infants who showed evidence of permanent brain damage are the first and last cases described in the text.

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SHORT REPORTS

Retrobulbar neuritis and infectious mononucleosis

In a recent leader in the *British Medical Journal*[1] on the aetiology of optic neuritis it was stated that, "By no means all cases of optic neuritis are due to multiple sclerosis and other causes, particularly in the older patients, should be remembered." We would like to support this statement by reporting a case of retrobulbar neuritis complicating infectious mononucleosis in an 18-year-old male student.

Case Report

An 18-year-old student was admitted to hospital with a 24-hour history of loss of vision. Two weeks previously he had had an upper respiratory tract infection and for one week bitemporal headache, pain when moving both eyes, and tiredness. On examination he was found to have bilateral retrobulbar neuritis, in addition to palatal petechiae and generalised lymphadenopathy and splenomegaly. Apart from the ocular signs no other neurological abnormality was shown then or subsequently.

Investigations showed haemoglobin 14·4 g/dl, erythrocyte sedimentation rate 28 mm in 1 h, white blood count $6{\cdot}2 \times 10^9$/l (6200/mm^3) (neutrophils 19%, lymphocytes 76%, monocytes 5%). Blood film showed many atypical lymphocytes. A Monospot test gave a strongly positive result; the titre of the Paul-Bunnell test was 1/1286; cerebrospinal fluid and Lange's test result were normal; and the Epstein-Barr virus titre (fluorescent antibody test) was 80. Vision in the right and left eyes was 6/36-1 and 6/60 respectively.

He was treated with 1 mg ACTH (Synacthen Depot) twice weekly. The patient reported some minimal improvement in his vision, but there was no objective evidence of this. After nine weeks the ACTH was increased to three times weekly but the optic atrophy progressed, particularly on the left. Because of the severity of the visual defect a prolonged course of treatment seemed justified. Treatment was finally stopped after a further nine weeks, his visual acuity remaining unchanged.

Discussion

Neurological complications in infectious mononucleosis are well known but seldom lead to significant permanent damage. The ocular manifestations of infectious mononucleosis were reviewed by Tanner[2] in 1954. He divided the clinical features into two groups: those possibly due to direct involvement of the eye, such as conjunctivitis, eyelid and periorbital oedema, episcleritis, uveitis, optic neuritis, papilloedema, retinal oedema, and haemorrhage; and those due to a more remote lesion in the central nervous system such as extraocular muscle palsies, ptosis, and disturbances of conjugate deviation.

Probably the earliest report of optic neuritis in glandular fever was by Clemens[3] in 1907, but corroborative details are lacking. The first authenticated report of retrobulbar neuritis without other central nervous system involvement was by Ashworth and Motto[4] in 1947; subsequent reports, together with a case report, were reviewed by Frey[5] in 1973—a total of 8 cases.

All the cases reported to date did well, with or without steroid therapy, and complete recovery was the rule. Unfortunately our patient did not follow this pattern. Possibly he has some other condition, but as yet none has been shown.

We suggest, therefore, that the possibility of infectious mononucleosis as a cause of retrobulbar neuritis should not be overlooked.

We thank Dr C R S Jackson and his staff, at Princess Alexandra Eye Pavilion, Royal Infirmary, Edinburgh, for their help in management of this case, and Mrs G B McKenzie for her secretarial help.

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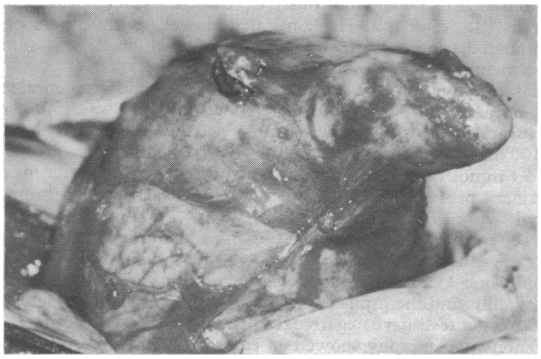
Hydatid cysts in pancreas

In only two out of 780 cases of hydatid disease affecting various tissues and organs operated on in one surgical unit in Baghdad during the period 1963-75 was the cyst located in the pancreas—an incidence of 0·25%.

Case reports

The first case was that of a 27-year-old woman complaining of a gradually growing abdominal lump and heaviness in the left upper abdominal quadrant for the past year. There was a palpable mass ($7{\cdot}6 \times 10{\cdot}2$ cm) notched in its lower pole, in the left hypochondrium. It moved vertically with respiration, was smooth, mobile, and not tender and was thought to be a large spleen. The results of *x*-ray examination of the chest and abdomen, routine haematological investigation, liver function tests, and Casoni's test were all normal.

At laparatomy a large hydatid cyst was found protruding below the stomach and adherent to the transverse colon, mesocolon, and omentum. It arose from the body of the pancreas at its junction with the tail and had a bud on its lower pole, producing the notch mentioned above (see fig). The liver and other abdominal viscera were normal. The cyst cavity was full of milk-coloured hydatid fluid, with many daughter cysts and shredded membranes.



Hydatid cyst of body of pancreas.