that eye, and visual acuity is poor. Limited visual outcome in these patients can be attributed to severe intracranial damage (Table 2), severe retinal hemorrhages (Table 2), and aphakia with amblyopia.

The presence of a macular hole in SBS is a poor prognostic finding. Affected patients usually have severe visual acuity deficits, even with successful anatomical repair. Additionally, macular hole may be a predictor of severe neurologic injury in SBS, as was the case in 3 of the 5 patients we described.

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**Transorbital Penetrating Brainstem Injuries**

Penetrating injury to the posterior fossa is uncommon, and when it occurs, it is typically due to projectiles that pierce the cranial bones. Morbidity and mortality from these injuries are high. We present 3 cases in which objects that were thrust through the orbit penetrated the upper brainstem. All patients survived their injuries.

Report of Cases. Case 1. A 21-year-old man was struck below the left eye by a wire 4 mm in diameter while laying concrete-reinforcing steel mesh. He had a puncture site evident on his left lower lid. He complained of vertical and horizontal diplopia, mild left ptosis, decreased coordination of the right side of his body, and slurred speech.

Examination showed visual acuities of 20/15 OU. There was mild ptosis with limited adduction, abduction, and elevation in the left eye. His pupils were symmetric and reactive without a relative afferent pupillary defect. There was no evidence of globe injury. Goldmann perimetry testing results were normal. He had poor coordination of the right side of his body. There was no weakness. Speech was dysarthric without aphasia.

A computed tomographic scan showed minimal hemorrhage in the region of the left inferior rectus muscle. No bony fracture was present. Magnetic resonance imaging revealed a linear lesion in the inferior midbrain that began in the cerebral peduncle and was directed back toward the aqueduct (Figure 1). There was no retrobulbar hemorrhage.

A follow-up examination 2 years later revealed residual diplopia and a mild right hemiparesis.

Case 2. A 38-year-old man was stabbed in the upper left orbit and immediately became paralyzed on his right side. He remained conscious. He also complained of an inability to see out of his left eye secondary to complete ptosis. He reported local orbital pain, but had no other sensory symptoms.

Examination revealed acuities of 20/20 OD and 20/100 OS. Color vision and confrontation visual fields were normal. A small entry wound was discovered in the left medial upper lid and measured less than 1 cm in length. The right eye moved normally but the left was immobile and had a fixed, dilated pupil without a relative afferent pupillary defect. Dilated funduscopic examination did not reveal any abnormalities. He had a right central seventh nerve palsy and a right hemiparesis with upgoing toe.

Magnetic resonance imaging of the brain revealed a linear lesion in the superior pons angling from the left ventrolateral side medially toward the fourth ventricle (Figure 2). The lesion was dark on gradient echo imaging and bright on diffusion-weighted imaging. A computed tomography angiogram showed no evidence of a vascular injury.

The hemiparesis gradually improved and the patient walked into the clinic for his follow-up visit 3 months later. At that time, he had visual acuities of 20/15 OD and 20/20 OS. Orbital motility revealed minimal adduction, elevation, and infraction of the left eye. He had moderate abduction and the eye was intorted. The pupil was fixed and dilated and a subtle right hemiparesis persisted.

Case 3. A 13-year-old boy was struck below his right eye by a beach umbrella tine ⅛ of an inch in diameter. His mother reported that he did not lose consciousness but was
orbital roof fractures, the superior etracting injuries commonly occur via have found that intracranial pen-
ptosis and diplopia.

hemiparesis and significantly less abnormalities.
Cerebral angiography did not show
cerebellar vermis.
The right cerebral peduncle (arrow) and image from a young boy who was struck by an
right upper pons that extended to
showed a hemorrhagic lesion of the
malities of the retrobulbar struc-
scan revealed no fractures or abnor-
left hemiparesis with mild dysmet-
ner lid ptosis. He did not complain
visual acuities of 20/20 OU. He had
sistance with ambulation immedi-
dazed at the scene and required as-
complained of complete right upper
. He did not complain of weakness or uncoordination.
Examination revealed corrected visual acuities of 20/20 OU. He had
icnosis of the medial right lower
lid without skin laceration. There
plete right upper lid ptosis. He had limitation of suprduction,
adduction, and abduction of the
. His left eye moved nor-
right pupil was fixed and dilated and there was no relative af-
fapper pupillary defect. A subcon-
ductal hemorrhage was found on
junctiva should not dissuade imag-
entry wound is important in patho-
genesis because lesions through the
upper eyelid or above the globe
ng through the orbit is a rare occur-
None of our patients suffered se-
ious globe injury. Furthermore, it
remarkable that none of our pa-
tients suffered a vascular injury to
terior cerebral arteries and that none
mained of them suffered from delayed
meningitis. Although not unheard of, pen-
trating injury to the brainstem
. We recom-
end obtaining magnetic reso-
nance imaging of the brain and in-
tracranial vasculature in patients
velop diplopia, even after a
or minor injury to the region around
the orbit. The lack of a significant en-
trance wound in the eyelid or con-
jectiva should not dissuade imaging
cause external injuries may be
subtle, as was the case with our
third subject. Patients should be
berved closely for the appearance
of subsequent meningitis. If pa-
tsive the initial injury, then
Their prognosis is good for a near-
complete recovery.

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Pharmacologic Treatment of Congenital Nystagmus

Pharmacologic treatment has been used in acquired nystagmus with mixed success. Treatments have included baclofen, sodium valproate, gabapentin, and memantine. However, in congenital nystagmus, little is known about the effect of drugs. We describe a patient with congenital nystagmus and corneal dystrophy who improved dramatically with gabapentin treatment.

Report of a Case. A 37-year-old man complained of difficulty crossing roads and reading since childhood due to his poor vision. The patient claimed that these symptoms were alleviated by the consumption of alcohol. He had no oscillopsia. He had congenital nystagmus from birth and was noted at the time to have bilateral corneal opacities. The left eye was amblyopic despite occlusion therapy, and a corneal graft had been performed 20 years previously. Histologic findings from the graft confirmed the diagnosis of congenital granular stromal corneal dystrophy.

The initial visual acuity was 20/80 OD, 20/600 OS, and 20/80 OU. He had a small esotropia in the left eye and a conjugate, horizontal, pendular, and jerk nystagmus. The null point was in pri-

Figure 3. A T2-weighted magnetic resonance image from a young boy who was struck by an umbrella tine shows hyperintense lesions in the right cerebral peduncle (arrow) and cerebellar vermis.