Conflict of interest
The authors declare no conflict of interest.

References
1 Wu W, Dawson DG, Sugar A, Elner SG, Meyer KA, McKey JB *et al*. Cataract surgery in patients with nanophthalmos: results and complications. *J Cataract Refract Surg* 2004; **30**(3): 584–590.
2 Yuzbasioglu E, Artunay O, Agachan A, Bilen H. Phacoemulsification in patients with nanophthalmos. *Can J Ophthalmol* 2009; **44**(5): 534–539.
3 Yalvac IS, Satana B, Ozkan G, Eksioglu U, Duman S. Management of glaucoma in patients with nanophthalmos. *Eye* 2008; **22**(6): 838–843.
4 Faulborn J, Kolli H. Sclerotomy in uveal effusion syndrome. *Retina* 1999; **19**(6): 504–507.
5 Rufer F, Varde MA, Roider J. Intravitreal triamcinolone and bevacizumab injections for alternative treatment of nanophthalmic uveal effusion syndrome. *Klin Monatsbl Augenheilkd* 2008; **225**(6): 594–596.

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Sir,
A possible genetic answer to a recently reported novel phenotype

We read with interest the recent article of Shen *et al*,[1] who report a unique Chinese pedigree with the features of ectopia lentis and varicose great saphenous vein. Marfan's syndrome (MFS), clinically diagnosed by characteristic multiple-system abnormalities, lies at one end of a phenotypic spectrum. At the other end of that spectrum are members of the general population who have one feature common to those with MFS.[2] Of those patients who fulfil the modified Ghent criteria for full MFS, up to 97% are found to have FBN1 mutations.[3] However, the patients presented by Shen *et al* are atypical. An alternative approach would be to try to postulate an all-encompassing molecular diagnosis that best fits the clinical signs. Venous varicosity is usually secondary to valvular incompetence, a condition that has been strongly associated with heterozygous mutations in the FOXC2 gene on chromosome 16.[4] Similarly, a range of anterior segment phenotypes have been described, with mutations in FOXC2 inherited in a dominant manner.[5] When aiming for a genetic diagnosis in this family, we would therefore advocate including FOXC2 in the screening set of genes. If a FOXC2 mutation were found in this family, this would represent an interesting extension to the associated phenotype.

Conflict of interest
The authors declare no conflict of interest.

References
1 Shen W, Fu Q, Sui R, Wu J, Liu L. Unique phenotype in a Chinese family pedigree: ectopia lentis with varicose great saphenous vein. *Eye* 2010; **24**(10): 1614–1617.
2 Pyeritz RE. The Marfan syndrome. *Annu Rev Med* 2000; **51**: 481–510.
3 Loeys BL, Dietz HC, Braverman AC, Callewaert BL, De Backer J, Devereux RB *et al*. The revised Ghent nosology for the Marfan syndrome. *J Med Genet* 2010; **47**(7): 476–485.
4 Mellor RH, Brice G, Stanton AW, French J, Smith A, Jeffery S *et al*. Mutations in FOXC2 are strongly associated with primary valve failure in veins of the lower limb. *Circulation* 2007; **115**(14): 1912–1920.
5 Smith RS, Zabaleta A, Kume T, Savinova OV, Kidson SH, Martin JE *et al*. Haploinsufficiency of the transcription factors FOXC1 and FOXC2 results in aberrant ocular development. *Hum Mol Genet* 2000; **9**(7): 1021–1032.

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Sir,
Response to Khan *et al*

We thank Khan *et al*[1] for their insightful comments on our recent paper.[2] Their suggestion of including *FOXC2* in the screening set of genes is very interesting. It opens a possibly new aspect of an interesting extension to the associated phenotype in the reported Chinese family. We have already collected 18 genomic DNA samples from three generations of this family. Linkage to *FBN1* locus cannot be ruled out by microsatellite markers. A novel missense mutation was identified in *FBN1* gene, which co-segregated with the ocular phenotype (data not published). Association of single-nucleotide polymorphisms in *TGFβR2* gene was not confirmed. Obviously, this is different from the features associated to disposition to aortic dilatation and dissection of a UK family reported by Law *et al*.[3] *FOXC2*[4,5] or other genes may be the possible genetic factors as Khan *et al* pointed out. Whole-genome scanning using single-nucleotide polymorphism chips is our future strategy, which we hope can answer the question shortly.

Conflict of interest
The authors declare no conflict of interest.

References
1 Khan K, Ali M, Inglehearn C. A possible genetic answer to a recently reported novel phenotype. *Eye* 2011; **25**: 529.
2 Shen W, Fu Q, Sui R, Wu J, Liu L. Unique phenotype in a Chinese family pedigree: ectopia lentis with varicose great saphenous vein. *Eye* 2010; **24**(10): 1614–1617.
3 Law C, Bunyan D, Castle B, Day L, Simpson I, Westwood G *et al*. Clinical features in a family with an R460H mutation in transforming growth factor b receptor2 gene. *J Med Gent* 2006; **43**: 908–916.

