for the pathogenesis of this condition is discussed.

Ectropion in adults typically affects the lower eyelid and is thought to result primarily from involution, paralysis and cicatrization.^{1,2} We report an unusual case of bilateral upper eyelid ectropion associated with blepharospasm in an elderly man who responded to treatment with botulinum A toxin.

Case report

A 73-year-old man was referred to our clinic with bilateral upper eyelid ectropion. The ophthalmic history showed that his symptoms started about 5 years earlier and that he had been treated unsuccessfully with lubricants and topical steroids. The patient reported that he sometimes tied a towel around his upper eyelid to raise the eyelid. There was no history of ocular surgery or treatment.

On clinical examination, the best-corrected visual acuity was 20/25 in both eyes, and the anterior and posterior segments were unremarkable except for senile cataract. Ectropion along the full width of both upper eyelids was observed, and the everted tarsal conjunctiva were inflamed and thickened (fig 1A). The eversion of the bilateral superior tarsi occurred immediately after the eyelids were manually repositioned, and severe blepharospasm was observed (fig 1B). The ocular surface was unaffected, and no epithelial damage was observed in either eye.

The patient was treated with injections of botulinum A toxin (Botox, GlaxoSmithKline, London, UK) into the bilateral orbicular muscles (six injections of 2.5 U on each side), the corrugator muscles (2.5 U on each side) and the procerus muscle (2.5 U). One week after the injections, the blepharospasm had almost resolved and the eversion of the bilateral tarsi had resolved (fig 1C).

Comment

Ectropion is due to an imbalance between the anterior and posterior lamellae, and usually develops in the lower eyelids.¹ Recently, rare cases of non-cicatricial upper eyelid ectropion have been reported.³ The current case is unusual in that ectropion developed bilaterally in the upper eyelids and was associated with blepharospasm.

We theorised that the following mechanism may have caused the ectropion in this case. Because of the difficulty associated with eyelid opening caused by blepharospasm and blepharoptosis, the patient lifted the upper eyelids mechanically, which resulted in a functional shortening of the anterior lamellae. The patient might have naturally excessive posterior lamellae, or, because he has age-related aponeurotic ptosis, the tension of both the levator muscle and the superior tarsal muscle, which prevent tarsal prolapse, may have been weak.

Prolonged spasmodic contractions of the orbicularis muscle caused the upper tarsi to herniate. In addition, the thickening of the tarsal conjunctiva, caused by longstanding exposure, increased the conjunctival volume, resulting in the failure of the tissue to return to the normal position in the conjunctival sac, making the tarsal herniation chronic.

Blepharospasm is presumed to be the underlying cause in this case; therefore, injection of botulinum A toxin was effective.^{4,5} Because the effect of botulinum toxin is transient,^{4,5} the

recurrence of blepharospasm and consequent ectropion should be carefully followed up. Additional eyelid surgery may have been helpful in this patient.

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Sudden loss of vision caused by a vasculitic ophthalmic artery occlusion in a patient with ankylosing spondylitis and Crohn's disease

We report for the first time a vasculitic ophthalmic artery in an HLA-B27 positive patient with ankylosing spondylitis and a new presentation of Crohn's disease.

Case report

A 37-year-old woman presented with sudden painless loss of vision in the right eye to perception of light, the left having poor vision from chronic uveitis and glaucoma. Examination showed iritis, an intra-ocular pressure of 2 mm Hg, a cherry red spot at the fovea with cloudy swelling, attenuated blood vessels and segmented blood flow consistent with global ocular ischaemia. The left eye showed a pale disc from long standing glaucoma. General examination showed that sinus tachycardia and blood pressure was normal.

The patient had a history of bilateral uveitis and ankylosing spondylitis for 14 years and was HLA-B27 positive. She had undergone cataract surgery bilaterally, followed by the development of glaucoma, requiring bilateral trabeculectomies and subsequently Molteno implants for its control.

Some weeks before admission, she had reported general constitutional symptoms, abdominal pain and loose stools which were controlled with sulphasalazine.

