from those associated with von Hippel-Lindau disease by uniocular, negative family history, and the absence of large dilated tortuous feeder vessels.3 The exact cause is unknown, although it has been proposed that they could be expressions of vascularization of pigment epithelial proliferation or reactive gliosis.3 We postulate that in the setting of chronic ROP and familial exudative vitreoretinopathy, there is retinal ischemia that produces a microenvironment conducive to vascular proliferation.

Ophthalmologists who care for patients with a history of ROP should be aware of this late sequela because it is responsive to treatment and may cause additional vision loss. This lesion may be underreported because it may be difficult to identify in the setting of fibrotic residua and tractional elements. We recommend fluorescein angiography if new retinal thickening or exudates are seen in order to identify treatable lesions. In this case, we were able to identify the lesion before massive exudation occurred. Treatment options include laser photocoagulation, cryotherapy, photodynamic therapy, and, more recently, antivascular endothelial growth factor such as bevacizumab.7,8

Clement C. Chow, MD
Michael P. Blair, MD
Michael J. Shapiro, MD

Author Affiliations: Department of Ophthalmology and Visual Sciences, Illinois Eye and Ear Infirmary, University of Illinois at Chicago (Drs Chow, Blair, and Shapiro), and Retina Consultants, Ltd, Des Plaines (Drs Blair and Shapiro).

Correspondence: Dr Shapiro, Department of Ophthalmology and Visual Sciences, Illinois Eye and Ear Infirmary, University of Illinois at Chicago, 1855 W Taylor St, M/C 648, Chicago, IL 60612 (michaelj.shapiro@gmail.com).

Author Contributions: Dr Shapiro 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 an unrestricted grant from Research to Prevent Blindness.

Role of the Sponsor: The sponsor had no role in the design or conduct of this research.

4. Houston SK, Bourne TD, Lopes MB, Ghazi NG. Bilateral massive retinal gliosis before massive exudation occurred. Treatment options include laser photocoagulation, cryotherapy, photodynamic therapy, and, more recently, antivascular endothelial growth factor such as bevacizumab.7,8

©2011 American Medical Association. All rights reserved.
Calculating growth factor might be responsible for the findings in BDUMP, plasmapheresis was initiated 3 times per week for the ophthalmic abnormalities.

After 12 sessions, best-corrected visual acuities were 20/20−2 OD and 20/25−2 OS. There was disappearance of serous detachments, thinning of the choroid, a decrease in giraffe-type pigmentation, and increased visibility of underlying pigmented tumors. Plasmapheresis was decreased to once weekly. After 17 sessions, visual symptoms were entirely resolved, and best-corrected visual acuities were 20/20 OD and 20/25−2 OS (Figure 2).

Seven months after the initial ophthalmologic visit, the patient became too ill to continue plasmapheresis treatments. Visual acuity was 20/20 OU. Once plasmapheresis was stopped, there was a relapse of fundus abnormalities and subretinal fluid returned; 1 month prior to the patient’s death, best-corrected visual acuities declined to 20/200 OD and 20/30 OS. Death occurred 13 months after the onset of visual symptoms.

The globes were sectioned and examined with hematoxylin-eosin (Figure 2). Serum was tested for antiretinal autoantibodies by Western blotting and was positive for autoantibodies against 33- and 34-kDa human retinal proteins. These autoantibodies were tested against proteins extracted from the patient’s lung tumor, and no specific staining was noted. Against whole rat eye sections, they showed positive staining of photoreceptors (especially outer segments), some ganglion cells, and the cytoplasm of some choroid and iris cells.

Comment. Nearly all patients with BDUMP have been treated for their underlying malignant neoplasm, but our case is the first to our knowledge to demonstrate successful treatment for the eye findings with return to baseline visual acuity and resolution of visual symptoms.

Although rare, BDUMP has consistently resulted in devastating visual consequences. Usually during the year preceding death, patients with this paraneoplastic syndrome have severe bilateral vision loss. Vision decline has been attributed to destruction of photoreceptors and underlying RPE, serous retinal detachments, and, later, cataracts.1–3 In our patient, cataracts never developed, subretinal fluid and choroidal thickening resolved, and visual acuity improved to 20/20 following plasmapheresis. As
plasmapheresis works by removing proteins from blood, our patient’s positive response suggests that circulating antibodies or growth factors may be responsible.

Histopathologic findings were consistent with BDUMP, with the exception of areas of RPE hypertrophy instead of more typical RPE loss.1,3 Hypertrophy of the RPE with cells dividing, accumulating, and migrating into the subretinal space can occur when subretinal fluid is present, and RPE acquires lipofuscin as the cells phagocytize photoreceptor outer segments. We hypothesize that the RPE hypertrophy may correspond to giraffe-type pigmentation; however, we do not have a point-by-point comparison between histopathologic specimens and fundus photographs.

