<table>
<thead>
<tr>
<th>Title</th>
<th>Acute unilateral conjunctivitis after rubella vaccination: the detection of the rubella genome in the inflamed conjunctiva</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author(s)</td>
<td>Kitaichi, N.; Ariga, T.; Ohno, S.; Shimizu, T.</td>
</tr>
<tr>
<td>Citation</td>
<td>British Journal of Ophthalmology, 90(11): 1436-1437</td>
</tr>
<tr>
<td>Issue Date</td>
<td>2006</td>
</tr>
<tr>
<td>Doc URL</td>
<td><a href="http://hdl.handle.net/2115/15830">http://hdl.handle.net/2115/15830</a></td>
</tr>
<tr>
<td>Type</td>
<td>article</td>
</tr>
<tr>
<td>File Information</td>
<td>BJO90-11.pdf</td>
</tr>
</tbody>
</table>

Hokkaido University Collection of Scholarly and Academic Papers: HUSCAP
Acute unilateral conjunctivitis after rubella vaccination: the detection of the rubella genome in the inflamed conjunctiva by reverse transcriptase-polymerase–chain reaction

N Kitaichi, T Ariga, S Ohno and T Shimizu

doi:10.1136/bjo.2006.096008

Updated information and services can be found at:
http://bjo.bmj.com/cgi/content/full/90/11/1436

These include:

References
This article cites 4 articles, 1 of which can be accessed free at:
http://bjo.bmj.com/cgi/content/full/90/11/1436#BIBL

Rapid responses
You can respond to this article at:
http://bjo.bmj.com/cgi/eletter-submit/90/11/1436

Email alerting service
Receive free email alerts when new articles cite this article - sign up in the box at the top right corner of the article

Notes

To order reprints of this article go to:
http://www.bmjjournals.com/cgi/reprintform

To subscribe to British Journal of Ophthalmology go to:
http://www.bmjjournals.com/subscriptions/
vision in his right eye. His medical history was remarkable for classic Wegener’s granulomatosis that had been in remission for the past year. His best-corrected visual acuities were 20/25 in the right eye and 20/20 in the left eye. No relative afferent pupillary defect was evident. A slit-lamp examination of the anterior segment was unremarkable. Fundus examination of the right eye showed clear vitreous, hyperemic optic disc, peripapillary retinal haemorrhages, cotton wool spots, and dilatation and tortuosity of the retinal venous system (fig 1A). Fluorescein angiography showed delayed and prolonged filling of the retinal vasculature, blocked fluorescence as a result of the retinal haemorrhages and mild vessel staining in a few areas in the late phases (fig 1B–D). Fundus examination of the left eye was normal. The patient was diagnosed as having a central RVO and was urgently referred to his rheumatologist for evaluation of a possible relapse of systemic Wegener’s granulomatosis.

Comment
Retinal manifestations in Wegener’s granulomatosis include choroiditis, retinitis, choroidal neovascularisation, macular oedema, retinitis with cotton wool spots, acute retinal necrosis, peripheral retinitis, central retinal artery occlusion and exudative retinal detachment. Five cases of RVO in Wegener’s granulomatosis have been reported in the literature, all occurring in patients with classic Wegener’s granulomatosis.1–3 These patients also showed relatively good visual acuity (the worst was 20/60). RVO is believed to be caused by focal necrotising vasculitis.4 However, all five patients failed to show any intraocular inflammation or retinal vasculitis at presentation. One of the eyes was unenculturated owing to intractable neovascular glaucoma and was evaluated histopathologically, showing patchy areas of chronic choroiditis with no evidence of inflammation in the retinal vessels.5 It was proposed that RVO may be due to inflammation occurring in the laminar or retrolaminar portion of the optic nerve that may not be clinically evident.6 The observation of RVO only in patients with classic Wegener’s granulomatosis suggests that the mechanism may be similar to that of renal pathology in these patients.

Pauci-immune necrotising extracapillary granuloma formation is a common feature of glomerulonephritis in small vessel vasculitis, such as Wegener’s granulomatosis, Churg–Strauss syndrome and microscopic polyangiitis.7 No cases of RVO have been reported in patients with microscopic polyangiitis, but the two reported cases of RVO in Churg–Strauss syndrome also did not show any evidence of vitritis or retinal vasculitis.8 In the first patient, a presumed hyperaemal state and associated thromboembolism were purported to have led to RVO, whereas in the second patient, RVO occurred while the patient was adequately anticoagulated.9 Lack of granulomatous inflammation is the distinguishing feature of microscopic polyangiitis from both Wegener’s granulomatosis and Churg–Strauss syndrome.4 We postulate that compression of the central retinal vein (in a laminar or retrolaminar location) by such extracapillary granulomatous lesions may be the mechanism of RVO in such patients. This pathogenic mechanism can also explain the lack of clinical evidence of retinal vasculitis in these patients.

M Wang, R N Khurana, S R Sadda
Doheny Eye Institute, University of Southern California Keck School of Medicine, Los Angeles, California, USA

Correspondence to: S R Sadda, Doheny Eye Institute, Keck School of Medicine, University of Southern California, 1450 San Pablo Street DE 3610, Los Angeles, CA 90033, USA; ssadad@doheny.org
doi: 10.1136/bjo.2006.095703
Accepted 4 June 2006

Competing interests: None declared.

