

lence. Surgery can lead to iridodialysis, cyclodialysis, and subsequent bleeding [5]. The following steps prevented these complications in the two patients presented here. First, we used a modified Siepser technique for creation of the knot *in situ*. This type of knot minimizes the force pulling on the iris from the direction of the corneolimb angle. Second, we used an IOL manipulator to create a counter-force when the needle was passed through the iris. Third, the viscoelastics is inserted in a step-wise manner. This was performed to prevent iris prolapse through the primary incision, which would subsequently trigger a sharp spike in IOP. Finally, the needle was maneuvered extremely gently when passing horizontally through the anterior chamber to as to avoid contact with the lens. This is the first report to describe the adaptation of a modified Siepser slip-knot technique to treat symptomatic LPI in phakic eyes.

Eun Hye Jung

Department of Ophthalmology, Seoul National University Hospital, Seoul National University College of Medicine, Seoul, Korea

Mee Kum Kim, Won Ryang Wee

Department of Ophthalmology, Seoul National University Hospital, Seoul National University College of Medicine, Seoul; Laboratory of Ocular Regenerative Medicine and Immunology, Seoul Artificial Eye Center, Seoul National University Hospital Biomedical Research Institute, Seoul, Korea  
E-mail: kmk9@snu.ac.kr

## Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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## Ethmoidal Sinus Mucocele as a Cause of Acquired Brown Syndrome

Dear Editor,

A mucocele is composed of a respiratory epithelial lined mucus-containing lesion with accumulation of mucoid secretion. Sometimes, it produces remodeling of the bony structure and influences the adjacent tissues [1]. In this case, extension of the ethmoid sinus mucocele and remodeling of the orbital structure were major causes of acquired Brown syndrome. Although various causes of acquired

Brown syndrome have been described, this is the first reported case of acquired Brown syndrome due to ethmoidal sinus mucocele in Korea.

A 69-year-old male presented to our institution with a newly-developed diplopia. There was no history of trauma or any medical illness. At initial examination, visual acuity was 20 / 30 in both eyes. The intraocular pressure was 17 mmHg in the right and 20 mmHg in the left eye. There was no relative afferent pupillary defect and color vision was normal.

A soft compressible tender mass measuring 2 × 2 mm on the superonasal aspect of the left upper lid extending from the trochlea to the medial canthal tendon was noted. A motility examination showed an underelevation in adduction of the left eye mimicking Brown syndrome (Fig. 1A). A



**Fig. 1.** (A) Preoperative versions of subject in nine diagnostic positions of gaze, demonstrating under-elevation in adduction of the left eye. (B) Orbital computed tomography scan showing the nonenhancing 30 × 25 mm mass (arrow) of the left ethmoidal sinus having an intra-orbital extension.

left hypotropia of 2 prism diopters (PD) to 4 PD in primary gaze, which increased to 6 PD in right and upgaze, was present. Forced duction testing indicated a restriction of elevation in adduction of the left eye. Computed tomography (Fig. 1B) revealed an expansile nonenhancing 30 × 25 mm mass of the left ethmoidal sinus having an intraorbital extension consistent with a mucocele. The mass appeared to be pressing on the globe causing effacement of the left medial rectus and superior oblique tendon with anterolateral displacement of the trochlea. The patient underwent endoscopic ethmoidectomy and evacuation of the mucocele by an otolaryngologist. Postoperatively at two months, there was complete resolution of the diplopia and the patient was asymptomatic. A forced duction test revealed no restrictions.

Brown syndrome is characterized by limited elevation in adduction with positive forced duction testing [2]. The mechanism of acquired Brown syndrome in this case was thought to be the ethmoidal sinus mass preventing anterior tendon movement through the trochlea or the spread of inflammation from an adjacent sinus disease [3]. Complete resolution of symptoms after surgery suggests that mechanical effects were the main cause in this case. Although acquired Brown syndrome is rare, ethmoidal sinus mucocele should be considered in differential diagnosis of acquired Brown syndrome.

Seung-Jun Lee

*Department of Ophthalmology, Kangwon National University School of Medicine, Chuncheon, Korea*

Jun Yeon Won

*Department of Otolaryngology, Kangwon National University School of Medicine, Chuncheon, Korea*

Moosang Kim

*Department of Ophthalmology, Kangwon National University School of Medicine, Chuncheon, Korea  
moosangkim@kangwon.ac.kr*

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