postoperatively, the patient’s uncorrected vision was 20/50 OS. The left eye was correctable to 20/20 with +1.50 – 1.75 × 60.

The patient was followed up every 2 weeks for 5 months until his vision and refraction stabilized in the left eye (without correction, visual acuity was 20/20 and with correction, –1.75 – 2.50 × 45, visual acuity was 20/20). Keratometry in the left eye at this time was 41.25 D at 136 degrees, 38.75 D at 46 degrees, and pachymetry in the left eye was 572 µm. The topography of the left eye just prior to the enhancement is shown (Figure 3). The left eye was retreated on January 15, 2003, for –1.8 – 2.50 × 45. The flap was not recut but lifted up with some difficulty, as it had adhered very strongly to the corneal bed. At 1 day postoperatively, the uncorrected vision was 20/20 OS.

The final uncorrected vision, 3 months after retreatment, was 20/20 – 1 OS. Uncorrected near vision was Jaeger measure 2 OS. The patient was very happy with his final visual outcome.

This is the first known case of LASIK for myopia being performed after epikeratophakia. This report shows that LASIK following epikeratophakia can be performed successfully.

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Macular Schisis Detachment Associated With Angle-closure Glaucoma

Optic disc pits represent congenital anomalies in the optic nerve head commonly associated with retinoschisis and serous retinal detachments. In contrast, acquired glaucomatous damage to the optic nerve, both localized acquired pits and diffuse Schnabel optic atrophy, has not been linked to retinal detachment. A recent report by Spaide et al demonstrated schisis and outer layer detachment, the characteristic features of optic pit maculopathy, in the absence of an optic pit. We describe a patient who developed macular schisis and underlying serous detachment in an eye with a large optic cup following repeated attacks of angle-closure glaucoma.

Report of a Case. A 54-year-old man was seen by an ophthalmologist and complained of 4 weeks of intermittent pain and blurring of vision in his right eye. A right afferent pupil defect was present, and the visual acuity was 20/200 OD and 20/25 OS. Significant asymmetry of the optic nerves was observed, with cup-disc ratios of 0.9 OD and 0.2 OS (Figure 1). The fundus of the left eye was unremarkable, but the right eye had a serous retinal detachment with fluid extending from the disc margin through the macula (Figure 2A), as well as a posterior vitreous detachment. Contact lens examination revealed a small area of dehiscence in the internal limiting membrane just temporal to the right optic disc.

An area of hyperfluorescence deep in the central and inferotemporal margin of the right optic cup without leakage into the subretinal space was present on fluorescein angiography (Figure 2B). Optical coherence tomography demonstrated an area of retinoschisis continuous with the optic nerve with an associated neurosensory retinal detachment extending through the macula (Figure 2C and D). The patient has deferred any surgical intervention. His intraocular pressure remains well controlled with timolol maleate in the right eye.
Comment. The etiology of the schisis and serous retinal detachment in this case remains uncertain. The optical coherence tomographic findings demonstrate retinoschisis and retinal detachment characteristic of the maculopathy associated with congenital optic pits, yet a congenital optic pit could not be identified. The history of a central scotoma that followed acute rises in intraocular pressure suggests that the increased pressure and optic nerve cupping may have played a role in the production of the schisis detachment. We cannot exclude the possibility of a congenital optic pit that was obscured by the significant cupping of the nerve head. The patient reportedly had normal fundus examination results in the past, although photographs are not available.

Animal studies of Schnabel optic atrophy have demonstrated that prolonged rises in intraocular pressure may lead to ruptures in the inner limiting membrane and subsequent penetration of vitreous into the retrolaminar space. In our patient, the sustained rise in intraocular pressure led to severe optic nerve cupping and may have allowed liquid vitreous to enter the retina via the nerve fiber layer. This is supported by the direct communication of the schisis cavity with the optic nerve, as shown by optical coherence tomography, with the outer layer detachment likely occurring as a secondary event.

We report this case to document the development of macular
schisis and retinal detachment in the absence of a congenital optic pit. This case raises the question whether acute rises in intraocular pressure from glaucoma can produce structural defects in the optic nerve head that can lead to a schisis detachment similar to that seen in cases of congenital optic pits.

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Uveal melanoma is the most common primary intraocular malignancy in adults. A collar button-shaped lesion is most often a melanoma, particularly when it has low internal reflectivity and moderate vascularity on ultrasonography. We describe a patient who had a choroidal mass with these features, which was identified as a fi-