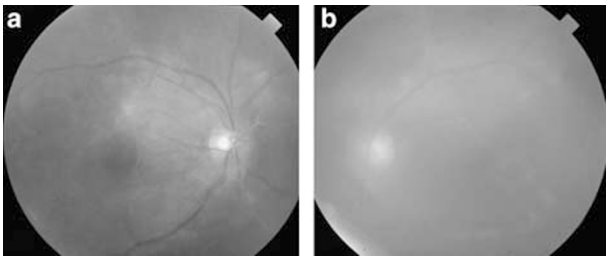

Figure 2 (a) Fundus photography showed macular mottling without oedema in the right eye after *pars plana* vitrectomy. (b) Vitreous haze still obscured retina in the left eye.

macular oedema, and a markedly compromised vision, suggesting diffuse involvement of the intraocular vessels.

Pathology has demonstrated lipid deposition in the vascular smooth muscle cells, the perithelial cells, and the endothelial cells.[3] We believe this may disrupt the blood–ocular barrier, leading to a picture of chronic uveitis. Triamcinolone acetonide has been shown to reduce the breakdown of blood–retinal barrier,[4] introducing the rationale for corticosteroid use in diabetic macular oedema[5] and this case as well.

As the effect of periocular steroid was temporary and the ocular manifestations were well controlled after a prolonged course of ERT alone, the concurrence of Fabry disease and other uveitis seems unlikely. ERT has been shown to be effective in clearing lipid deposition in renal microvascular tissue.[1] In this case, ERT may have reduced the lipid deposition in ocular vascular tissue, leading to clinical improvement.

In conclusion, Fabry disease may significantly alter the vascular permeability and present as chronic uveitis. Periocular steroid injection may temporarily reduce vascular permeability and relieve the ocular manifestations. Long-term ERT could relieve the ocular manifestations.

References

1 Desnick RJ, Brady R, Barranger J, Collins AJ, Germain DP, Goldman M. Fabry disease, an under-recognized multisystemic disorder: expert recommendations for diagnosis, management, and enzyme replacement therapy. *Ann Intern Med* 2003; **138**: 338–346.
2 Sher NA, Letson RD, Desnick RJ. The ocular manifestations in Fabry's disease. *Arch Ophthalmol* 1979; **97**: 671–676.
3 Riegel EM, Pokorny KS, Friedman AH, Suhan J, Ritch RH, Desnick RJ. Ocular pathology of Fabry's disease in a hemizygous male following renal transplantation. *Surv Ophthalmol* 1982; **26**: 247–252.
4 Wilson CA, Berkowitz BA, Sato Y, Ando N, Handa JT, de Juan E Jr. Treatment with intravitreal steroid reduces blood–retinal barrier breakdown due to retinal photocoagulation. *Arch Ophthalmol* 1992; **110**: 1155–1159.
5 Martidis A, Duker JS, Greenberg PB, Rogers AH, Puliafito CA, Reichel E. Intravitreal triamcinolone for refractory diabetic macular edema. *Ophthalmology* 2002; **109**: 920–927.

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Sir,

A Hazard of undiagnosed diabetes with benign prostatic hyperplasia: bilateral endogenous bacterial endophthalmitis

Case report

A 61-year-old male presented with a history of floaters, blurred vision and discomfort for 1 week in his left eye and 2 days in his right. He had recently been polyuric and had lost 10 kg in weight. He was treated for a urinary tract infection 2 weeks prior to presentation.

Examination found best-corrected visual acuity (BCVA) of 6/60 in each eye. There was bilateral panuveitis, and intraocular pressures were 4 mmHg bilaterally. Retinal haemorrhages were present in the right fundus. The left fundus was not visible; a B-scan showed an attached retina. Blood tests showed raised blood glucose (43.5 mmol/l), and marked neutrophilia (29.8×10^9/l).

A diagnosis of bilateral endogenous bacterial endophthalmitis (EBE) was made. The patient was admitted and intravenous insulin started. Bilateral anterior chamber and vitreous biopsies were performed

under local anaesthesia and intravitreal vancomycin, ceftazidime, and dexamethasone administered. Intravenous flucloxacillin and ciprofloxacin, topical ciprofloxacin, and both topical and oral steroids were given. Urine and blood cultures revealed *Staphylococcus aureus*. Further investigation showed benign prostatic hyperplasia (BPH), urinary retention, and bilateral hydronephrosis. Microscopy and culture of the ocular samples was negative.

At 3 weeks later, hypotony of the right eye resolved and BCVA in the right eye improved to 6/9. The left eye remained hypotonous for 2 months, and BCVA improved to 6/18.

Comment

EBE is rare, occurring in 0.24% of bacteraemic patients. Patients often have predisposing conditions such as diabetes (35%), and in this case BPH.[1]

The visual prognosis in EBE is worse than in other forms of endophthalmitis. Jackson *et al*[1] report that only 32% of patients are left with visual acuity of counting fingers or better. Given that in cases of endophthalmitis the presence of severe vitritis, retinal haemorrhages,[2] and infection with a virulent organism[3] are associated with a worse prognosis, it is noteworthy that this patient's visual outcome was good.

This case illustrates that even in the presence of poor prognostic factors, EBE may have an acceptable outcome if treated promptly and aggressively. It is likely that earlier diagnosis of diabetes and BPH might have prevented this incident.

References

1 Jackson TL, Eykyn SJ, Graham EM, Stanford MR. Endogenous bacterial endophthalmitis: a 17-year prospective series and review of 267 reported cases. *Surv Ophthalmol* 2003; **48**: 403–423.
2 Greenwald MJ, Wohl LG, Sell CH. Metastatic bacterial endophthalmitis: a contemporary reappraisal. *Surv Ophthalmol* 1986; **31**: 81–101.
3 Hassan IJ, MacGowan AP, Cook SD. Endophthalmitis at the Bristol Eye Hospital: an 11-year review of 47 patients. *J Hosp Infect* 1992; **22**: 271–278.

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Sir,

Nd:YAG laser subretinal membranotomy in young patients with long-term retinal detachment

Subretinal bands usually occur in younger patients with long-term retinal detachment.[1] After a scleral buckle procedure, a major subretinal band may prevent the fovea reattachment. It may be necessary to perform vitrectomy and retinotomy with removal or cutting of a band.[2] We described two young patients with persistent fovea detachment after scleral buckling for long-term retinal detachment. Delayed development of a major subretinal band, which uplift the macula, was disrupted with neodymium:yttrium–aluminium–garnet (Nd:YAG) laser. Subretinal laser membranotomy allowed the retina to reattach gradually. Optical coherence tomography (OCT) disclosed macula reattachment after 4 and 12 months, respectively.

Case reports

Case 1

A 12-year-old boy with a 9-month history of blurred vision in his right eye presented with a long-term total retinal detachment and the best-corrected visual acuity of 20/400. After a scleral buckle procedure, inferior subretinal fluid persisted with the occurrence of a major taut subretinal band (Figure 1a) preventing macula reattachment for 4 months. Nd:YAG laser (Lightmed, USA) subretinal membranotomy was performed with a wavelength of 1064 nm, a pulse width of 4 ns, and a focal plan of up to 250 μm anteriorly. After mounting the Golmann contact lens (Haag-Streit, UK), the laser was applied to the thinner part of a band far from the macula. The end point of treatment was disruption of a band with total six pulses of 5.0 μJ/pulse. Preretinal and subretinal haemorrhage (Figure 1b) was found immediately after the procedure and resolved spontaneously within