mal. Magnetic resonance angiographic and venographic findings were normal. The hypothalamic-pituitary axis was normal.

Comment. To our knowledge, we report the first case of an infant diagnosed as having MGDA and ipsilateral optic pathway glioma. Optic pathway tumors may lead to progressive vision loss and visual field defects. Our patient has no vision deficit in the contralateral eye at this time.

The etiology of MGDA is yet unknown but may result from abnormal development of the lamina cribrosa and posterior sclera. Persistent fetal vasculature in association with MGDA has been described. Vision is typically poor, with only 30% of patients achieving a visual acuity of 20/40 or better. Afferent pupillary defect is also common because the disorder is typically unilateral and retinal detachment can occur in the affected eye.

Morning glory disc anomaly has been reported in association with a variety of midline defects including hypertelorism, cleft lip and palate, agenesis of the corpus callosum, type I Chiari malformation, encephalocele, and endocrinologic abnormalities involving the pituitary gland. Central nervous system vascular anomalies including moyamoya syndrome are seen with increased frequency. Morning glory disc anomaly is rarely associated with genetic disorders, although 2 cases have been reported in the setting of neurofibromatosis type 2, with distinctive clinical features not found in our case.6

We recommend that any patient with MGDA undergo dedicated magnetic resonance imaging for evaluation of other midline defects as well as magnetic resonance angiography given the association with vascular abnormalities. Early recognition and management of amblyopia and possible retinal detachment are essential to optimize visual acuity. Our patient, whose MGDA is seen in association with optic nerve glioma, faces the additional risk of vision loss in the contralateral eye. Thus far, he has not required any tumor-directed therapy. It is important that clinicians and radiologists be aware of this possible association of MGDA with optic nerve glioma as change in the size of the tumor and/or change in visual acuity or visual fields would prompt tumor-directed therapy to preserve vision in the contralateral eye. This report expands on the spectrum of clinical associations with MGDA.

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Silicone oil tamponade is commonly used in surgical repair of recalcitrant retinal detachments. Complications of intraocular silicone oil include corneal decompensation, cataract formation, and glau-
Silicone oil has been reported to migrate through the optic nerve into the brain. Free silicone oil within tissues can cause a chronic granulomatous inflammatory reaction, which, depending on the location, can result in impairment of involved structures. Silicone oil has been reported to cause granulomatous anterior episcleral nodules following transscleral migration through vitrectomy sites. We have found no cases of posterior orbital silicone oil granulomas incidentally discovered during enucleation.

**Report of a Case.** A 44-year-old highly myopic (approximately 20 diopters) woman had an outpatient surgical consultation for a blind, painful left eye. A decade prior, she was struck in the left eye, causing a retinal detachment. Four vitreoretinal operations were performed and no encircling band was placed. During the most recent retinal surgery, 5 years prior to her consultation, silicone oil tamponade was performed. Her visual acuity had been no light perception since surgery. She did not start developing severe pain until 2 years prior to her consultation with us. She described her discomfort as a nearly constant ache in the orbit and brow that worsened with eye movement.

Anterior segment examination showed a closed angle without inflammation and a well-centered posterior chamber intraocular lens implant. The posterior segment showed approximately 70% silicone oil fill over a flat retina. The intraocular pressure was 55 mm Hg.

An enucleation was carried out in the standard fashion. As the enucleation scissors were passed to sever the optic nerve, a hard mass was felt posterior to the globe. Dissection was carried out posterior to the Tenon fascia, and a retrobulbar mass was discovered. The entirety of the granulomatous mass was removed, remaining attached to the posterior aspect of the globe. The orbital tissues were rinsed and wiping debridement of any silicone oil remnants was performed. An implant was placed and the remainder of the procedure was completed as per our usual technique.

Histopathologic evaluation of the globe showed thinning of the posterior sclera consistent with a myopic staphyloma. The axial length was 29 mm. There was neovascularization of the iris and angle, with peripheral anterior synechiae, correlating with angle-closure glaucoma noted clinically. The retina exhibited extensive degeneration as well as silicone oil spaces without any associated inflammation. A large posterior episcleral mass was evident, consisting primarily of silicone oil droplets, some with associated foreign body giant cell reaction (Figure, B and C). No foreign body giant cell reaction was seen intraocularly.

At follow-up visits, the patient described resolution of all pain.

**Comment.** Pain in the blind eye can be secondary to many reasons, including elevated intraocular pressure and development of phthisis bulbi. Extraocular masses can also lead to discomfort especially if associated with inflammation. In our patient, it is difficult to determine whether her pain was only secondary to the elevated intraocular pressure or the chronically inflamed orbital mass.

Pathologic myopia is characterized by an excessively long globe and commonly has thinned or dehiscent layers of the ocular side wall. The silicone oil nidus for the inflammatory reaction may have escaped through dehis-
cent scleral channels. The several years between the silicone oil placement and onset of discomfort may be explained by long-term, slow leakage of silicone oil through the sclera.

Free silicone oil within the extracellular matrix commonly causes a chronic granulomatous reaction that may lead to inflammation or functional impairment. Our patient described late development of ocular and orbital pain in a blind eye treated with silicone oil. Enucleation and orbital granuloma removal resolved the pain. It is important to consider extrascleral silicone oil granulomas in patients with ocular and orbital pain following treatment with silicone oil tamponade.

**Progression of Primary Acquired Melanosis With Atypia During Pregnancy**

Primary acquired melanosis (PAM) of the conjunctiva manifests as unilateral patchy areas of pigmentation usually in middle-aged or elderly patients. It can be differentiated histologically by the degree of atypia of melanocytes. Without atypia, PAM is a benign melanocytic proliferation. With atypia, PAM may progress to malignant melanoma. With severe atypia, PAM progresses to melanoma in about 13% of cases. We describe a case of PAM that progressed during pregnancy in a young patient.

**Report of a Case.** A 28-year-old woman with brown irides had an 8 × 7-mm pigmented area on the right temporal bulbar conjunctiva (Figure 1A). She had noted this several years earlier but felt it was increasing in size. The area was biopsied and showed PAM with moderate atypia (Figure 2A). She was treated with a standard 9-week course of topical mitomycin C, 0.04%, 4 times/d, prednisolone acetate eyedrops, 0.5%, 4 times/d, and ocular lubricants. The pigmented area regressed and remained stable during the next 18 months (Figure 1B). Seven months later, an increase in size and pigment density was noted (Figure 1C). A repeated biopsy showed PAM with moderate atypia (Figure 2B). It was treated with a second course of mitomycin C with good response (Figure 1D).