pushed the globes back to their normal position.

On examination, the patient had blepharitis and corneal haze in both eyes (Figure 3). Ophthalmic examination showed no light perception in the right eye and a visual acuity of 20/200 in the left eye. Slit-lamp examination showed palpebral conjunctival hyperemia with papillary hypertrophy and tears in the Descemet membrane in both eyes (Figure 4). Funduscopic examination showed bilateral optic atrophy, more marked in the right eye. The optic disc was uniformly white without cupping in both eyes. The remainder of the results of fundus examination and the intraocular pressure were normal. The patient's poor vision did not permit visual fields to be obtained. Ultrasound scan, Hertel measurements, and thyroid function test results showed no abnormalities. Electro-physiologic testing showed substantial reduction of the latent time of the visual evoked responses. Results of further neurologic examination, including magnetic resonance imaging, for demyelinating disease, drug toxic effects, and thyroid eye disease were negative.

The patient was instructed to avoid luxating his globes, as he refused surgical treatment of the floppy eyelids. Stabilization of his psychiatric disease allowed the patient to be cooperative. Unfortunately, 4 months later he was totally blind. His parents reported that he had never stopped luxating his globes.

Comment. We suspect that the blindness of the patient described in this case was due to a unique traumatic optic neuropathy. The easily everted floppy eyelids of this obese man enabled the voluntary luxation of the globes by inserting the finger deeply into the orbit. The patient's psychiatric disorder aggravated the condition. Concomitant tears in the Descemet membrane support the traumatic origin of the neuropathy.

In the literature we have found reported cases of mental retardation and floppy eyelid syndrome\(^1\) and one case report of spontaneous globe luxation associated with floppy eyelid syndrome.\(^6\) There are also reported cases of self-inflicted ocular injuries related to psychiatric problems.\(^7,8\) To our knowledge, this is the first reported case of voluntary globe luxation and bilateral optic neuropathy associated with floppy eyelid syndrome.

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**Imitation of Typical Birdcall Causes Ocular Perforation by a Tawny Owl Attack**

Bird attacks on people are rare, but they have been described for several species.\(^1\) Most reports involve domestic birds such as roosters, where the mistreated bird seems to have acted in self-defense. In the wilderness, owls, birds of prey, and magpies are known to attack people. Whereas fast-moving objects on the ground, such as joggers, seem to trigger assaults by birds of prey, magpies are reported to attack mostly children and often from behind.\(^2\) Owl attacks have been reported to occur mainly in springtime, when the young are leaving the nest.\(^3\) In this case, the attack was most likely provoked by the imitation of the typical birdcall of this rather aggressive species during the highly vulnerable prebreeding season, which...
is marked by the final establishment of tawny owls’ breeding territories. The fact that the injury was caused by the bird’s claw may be typical for this species because this is their strongest weapon. This is in contrast to most other reports on bird attacks, in which injuries are inflicted by beak hits.

**Report of a Case.** On a late December night, a hunter on a raised hide was attacked by a tawny owl (Strix aluco) immediately after he had imitated the characteristic birdcall of this species. During the summer, he had mimicked this birdcall many times. Never before had he experienced any aggressive behavior by the bird, but instead he was usually answered by the owl’s song. The attack resulted in several superficial skin wounds on his right cheek and nose and radial limbal-scleral perforation with uveal, vitreal, and retinal incarceration. The lesions’ distribution revealed the typical pattern of the bird’s claw (Figure). Because of intraocular hemorrhage and massive inflammatory infiltration, which is typical for perforating injuries by organic material, vision was reduced to light perception. After resection of the incarcerated tissue, the corneal and scleral wounds were sutured, and cryocoagulation was applied to the retinal defects. Ofloxacin eyedrops (four times daily) and dexamethasone eyedrops (one week four times daily, another week twice daily) were given topically. Oral ciprofloxacin (750 mg twice daily for one week) and oral prednisone (100 mg once a day for 4 days, then down-titrated for 10 days until discontinued) were given as systemic treatment. Eight weeks later, vitreous traction caused a retinal break, which was successfully treated by laser coagulation. During a 5-month follow-up, the vitreous cleared progressively and visual acuity increased to 20/25.

**Comment.** In conclusion, this case demonstrates that, depending on species and season, special caution is needed when attracting birds by imitating their call. Furthermore, this example confirms that successful treatment of perforating eye injuries after bird attacks is possible if immediate surgical care as well as consequential treatment of the usually subsequent severe septic inflammation is provided, in our case with high-dose systemic and local antibiotics and steroids.

**Circumferential Peripheral Retinal Cavernous Hemangioma**

Cavernous hemangioma of the retina (CHR) is a rare vascular tumor first described in 1934 by Niccol and Moore, who termed this condition angiomatosis retinae. Gass later recognized CHR as a distinct clinical entity.

Cavernous hemangioma of the retina appears most commonly as a solitary vascular lesion of limited size (1 or 2 disc diameters) in the mid-peripheral or peripheral retina, although occasionally the lesion can be found in the posterior pole or optic nerve head.