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Sir,

Occult optic disc pit with macular schisis

We would like to thank Dr Shukla for his comments related to our recent case report relating to a child with an outer retinal layer anomaly at the fovea.[1] Shukla claims that we were incorrect to classify this as a full-thickness macula hole. We note that we did not claim that this was a full-thickness macular hole, and our case report highlights that the defect was only affecting the outer retinal layers,[2] which when defined by Gass would fit with a stage I macula hole.

However, we agree that we were incorrect to classify this curious outer retinal layer dehiscence with macula hole nomenclature, as on reflection we agree that this is more likely to be a case of an occult optic disc pit with macular schisis. We read with interest the case series of Shukla *et al*'s relating to the optic disc pit,[3] but regret that we were unaware of this article at the time of our initial case presentation, which was submitted for publication before Shukla *et al*'s published case series.

We are impressed that Shukla found this case of optic disc pit to be 'open-and-shut'. Even on subsequent review of our images, we find that the optic disc is the same size as the fellow eye and this is atypical, as 79% of optic disc pits occur in discs that are larger than the fellow eye.[4] Further, although the disc image (Figure 1) is suggestive of a probable disc pit temporally, the disc OCT (Figure 2) does not clearly demonstrate this.

In summary, we therefore agree with Shukla that this case is probably an optic disc pit associated with macular schisis, and we are glad that their management would have been similar and indeed the patient has done well post-operatively. We do, however, feel that this case is not that typical, and overall there remains more to be learnt about optic disc pits and macular schisis. Hopefully, more information will be obtained about optic disc pits from the planned UK prospective study in association with the British Ophthalmic Surveillance Unit.

Conflict of interest

The authors declare no conflict of interest.

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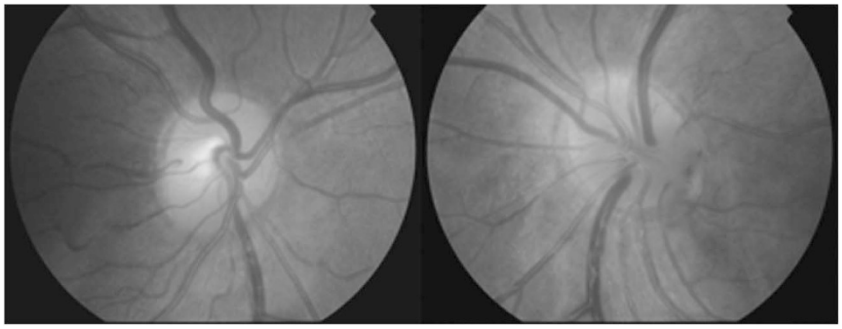

Figure 1 The right optic disc appears normal. The left optic disc is the same size, but despite this it appears to have a probable optic disc pit temporally.

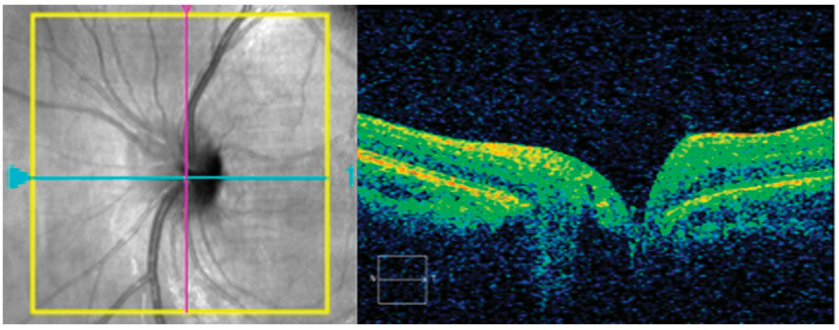

Figure 2 OCT of the left optic disc.

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Sir,

Paraneoplastic optic neuropathy associated with cerebellar choroid meningioma

Paraneoplastic optic neuropathy (PON) is a rare disorder that is associated with malignant tumors, such as small-cell lung carcinoma and lung adenocarcinoma and malignant lymphoma.[1,2] PON caused by non-malignant tumors has not yet been reported in the literature.

