



Figure 1 Bilateral RPE hamartoma on the macula.

and intrinsic vascularisation. Associated features commonly include minimally dilated retinal feeding vessels and surrounding retinal traction.³

Visual acuity is usually normal, but visual loss can occur from surrounding foveal traction or central foveal involvement. They generally remain stable without growth. The differential diagnosis includes congenital hypertrophy of the RPE, combined with hamartoma of the retina and RPE, adenoma or adenocarcinoma of the RPE, and RPE hyperplasia. Even though they are extremely infrequent, congenital RPE hamartomas have a very distinct appearance and can be recognised solely on their clinical features, most commonly being unilateral.

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A Panagopoulos, K Chalioulias and AT Murray

Department of Ophthalmology, Birmingham and Midland Eye Centre, Birmingham, UK
E-mail: andypanagopoulos@yahoo.com

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Sir,
Hypotony and choroidal detachment as a complication of travoprost after trabeculectomy surgery

We present a case of recurrent choroidal detachment in a patient using travoprost, and suggest that

prostaglandin analogues should be used with caution in patients who have undergone filtration surgery.

A 79-year-old man with primary open angle glaucoma underwent bilateral trabeculectomies in 1999. By 2003, his right bleb had failed, and latanoprost was prescribed to control his intraocular pressure (IOP). After 1 year, he returned with visual disturbance and right IOP of 4 mmHg, and was noted to have right 360-degree choroidal detachment (Figure 1). All topical treatment to the right eye was stopped; the choroidal detachment resolved over 5 months but the IOP rose to 25 mmHg, so travoprost was commenced. After 3 weeks, he again presented with right 360-degree choroidal detachment and IOP of 4 mmHg. Travoprost treatment was stopped, the choroidal detachment resorbed, but the IOP increased to 26 mmHg. A dorzolamide–timolol fixed combination was prescribed, maintaining IOP at 15 mmHg, with no sign of recurrent choroidal detachment to date.

Recommencement of topical ocular hypotensives following surgery is also known to precipitate hypotony and ciliochoroidal detachment. Discontinuation of topical therapy results in reattachment.¹ Prostaglandin analogues increase uveoscleral outflow of aqueous, possibly by relaxation of the ciliary muscle associated with increased metalloproteinase activity. Choroidal detachment after the use of topical latanoprost has been reported previously.^{2,3} To our knowledge, choroidal detachment has not been previously reported with topical travoprost after glaucoma filtration surgery, although there are reports of choroidal detachment in eyes with chronic angle closure, but no history of glaucoma surgery.⁴ As the uveoscleral pathway is pressure-independent, it has been suggested that prostaglandin analogues could lower IOP below episcleral venous pressure, and thereby cause hypotony and choroidal detachment.⁵ We, therefore, suggest that in patients who have undergone previous glaucoma surgery who subsequently need topical antihypotensive medication, prostaglandin analogues should be used with caution, as they may precipitate hypotony and choroidal detachment.



Figure 1 B-scan ultrasonography showing the typical appearance of a smooth, dome-shaped thick membrane with an echolucent area behind it, confirming the clinical diagnosis of serous choroidal detachment.

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P Alexander and S Ramirez-Florez

Department of Ophthalmology, Peterborough
District Hospital, Peterborough, UK
E-mail: doctoralexander@gmail.com

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