

Ciliary Body Reattachment Surgery

To the Editor.—We would like to draw attention to the historical priority in ciliary body reattachment surgery that has been established by Mackensen and Corydon.¹

In our article entitled "Ciliary Body Reattachment in Ocular Hypotony," published in the February ARCHIVES (1981;99:278-281), this valuable reference was unfortunately overlooked.

We trust that publication of this letter will be sufficient to correct this error.

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1. Mackensen G, Corydon L: Verbesserte Eingriffen gegen das Hypotonie-Syndrom mit Kammerwinkelspalt nach drucksenkender Operation. *Klin Monatsbl Augenheilkd* 1974;165:696-704.

Orbital Metastasis From Prostatic Carcinoma

To the Editor.—Winkler et al, in an article entitled "Orbital Metastasis From Prostatic Carcinoma: Identification by an Immunoperoxidase Technique" in the August ARCHIVES (1981;99:1406-1408), reported an unusual case of prostatic carcinoma that was seen initially with an orbital metastasis. Although this circumstance is undoubtedly rare, actual metastasis to the orbit is probably more common than was inferred.

Report of a Case.—A 54-year-old man was seen initially for a routine examination on Nov 20, 1980. His condition was diagnosed as cancer of the prostate gland in 1979, and, subsequently, he underwent radical prostatectomy. The next year, osseous metastases developed, and orchiectomy was performed, with remission of pain. In July 1980, there was involvement of the lower thoracic spine, which responded to decompressive laminectomy and radiotherapy (4,000 rad).

Findings from an ocular examination indicated the visual acuity corrected to 20/20 OD and 20/25 OS, Jaeger 1 OU. There were mild degenerative changes of the retinal pigment epithelium in both maculae. The findings from the remainder of the examination were normal. On Jan 14, 1981, he returned with an acute loss of vision in the left eye to light perception. There was a mild afferent pupillary defect and only a nasal island on visual field examination. The right eye also demon-

strated a centrocecal defect, although the visual acuity was still good at 20/25 OD and discs appeared normal. A computed tomographic (CT) scan suggested an anterior chiasmic lesion, and chemotherapy and prednisone therapy were started.

For several months, his condition was stable, but on July 7, 1981, he returned with an acute loss of vision in the right eye during the preceding several days. Visual acuity was light perception in the right eye and no light perception in the left eye. There was edema of the right disc and atrophy of the left disc, and a right sixth cranial nerve palsy was present. He was admitted to the hospital and found to have more generalized carcinomatosis with multiple metastases. During the next several days, a typical orbital apex syndrome developed with proptosis and orbital chemosis and paralysis of the cranial nerves III, IV, V, and VI. A CT scan demonstrated a soft-tissue mass at the apex of the right orbit. There was no bony involvement of the orbit. This failed to respond to radiotherapy. The general course was one of progressive metastatic complications. The patient died on July 28, 1981.

Comment.—The end-stage manifestations of prostatic carcinomatosis can involve the orbit more frequently than published reports suggest. However, the diagnosis at that stage is obvious. The authors are to be commended for the report of the immunoperoxidase test in establishing the diagnosis in the rare instance of initial manifestation.

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Anterior Segment Configuration

To the Editor.—I was interested in the article entitled "Anterior Segment Configuration Correlated With Shaffer's Grading of Anterior Chamber Angle" by Chan et al in the January ARCHIVES (1981;99:104-107).

These authors have measured central and peripheral corneal thickness and central and peripheral anterior chamber depth using attachments 1 and 2, respectively, to the slitlamp (Haag-Streit).

I have made similar measurements since 1969.¹ In 1971, I advised to measure the peripheral anterior chamber

depth for ascertaining the anterior chamber angle width independently from gonioscopic studies.² In 1972, I published the values of the central and peripheral anterior chamber depth obtained from eyes with primary angle-closure glaucoma.³ In 1978, I measured the peripheral corneal thickness in eyes with primary angle-closure glaucoma and in eyes with primary open angle glaucoma.⁴

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1. Iuglio N: Effects of topical dexamethasone on the dimensions of the anterior segment and on lens thickness. *Ann Ottalmol Clin Ocul* 1969; 95:921-925.

2. Iuglio N: Effects of peripheral iridectomy on anterior chamber biometry of the eye with angle closure glaucoma (Effetto dell' iridectomia periferica sulla biometria della camera anteriore dell' occhio con glaucoma da chiusura dell' angolo). *Boll Soc Ital Biol Sper* 1971;47:466-468.

3. Iuglio N: Role of the vitreous in the pathogenesis of the glaucomas (Ruolo del vitreo nella patogenesi del glaucoma). Read before the 54th congress of the Society of Italian Ophthalmologists, Rome, Nov 23-25, 1972.

4. Iuglio N: Peripheral corneal thickness in primary glaucoma (Lo spessore corneale periferico nel glaucoma primario). *Ann Ottalmol Clin Ocul* 1978;104:227-232.

In Reply.—The Haag-Streit attachments for the measurement of the corneal thickness and anterior chamber depth were designed from principles developed by Jaeger (*Albrecht Von Graefes Arch Klin Exp Ophthalmol* 1952;153:120-131) (Heidelberg) in 1952.

These attachments are commercially available and have been used for almost two decades by many observers to measure the corneal thickness and the anterior chamber depth under a variety of circumstances.

To our knowledge, our article was the first to report the use of the instrument to measure corneal thickness and central anterior chamber depth and to correlate this with angle width as seen on gonioscopy.

Thus, by using our calculations, which were published in the article, an estimation of the anterior chamber angle width can be made in those clinical situations where gonioscopy is impossible or where there is no trained gonioscopist available.

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