Reference

Acute unilateral conjunctivitis after rubella vaccination: the detection of the rubella genome in the inflamed conjunctiva by reverse transcriptase-polymerase–chain reaction

The efficacy of long-term rubella vaccine is >90%, and the anti-rubella vaccination causes few side effects. Some cases of anterior uveitis were reported after a combined vaccination for measles, mumps and rubella, but not when vaccination for rubella alone was administered.9 Another study reported that, after smallpox vaccination, 16 out of 450 000 subjects vaccinated had ocular complaints including conjunctivitis, keratitis and eyelid oedema, and only 5 of those cases were confirmed positive for vaccinia by culture or PCR.10 However, conjunctivitis after rubella vaccination with laboratory confirmation has never been reported.

Case report
A 43-year-old man was referred to the Department of Ophthalmology and Visual Sciences, Hokkaido University Graduate School of Medicine, Japan, with a history of conjunctival redness in his left eye for 2 days (table 1, figs 1A,B). The patient’s vision was 20/20 with correction in each eye. He had received an intramuscular anti-rubella vaccine on his left arm (Biken, Tanabe, Japan) 4 days before the onset of his left neck lymphadenopathy. He showed a flare-up at the site of injection 6 days before his eye symptoms developed. He also had itching at the injected site on day 12 after vaccination. No fever was observed. Biomicroscopy showed normal eyelids and lachrymal system. He had conjunctival flush with follicles in the left eye, but not in the right eye. The anterior chamber and fundus were normal in both the eyes. The virus was not detected with immunochromatography (Adenochrome, Santen, Osaka). The patient’s conjunctiva was scraped to collect samples. The possible presence of rubella virus mRNA expression in the conjunctiva was examined by RT-PCR (Mitsubishi Chemical Bio-Clinical Laboratories, Tokyo, Japan) as described elsewhere.11 The results were positive for rubella mRNA expression (fig 1C). The inflammation of the eye improved without treatment in a few days. His antisera rubella dilution titre was reported to be negative before vaccination and positive (>1:64) after injection.

Comment
In this patient, it is assumed that the acute unilateral conjunctivitis resulted from an ocular infection with rubella virus, caused by an attenuated vaccine. However, another possibility is that the conjunctivitis was caused by a contiguous infection from other people. We interviewed the patient carefully, but none among his family and associates had received rubella vaccine. Another study12 reported that, among his family and associates had contacts with anyone who had rubella. Negative result in his serum rubella titre was reported to be negative before vaccination and positive (>1:64) after injection.

1436 PostScript
www.bjophthalmol.com

Table 1 Clinical course of the patient

<table>
<thead>
<tr>
<th>Days after vaccination</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Left neck lymphadenopathy</td>
</tr>
<tr>
<td>12</td>
<td>Left conjunctivitis/itching of injected skin</td>
</tr>
<tr>
<td>16</td>
<td>Medical examination/collection of samples Improve of symptoms</td>
</tr>
</tbody>
</table>

Downloaded from bjo.bmj.com on 15 November 2006
Bilateral upper eyelid ectropion associated with blepharospasm

An unusual case of bilateral upper eyelid ectropion thought to be caused by blepharospasm is described. Botulinum A toxin injection yielded a good clinical response. A hypothesis for the pathogenesis of this condition is discussed.

Ectropion in adults typically affects the lower eyelid and is thought to result primarily from involution, paralysis and cicatrisation. We report an unusual case of bilateral upper eyelid ectropion associated with blepharospasm in an elderly man who responded to treatment with botulinum A toxin.

Case report

A 73-year-old man was referred to our clinic with bilateral upper eyelid ectropion. The ophthalmic history showed that his symptoms started about 5 years earlier and that he had been treated unsuccessfully with lubricants and topical steroids. The patient reported that he sometimes tied a towel around his upper eyelid to raise the eyelid. There was no history of ocular surgery or treatment.

On clinical examination, the best-corrected visual acuity was 20/25 in both eyes, and the anterior and posterior segments were unremarkable except for senile cataract. Ectropion along the full width of both upper eyelids was observed, and the everted tarsal conjunctiva were inflamed and thickened (fig 1A). The ptosis of the bilateral superior tarsi recurred immediately after the eyelids were manually repositioned, and severe blepharospasm was observed (fig 1B). The ocular surface was unaffected, and no epithelial damage was observed in either eye.

The patient was treated with injections of botulinum A toxin (Botox, GlaxoSmithKline, London, UK) into the bilateral orbicular muscles (six injections of 2.5 U on each side), the corrugator muscles (2.5 U on each side) and the procerus muscle (2.5 U). One week after the injections, the blepharospasm had almost resolved and the eversion of the bilateral tarsi had resolved (fig 1C).

Comment

Ectropion is due to an imbalance between the anterior and posterior lamellae, and usually develops in the lower eyelids. Recently, rare cases of non-cicatricial upper eyelid ectropion have been reported. The current case is unusual in that ectropion developed bilaterally in the upper eyelids and was associated with blepharospasm.

We theorised that the following mechanism may have caused the ectropion in this case. Because of the difficulty associated with eyelid opening caused by blepharospasm and blepharoptosis, the patient lifted the upper eyelids mechanically, which resulted in a functional shortening of the anterior lamellae. The patient might have naturally excessive posterior lamellae, or, because he has age-related aperineural ptosis, the tension of both the levator muscle and the superior tarsal muscle, which prevent tarsal prolapse, may have been weak.

Prolonged spasmodic contractions of the orbicularis muscle caused the upper tarsi to herniate. In addition, the thickening of the tarsal conjunctiva, caused by longstanding exposure, increased the conjunctival volume, resulting in the failure of the tissue to return to the normal position in the conjunctival sac, making the tarsal herniation chronic.

Blepharospasm is presumed to be the underlying cause in this case; therefore, injection of botulinum A toxin was effective. Because the effect of botulinum toxin is transient, the

References