Correspondence

Neurilemmoma of the ciliary body

SIR, I have read with interest the article 'Neurilemmoma of the ciliary body: report of a case' by Renato Rosso *et al.*,[1] where they reported an unusual clinicopathological case. But I would like to propose some considerations. The authors state that only six cases of uveal tract neurilemmoma are reported in the literature and only one of them is a ciliary body neurilemmoma. This is not correct, because according to Shields *et al.*[2] (not cited) the reported cases of neurilemmoma are eight at least (associated and unassociated with neurofibromatosis), and two of them affected the ciliary body. Secondly, I would point out that in the case reported a fine needle aspiration biopsy could be extremely useful. My colleagues and I[3,4] and others too[5] obtained excellent results using this cytological technique in doubtful cases of intraocular neoplasms. Perhaps even if an efficacious therapeutic approach to ocular neurilemmoma is not yet established, this could be a case not 'dedicated' to enucleation.

Unfortunately I must conclude with the statement of Shields *et al.*[1]: 'At present, it seems probable that future patients with rare peripheral nerve tumors of the uvea will be diagnosed clinically as having a malignant melanoma and will be managed accordingly.'

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SIR, Dr Midena's letter raises some interesting points of discussion. Concerning the number of uveal neurilemmomas reported in the literature, it must be stressed that we included only cases with clinicopathological features unquestionably supporting their origin from peripheral nerves of the anterior segment of the globe. Inconclusive data on the exact localisation and the real nature of the nervous tumours led to the omission of some cases reported by Shields *et al.* The original case described by these authors was not included because the lesion arose in the macular region, and despite extensive investigations it was not definitively ascertained whether the tumour was a neurofibroma or a neurilemmoma.

Regarding the usefulness of fine needle biopsy cytology in the diagnosis of intraocular neoplasms, we agree with Czerniak *et al.* that this technique is not to be considered as a routine procedure, while being useful for selected cases of melanoma. We have serious doubts about the role that this method may play in the preoperative diagnosis of peripheral nervous tumours. Cytological differentiation between malignant melanomas, epithelioid neurofibromas, and pigmented neurilemmomas may be extremely difficult; moreover the distinction between benign, borderline, and malignant Schwannomas is often based on the number of mitoses observed in a large number of high-power microscopic fields.[1] The differential diagnosis between neurofibromas and neurilemmomas, tumours with completely different evolutionary possibilities, sometimes presents severe problems even on ultrastructural examination.[2]

In conclusion, we think that only careful histological examination may have a definitive role in the diagnosis of peripheral nerve tumours, at least until new techniques (e.g., immunocytology) will permit reliable conclusions to be drawn from fine needle specimens.

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Recurrence of keratoconus

SIR, I read with great interest the paper by Nirankari and co-workers[1] in which they describe recurrent keratoconus in a donor cornea 22 years after successful keratoplasty. I highly doubt whether this represents recurrent disease; I believe the patient inadvertently received a donor cornea with keratoconus. This suggestion is further demonstrated by the unilaterality of the 'recurrence.' If this disease were due to some type of intrinsic effect from the host, the 'recurrent' keratoconus should be bilateral. An examination of the recipient of the fellow donor eye would be of great value in this controversy. This information may dispel the notion of 'recurrent' keratoconus.

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Reference

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SIR, It is certainly possible that what we describe[1] could represent the inadvertent use of a donor cornea with kerato-

conus. We, however, feel this is highly unlikely, as the donor cornea in that eye came from a 51-year-old white female who had no known history of any ocular disease. Also following surgery the donor cornea was crystal clear with minimal astigmatism and 20/20 vision with spectacle correction.

Eighteen years following the corneal grafting the cornea started showing changes typical of keratoconus, including increase in myopic oblique astigmatism, corneal protrusion and thinning, and the development of subepithelial and stromal scarring with a reduction in best corrected visual acuity to 20/400. The histopathological changes also showed changes consistent with keratoconus, including abnormalities in the basal epithelium, breaks in basement membrane, duplication and thickening of Bowman's layer, and abnormal stromal keratocytes with accumulation of granular intra- and extracellular material. It seems unlikely that the donor cornea, which was grafted at age 51, would not have shown keratoconus changes at that time and started showing changes 22 years later.

Findings similar to ours have been reported before.[2-5] Unfortunately we do not have any information on the recipient of the fellow donor eye, as the surgery occurred 22 years ago and such information was not available. It is also not unusual for abnormal host factors to affect donor tissue, resulting in the recurrence of original pathology, as is seen in lattice macular and granular dystrophy.[6]

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Book reviews

Ophthalmic Surgery: Principles and Practice. By GEORGE L. SPAETH. Pp. 775. £69·75. W. B. Saunders: London. 1982.

As expected, this book reflects the competence, enthusiasm, and integrity of its editor. The whole book is manageable in size and is largely up to date—always difficult in a textbook because of the time taken in publication. The comments on intraocular lenses show a careful balance of views. There is no reference to the use of viscoelastic substances because this development has been so recent.

Many of the specialised chapters have been written by invitation, but each has been reviewed by another author before being passed for publication.

There is a thoughtful introduction which reflects the editor's own experience and contains much useful advice. The emphasis in other chapters is not always directly applicable worldwide. The text is aimed at the US ophthalmologist. Proprietary names are used which are not always known elsewhere. A statement that 'Local anesthesia remains the favorite method of most ophthalmic surgeons for cataract surgery' would not be so readily accepted in Europe. Few intraocular lens implantations would 'last between 1 and 2 hours in duration' on this side of the Atlantic. It continues to surprise me that in the United States local anaesthesia is so often advised as the method of choice, particularly when operations of 1–2 hours are being described. The quality of general anaesthesia must be very different from that in the United Kingdom, if one of the authors lists among the advantages of local anaesthesia that total operating room time is decreased. In my experience induction and recovery from general anaesthesia are rapid and take place outside the operating room. The patient comes into the operating room ready for surgery with an uncongested soft eye.

The chapter on fundamental surgical principles is excellent and provokes thought. There is a welcome economy of words, which helps towards clear understanding. Seidel's test is well described, but would seem better placed in a chapter on postoperative management. A useful table on the relationship between magnification, diameter, and depth of field of a Gallilean microscope seems misplaced in the middle of this piece of text.

Instruments and sutures are described in another excellent chapter. Intraocular infections are also well covered. The chapter on ophthalmic conditions requiring prompt care is valuable, but many of the conditions are not surgical.

The quality and style of the chapters on surgical disorders shows some variety as is to be expected in a multiauthor text. In some chapters the references are sequential, following the text, but in others they have been listed alphabetically. When some of the writing is so good it is annoying to come across loose comments such as 'even after the patient is 35 to 40 years of age or older' or 'glob of formed vitreous'. There are many ophthalmic surgeons who will not know what a 'frisbee' is and they would not find its description in a medical dictionary. The 'Sheets glide' is mentioned but not described or illustrated. I cannot agree that 'one of the most important advances in cataract surgery has been the introduction of anterior vitrectomy for vitreous prolapse'.

The first 90 pages in the chapter on the surgery of the orbit consist of clinical manifestations and are rather heavy reading. The last 25 pages of this chapter give only a broad guide to surgical method. The proportion seems wrong and this chapter is not as useful to a surgeon needing technical advice.