Comment
Migration of silicone oil into the orbit has been previously reported resulting in blindness due to the blockage of Ahmed valve and rubeosis.[3] Gas is less likely to escape compared with silicone oil in these circumstances due to its larger surface tension. However, once the defect is breached by the gas bubble, its surface tension forces are reduced resulting in gas escaping to the orbit. It is thus important to avoid raising the intraocular pressure postoperatively to limit gas escape.

References
1 Thylefors B. Epidemiologic patterns of ocular trauma. *Aust N Z J Ophthalmol* 1992; **20**: 95–98.
2 Abu El-Asrar AM, Al-Amro SA, Khan NM, Kangave D. Visual outcome and prognostic factors after vitrectomy for posterior segment foreign bodies. *Eur J Ophthalmol* 2000; **10**: 304–311.
3 Nazemi PP, Chong LP, Varma R, Burnstine MA. Migration of intraocular silicone oil into the subconjunctival space and orbit through an Ahmed glaucoma valve. *Am J Ophthalmol* 2001; **132**: 929–931.

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Sir,

Recurrent hypopyon due to methicillin-resistant *Staphylococcus aureus* after cataract surgery

Methicillin-resistant *Staphylococcus aureus* (MRSA) ophthalmic infections are increasing as MRSA becomes more prevalent in the community.[1]

Case report
A 79-year-old man had uncomplicated left eye phacoemulsification and lens implant on 12 June 2007. He presented 6 days postoperatively with left hypopyon and visual acuity (VA) of 6/24. He received subconjunctival gentamicin–betamethasone–mydricaine and oral ciprofloxacin. His vision dropped to hand movements (HM) before intravitreal antibiotic (vancomycin + amikacin) injection on 25 June. The vitreous specimen did not show pus cells and no organisms could be grown on culture. However, the eye rapidly improved and the VA was 6/12 by 2 July. A week later, the hypopyon recurred but inflammation resolved after another subconjunctival injection. Unfortunately, the hypopyon recurred for a third time on 30 July prompting a referral to our unit.

On 31 July, we found a 2 mm hypopyon, white deposits on the posterior capsule, vitreous cells and HM vision. The IOL and capsule were removed surgically and intravitreal ciprofloxacin and teicoplanin were injected. Culture of the capsular bag showed MRSA sensitive to teicoplanin but resistant to ciprofloxacin and gentamicin. Screening found MRSA in his nose and groins.

His corrected VA was 6/9, there were no further recurrences, and he is awaiting secondary IOL implantation.

Comment
There have been previous reports of endophthalmitis caused by MRSA but not of low-grade endophthalmitis with organisms confined to the capsular bag.[2]

The department of health in England estimates that 30% of the population are colonised by *S. aureus* and in 3%, this is MRSA.[3]

Kato in 1998 found MRSA in 8 (1.3%) of 628 patients from preoperative conjunctival swabs.[4]

MRSA usually causes mild disease such as blepharoconjuctivitis[2] but sight-threatening disease can occur including endophthalmitis, blebitis, and corneal ulcers.[1] Patients often have ocular surface disease, atopy, or a debilitating illness.[5] Our patient had been previously hospitalised for major bowel surgery.

Ophthalmologists need a higher index of suspicion particularly in 'at risk' individuals such as hospitalised elderly patients. Clinicians may need to re-evaluate antibiotic regimens in endemic areas, keeping in mind that MRSA remains susceptible to vancomycin and chloramphenicol but is often resistant to ciprofloxacin.[2,5]

References
1 Blomquist PH. Methicillin-resistant *Staphylococcus aureus* infections of the eye and orbit (an American Ophthalmological Society thesis). *Trans Am Ophthalmol Soc* 2006; **104**: 322–345.
2 Freidlin J, Acharya N, Lietman TM, Cevallos V, Whitcher JP, Margolis TP. Spectrum of eye disease caused by methicillin-resistant *Staphylococcus aureus*. *Am J Ophthalmol* 2007; **144**(2): 313–315.
3 A simple guide to MRSA. 16 July 2007, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_411388.
4 Kato T, Hayasaka S. Methicillin-resistant *Staphylococcus aureus* and methicillin-resistant coagulase-negative staphylococcifrom conjunctivas of preoperative patients. *Jpn J Ophthalmol* 1998; **42**(6): 461–465.
5 Shanmuganathan VA, Armstrong M, Buller A, Tullo AB. External ocular infections due to methicillin-resistant *Staphylococcus aureus* (MRSA). *Eye* 2005; **19**(3): 284–291.

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