Author's response Comments on Repeat gas insufflation for successful closure of idiopathic macular hole following failed primary surgery

Dear Editor,
We thank the authors for their interest in our article.[1] We welcome their inputs and opinion about “inner retinal dimpling” and “temporal retinal thinning.” Their observation about the fundus picture 2 weeks after the repeat procedure not showing “any” gas bubble is pertinent. However, it is noteworthy that residual gas bubble in the superior fundus is not seen in the picture. Their contention on the likelihood of a wound leak causing premature escape of gas and a similar leak during the first surgery causing its failure seems unlikely because we did not encounter any hypotony in the postoperative period on both occasions. Also, the surface tension of the gas bubble may not allow its rapid escape. However, possible causes could include sub-optimal gas fill or its rapid absorption.

We would also like to add that we always prefer to perform a thorough removal of the peripheral vitreous to reduce the risk of vitreous incarceration in the sclerotomy. At conclusion of surgery, we irrigate the sclerotomies to check for possible leakage. If there is any leakage from any of the sclerotomies, we perform a gentle massage of the sclerotomy with a cotton-tipped applicator. If there is still leakage, we do not hesitate placing a single 7.0 Vicryl suture through the sclerotomy to close it. We cannot emphasize enough that suture closure of sclerotomies avoids the risk of postoperative hyptony, choroidal detachment or choroidal hemorrhage.

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Reference
1. Rishi P, Reddy S, Rishi E. Repeat gas insufflation for successful
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Primary cutaneous aggressive epidermotropic CD8\(^+\) T-cell lymphoma on upper eyelid

Sir,

Primary cutaneous aggressive epidermotropic CD8\(^+\) T-cell lymphoma constitutes less than 1% of all cases of cutaneous T-cell lymphoma (CTCL).\(^1\) Although common subtypes of CTCL, such as mycosis fungoides (MF), are originated from CD4\(^+\) memory T cells, this subtype is derived from a cytotoxic T-cell subset and follows a more aggressive clinical course with poor prognoses.\(^2\)

An 80-year-old man was referred with the well-demarcated, indurated plaque with central necrotic ulceration on his left upper eyelid (Fig. 1). He developed a single, erythematous lesion on left upper eyelid 2 years ago. In a tertiary hospital, he was diagnosed with pseudolymphoma and had been treated with steroid intralesional injection and tacrolimus ointment. During the next year, his disease progressed and the lesion tended to bleed and he had to use an eye patch. On exam, no afferent pupillary defect, diplopia, or proptosis was present. Slit lamp examination was unremarkable. He could not elevate the upper eyelid due to mass. There was no involvement in the conjunctiva, upper fornix, and ocular surface.

A biopsy was performed and histology showed appearances suggestive of a malignant lymphoma (Fig. 2). Skin biopsy specimen revealed a bandlike, epidermotropic, and perivascular atypical lymphocytic infiltration with large-cell morphology, which extends to the reticular dermis and subcutis. The tumor cells were positive for CD3, CD8, Bcl-2, CD56, and granzyme B (in a few scattered cells only), and negative for CD10, CD25, CD20, CD30. In situ hybridization for Epstein–Barr virus was negative. HIV testing and the test for monoclonal rearrangement of the T-cell antigen receptor genes were not performed. Other organ involvement was not found at a computed tomography and PET-CT. He was diagnosed with primary cutaneous aggressive epidermotropic CD8\(^+\) T-cell lymphoma and transferred to the oncologist for the combined chemotherapy with CHOP (cyclophosphamide, adriamycin, vincristine, prednisone). However, the treatment was not effective after three cycles of the combined chemotherapy. We planned to perform the radiotherapy and flap surgery, but the patient refused the surgery because of his general medical conditions such as previous myocardial infarction and diabetes.

There are approximately 30 cases of primary cutaneous aggressive epidermotropic CD8\(^+\) cytotoxic T-cell lymphoma reported in the literature, and most of the cases represented multiple or widespread papules, nodules, and tumors, often with hemorrhage, ulceration, and necrosis.\(^3\) One case of solitary ulcerated lesion at ear pinna similar to this case was reported by Fika et al.\(^4\) The prognosis is very poor, according to studies by Berti et al.,\(^2\) which found median survival to be only 32 months. This case generally follows an indolent clinical course similar to that of the more common, classic CD4\(^+\) variants. The other case, reported by Fika et al.,\(^4\) showed solitary lesion, with slow progression, excellent responsiveness to local radiotherapy. The CD8\(^+\) immunophenotypic variant of MF, reported by Dummer et al.,\(^5\) is also characterized by...