4 Mellor RH, Brice G, Stanton AW, French J, Smith A, Jeffery S *et al*. Mutations in FOXC2 are strongly associated with primary valve failure in veins of the lower limb. *Circulation* 2007; **115**(14): 1912–1920.
5 Smith RS, Zabaleta A, Kume T, Savinova OV, Kidson SH, Martin JE *et al*. Haploinsufficiency of the transcription factors FOXC1 and FOXC2 results in aberrant ocular development. *Hum Mol Genet* 2000; **9**(7): 1021–1032.

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Sir,

Acute endophthalmitis after cataract surgery at a referral centre in Northern Taiwan: review of the causative organisms, antibiotic susceptibility, and clinical features

We read with interest the study by J-H Cheng *et al*[1] describing the bacterial isolates and treatment outcomes of endophthalmitis after cataract surgery at a referral centre in Northern Taiwan. However, there are a few issues that we would like to discuss, especially regarding the information on presenting and final visual acuity (VA) specified to the causative organisms, and the choice of the intravitreal antibiotics.

As the authors state, the poorer visual outcome in their study (only 7 (11.9%) of the 59 patients had a final VA of $>20/40$) may indeed be partly explained by the high percentage of more virulent organisms. Unfortunately, detailed information on both the presenting VA and the final VA for all types of bacterial cultures is not provided, except for the information that 1 (7.7%) out of the 13 patients with a bacterial culture of *Pseudomonas aeruginosa* achieved a final VA better than 5/200.

The presenting VA and final VA for the 8 patients with a culture of *Staphylococcus aureus* and the 25 patients with a negative bacterial culture would be of special interest, as the quantities of these groups make them major determinants in the overall final VA. In literature, the percentage of patients achieving a final VA $>20/40$ range from 20.0 to 45.0% for *S. aureus* and from 55.3 to 58.3% for a negative bacterial culture.[2–4] As known from previous studies, presenting VA is a major determinant in final treatment outcome.[2,5] Details on presenting VA and final VA, especially for *S. aureus* cultures and negative bacterial cultures, may therefore provide essential information on the poor overall outcome in their study and would improve the ability to compare their data with previous studies.

Regarding optimal antibiotic treatment, the authors correctly emphasize the importance of geographical variations as well as the need for periodic susceptibility testing to anticipate (changes in) the microbiological spectrum and antibiotic sensitivities. Surprisingly however, they state that the use of vancomycin and amikacin still provides good coverage for pathogens after cataract surgery in their region, despite the fact that their own data do not support this statement. Their reported susceptibility to amikacin was 89.5% for Gram-negative isolates and 90.9% for Gram-positive isolates, compared with 94.7 and 100% susceptibility to ceftazidime. Using ceftazidime instead of amikacin may positively influence the future treatment outcome in acute postoperative bacterial endophthalmitis after cataract surgery for the population in Northern Taiwan.

Conflict of interest

The authors declare no conflict of interest.

References

1 Cheng J-H, Chang Y-H, Chen C-L, Chen Y-H, Lu D-W, Chen J-T. Acute endophthalmitis after cataract surgery at a referral centre in Northern Taiwan: review of the causative organisms, antibiotic susceptibility, and clinical features. *Eye* 2010; **24**: 1359–1365.
2 Pijl BJ, Theelen T, Tilanus MA, Rentenaar R, Crama N. Acute endophthalmitis after cataract surgery: 250 consecutive cases treated at a tertiary referral center in the Netherlands. *Am J Ophthalmol* 2010; **149**: 482–487.
3 Endophthalmitis Vitrectomy Study Group. Microbiologic factors and visual outcome in the endophthalmitis vitrectomy study. *Am J Ophthalmol* 1996; **122**: 830–846.
4 Lalwani GA, Flynn Jr HW, Scott IU, Quinn CM, Berrocal AM, Davis JL *et al*. Acute-onset endophthalmitis after clear corneal cataract surgery (1996–2005). Clinical features, causative organisms, and visual acuity outcomes. *Ophthalmology* 2008; **115**: 473–476.
5 Endophthalmitis Vitrectomy Study Group. Results of the Endophthalmitis Vitrectomy Study: a randomized trial of immediate vitrectomy and of intravenous antibiotics for the treatment of postoperative bacterial endophthalmitis. *Arch Ophthalmol* 1995; **113**: 1479–1496.

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Sir,

Response to Pijl and Crama

We thank Drs Benjamin Pijl and Niels Crama[1] for their instructive comments regarding our article.[2] Benjamin Pijl and Niels Crama highlighted the following introductory statement: 'The information of presenting and final visual acuity (VA) specified to the causative organisms and the choice of the intravitreal antibiotics.'

The aim of our paper was to show the spectrum of bacterial isolates that caused endophthalmitis after