Our study suggests that the deteriorating BCVA after the initial DSEK resulted from slowly progressive optical failure of the transplanted cornea itself, because secondary DMEK provided complete visual rehabilitation. Clinically, the decline in BCVA concurred with an increasing centripetal contraction of the DSEK graft within the first half year after surgery, associated with variability in graft thickness and irregularity of the posterior corneal surface. With histopathology, abnormal tissue morphology could not be differentiated from changes relating to the explantation trauma.

It has been speculated that interface irregularities and/or an abnormal orientation of stromal lamellae could contribute to limited visual recovery after DSEK/DSAEK.[5] However, virtually complete visual recovery after deep anterior lamellar keratoplasty (basically the same combination of a donor-to-host interface and/or random tissue orientation) would lead away from such a theory. Alternatively, contraction of the donor posterior stroma may relate to compromised optical performance of the transplanted cornea. This would agree with the observations in pathology specimens of corneas after keratoplasty, which frequently show contraction of the posterior corneal trephination wound.[6] If so, variable endothelial graft contraction and associated compromised optical quality of the tissue, could—in part—explain a limited visual acuity with a clinically 'clear' cornea after DSEK/DSAEK, while more complete visual recovery may be obtained after DMEK.

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Iris melanoma in a child treated with iridectomy and a phakic iris repair implant lens: a case report of 8 years postoperative follow-up

The incidence of iris melanoma is 8% of all the uveal melanomas.[1] In children and adolescents, iris melanoma accounts for 0.6—1.6% of all the uveal melanomas.[2] We present a case of iris melanoma in a young boy treated with iridectomy and a phakic iris repair implant lens.

A 12-year-old boy was referred to the Department of Ophthalmology, Antwerp and then to Leiden because of a melanocytic lesion on the right iris without complaints. The visual acuity was 20/20 in both the eyes. Slit-lamp examination showed a pigmented iris lesion in the inferior quadrant of the right eye with diameter of 6.8 mm. The pupil showed a visible deformation, and an abnormal vasculature was present with ectropion uvea (figure 1A). Gonioscopy revealed a flat pigmented lesion extending in the open anterior chamber angle. There was no cataract, and the optic disc was normal. Fluorescence angiography of the right eye showed abnormal vessels. The left eye was normal. The intraocular pressure (IOP) was 33 mm Hg in the right eye and 17 mm Hg in the left eye. The high IOP was believed to be steroid-induced, as the patient was already being treated with steroid drops to rule out xanthogranuloma. The topical treatment was ended, and IOP returned to normal afterwards. Ultrasound biomicroscopy demonstrated an iris tumour of 1 mm thickness, with secondary cysts but without extension to the ciliary body. These findings were in favour of iris melanoma (figure 1B). The most probable diagnosis put forward on clinical findings and UBM was an iris melanoma. The follow-up examinations showed progression of the lesion, and it was decided to excise the tumour.

Local excision was performed by one of the authors (MJT) in April 2001 and involved a sectoral iridectomy and implantation of a customised designed phakic iris repair implant to reduce postoperative photophobia (figure 2A). The main consideration was to implant the iris-clip lens over the natural crystalline lens, clipped in the remaining iris tissue. Postoperative visual acuity was 20/20 without correction and remained unchanged during the last 8 years' follow-up. Histology showed iris melanoma spindle cell type A. The patient and family are completely satisfied with the cosmetic and functional results of the treatment (figure 2B).

DISCUSSION

The diagnosis of an iris melanoma is difficult in children. Iris naevi, cystic lesions, inflammatory processes and neoplasms can simulate iris melanoma.[3] The diagnostic approach was based on our clinical experience and the Harbour classification.[4] In our patient, three points of Harbour classification were positive.

Treatment options for iris melanoma are: local excision (iridectomy), enucleation and plaque or proton beam radiotherapy.[5] Complications of iridectomy are photophobia, cataract, corneal oedema, astigmatism and retinal detachment. Also, the spherical aberrations in phakic eyes have shown rising values with increasing pupillary diameter and can be a problem after iridectomy due to the increase pupillary size.[6] Our therapeutical approach was based on the young age of the patient and the fact that radiation complications in children are not uncommon.[7] Thus, we preferred local excision and designed a phakic iris lens in collaboration with

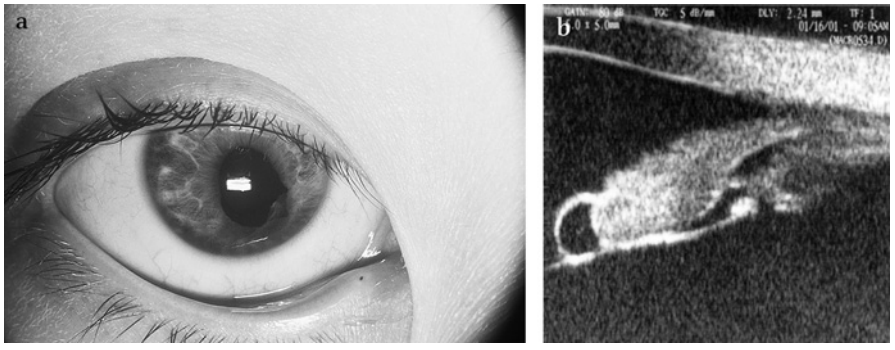

Figure 1 (A) Iris melanoma located in the right eye of our patient. (B) UBM image showing iris tumour having secondary cysts, with no extension to ciliary body or anterior chamber.

