Letter to the editor

Ocular myocysticercosis: an unusual case of ptosis

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Dear Editor,

The authors Agarwal et al (2013) have reported a case with ocular myocysticercosis wherein the cysticercus cyst was located in the levator palpebrae superioris (LPS) and superior rectus muscle complex. The cysticercus cyst involving the LPS muscle is infrequently reported and Chan and Looi (2010) have reported the sixth case of involvement of the LPS muscle. The extraocular muscles have a good vascular supply and thus these are the frequent sites for the location of the cysticercus cyst during orbital involvement. Inside the orbit, the orbital lesions have been found to be localized more often on the nasal side, which may be due to the course of the ophthalmic artery, which after giving off the lacrimal branches, runs along the medial side of the orbit and divides into its terminal branches (Malik et al, 1968). Even in the CT scan picture shown by Agarwal et al, the cysticercus cyst appears to be located medially. The lateral branch of the ophthalmic artery supplies the lateral and superior rectus muscles, the levator muscle of the upper lid, and the superior oblique muscle while the medial branch of the ophthalmic artery, which is the larger of the two, supplies the inferior and medial rectus muscles and the inferior oblique muscle. In the above case, there is involvement of the superior rectus and levator palpebrae superioris muscles which are supplied by smaller branch of the ophthalmic artery. The superior rectus has been earlier reported by Rath et al (2010) in their review of 171 patients of orbital cysticercosis to be the most frequently involved extraocular muscle, i.e. in 33.3 %, among all extraocular muscle involvements. It is obvious that the case presented by Agarwal et al (2013) specifically highlights the role of radiological studies while treating a case of ptosis. In the case reported by Chan and Looi (2010), the LPS action was reduced to 3 mm in the affected eye as compared to 13 mm in the normal eye. It would have been better if the authors had given the measurements of the ptosis and of the LPS action, so that magnitude of affection of the LPS action by this pathology could have been documented and which could have conspicuously added to the existing literature for giving guidelines in the management of patients of ptosis specifically if they come from an area which is endemic for cysticercus infestation.

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Letter to the editor

Optical coherence tomography in diabetic macular edema: sub-retinal fluid pattern and related risk factors

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Dear Editor

We read with interest the article by Ahmadpour-Baghdadabad M et al (2013) in which the authors studied the association of various patterns of diabetic macular edema (DME) with the risk factors of DME based on the optical coherence tomography (OCT) findings.

In a retrospective cross-sectional study, we too evaluated the systemic risk factors associated with sub-retinal fluid (SRF) pattern of DME. We compared 37 eyes with SRF pattern of DME (designated cases) versus 30 eyes having DME (sponge like retinal swelling or cystoid macular edema) without SRF (designated controls) on spectral domain-OCT. We too found that the SRF pattern was more common in males than in females (84.8 % of cases were males versus 66.7 % of controls). We did not find an association of HbA1C (mean HbA1C of 6.73 in cases versus 6.71 in controls, $p = 0.859$) and anemia (mean Hb of 10.71 in cases versus 11.77 in controls, $p = 0.118$) with the SRF pattern of DME.

There was no significant difference between the presence of hypertension among cases and controls (diagnosis of hypertension found in 72.7 % of cases and in 66.7 % of controls, $p = 0.634$). However, we did find a positive association between high systolic (SBP) and diastolic blood pressures (DBP) and the SRF pattern of DME. On measuring the levels of blood pressure in all cases and controls, both the SBP (mean SBP 147.84 in cases versus 141.0 in controls, $p = 0.039$) and the DBP (mean DBP 85.24 in cases versus 81.47 in controls, $p = 0.043$) were found to be raised in patients with SRF pattern of DME in comparison to DME without SRF. The reason for this can be unreported hypertension in the cases or higher uncontrolled blood pressures in the hypertensive cases than in the hypertensive controls. The occurrence of SRF in DME can be secondary to excessive leakage in the retina or to a poorly functioning retinal pigment epithelium (RPE). Raised blood pressure can lead to increased retinal leakage as well as ischemic damage to the RPE. We reported the presence of outer retinal communications, seen as defects in the outer border of the elevated retina in eyes with SRF pattern of DME (Gupta A et al, 2013). These defects may represent a path for the flow of fluid and proteins from intra-retinal cysts or from the outer layers of the edematous retina into the sub-retinal space.

In conclusion, we congratulate Ahmadpour-Baghdadabad M et al on their study and support their findings. We also recommend measuring the SBP and DBP in subjects with SRF pattern of DME besides evaluating a history of hypertension. It might be helpful to provide a more aggressive control of blood pressures in subjects with the SRF type of DME than in DME without SRF.

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