S. marcescens is multiresistant Gram-negative bacillus that can produce a red pigment causing a pink hypopyon.[7] To our knowledge, this is the first reported case of *S. marcescens* pneumonia as a primary source for EE (the lung is the most common site for these pathogens[8]). Despite appropriate systemic and intravitreal antibiotics, the visual outcome was poor and the patient eventually died. As the incidence of EE (especially Gram-negative infections) appears to be rising,[3] then this aggressive organism may become a more common cause for this devastating condition.

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Sir,

Tractional retinal break and rhegmatogenous retinal detachment consequent to branch retinal vein occlusion

Traction on neovascular tissue causing tractional retinal breaks and consequent rhegmatogenous retinal detachment is an infrequent complication of branch retinal vein occlusion (BRVO). We report a case which was successfully managed with barrier laser photocoagulation.

Case report

A 73-year-old man presented to ophthalmic casualty with history of sudden painless loss of vision in the left eye. There was no significant ophthalmic history and he suffered from hypertension. Visual acuities were 6/6 in right eye and hand movements in left eye. Anterior segment examination was normal; there was no fundus view due to dense vitreous haemorrhage. B-scan confirmed vitreous haemorrhage and flat retina.

Vitreous haemorrhage cleared 2 months later and visual acuity improved to 6/6 in the affected eye. Fundoscopy revealed a large posterior horseshoe retinal tear at 2 O'clock position with surrounding localised retinal detachment above the superotemporal retinal vessels. There was an avulsed neovascular frond attached to posterior hyaloid face and ghosting of superotemporal blood vessels suggesting an old BRVO (see Figure 1).

Barrier laser photocoagulation was performed surrounding the area of retinal detachment. After 6 months the patient's vision was stable with no progression of retinal detachment or development of further complications.

Comment

BRVO may be associated with a number of complications including macular oedema, epiretinal membrane, retinal neovascularisation, vitreous haemorrhage, retinal breaks, and rhegmatogenous retinal detachment. Retinal breaks

Figure 1 Left eye fundoscopy showing localized retinal detachment with horseshoe retinal tear at 2O'clock and an avulsed neovascular frond with ghosting of superotemporal blood vessels.

following BRVO are of two types—holes without traction and tears with vitreous traction with or without retinal neovascularisation.[1–3] Tears and retinal detachment due to traction on neovascular tissue are infrequent.

A strong association between BRVO with vitreous haemorrhage and posterior tractional retinal breaks was reported by Joondeph *et al*.[2] They reviewed 358 cases with BRVO and reported 1.6% incidence of posterior tractional breaks leading to rhegmatogenous retinal detachment in 0.6% of patients.[1] Kir *et al*[4] reported 3% incidence of retinal breaks and 1.3% of rhegmatogenous retinal detachment.

Retinal breaks are almost exclusively found in the distribution of the occluded vessel and often located at or posterior to equator.[4]

The most widely accepted hypothesis for pathogenesis of tractional retinal break in BRVO is vitreoretinal traction caused by vitreous contraction following retinal neovascularisation.[1–3] The influence of laser photocoagulation and/or vitreous haemorrhage resulting in retinal break formation remains controversial.[5]

Our case emphasises that vitreous haemorrhage in eyes with BRVO should alert the examiner to closely monitor the situation since traction on neovascular fronds may lead to retinal breaks and consequent retinal detachment.

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Sir,

Bilateral acute retinal necrosis syndrome following herpes simplex type 1 encephalitis

Acute retinal necrosis syndrome (ARN) associated with herpes simplex viral encephalitis has been well described. Bilateral acute retinal necrosis (BARN) in this context is described but is extremely rare. We present a case of BARN following recent herpes simplex type 1 (HSV-1) encephalitis (HSE) in an immune competent patient.