Acute investigations showed an erythrocyte sedimentation rate of 67 mm/h, C

reactive protein 142 IU, neutrophilia and macrocytic anaemia (Hb 11.4 g/dl). Initial management comprised methylprednisolone (1 g/day) followed by 80 mg of prednisolone daily with a rapid taper and subcutaneous heparin. Magnetic resonance imaging and magnetic resonance angiography showed no evidence of cerebral vasculitis and normal flow in the ophthalmic arteries. Echocardiogram showed no source of embolus. Carotid ultrasound was normal. She was then referred for further management.

At this stage, she was on 40 mg of prednisolone and her vision had improved to count fingers in the right eye. Goldman visual fields showed marked constriction to all targets with a central scotoma to the V4e in the right eye. The intra-ocular pressure was 11 mm Hg bilaterally. Right fundal examination showed attenuated blood vessels and a pale disc. Inflammatory markers had risen again with a C reactive protein 108 IU. Antineutrophil cytoplasmic antibody, lupus anticoagulant and thrombophilia screen were normal. Colonoscopy showed moderate to severe pancolitis including the terminal ileum. Histopathology of the large-bowel mucosa showed chronic active colitis, cryptitis, crypt abscesses and a diagnosis of active Crohn's disease was made. TNF α blockade treatment using infliximab was instituted with improvement of bowel and joint symptoms but her vision remained unchanged.

Comment

Iritis is the most common extra intestinal feature of inflammatory bowel disease (2% in women; 1.1% in men).¹ Common ocular features in Crohn's disease include anterior uveitis, episcleritis and more rarely scleritis, keratitis, orbital pseudotumour and retinal vasculitis which may cause retinal artery occlusion.^{2–5} Branch retinal artery occlusion as a complication of retinal vasculitis causing subsequent retinal neovascularisation has also been reported⁶ and fluorescein angiography has confirmed evidence of subclinical retinal vasculitis in patients with inflammatory bowel disease.⁷

A case of Crohn's disease with joint involvement has been reported after presentation with ophthalmic artery occlusion⁸ but this is the first case report of ophthalmic artery occlusion with ocular ischaemia associated with ankylosing spondylitis (HLA-B27 positive) and later diagnosis of Crohn's disease.

Summary

The likely aetiology is an obliterative vasculitis caused by granulomas in the blood vessel wall.⁹ Crohn's disease has also been reported in association with large vessel arteritis and axillary artery occlusion.¹⁰

Anti-TNF α agents have shown effectiveness in the treatment of spondyloarthropathies and Crohn's disease; amelioration of the extra-intestinal manifestations of the disease is variable. This case highlights the need to consider vasculitic causes of ocular ischaemia in patients with seronegative arthropathies who are HLA-B27 positive and should alert ophthalmologists that further investigation is necessary.

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Orbital brachytherapy for extrascleral extension of choroidal melanoma

Extrascleral extension of choroidal melanoma increases the risk of metastasis.¹ Anterior extrascleral extension can be treated by local resection with enucleation or scleral reinforcement after local radiation therapy. Advanced cases are dealt with by enucleation with resection of all visible orbital melanoma followed by radiation. External beam radiation therapy (EBRT) is used for presumed residual microscopic orbital melanoma.² Massive extrascleral extension may require orbital exenteration (also followed by irradiation).³ Treated similarly, extrascleral extension can also occur after plaque radiation, local resection and trans-scleral thermotherapy (TTT).⁴

Radiation therapy is used to reduce the rates of orbital and systemic recurrence.^{5–6} We report on the first use of orbital brachytherapy as an alternative to EBRT for extrascleral extension of choroidal melanoma.

A 63-year-old man presented to The New York Eye Cancer Center, with an American Joint Committee on Cancer (AJCC) T4N0M0 choroidal melanoma.^{7–8} Ultrasound disclosed a 6.5-mm-high tumour, 25×23 mm base, with extrascleral extension.

A metastatic survey was negative.⁹ The eye and all visible extrascleral tumour was removed and a 20-mm polymethylmethacrylate implant was inserted. Histopathology showed an epithelioid malignant melanoma,