umab, but 2 months later a second, more anterior stage 3 complex developed. Although the occurrence of multiple ridges is well documented, it is a rare event compared with other patterns of ROP regression. To our knowledge, this is the first angiographic documentation of circumferential anastomosis at the bevacizumab-induced regression site with radial vessels progressing anteriorly to form a second stage 3 complex. The time course seems to indicate quiescence due to bevacizumab followed by reactivation from its waning effect. Although this case provides further evidence of the efficacy of bevacizumab as a treatment option for patients with ROP when laser treatment is not feasible, it also emphasizes that the angiogenic stimulus potentiating the sight-threatening complications of ROP may recur or persist after a single injection of an anti-VEGF agent. This case also provides further support that intravitreal bevacizumab does not necessarily inhibit subsequent retinal vascular development.3

Quan V. Hoang, MD, PhD
Daniel F. Kiernan, MD
Felix Y. Chau, MD
Michael J. Shapiro, MD
Michael P. Blair, MD

Author Affiliations: Department of Ophthalmology and Visual Sciences, University of Illinois at Chicago (Drs Hoang, Kiernan, Chau, Shapiro, and Blair); and Retina Consultants, Ltd, Des Plaines, Illinois (Dr Shapiro).

Correspondence: Dr Blair, Department of Ophthalmology and Visual Sciences, University of Illinois at Chicago, 1855 W Taylor Street, M/C 648, Chicago, IL 60612 (mblair2@uic.edu).

Author Contributions: Dr Blair 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.

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Methods. The Singapore Cohort Study for Risk Factors in Myopia cohort has been previously described.3,4 The students enrolled in the study are examined annually, and serial eye measurements are taken using standardized protocols. These include cycloplegic refraction and axial length measurement of the eyeball. To remove ethnicity as a potential source of population heterogeneity, we only included children of Chinese descent in this genotyping exercise (n=978). Phenotypic classification of the children into those with severe myopia, those with nonsevere myopia, and nonmyopic controls was made at visit 4 when the children were aged 10 to 12 years. The SE was defined as sphere plus half-negative cylinder. High myopia was defined as an SE of −5.0 D or less; mild to moderate myopia was defined as an SE between −5.0 D and −0.5 D; and nonmyopic controls included those with an SE greater than −0.5 D. The axial length of the globe was measured by contact ultrasound A-scan biometry as previously described.3,4 The SNP rs4803455 was analyzed in an opportunistic but hypothesis-driven manner as the data were available from an ongoing genome-wide association study using the Illumina HumanHap 550 Beadchips (Illumina, Inc, San Diego, California; http://www.illumina.com). Rigorous quality-control steps were performed, including genotype success rate, missingness, population stratification, departure from Hardy-Weinberg equilibrium in controls, monomorphism, excess heterozygosity, cryptic relatedness, and sex discrepancy. Data analysis was performed using SPSS version 17 statistical software (SPSS Inc, Chicago, Illinois). Pairwise linkage disequilibrium between markers was computed based on the squared Pearson correlation coefficient (r2) using the overall data set. We used the linkage disequilibrium information to select a set of 4000 independent autosomal markers (r2<0.16) with approximately equal intermarker distance (approximately 670 kilobases [kb]) across the genome. This set of markers was used to examine sample relationships with the Graphical Representation of Relationships program (Cen-
Table. Association Between TGFB1 rs4803455 and Myopia

<table>
<thead>
<tr>
<th>Genotype or Association</th>
<th>Zha et al, † 2009</th>
<th>SCORM Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Controls</td>
<td>High Myopia</td>
</tr>
<tr>
<td>G/G</td>
<td>115</td>
<td>142</td>
</tr>
<tr>
<td>G/T</td>
<td>141</td>
<td>140</td>
</tr>
<tr>
<td>T/T</td>
<td>44</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>300</td>
<td>300</td>
</tr>
<tr>
<td>Association test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genotypic P</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Recessive P</td>
<td>4.9 × 10⁻⁴</td>
<td></td>
</tr>
<tr>
<td>OR (95% CI)a</td>
<td>0.37 (0.20-0.68)</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: CI, confidence interval; OR, odds ratio; SCORM, Singapore Cohort Study for Risk Factors in Myopia.

a Odds ratio for the recessive model.