Figure 2. Six months later, after treatment with plasmapheresis, resolution of symptoms, and return of visual acuity to 20/20 OU. A, Color fundus photograph of the right eye showing increased visibility of round, darkly pigmented tumors and resolution of subretinal fluid. B, Color fundus photograph of the left eye showing increased visibility of darkly pigmented tumors and decrease in overlying orange pigment. C, Optical coherence tomographic scan showing resolution of subretinal fluid. D, Low-power photomicrograph of the retina and choroid showing artifactual retinal detachment, diffusely thickened choroid with increased uveal melanocytic cells, areas of normal retinal pigment epithelium, and areas of hyperplastic retinal pigment epithelium (hematoxylin-eosin). E, High-power photomicrograph of hyperplastic retinal pigment epithelium, also showing some of the uveal melanocytic cells, which were mainly spindle cells with no atypia (hematoxylin-eosin).
As has been reported in other cases of BDUMP,1,2 our patient had circulating antiretinal autoantibodies. The significance of our patient’s 33- and 34-kDa retinal proteins to which these autoantibodies react is not known. Much is still to be learned in the field of antiretinal autoantibodies, but this raises the possibilities that patients with BDUMP can have such antibodies and that these antibodies may be at least partially responsible for the loss of photoreceptors.4

In our patient, we believe that a circulating growth factor or antibody may have been responsible for stimulation of the pathologic changes noted in BDUMP. This notion is supported by the return of good visual acuity, resolution of subretinal fluid, and decreased choroidal thickening during plasmapheresis treatments and also by the recurrence of these abnormalities with cessation of plasmapheresis.

We report a new treatment modality that has the potential to improve and stabilize vision in a disease that results in bilateral vision loss preceding death in patients with systemic malignancy. Plasmapheresis should be considered in patients with BDUMP.

Rebecca B. Mets, MD, MPH
Pamela Golchet, MD
Grazyna Adamus, PhD
Roberto Anitori, PhD
David Wilson, MD
John Shaw, MD
Lee M. Jampol, MD

Author Affiliations: Department of Ophthalmology, Feinberg School of Medicine, Northwestern University (Drs Mets, Golchet, and Jampol) and Hematology and Oncology Associates (Dr Shaw), Chicago, Illinois; and Casey Eye Institute, Oregon Health Sciences University, Portland (Drs Adamus, Anitori, and Wilson). Dr Mets is now with the Department of Ophthalmology, Children’s Hospital Colorado, University of Colorado, Aurora.

Correspondence: Dr Mets, Department of Ophthalmology, Department of Ophthalmology, Children’s Hospital Colorado, University of Colorado, 13123 E 16th Ave, Box B430, Aurora, CO 80045 (beccamets@gmail.com).

Financial Disclosure: None reported.

Funding/Support: This work was supported in part by an unrestricted grant from Research to Prevent Blindness and grant EY13053 from the National Institutes of Health.


**Eosinophilic Variant of Wegener Granulomatosis in the Orbit**

Wegener granulomatosis (WG) is a multisystem vasculitis of unknown etiology that preferentially involves small to medium-sized vessels, with a peak incidence in the fifth decade of life.1,2 The typical histologic triad described in WG consists of tissue necrosis, vasculitis, and granulomatous inflammation. Although mild eosinophilia has been reported in WG, significant eosinophilia is rare. The eosinophilic variant is a clinical and histologic variant characterized by significant tissue eosinophilia that is clinically consistent with WG in the absence of asthma or atopy.3,4 We describe an eosinophilic variant of WG occurring in the orbit in association with local IgE production.

**Report of a Case.** An 84-year-old woman had a 2-month history of left ptosis, painless proptosis, and binocular vertical diplopia. Magnetic resonance imaging identified a 2.5 × 2.5 × 1.5-cm left inferomedial orbital mass. An incisional biopsy suggested the diagnosis of eosinophilic angiocentric fibrosis, and she was referred for further management.

Clinically, her visual acuity was 20/40 OU. Orbital examination revealed a left ptosis with 2.5 mm of relative proptosis, 15 prism diopters of left hypertropia with decreased depression, and a left lower eyelid ectropion (Figure 1A).

![Image A](https://example.com/image1.png)

**Figure 1.** Clinical photograph and magnetic resonance images. A, Clinical photograph shows hypertropia and lower eyelid ectropion of the left eye. Coronal (B) and axial (C) T1-weighted magnetic resonance imaging with fat suppression demonstrates a left inferomedial orbital mass involving the orbital floor and inferior rectus, with extension into the area of the nasolacrimal fossae.

©2011 American Medical Association. All rights reserved.