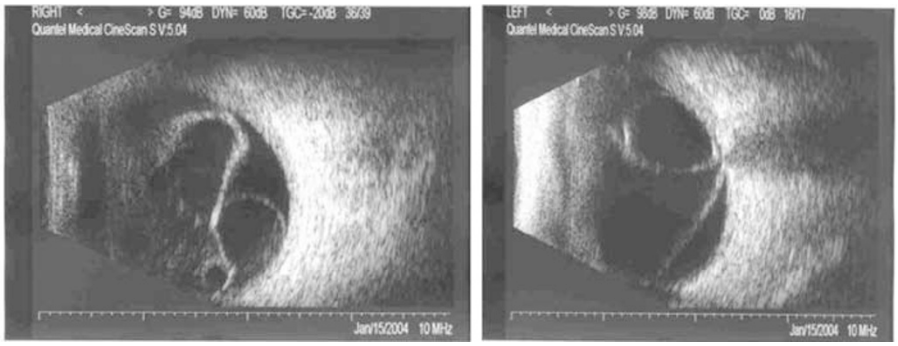

Figure 2 B scan ultrasonography showing bilateral retinal detachments and intraretinal macrocysts.

waiting list for left retinal detachment surgery with guarded prognosis.

Discussion

Intraretinal macrocysts can occur in long-standing retinal detachments. They are seen in 3% of detachments, usually of at least a month duration.[7] In total, 53% of cases occur in inferotemporal dialysis, as these are slowly progressive and diagnosed late.[7] Chronic detachments undergo photoreceptor atrophy due to the loss of their choroidal blood supply. Cystic degenerative changes occur in the outer plexiform layer of the retina, which results in macrocyst formation.

These retinal macrocysts are schistic cavities between 3 and 6 mm in diameter in detached retina, usually located in the equator. They may be solitary or multiple. They differ from foveal cysts, in which the intraretinal splitting results in cystoid spaces and these are usually associated with tangential vitreal traction and may develop into a macular hole.[8] They differ from retinoschisis as they do not have inner or outer leaf breaks or white flecks. Haemorrhagic retinal cysts have been described in Advanced Coats disease.[9]

Intraretinal macrocysts, demarcation lines, retinal thinning, subretinal fibrosis, and lack of retinal mobility are all signs of a long-standing retinal detachment. The intraretinal macrocysts do not require specific treatment and resolve spontaneously after successful retinal reattachment surgery. In total, 60% resolve within the first 3 days of surgery and 100% within a month.

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Sir,

Reply to BB Patil *et al*

Many thanks for bringing to my attention this interesting case by Patil *et al*.

The author has described that there was no history of trauma but despite a negative history, signs of ocular trauma have been observed in similar cases, which is worth looking at ocular examination. In total, 6% of patients with inferotemporal dialysis with no history of trauma were found to have signs of preceding trauma.[1]

Did this patient have any associated refractive error? As we are aware simultaneous bilateral retinal

detachment is usually found in relatively young and myopic patients with round, atrophic holes.[2]

It will also be interesting to know if this patient had any signs of PVR, though it is rare as noted in only 5.6% of patients in the presence of obvious signs of chronic retinal detachment like macrocysts and demarcation lines.[3]

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Sir,

Choroidal neovascularization (CNV) secondary to septic emboli from endocarditis: a case report

Age-related macular degeneration (AMD) is the most common cause of choroidal neovascularization (CNV) in individuals over the age of 50 years. We report a case of CNV secondary to septic emboli from prosthetic valve endocarditis.

Case report

A 63-year-old Caucasian male was brought to the hospital in a confused state with fever, lethargy, breathlessness, and abdominal pain. He later developed multiple lesions suggestive of vasculitis or septic embolism. He had an aortic valve prosthesis inserted 10 years ago, for severe aortic regurgitation and atrial fibrillation.

Urinanalysis showed proteinuria and microscopic haematuria. He had raised ESR, CRP, and leucocytes count. Blood cultures were positive for *Staphylococcus aureus*, which was highly sensitive to vancomycin. A diagnosis of prosthetic valve endocarditis was made.

Intravenous vancomycin was given for 40 days. After 10 days of intravenous vancomycin, he recovered consciousness fully and he noticed distortion of vision (metamorphopsia) in the right eye. He was at this stage referred to ophthalmologist for opinion.

His visual acuity on presentation in the eye clinic was 6/18 in the right eye and 6/5 in the left. The anterior segment in the right eye was unremarkable, while the posterior segment showed a juxta foveal well-demarcated, grey, elevated choroidal neovascular membrane surrounded by subretinal blood (Figure 1a). The left eye was normal. This membrane was successfully treated by argon laser (Figure 1b). Figure 2a and b shows prelaser fundus fluorescein angiography pictures confirming the presence of CNV and postlaser blockage of the membrane after successful laser treatment. He was symptomatically better within 2 weeks. Visual acuity in the right eye at 4 months was 6/5 and was maintained at discharge.

Comment

The proposed theories of septic CNV are a combination of acute suppurative choroiditis and choriocapillaries

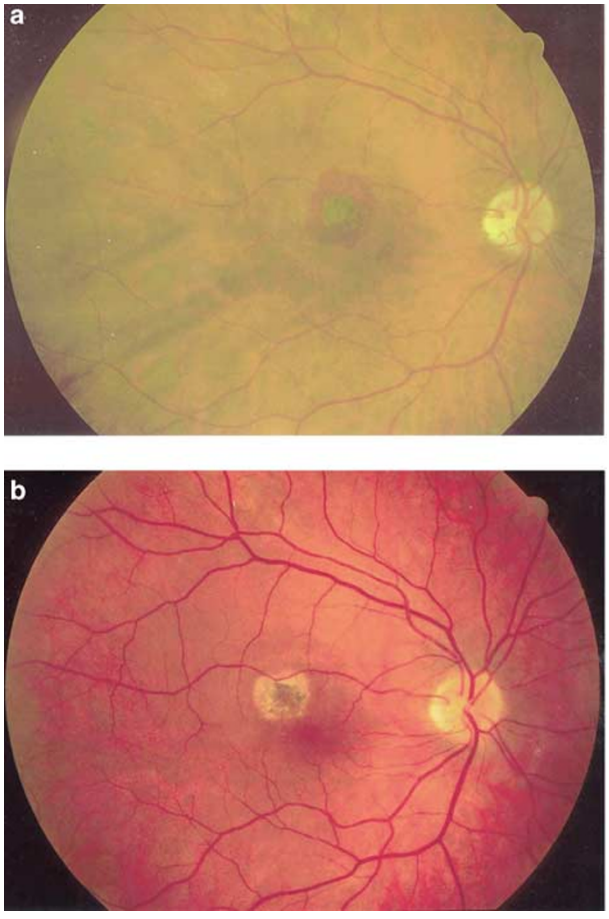

Figure 1 (a) Fundus photograph of the right eye showing discrete greyish juxtafoveal lesion surrounded by subretinal haemorrhage and serous detachment of macula (before laser). (b) Scarring at site of CNV with absorbed SRF (after laser).