optic nerve, muscle cones, and right medial rectus muscle; and engorgement of bilateral opthalmic arteries.

Right medial orbitotomy and biopsy revealed a large-cell T-cell lymphoma (TCL) with immunohistochemical staining positive for CD20, CD3, CD43, CD45RO, and leukocyte common antigen. Specimens stained negative for CD30, CD15, CD79a, S100, AE1/3, epithelial membrane antigen, chromatogranin, and synaptophysin. Anti–human T-cell leukemia virus I/II antibody reactivity was present.

The patient was treated with rituximab, etoposide, doxorubicin, vincristine, cyclophosphamide, and prednisolone and underwent left tarsorrhaphy. The proptosis and chemosis reduced dramatically, and vision improved to counting fingers OS.

Lymphoid neoplasms represent 6%–8% of orbital tumors, and up to 15% of ocular adnexal tumours.1 Up to 25% of cases present bilaterally. Non-Hodgkin’s lymphomas of all anatomic sites have been increasing at a rate of 3%–4% per year and may originate from B (90%) or T (10%) cells. Most low-grade B-cell lymphomas express surface CD20 (L26).

The pathogenesis of CD20+ TCL is not clearly understood, and has not been described previously with orbital TCL. It may derive from a circulating T-cell subset that has undergone neoplastic transformation.2 Alternatively, CD20 may be a marker of activation or proliferation. CD20 expression itself is insufficient to assign B lineage. In this case, CD3, CD4, CD5, CD8, and CD45RO identify the tumour as TCL.3 The CD20 expression represents an aberrant immunophenotype.

Despite its broad clinical and pathologic spectrum, CD20+ TCL affects elderly males more commonly and may behave aggressively. Some cases fall into defined TCL subtypes, whereas most are peripheral TCL. To our knowledge, this is the first reported case of CD20+ orbital TCL. Anti-CD20 directed therapy (e.g., rituximab) may be of therapeutic benefit in such cases.2,4-5 More study is needed to further explore the significance of CD20 TCL expression.

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Usefulness of anterior segment optical coherence tomography in the demonstration of intralenticular foreign body in traumatic cataract

Penetrating injury with intraocular foreign body (IOFB) is a common condition presenting in emergency services. Most of the time, accurate ocular assessment may not be possible in these cases. We report a case of retained intralenticular foreign body with clinical features, anterior segment photograph, and anterior segment optical coherence tomography (OCT) scan.

A 43-year-old male presented with complaints of decreased vision in the right eye for 3 weeks. The patient, a blacksmith by profession, gave a history of work-related injury while working with a hammer 3 weeks earlier. On examination his best-corrected visual acuity was counting fingers OD and 6/6, N6 OS. Anterior segment examination of the right eye showed a sealed corneal tear at the 12 o’clock position, just outside the central visual axis, and a brown opaque lens with ruptured anterior lens capsule (Fig. 1). There was no heterochromia or active inflammation. Pupil reactions were normal. The fundus in the left eye was normal, and in the right eye it could not be seen because of the cataract. B-scan ultrasonography revealed a highly echogenic core.

Fig. 1—Slit-lamp biomicroscopic photograph showing anterior capsule tear (arrow) with traumatic cataract in the right eye.

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mass just adjacent to the posterior capsule with a normal posterior segment. Anterior segment OCT (Visante, Carl Zeiss Meditec, Germany) was done to identify the exact location of the IOFB and assess the status of the posterior capsule. This showed a highly reflective foreign body located well within the substance of the lens (away from the posterior capsule) with after shadowing (Fig. 2). The exact dimensions of the IOFB could also be measured (1.29 mm in length). The patient underwent a manual, small incision, cataract extraction with IOFB removal and posterior chamber intraocular lens implantation. The patient’s vision recovered to 6/6 OD immediately after the surgery.

Intralenticular foreign bodies comprise about 5% to 10% of all IOFBs and can result in serious complications. The management and outcome depend on factors such as size, location, material type, and risk of infection.1 B-scan ultrasonography and CT scan can reveal the location of the intralenticular foreign body.2 However, B-scan ultrasound in the case of penetrating injury is often not advisable because of open injury. CT scan may be useful in such cases but is an expensive investigation modality with the added risk of radiation exposure. In such situations anterior segment OCT is a handy, noncontact, and noninvasive diagnostic tool that can provide the location and size of the intralenticular foreign body along with its relation to the posterior capsule. It has better resolution than B-scan ultrasonography.

To conclude, anterior segment OCT can be a potential investigational tool to diagnose, prognosticate, and tailor the surgical approach in the case of intralenticular foreign bodies.

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Fig. 2—Anterior segment optical coherence tomography high-resolution scan revealing highly reflective intralenticular foreign body with after shadowing (star).

Spontaneous resolution of foveal cysts associated with X-linked retinoschisis as observed by optical coherence tomography

X-linked retinoschisis (XLRS) is an inherited disorder characterized by splitting of the retinal layer. There are no known effective therapeutic interventions for patients with XLRS. In recent years, however, the use of carbonic anhydrase inhibitors1–3 and vitrectomy4 have been reported to be effective in reducing foveal retinoschisis. We encountered a case of XLRS in which spontaneous regression was observed by means of optical coherence tomography (OCT). A 22-year-old male presented with a chief complaint of decreased visual acuity that had been present since childhood. The best-corrected visual acuity (BCVA) was 20/125, and refractive error was 2 D myopia OU. The anterior segment was normal, and intraocular pressure was 16 mm Hg OU. A fundus examination revealed a cystic lesion in the fovea and retinoschisis in the perifoveal area of both eyes. The presence of a cystic space in the fovea resulted in the internal layer of the retina being folded in a cartwheel-like configuration (Fig. 1).

Predominant b-wave amplitude reduction was observed on electroretinography.

On OCT it was seen that 2 layers of the retina were connected superficially by thin-walled, vertical palisades, separated by low-reflective, cystoid spaces, which were confluent and most prominent in the foveal region. Central macular thickness was increased to 533 μm OD and to 534 μm OS (Figs. 2A, B).

Fig. 1—Fundus photography showed that the patient had the typical stellate maculopathy of radiating cystoid spaces, also known as spoke wheel-like maculopathy. Foveal atrophy was identified in the foveolar area of both eyes.