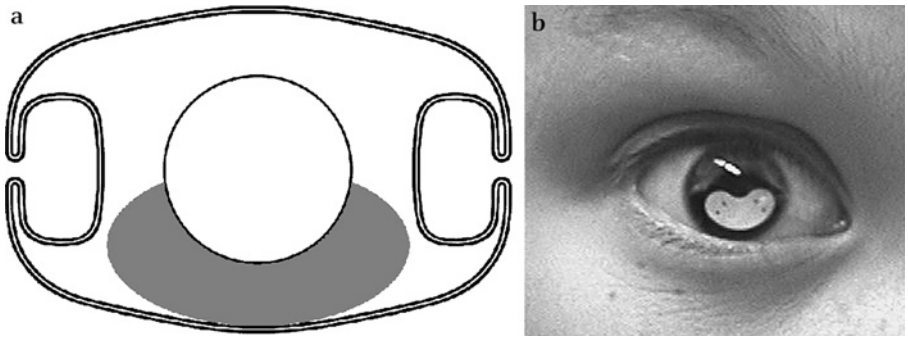

Figure 2 (A) Customised Ophtec phakic iris repair implant. (B) Postoperative result showing the iris repair implant in place.

Ophtec to cover the excised area. It should be noticed that the iris implant was intended to be positioned over the patient's natural lens. We have now 8 years of follow-up, and the patient's vision still remains at 20/20 for both the eyes and with no complication.

CONCLUSION

Management of an iris melanoma in selected cases, where radiation is undesirable, can consist of iridectomy with a special phakic iris-clip lens to achieve a good functional and cosmetic result provided the lesion is limited to the iris. Long-term follow-up is necessary to detect recurrence of melanoma and any postoperative complications.

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Isolated superior division oculomotor palsy in neurocysticercosis: a rare presentation

Cysticercosis is the most common parasitic disease involving the CNS. It is caused by infestation of the larval form of *Taenia solium*, with humans being the primary host. Neurocysticercosis commonly presents with seizures, raised intracranial tension and dementia. The unusual location of the cysts may result in uncommon manifestations mimicking a host of neurological disorders.

CASE REPORT

A 15-year-old boy presented with a complaint of drooping of his right eyelid for 3 days that was sudden in onset. No history of trauma or any other significant history could be elicited. On examination, there was right-sided severe ptosis (7 mm) with very poor levator action (3 mm). There was limitation of movements only in dextroelevation on the right side (figure 1A), and ocular movements were not associated with pain. The patient complained of mild headache. The pupil was round, regular and reactive. His vision was 20/40.

The results of the laboratory examination were normal. The left-side examination was normal. An initial contrast-enhanced CT scan was performed and revealed a conglomerated lobulated ring-enhancing lesion in the brainstem on the right side with mild perifocal oedema and eccentric calcified speck (figure 2A).

Subsequently, an MRI was performed in which SET1and FSET2 axial images of brain with saggital T2W and coronal FLAIR images reported two small cystic lesions in midbrain on the right side with eccentric speck within them and moderate perilesional vasogenic oedema suggestive of inflammatory granuloma/NCC (figure 2B).

Based on the imaging results and the high prevalence of disease in our region, these findings were thought to represent neurocysticercosis.

The patient's serum ELISA was positive for cysticercosis. He was referred to the Neurology Department and was treated conservatively and given systemic steroids, which resolved the symptoms completely within 7 days. No surgical intervention was carried out. There was no ptosis on re-examination (figure 1B), and the ocular movements were complete in all directions.

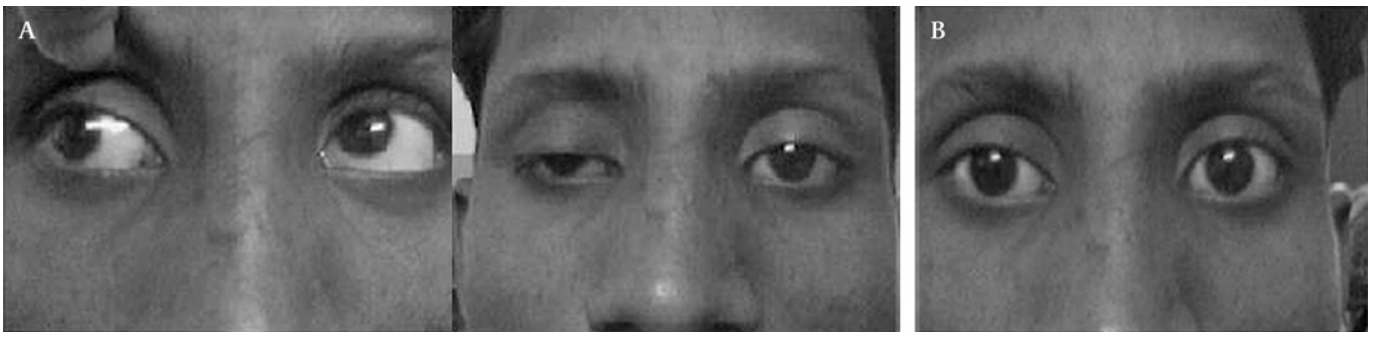

Figure 1 (A) Picture of the patient showing limited movements only in dextroelevation along with severe ptosis on the right side. (B) Picture of the patient after treatment.

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