mune reaction to melanocytes. It is typically found in darkly pigmented women aged 30 to 39 years. It can also be associated with systemic features including meningismus, hearing changes, and skin manifestations.6,7

To our knowledge, this is the first case report of a patient with hemophagocytic syndrome with features resembling ocular Vogt-Koyanagi-Harada disease. It is possible that the hyperinflammatory state of hemophagocytic syndrome causes a uveal inflammatory reaction with histiocytic infiltration resulting in ocular features similar to ocular Vogt-Koyanagi-Harada disease. An alternative explanation would be that the patient had 2 separate disease processes, although this would seem to be less likely.

In summary, we describe another possible ophthalmic manifestation of hemophagocytic syndrome. This can be added to the previously described abnormalities resembling leukemic retinopathy and acute multifocal placoid pigment epitheliopathy.

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Financial Disclosure: None reported.

Funding/Support: This article was supported in part by unrestricted grant 6-35233 from Research to Prevent Blindness, Inc.


Stage 1 Macular Hole as a Complication of Laser Iridotomy

Laser peripheral iridotomy (LPI) is performed in patients with narrow anterior chamber angles at risk for angle-closure glaucoma. Argon or green diode and Nd:YAG lasers are often used sequentially in dark irides to create an iridotomy with a minimum amount of laser energy. Posterior segment complications of LPI are uncommon and generally related to direct laser-induced damage.1 Herein we report the development of a stage 1 macular hole following LPI and its
resolution with the aid of the optical coherence tomography/scanning laser ophthalmoscope (OCT/SLO) (Ophthalmic Technologies Inc, Toronto, Ontario).

**Report of a Case.** A 60-year-old woman with a history of ocular trauma in the right eye underwent a routine eye examination. Corrected visual acuity was 20/25 OD and 20/20 OS with an intraocular pressure of 16 mm Hg OU. Examination revealed brown irides and a mild cataract with angle recession in the right eye and a narrow, potentially occludable anterior chamber angle in the left eye.

An LPI was performed on the left eye at the 1-o’clock position. A total of 387 applications were delivered with a 532-nm green diode laser using 600 to 800 mW per application, a pulse duration of 50 milliseconds, and a spot size of 75 µm followed by 9 pulses in the single-burst mode with the Nd:YAG laser, delivering a total energy of 49.2 mJ. The initial opening and subsequent enlargement were performed with the Nd:YAG laser.

Two days postoperatively the patient complained of a central scotoma she noted immediately after the LPI. The visual acuity was 20/30 OS. Dilated fundus examination revealed a yellow dot in the fovea (Figure 1A). The OCT/SLO images demonstrated vitreofoveal traction consistent with a stage 1A macular hole (Figure 1B). Five months postoperatively, the vision improved to 20/20 with resolution of the scotoma. Repeat OCT/SLO imaging (Figure 2) demonstrated vitreous separation with spontaneous resolution of the macular hole and return to normal foveal contour.

**Comment.** Reported complications of LPI include transient elevation of the intraocular pressure, localized corneal opacities and endothelial damage, iris bleeding, and lens damage.4,5 Macular hole formation has been reported following Nd:YAG posterior capsulotomy.6 However, we are unaware of previous reports of macular hole formation complicating LPI and could find no reference to it when we searched MEDLINE.

The mechanism of macular hole formation in our patient is most likely related to the concussive force exerted by the Nd:YAG laser. As the laser is applied at the iridotomy site, plasma formation and photodisruption produce shock waves that propagate through to the anterior hyaloid face and the vitreous body. An additional potential mechanism includes the thermal effects of the diode laser on the anterior vitreous. The resultant concussive and thermal effect on the vitreous may then cause a perifoveal vitreous detachment with subsequent foveolar traction and a stage 1 macular hole formation.

In conclusion, stage 1 macular hole formation is a possible complication

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**Figure 1.** Eight days after laser peripheral iridotomy. A, Fundus photograph of the left eye demonstrates a yellow spot in the foveola (short arrow), a stage 1 macular hole. B, Optical coherence tomography/scanning laser ophthalmoscope image demonstrates vitreofoveal traction (long arrow) and foveola floor elevation (arrowhead) corresponding to the fundus photograph.

**Figure 2.** Serial ocular coherence tomography/scanning laser ophthalmoscope images. A, Seven weeks postoperatively. The posterior hyaloid face (long arrow) is completely detached with persistent foveola floor elevation (arrowhead). B, Five months postoperatively. The posterior hyaloid is completely detached and out of view with resolved foveola elevation (arrowhead).
of LPI. This may be followed by complete posterior vitreous detachment and resolution of the macular hole with improvement in symptoms.

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Financial Disclosure: None reported.

Funding/Support: This report was supported by the Department of Ophthalmology Research Fund of the New York Eye and Ear Infirmary and the Norma Lazar Ophthalmology Research Fund.


ARCHIVES Web Quiz Winner

Congratulations to the winner of our June quiz, Azhar Aldouri, MD, PhD, Manchester Royal Eye Hospital, Manchester, England. The correct answer to our June challenge was tamoxifen keratopathy. For a complete discussion of this case, see the Clinicopathologic Reports, Case Reports, and Small Case Series section in the July ARCHIVES (Zinchuk O, Watanabe M, Hayashi N, Fukushima A, Ueno H. A case of tamoxifen keratopathy. Arch Ophthalmol. 2006;124:1046-1048).

Be sure to visit the Archives of Ophthalmology Web site (http://www.archophthalmol.com) and try your hand at our Clinical Challenge Interactive Quiz. We invite visitors to make a diagnosis based on selected information from a case report or other feature scheduled to be published in the following month’s print edition of the Archives. The first visitor to e-mail our Web editors with the correct answer will be recognized in the print journal and on our Web site and will also be able to choose one of the following books published by AMA Press: Clinical Eye Atlas, Clinical Retina, or Users’ Guides to the Medical Literature.