ing uveal pigment and blood become clinically visible, resulting in the blue appearance of the sclera.

We report the treatment of rhegmatogenous retinal detachment in 4 eyes of 3 patients with OI. Scleral buckling surgery, pneumatic retinopexy, and primary vitrectomy are the standards for repair of uncomplicated rhegmatogenous retinal detachments. In patients with OI, however, the thin sclera provides an increased risk of scleral perforation during the buckling procedure. In our first patient, demarcation laser photocoagulation was applied (5 years ago) and proved to be successful in preventing extension of the detachment. It has been reported that demarcation laser photocoagulation may be an effective method to manage acute or chronic macula-sparring shallow retinal detachments without proliferative vitreoretinopathy.1,3,4 Laser photocoagulation rapidly enhances retinal adhesion to 140% of normal in 24 hours and twice normal between 3 days and 4 weeks.5 For laser treatment to be effective, confluent laser photocoagulation burns should surround the entire detachment.

In the left eye of our third patient, the presence of multiple inferior breaks and the extent of the detachment presented the options of scleral buckling or pars plana vitrectomy. Early in the procedure, it became evident that performing a scleral buckle was not possible. In our experience, the lack of blue discoloration of the sclera in the buckling area may be misleading when considering suture placement. In patients with OI, the sclera has an abnormal consistency, which may lead to inadvertent needle perforation, even with conservative suture depth. Pars plana vitrectomy in these patients may also be challenging. During vitrectomy, increased infusion pressure may be needed to prevent collapse of the globe during instrument exchange. This is secondary to the laxity of the sclera and its lack of rigidity. At the end of surgery, closure of the sclerotomy wounds with partial-thickness scleral sutures requires care to prevent perforation.

Based on a MEDLINE search, this is the first report of treating retinal detachment in patients with OI with demarcation laser photocoagulation or pars plana vitrectomy. There are challenges facing the surgeon during vitrectomy surgery because of decreased scleral rigidity. The thin sclera in patients with OI makes the scleral buckling procedure a less desirable choice of treatment, even when the sclera appears white.

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A brain magnetic resonance imaging scan showed no abnormalities. Lumbar puncture showed an increased opening pressure (225 cm H$_2$O), but the cerebrospinal fluid showed no cells, no hypoglycorrhachia, and no elevation in the protein concentration.

Treatment with ATRA was discontinued, and the APML was treated with a combination of arsenic trioxide, daunorubicin hydrochloride, and cytosine arabinoside. Over the next 6 weeks, subsequent to and corresponding with the discontinuation of ATRA therapy, the headache, papilledema, and abducens palsy resolved. Treatment with arsenic trioxide, daunorubicin, and cytosine arabinoside was continued for 3 months, and the patient has remained in remission.

**Comment.** The differential diagnosis in this case included meningeal invasion of APML cells that then caused increased intracranial pressure and bacterial meningitis in an immunocompromised (APML) patient. Pseudotumor cerebri (secondary to ATRA treatment) was diagnosed. Abducens palsy and papilledema reversed following discontinuance of treatment with ATRA (the combination of arsenic trioxide, daunorubicin, and cytosine arabinoside were successful in the induction of remission).

In this patient, papilledema was secondary to pseudotumor cerebri induced by treatment with ATRA. Retinoic acid is an oxidized form of retinol (vitamin A). The pathogenesis of pseudotumor cerebri in patients with APML being treated with ATRA is thought to be similar to the mechanism in vitamin A overdose: overdosage of vitamin A is postulated to impair cerebrospinal fluid absorption at the level of the arachnoid vili or granulations. Normalization of intracranial pressure resolved other accompaniments of increased intracranial pressure, such as abducens palsy and headache. This case emphasizes the importance of recognition by ophthalmologists of this potential side effect of ATRA in the treatment of APML.

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**Adult Nasolacrimal Duct Mucocele**

Nasolacrimal duct mucoceles (NLDMs) are encountered almost exclusively in the pediatric population. Recognition of a mucocele associated with nasolacrimal duct obstruction is important, as its presence dictates alternate management. In this report, we describe an unusual occurrence and the management of an NLDM found in conjunction with lacrimal drainage obstruction in an adult, emphasizing the need for thorough evaluation of the nasal passage in not only pediatric but also adult patients.

**Report of a Case.** A 51-year-old white woman was evaluated for right eye epiphora and progressive ipsilateral nasal congestion of 3 years’ duration. She denied epistaxis, facial fracture, malignancy, and known sinonasal diseases. Ophthalmic examination findings were only notable for an increased right eye tear lake. Findings from the remainder of the right eye examination and the entire left eye examination were unremarkable, including normal eyelid position and structure, with all puncta patent, and no palpable lacrimal sac distention or mass. Dye disappearance was markedly delayed on the right eye; nasolacrimal duct obstruction was confirmed with irrigation. Intranasal examination revealed a mass located below the inferior turbinate. Computed tomography demonstrated a fluid-filled cyst and ipsilateral nasolacrimal duct dilatation (Figure 1). There was no radiographic evidence of sinus disease.

Endoscopically, a smooth, nodular, light pink mass was found below the inferior turbinate (Figure 2). Following marsupialization with mucosal wall resection, the lacrimal drainage system irrigated freely, and a bicanalicular stent was placed. Histologically, the excised tissue consisted of chronically inflamed ciliated columnar epithelium with goblet cells and submucosal fibrosis consistent with a mucocele. Postoperatively, she was treated with an oral antibiotic (cephalexin hydrochloride), nasal decongestant (oxymetazoline), and a topical antibiotic/steroid drops (tobramycin/dexamethasone). The stent was removed after 3 months, and she remains asymptomatic 1 year postoperatively.