Our patient had mild bilateral pigment dispersion syndrome. We speculate that the unilateral episodes of elevated intraocular pressure were due to the recurrent hematomas and not to the pigment dispersion. Some iris melanomas can also be highly vascular and simulate a hemangioma. However, the diagnosis of cavernous hemangioma should be suspected when the entire lesion is composed of large venous channels without a solid melanocytic component.

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Author Contributions: Dr J. A. Shields had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

Financial Disclosure: None reported.

Funding/Support: This work was supported by a donation from the Eye Tumor Research Foundation, Philadelphia, Pennsylvania (Drs C. L. Shields and J. A. Shields), Mellon Charitable Giving from the Martha W. Rogers Charitable Trust (Dr C. L. Shields), the Paul Kayser International Award of Merit in Retina Research, Houston, Texas (Dr J. A. Shields), the LuEsther Mertz Retina Research Foundation (Dr C. L. Shields), the Noel T. and Sara L. Simmons Endowment for Ophthalmic Pathology (Dr Eagle), and a donation from Michael, Bruce, and Ellen Rattner, New York, New York (Drs C. L. Shields and J. A. Shields).

Role of the Sponsors: The sponsors had no role in the preparation of the manuscript.


Peripheral Iridoplasty Efficacy in Refractory Topiramate-Associated Bilateral Acute Angle-Closure Glaucoma

Simultaneous bilateral acute angle-closure glaucoma (BAACG) is a rare phenomenon. From 2001 through 2007, there have been about 100 reports of topiramate-associated secondary BAACG, establishing topiramate as a leading cause of this condition in patients younger than 40 years. In 83 cases of bilateral and 3 cases of unilateral topiramate-associated acute secondary angle-closure glaucoma, 7 patients sustained permanent vision loss. Topiramate (Topamax; Ortho-McNeil Neurologics, Titusville, New Jersey) was approved by the Food and Drug Administration to prevent seizures in 1996 and migraine headaches in 2004, but it is also being used off-label for depression and bipolar disorders, neuropathic pain, and weight reduction. In 2001, a warning was added to the package insert describing a rare syndrome consisting of ciliochoroidal effusion, forward displacement of the lens-iris diaphragm, marked anterior chamber shallowing, acute myopia, and secondary angle-closure glaucoma. This process is usually reversible if topiramate is discontinued and ocular hypotensive therapy is instituted.

We describe 4 patients (8 eyes) who were effectively treated with argon laser peripheral iridoplasty (ALPI) for topiramate-associated BAACG unresponsive to ocular hypotensive therapy and topiramate discontinuation. To our knowledge and according to a MEDLINE literature review performed in March 2008, there are no published reports on the use of ALPI for this condition.

Report of Cases. Table 1 and Table 2 contain patient demographics, rationale and duration of topiramate treatment, clinical parameters of topiramate-associated BAACG before and after ocular hypotensive therapy, peripheral iridoplasty treatment and effect, and clinical parameters of topiramate-associated BAACG after peripheral iridoplasty. Because bilateral complete angle closure developed and persisted in 4 white women despite medical therapy and topiramate discontinuation, ALPI (300- or 500-µm spot size, 0.5-second duration, 200- to 400-mW power range) was performed (by A.H.Z.) in all of the 8 eyes (Figure). Within 30 minutes of ALPI, the intraocular pressure was markedly reduced and the peripheral anterior chamber had significantly deepened in all of the eyes. In an effort to prevent a subsequent pupillary block, all of the eyes underwent a laser iridotomy later the same day. Five months after iridoplasty, the intraocular pressure was normal in all of the eyes in the absence of ocular medications; only 4 eyes had mild, residual peripheral anterior synechia.

Comment. Argon laser peripheral iridoplasty is a relatively easy, safe, and effective treatment for refractory topiramate-associated BAACG. To our knowledge, this case series represents the first report describing the use of ALPI for this condition. The ALPI technique is a well-recognized procedure used to treat angle closure from mechanisms other than pupillary block. Although this report is limited by its small sample size and lack of a control eye, refractory topiramate-associated BAACG should be added to the list of indications for ALPI.

A unique finding in this case series was progressive central anterior chamber shallowing even after ALPI eliminated appositional angle closure. While the mechanism is unclear, we believe that the topiramate-associated...
BAACG occurred before maximum development of the ciliochoroidal effusions. Because of this consideration and the unpredictable effects of miotics and cycloplegics, laser iridotomy was performed after ALPI as a simple, low-risk, precautionary measure to prevent subsequent pupillary block. While laser iridotomy may have been an unnecessary procedure, recurrent angle closure did not occur in any eye.

Whenever BAACG occurs with acute myopia in patients younger than 40 years, topiramate-associated ciliochoroidal effusion syndrome should be strongly suspected. Because topiramate has a growing list of approved
and off-label uses, ophthalmologists should anticipate an increasing number of topiramate-associated BAACG cases and perform ALPI if discontinuation of topiramate and ocular hypotensive therapy fail to reverse this sight-threatening disease.

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Financial Disclosure: None reported.


Cystoid Macular Edema Secondary to Albumin-Bound Paclitaxel Therapy

Cystoid macular edema (CME) without capillary leakage is a rare subtype of CME recently associated with the taxane drugs docetaxel (Taxotere; Sanofi-Aventis US LLC, Bridgewater, New Jersey) and paclitaxel (Taxol; Bristol-Meyers Squibb Co, Princeton, New Jersey).1,3 Protein-bound paclitaxel (Abraxane; Abraxis BioScience Inc, Los Angeles, California) is an albumin-stabilized nanoparticle formulation of paclitaxel reported to be more effective and better tolerated than standard paclitaxel.4 We report for the first time to our knowledge a case of profound CME with minimal fluorescein leakage secondary to treatment with the newer albumin-bound paclitaxel, which resolved on discontinuation of the drug.

Report of a Case. A 56-year-old white woman had a 2-month history of decreased vision in both eyes with no other associated symptoms. She had been receiving protein-bound paclitaxel for approximately 2.5 years at a dosage of 400 mg every 3 weeks concomitant with trastuzumab (Herceptin; Genentech Inc, South San Francisco, California) for stage IV breast cancer, with the last intravenous infusion 3 weeks prior to her initial visit. Visual acuity corrected to 20/80 OD and 20/60 OS. Anterior segment examination revealed no inflammation and 1+ nuclear sclerosis in both eyes. Dilated fundus examination showed marked CME bilaterally. Spectral-domain optical coherence tomography (Carl Zeiss Meditec Inc, Dublin, California) determined the central retinal thickness to be 630 µm OD and 585 µm OS (Figure 1). Profound CME with well-defined septa was evident in the outer plexiform layer, with cystic changes clearly visible throughout all layers. Fluorescein angiography results were normal until late frames, where minimal leakage could be discerned centrally (Figure 2). The patient discontinued protein-bound paclitaxel therapy immediately but continued to receive trastuzumab.

On follow-up 4 weeks later, the patient noted marked improvement in her visual acuity (20/60 OU uncorrected) and ophthalmic examination confirmed dramatic reduction of the CME. Spectral-domain optical coherence tomography documented the central retinal thickness in the right eye to be 352 µm, a reduction of 278 µm. Similarly, the left eye reduced by 291 µm to a central retinal thickness of 294 µm. Only small cystic