A family with internal and external ophthalmoplegia is reported. Computed tomographic scanning showed absence of superior oblique, inferior oblique, and superior rectus muscles. These patients had iris transillumination defects, and the authors reason that these findings and enolase staining pattern of tissue from these patients support a neural crest cell origin for the abnormalities.

Lyn A. Sedwick, M.D.


A 76-year-old woman treated with lithium carbonate for 22 years presented with conjunctival chemosis. Ultrasound showed some extraocular muscle enlargement, although computed tomography “of orbital apex and cavernous sinus was normal.” Lithium was discontinued, and chemosis improved; extraocular muscle size decreased. Her thyroid-stimulating hormone level was 6.05 on lithium and decreased to 3.2 off lithium. The possible interactions between lithium, the orbit, and the thyroid gland are discussed.

Lyn A. Sedwick, M.D.


The authors report on an additional 1,278 patients with third, fourth, and/or sixth nerve palsy from the Mayo Clinic and add to these 3,000 other cases from Mayo studied by Rucker, Rush, and Younge previously. Their results are similar to those of the previous studies: “undetermined” remains the largest single diagnosis group for all palsies except multiple oculomotor nerve palsies, which generally were diagnosable and rarely undetermined. Very few patients were found on prolonged follow-up to have moved from undetermined to another diagnosis group.

Lyn A. Sedwick, M.D.


Two unrelated cases of congenital third nerve palsy, facial capillary hemangioma, and cerebellar hypoplasia are presented.

Lyn A. Sedwick, M.D.


Thirty-six members from four generations of a family with Leber’s were studied. Electrocardiography disclosed prolonged QT interval without apparent clinical symptoms, which the authors feel may represent a systemic manifestation of the 11778 mutation of mitochondrial DNA responsible for Leber’s in this family.

Lyn A. Sedwick, M.D.


A patient with allograft rejection of his seventh corneal transplant was given intravenous methyl-
prednisolone and immediately developed periorbital edema of the eye with the transplant, which resolved with diphenhydramine and did not recur until intravenous methylprednisolone was used again 2 years later. Allergy testing confirmed a response to intravenous methylprednisolone. This type of urticarial reaction must be remembered by ophthalmologists using high-dose intravenous methylprednisolone.

Lyn A. Sedwick, M.D.


These two children had severe, unilateral visual loss in the setting of varicella infection, one from central retinal artery occlusion and the other from neuroretinitis/phlebitis (probable acute retinal necrosis).

Lyn A. Sedwick, M.D.


A 32-year-old man with AIDS developed a papillitis right eye with visual loss. He presented 11 months later with proptosis: orbital biopsy revealed P. carinii, which responded very well to trimethoprim and sulfamethoxazole.

Lyn A. Sedwick, M.D.


This letter to the editor is a comment on the article by Dr. Spoor et al. in the August 1991 edition of the American Journal of Ophthalmology (v. 112, p. 117) regarding optic nerve sheath fenestration. The authors of this letter recommend a lateral approach to the optic nerve, usually without removal of orbital bone, in order to create a large enough fenestration to obviate repeat surgery for primary failure of fenestration.

Lyn A. Sedwick, M.D.


Chemosis and periorbital edema brought this patient, who then developed other findings consistent with systemic lupus erythematosus, and had a history of polyarthritis and Raynaud's phenomenon, to medical attention.

Lyn A. Sedwick, M.D.


A 34-year-old man with AIDS developed an orbital mass, which at biopsy proved to be large-cell lymphoma.

Lyn A. Sedwick, M.D.