Letters to the Editor

Bergmeister’s papilla

Papila de Bergmeister

Dear Editor:

Bergmeister papilla (BP) is a variant of the papilla formed by persistent fetal hyaloid artery remains presenting as a peripheral membrane that can partially or fully occlude the papilla, constituting an obstacle for visualization and study (Fig. 1). Regarded as a generally unilateral casual finding, BP has no clinical repercussion but can produce doubts in diagnostics.1,2

The embryonary hyaloid artery, a branch of the primitive dorsal ophthalmic artery, irrigates the lens during embryonary development and it progressively diminishes from the tenth week of gestation to disappear at birth. Incomplete disappearance of these embryonary structures over the optic nerve head produce the subsistence of glyal tissue at the beginning of Cloquet’s canal or Stilling’s duct that communicates the optic nerve with the lens, traversing the vitreous humor and which would be the complete remainder of the hyaloid artery.1,2

BP is a benign process which does not hinder individual development and has no clinical repercussion. In some cases, Mittendorf’s dot or a vestige of the same hyaloid artery is found in the posterior lens capsule. However, in severe forms, it is possible to find persistence of the primary vitreous, cataracts micro-ophthalmia and even tractional retinal detachment. Less frequently it is possible to find a complete hyaloid artery from the papilla to the lens posterior capsule which could contain blood and even rupture producing vitreous hemorrhage.2

BP can give rise to diagnostic doubts. Differential diagnostic should be performed in the presence of abundant fetal remains as well as myelin fibers, optic neuropathies, pseudo-papiledema and even incipient asymmetric papiledema.

BP was initially described by Otto Bergmeister, an Austrian ophthalmologist in the late nineteenth century. Born in Siltz (Tirol) in 1845. Bergmeister studied in Vienna where he worked as a professor, researcher and physician. Contemporary of von Graefe, Satler, Fuchs or Becker, he was disciple of Ferdinand Ritter von Arlt,3 an Austrian ophthalmologist. He published a number of articles, including About Buphthalmus congenitus (1881), About Corneal Dermoid (1884), About Fever in Relation to the Organ of Sight (1890) or About Treatment of Trachoma (1891). In addition he was a volunteer physician at the Leopoldstädter Children’s Hospital, which had over 115 beds, together with other physicians like Hofmokl (surgeon), Gruber (audiologist) or Pichler (dentist) assisting over 14,000 patients on an outpatient basis and entirely free of charge.

To conclude, may this Letter to the Editor be a homage to Otto Bergmeister and his work, and also to increase knowledge about said fetal remains of the hyaloid artery in the papilla among younger ophthalmologists who may encounter doubts in differential diagnostics between myelin fibers, papillitis or pseudo-papiledema, among others.

Fig. 1 – Bergmeister’s papilla.

REFERENCES


E. Santos-Bueso, A. Asorey-García, J.M. Vinuesa-Silva, J. García-Sánchez

Papilledema secondary to Burkitt lymphoma

Papiledema secundario a linfoma de Burkitt

Dear Sir,

Burkitt lymphoma (BL) is a type of rapid growth B-cell non-Hodgkin lymphoma affecting children and young adults. It can become endemic in Africa, sporadically or associated to immunodeiciencies. Characterized by sudden onset and aggressive growth, BL occurs due to translocation in the c-Myc gene of chromosome 8. It was described in 1958 by the Irish surgeon Denis Parsons Burkitt while working in Uganda.

The endemic variant of BL is most prevalent in equatorial Africa, possibly due to the association with chronic malaria infection which could produce diminished resistance to the Epstein–Barr virus. Regarding as the most frequent neoplasm in children in that region, this endemic form is characterized by a rapid growth tumor which generally appears on the maxillary or the jaw.

In its sporadic form, BL is not associated to the Epstein–Barr syndrome and accounts for 30–50% of childhood lymphomas, particularly in male children and young adults with a mean age of 10 years. It most frequently appears in the abdominal or cervical region and over 50% of patients exhibit disseminated or metastatic disease at diagnostic, with central nervous system infiltration in up to 20% of cases.

In the forms associated to immunodepression, BL develops in patients with AIDS or transplanted organs who take immunosuppressant drugs. BL can be one of the conditions associated to initial AIDS expressions.

We present the case of a male patient, 12, who visited due to holocranial headache with several weeks evolution which partially receded with usual analgesia. In addition, the patient exhibited asthenia, anorexia and constitutional syndrome with slight weight loss in the past month and painless cervical adenopathies. Upon exploration, visual acuity was 0.8 in both eyes (BE), with anterior pole, extrinsic and intrinsic ocular motility being normal. Intraocular pressure was 14 mm Hg in BE. Ocular fundus revealed asymmetric papilledema with peripapillary hemorrhages and hard exudates, predominantly in the left eye (Figs. 1 and 2).

![Fig. 1 - Right ocular fundus: papilledema with predominantly nasal inferior hemorrhages.](image)