portative d'enrichissement microbiologique [UPEM] pour une positivité >59 UPEM).

Les anticorps anti-PE font parti du groupe des anticorps antiphospholipides, mais sont distincts des anticardiolipines. Ils ne sont pas spécifiques de ce phospholipide mais sont pour la plupart dirigés contre des protéines plasmatiques liant la PE. De nombreuses observations de syndrome des antiphospholipides (SAPL)[1] mais aussi d'avortements à répétition[2] et de thromboses macro-vasculaires avec présence d'anticorps anti-phosphatidyléthanolamine isolés ont été décrites.[3]

Le SAPL était associé à ses débuts au lupus érythémateux systémique. Il est depuis 1988 devenu une entité à part entière, définie par les critères de Sapporo établis en 1999. Il consiste en l'association de critères cliniques de thrombose vasculaire (artérielle, artériolaire, veineuse ou capillaire) ou de morbidité obstétricale (≥ 3 fausses couches) et de critères biologiques avec la présence persistante d'anticorps antiphospholipides (d'anticorps anticardiolipine ou d'anticoagulant lupique). Les anticorps anti-PE ne sont pas pris en compte par la définition de Sapporo, mais peuvent cependant être à l'origine de tableaux thrombotiques sévères, et ne doivent donc pas être ignorés.

Devant ce cas de thrombose veineuse pour laquelle aucun autre élément prothrombotique que l'IgM anti-PE n'a pu être mis en évidence, et devant les donnés de la littérature, il semble être évident que ces anticorps soient les seuls responsables de la pathologie.

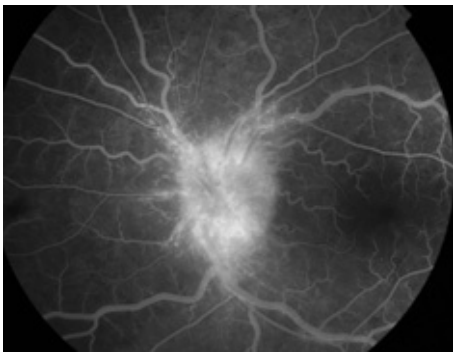

Fig. 2—Cliché d'angiofluorographie à 3 min 38 s après injection.

Cette association clinico-biologique entrant alors dans le cadre nosologique du « SAPL séronégatif ».[4,5]

La présence d'anticorps anti-PE dans le cadre d'un bilan de thrombose est une situation rare, mais leur recherche ne doit pas être négligée, en particulier chez les sujets jeunes et chez ceux ne présentant pas de facteurs de risque évident de thrombose.

Le fait qu'ils puissent être isolés ou associés à d'autres anticorps (en particulier lupiques), être isolés ou entrer dans le cadre d'un SAPL, leur confère un statut particulier entre élément d'une pathologie auto-immune plus vaste à bilanter de façon complète afin de ne pas la négliger au cours du suivi et de la prise en charge thérapeutique, et maladie immunologique évoluant pour son propre compte, isolée, et donc plus simple à cerner.

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Ocular adnexal lymphoma mimicking glaucoma: a case presentation

A 65-year-old male with a history of glaucoma, conjunctival hyperemia, and swelling and itching in the right eye for some time was referred to us. He had been followed with a diagnosis of glaucoma for approximately 18 months. The ophthalmological examination showed that the visual acuities on Snellen charts were 0.2 and 1.0 OD and OS, respectively. On slit-lamp examination, a conjunctival mass in the superior limbus with retrobulbar extension was noticed in the right eye. The left eye was normal except for a mild nuclear sclerosis. The intraocular pressure was 19 mm Hg in the right eye with antiglaucoma medication (beta blocker) and 14 mm Hg in the left eye without any medication. The cup to disc ratio was 0.9 OD and 0.2 OS. Automated visual perimetry revealed findings consistent with glaucomatous optic atrophy in the right

eye. Orbital MRI confirmed a subconjunctival mass extending from the superior limbus to the intraconal area in such a way that it encircled the optic nerve (Fig. 1). Biopsy and immunohistochemical staining confirmed mucosa-associated lymphoid tissue (MALT) lymphoma. We diagnosed the case as a primary ocular adnexal lymphoma (OAL) on the grounds that systemic investigations were negative.

According to the REAL (Revised European-American Classification of Lymphoid Neoplasms) classification, MALT lymphomas are extranodal marginal zone B cell lymphomas.[1] They have an indolent course and are usually localized to the original site, as in our case. These lymphomas can be differentiated with immunohistochemical staining.[2] Our case was CD-20 positive and CD-5 and CD-10 negative, which are the key characteristics of MALT lymphomas.

Chronic antigenic stimulation can lead to the formation of MALT lymphoma. Gastric MALT lymphoma is related to *Helicobacter pylori* colonization.[3] Some environmental factors, such as air pollution and plant dusts, might have played a role in our patient's condition. OAL may sometimes be misdiagnosed as chronic conjunctivitis, blepharitis, or strabismus.[4] A thorough eyelid and conjunctival examination may preclude misdiagnosis.[2] Akpek et al.[5] reported MALT lymphomas in chronic inflammatory ocular diseases.

Our case had been diagnosed as glaucoma because of high intraocular pressure, glaucomatous optic atrophy, and consistent visual field loss. The misdiagnosis might have arisen from inattention to any other causes. Our case is unique in terms of the development of rapid optic cupping and a retrobulbar mass, which had been overlooked for a long time. Although orbital lymphomas are not rare, an initial manifestation with glaucoma is an unusual property of lymphomatous lesions. In an extensive review of 5 case presentations by Coupland et al.,[1] no case was reported to have presented initially with glaucoma.

Advanced optic cupping in our case could be the result of either the mass effect of lymphoma on the optic nerve or high intraocular pressure. However, we were not able to determine which of these factors was responsible for the optic cupping. The complex presentation of OALs can make the diagnosis difficult in some challenging cases, as it was in our case. This possibility should be kept in mind in order to reach the correct solution in ambiguous situations.

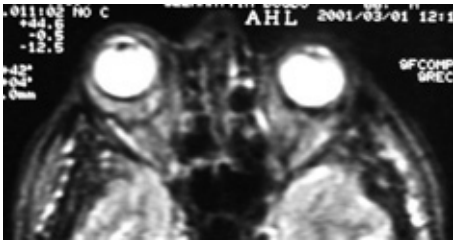

Fig. 1—On MRI the right eye is exophthalmic, and the globe wall is thickened diffusely (posterior wall 10 mm). There is no rectus muscle or optic nerve involvement.

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Basal laminar drusen and soft drusen have similar glycan composition

This case report describes the glycan composition of (small) basal laminar drusen (BLD) and (large) soft drusen using lectin histochemistry. Lectins have a high affinity for specific oligosaccharides. Because the lectin specificities for saccharides are known, the saccharide composition of both types of drusen can be inferred from their lectin-binding patterns.

Ocular tissue was obtained from a patient who died from end-stage renal failure. Prior to her demise she had undergone fluorescein angiography, which confirmed the presence of numerous small uniform drusen that fluoresced brightly in the arterial phase of the angiogram. In addition, there were larger, typical drusen, which fluoresced in the later phase (Fig. 1A). Histologic examination of the retina was undertaken post mortem on appropriate sections stained with periodic acid-Schiff. Drusen less than 75 μm were considered BLD. Other features characteristic of