Figure. Haploview version 3.2 plot showing a pairwise linkage disequilibrium map for single-nucleotide polymorphisms within a 100–kilobase (kb) flanking region centered on TGFB1 rs4803455 in the Singapore Cohort Study for Risk Factors in Myopia cohort. The r² algorithm was used. Single-nucleotide polymorphisms are identified by their dbSNP rs numbers, and their relative positions are marked by vertical lines. Numbers within the diamonds indicate the r² value expressed as a percentile. Increasing degrees of r² values are denoted by squares of a darker shade.

Results. We observed a marginally significant overall genotypic association at TGFB1 rs4803455 when children with any myopia vs nonmyopic children were compared (n=348 controls, 630 cases; P=.01) (Table). When analyzed spe-
specifically for high myopia, the association became more pronounced (n=348 controls, 107 cases; \(P=0.007\)). Children who were recessive for the minor T allele were markedly underrepresented among the high myopia cases (7.5%) compared with nonmyopic controls (14.9%) (\(P=0.046\)) (Table). The relationship between recessivity of the minor T allele and myopia-related quantitative traits in the entire Singapore Cohort Study for Risk Factors in Myopia cohort (n=978) was then assessed. Children who were recessive for the minor T allele had less myopic SEs (mean, \(-1.54\) D) and shorter axial lengths (mean, 23.94 mm) compared with wild-type children (mean SE, \(-1.95\) D; mean axial length, 24.15 mm) (\(P=0.04\) and \(P=0.05\), respectively).

When assessed in the context of the entire genome-wide association study, 2618 SNPs had single-point \(P\) values that exceeded the significance of \(\text{TGFB1 rs4803455}\) (lowest \(P=7.9 \times 10^{-6}\) at chromosome 11). Full correction for multiple testing in light of more than 400 000 independent tests rendered the \(\text{TGFB1 rs4803455}\) observation insignificant.

However, as our study was hypothesis-based with regard to \(\text{TGFB1}\), we proceeded to assess \(\text{TGFB1 rs4803455}\) in the context of the nearby flanking SNPs that were also genotyped. A linkage disequilibrium plot (Figure) using 32 SNPs genotyped within the 100-kb flanking region localized \(\text{rs4803455}\) to a small block that included 3 other neighboring SNPs (rs2241719, rs2241714, and rs1046909). All 3 showed marginal evidence of association (\(P=0.06\), \(P=0.04\), and \(P=0.02\), respectively), which did not exceed that observed with \(\text{rs4803455}\) (\(P=0.007\)). No other SNP within the 100-kb flanking region upstream and downstream of \(\text{TGFB1}\) \(\text{rs4803455}\) showed any evidence of association, thus localizing the signal to \(\text{TGFB1}\).

Comment. Zha et al\(^1\) identified a new marker within \(\text{TGFB1}\) that proved to be more informative in predicting the risk of high myopia in individuals of Chinese descent over and above the previously reported rs1800470.\(^2\) We provide evidence in another Chinese population in support of the observations by Zha and colleagues. We show new data linking \(\text{TGFB1}\) \(\text{rs4803455}\) and myopia-related quantitative traits. When our data are interpreted in the context of earlier results,\(^1,2\) association of \(\text{TGFB1}\) \(\text{rs4803455}\) was reproduced in both the broad genotypic model and specific recessive models, thus showing further consistency with previous studies. Even if this is not the functional variant(s) involved, the \(\text{TGFB1}\) SNP \(\text{rs4803455}\) is very likely the closest correlate. We are mindful of 2 previous reports that show no association between \(\text{TGFB1}\) genetic variation and high myopia.\(^6,9\) Although \(\text{rs4803455}\) was not genotyped in these 2 reports, Wang et al\(^9\) did genotype rs1800470, which was moderately correlated with \(\text{rs4803455}\) \((r^2=0.56)\), and failed to observe a significant association (recessive: odds ratio = 0.83; 95% confidence interval, 0.56-1.23). Despite not being significant, the disease odds ratio observed by Wang and colleagues is in keeping with that observed by the 2 previous studies.\(^1,2\) Meta-analysis of all available studies\(^1,2,5\) on the rs1800470 variant revealed suggestive evidence of an association with reduced susceptibility to high myopia \((P=3.0 \times 10^{-5})\). Meta-analysis of all available data (by Zha and colleagues and our study) on \(\text{rs4803455}\) resulted in a slightly stronger effect estimate \((P=9.88 \times 10^{-4})\). We acknowledge that the association observed with \(\text{TGFB1}\) \(\text{rs4803455}\) is not significant after being subjected to more than 400 000 independent tests and that the meta-analysis does not yield a genome-wide significant association. However, given the consistent evidence for the role of \(\text{TGFB1}\) and high myopia,\(^1,2\) and considering this in light of new evidence by Zha and colleagues and our study, the overall evidence thus far suggests support for an association between \(\text{TGFB1}\) and high myopia. Additional samples should be genotyped for the SNPs that have been implicated in this locus to increase power to detect a significant effect of this locus.

