shown that an appositional force of 90g externally placed on the eye increases intraocular pressure to approximately 90 mm Hg, which is sufficient to overcome systolic pressures and cease central retinal artery blood flow.

Given that even hard squeeze blinks have been shown to increase intraocular pressure in a range from 50 to 110 mm Hg, it is certainly conceivable that the appearance of peripheral ROP in this patient may have been altered through this mechanism.

Important advantages of wide-angle imaging for ROP include the opportunity for objective documentation of retinal structures, as well as serial comparison of findings. Using these images, telemedicine has the potential to improve the overall quality of ROP care through accessibility to experts and standardization of examination procedures. This report demonstrates that errors in image capture and interpretation can occur, even in severe posterior disease. Recognition of these cases, with adequate training of photographers and image graders, can improve the accuracy and reliability of wide-angle retinal imaging and telemedical ROP diagnosis.

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Macular Hole Formation Without Vitrefoveal Traction

Macular hole formation has been postulated to occur due to vitrefoveal traction based on sequential clinical examination features, inferences from histopathological studies, and imaging studies. Some reported cases seem to have occurred outside of the context of such traction, raising the possibility that traction is not the only precipitating factor in macular hole formation. This article demonstrates such a case with the clarity of optical coherence tomography (OCT).

Report of a Case. A 70-year-old woman had decreased vision in her left eye for several weeks. Visual acuity was 20/50. Funduscopic examination (Figure 1) showed a yellow spot in the central fovea, which correlated with a focal area of vitrefoveal traction as demonstrated by OCT (Figure 2A). There was no change 3 months later, but 6 months after the initial visit visual acuity had improved to 20/40; OCT imaging demonstrated release of the vitrefoveal traction (Figure 2B). The foveal contour had further improved 18 months later and visual acuity had increased to 20/30 (Figure 2C). The patient returned 6 months later (2 years after the spontaneous vitrefoveal release) with visual loss to 20/60 and a small central full-thickness macular hole (Figure 2D). Macular hole surgery was performed with successful closure and a return of visual acuity to 20/30.

Comment. Gass1 systematized the stages of macular hole formation based on clinical examination features, deducing that vitrefoveal traction at the time of posterior vitreous detachment appeared to mediate the formation. These observations were corroborated by ultrasonography2 and OCT studies.3

However, certain cases seemed not to be consistent with these observations, such as eyes with macular hole formation at least several months after definitive posterior vitreous separation, scleral buckling surgery (implying a well-established posterior vitreous detachment), and vitrectomy for unrelated disorders.4 These

Figure 1. Fundus photograph at the initial visit showing a yellow spot at the fovea. Visual acuity was 20/50.
exceptional cases seem to indicate that something in addition to a mechanical, tractional relationship participates in macular hole formation, at least in some instances. The OCT images in the case reported here depict this apparently tractionless sequence more clearly than previously described.

An alternative explanation is that the traction component is below the resolution of OCT. A possible mediator might be the outer wall of vitreoschisis as has been proposed by Sebag,5 and this may be depicted on the left side of Figure 2A and B as focal areas of minimal separation of what might alternatively be interpreted as the internal limiting membrane. Degenerative factors such as subtle defects or breaks in the internal limiting membrane (tractionally or senescently induced) may allow hydration of the fovea and distort tissue enough to form a full-thickness macular hole.6 This may explain why surgical removal of vitreofoveal traction does not uniformly prevent macular hole formation.

The mechanisms of macular hole formation are still incompletely understood but may involve degenerative and tractional factors. A full understanding of pathogenetic mechanisms would likely optimize treatment and prevention of full-thickness macular holes.

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Interdigitating Dendritic Cell Sarcoma of the Eyelid With a Rapidly Fatal Course

Interdigitating dendritic cells participate in the immune system as antigen-presenting cells, stimulating T lymphocytes. Interdigitating dendritic cells normally are localized in the T-cell–rich areas of lymph nodes and are believed to be derived from hematopoietic precursors and to belong to the mononuclear phagocytic system. Interdigitating dendritic cells sarcoma is an extremely rare malignancy derived from these antigen-presenting cells normally localized in lymphoid organs. Only 45 cases have been reported in the literature to date.1,2 We are unaware of previous reports of this sarcoma in the eyelid and could not find any reference to it in a MEDLINE search.

Report of a Case. A 72-year-old man who had an unknown recurrent lesion in his lower right eyelid for 8 months was referred to our department. Two prior biopsies revealed a nevoid lesion and dermatofibroma. The patient was referred to our clinic when the tumor recurred. His best-corrected visual acuity was 0.8 OD. A 20-mm x 6-mm multinodular, ulcerated tumor was present on his right lower eyelid (Figure 1). The anterior chamber and the vitreous were free of inflammation and the lens revealed a mild senile cataract. The patient underwent sufficient surgical resection with a 4-mm–wide tumor-free margin and reconstruction using a tarsocutaneous flap combined with a skin graft. Microscopically, the tumor consisted of medium to large spindle-shaped cells with hyperchromatic nuclei. The cells were arranged in fascicles and formed whorls. The mitotic count was high (Figure 2). The final diagnosis was interdigitating dendritic cell sarcoma. The tumor cells

Figure 2. Optical coherence tomographic images. A, Corresponding vitreous attachment and foveal elevation. B, Six months later, the image shows spontaneous vitreous traction release. Visual acuity was 20/40. C, Improved foveal contour 18 months after vitreous traction release corresponds to further visual acuity improvement to 20/30. D, Macular hole formation 2 years after vitreofoveal release. Visual acuity is 20/60.