Case report

A 39-year-old woman reported experiencing headache and was taking demulcents for 9 months. Six months prior, she had experienced fever, headache, and dizziness, followed by sudden vision loss in the left eye. She visited our hospital in March 2012. Her best-corrected visual acuity (BCVA) was 20/20 OD and 20/250 OS, with an afferent pupillary defect and paracentral scotoma OS. The right eye had normal visual field. Critical flicker frequency OS decreased to 15 Hz. Color vision, the slit-lamp and dilated funduscopic examinations, and full-field and multifocal electroretinogram findings were all unremarkable OU.

Magnetic resonance imaging (MRI) disclosed a gadolinium-enhancing lesion in the left cerebellar hemisphere (Figure 1a), but did not show any optic nerve abnormalities.

The patient's plasma, which was collected at the first visit, was cross-reacted with rat, monkey, and human optic nerve sections (Figure 1b).

Two months after presentation, the cerebellar tumor was surgically removed. The histopathological diagnosis of the tumor was chordoid meningioma. The patient felt visual improvement at the next day after the resection, and the BCVA OS improved to 20/33 after 1 week and to 20/20 after 1 month, with the resolution of other symptoms, which was maintained at the last visit for 1 year.

PON occurs in association with immunologic responses against neuronal antigens that are expressed by the underlying cancer.[3,4] In our case, immunoreactivities of the patient's plasma to the optic nerve sections strongly indicated the existence of a certain autoantibody that most likely targeted the optic nerve fibers.

Comment

Chordoid meningioma, which is assigned to WHO grade II (atypical meningioma), is a rare meningioma that is sometimes associated with Castleman syndrome and characterized by fever of unknown origin, hematological

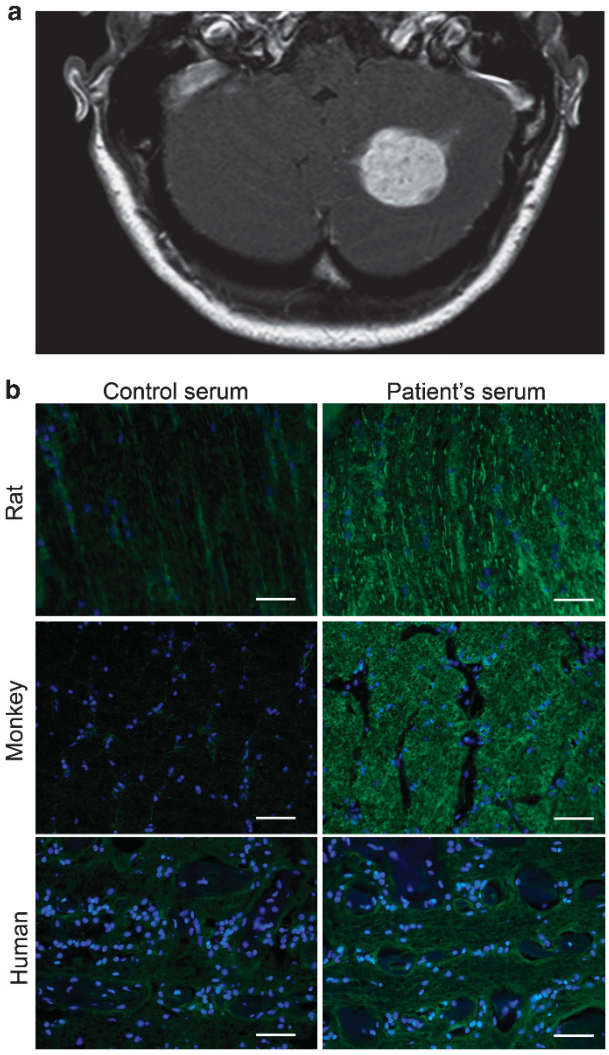

Figure 1 (a) Brain axial MRI (T1-weighted, post gadolinium enhancement). Note the well-defined gadolinium-enhancing lesion in the left cerebellar hemisphere. (b) Immunostaining using the patient's plasma on rat, monkey, and human optic nerve sections. The sections were blocked by 10% goat serum and incubated overnight in either the patient's or a healthy human's plasma diluted at 1 : 3 in phosphate-buffered saline with 0.01% Tween-100. Following extensive washes, the sections were incubated in fluorescein isothiocyanate-conjugated human IgG (green) for 1 h. The nuclei were counterstained with Hoechst dye 33258 (blue). The sections were intensively immunoreactive for the patient's serum but not for the control serum. Note the linear pattern in shape of immunoreactivity in the rat section, which corresponded to the nerve fiber arrays. Scale bar = 100 μm.