Chiea C. Khor, MD, PhD
Qiao Fan, MSc
Liang Goh, PhD
Donald Tan, FRCPhth
Terri L. Young, MD
Yi-Ju Li, PhD
Mark Seielstad, PhD
Denise L. M. Goh, MD
Seang Mei Saw, PhD

Author Affiliations: Division of Infectious Diseases, Genome Institute of Singapore (Drs Khor and Seielstad), Division of Genetic Medicine, Singapore Institute for Clinical Sciences, Agency for Science, Technology, and Research (Drs Khor and D. L. M. Goh), Department of Epidemiology and Public Health, Faculty of Medicine (Ms Fan and Dr Saw) and Department of Ophthalmology, Yong Loo Lin School of Medicine (Dr Tan), National University of Singapore, Duke—National University of Singapore Graduate Medical School (Drs L. Goh and Young), Singapore Eye Research Institute (Dr Tan), and Department of Paediatrics, Children’s Medical Institute, National University Health System and National University of Singapore and National University of Singapore—Genome Institute of Singapore Center for Molecular Epidemiology (Dr D. L. M. Goh), Singapore; and Center for Human Genetics, Duke University, Durham, North Carolina (Drs Young and Li).

Correspondence: Dr Khor, Division of Infectious Diseases, Genome Institute of Singapore, 60 Biopolis St, Genome, Singapore 138672 (khorcc@gis.a-star.edu.sg).

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6. Price AL, Patterson NJ, Plenge RM, Weinblatt ME, Shadick NA, Reich D.


Orbital Smooth Muscle Tumor Associated With Epstein-Barr Virus in a Human Immunodeficiency Virus–Positive Patient

Immune deficiency has been recognized as a risk factor for the development of orbital and adnexal tumors such as Kaposi sarcoma and non-Hodgkin lymphoma. Smooth muscle tumor (SMT) associated with Epstein-Barr virus (EBV) (SMT-EBV) is a rare entity that may be encountered in human immunodeficiency virus (HIV)–infected patients and organ transplant recipients. We describe an HIV-positive man who was diagnosed with an orbital SMT-EBV after presenting with a progressive retrobulbar mass.

Report of a Case. A 43-year-old HIV-positive man (CD4 lymphocyte count, 175/mL) was referred to the orbit service with progressive left proptosis and vision loss. On magnetic resonance imaging, there was a fusiform orbital mass surrounding the posterior portion of the optic nerve (Figure 1); the diameter of the mass had enlarged from 14 mm to 25 mm over a 9-month period on serial scans. The patient had visual acuity of no light perception, 2 mm of proptosis, and left optic disc edema. During orbital biopsy, the deep intracanal mass was noted to be a firm, whitish tumor. Permanent sections revealed the mass to be a proliferation of bland spindle cells with low mitotic activity (Figure 2A) and a Ki-67 labeling index of 18%. Immunohistochemistry results were negative for S-100 protein, desmin, epithelial membrane antigen, and CD34, but stains were positive for smooth muscle actin (Figure 2B). In situ hybridization study results were strongly positive for EBV (Figure 2C). The final pathologic diagnosis was SMT-EBV.

Comment. To our knowledge, this is the first case of a primary orbital SMT-EBV reported in the literature. Our patient had documented HIV but no previously identified SMTs elsewhere in the body. Although a rare entity, cases of SMT-EBV have been reported in HIV-positive patients, organ transplant recipients, and other immune-compromised individuals.1-4 Typically SMT-EBV is a multifocal disease, with tumors arising in the abdominal cavity, adrenal glands, liver, and epidura of the brain and spinal cord.1-4 A case series of 19 patients with SMT-EBV reported by Suankratay et al1 listed 1 patient with an orbital mass, although details were limited and the patient also had tumors in the spinal cord, vocal cord, and adrenal glands. There is no reliable treatment currently available for SMT-EBV; chemotherapy and radiotherapy are thought to be ineffective, and recurrences following surgical excision are common.2 A fusiform orbital mass in an HIV-positive patient that demonstrates progressive enlargement may be due to a rare entity: SMT-EBV.

Jonathan W. Kim, MD
Diana K. Lee, BA
Martin Fishman, MD