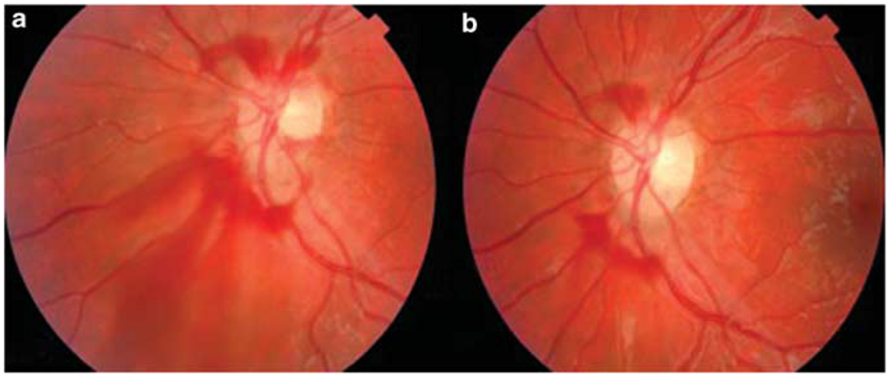

Figure 1 (a) Left fundus. Optic nerve swelling with peri-papillary haemorrhages. (b) Left fundus. Resolution of optic nerve swelling and reabsorbing haemorrhages.

were all normal, whereas PCR for HSV1 and 2, EBV, and CMV were all negative. LP was normal with an opening pressure of 14 mm Hg. An MR scan showed a number of peri-ventricular high-signal lesions. He was diagnosed with ADEM and optic neuritis, and treated with two doses of intravenous methyl-prednisolone followed by a reducing dose of oral prednisolone. He has made a good recovery with improved vision to 6/6 in his left eye, resolution of optic nerve swelling, and reabsorbing peri-papillary haemorrhages (Figure 1b). His right eye remains quiescent and there have been no further neurological or ophthalmic episodes.

Comment

To the best of our knowledge, this is the first report of ADEM with peri-papillary haemorrhages. This observation raises the question as to the underlying aetiology and although an autoimmune mechanism with HLA-DR linkage is likely, other forces may have a role to perform.[4,5] Further work is required to ascertain the possibility of a vasculitic element to the underlying processes.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Shield or not to shield? Postoperative protection after modern cataract surgery

The evolution of cataract surgery continues. Surgery has progressed rapidly from ICCE to sub-3-mm sutureless phacoemulsification. In 1996, 66% of anaesthetic was peribulbar, but modern surgery requires only subtenon (47%) or topical ± intracameral (27%) administration.[1] All these advances are backed by evidence. However, there is a relative paucity of data supporting postoperative ocular protection. Some surgeons routinely employ an eye shield for up to 6 weeks, whereas others completely avoid any ocular protection. Current practice is varied predominantly based on historical and anecdotal evidence. Shield users cite valid arguments. They confer confidence to both patient and surgeon by providing a physical barrier to recently operated eyes and protect from errant fingers. However, the routine use of shields was questioned 20 years ago,[2] yet there remains no definitive answer to whether they are still necessary for modern micro-incisional surgery?

A study of 133 patients following topical cataract surgery found that ocular protection confers no safety benefit but elicits higher rates of patient discomfort with 53% of patients feeling it was unnecessary.[3]

We retrospectively analysed electronically all cataract procedures between 1 April 2010 and 31 March 2011

Table 1 Comparing shield and shield-less cohorts

	Shieldless		*Shield*		P-*value*
Mean age (years)	72.8	±7.7	73.4	±7.2	
Total patients	425	30.2%	982	69.8%	
Scleral tunnel	298	70.1%	668	68.0%	
Clear corneal	127	29.9%	314	32.0%	
Uveitis	6	1.4%	19	1.9%	0.661
Corneal oedema	5	1.2%	9	0.9%	0.770
IOP >21 mm Hg	5	1.2%	8	0.8%	0.548
Iris prolapse	1	0.2%	1	0.1%	0.513
Endophthalmitis	0	0.0%	1	0.1%	1.000
Macular oedema	3	0.7%	15	1.5%	0.302

Abbreviation: IOP, intraocular pressure.

($n=1407$). One surgeon used no shields throughout this period (regardless of patient factors; $n=425$). All other cases ($n=982$) wore a Cartella shield overnight for three weeks. Both groups contained similar demographics and wound construction (Table 1). The shield-less regime conferred no safety disadvantage. All adverse events had nonsignificant *P*-values with Fisher's exact test (Table 1).

A total of 46 patients responded by anonymous questionnaire; 59% stating shields were 'uncomfortable' and 43% would have 'preferred to not wear' one. Comments included 'If it helps I will wear it' and 'I assume I was given it for a reason'. With the recent advances in wound construction, surgical outcomes and complication rates is the routine use of shields without evidence still necessary in 2011?

Conflict of interest
The authors declare no conflict of interest.

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Sir,

Response to: Idiopathic uveal effusion syndrome causing unilateral acute angle closure in a pseudophakic patient

We read with interest the case report of presumed idiopathic uveal effusion syndrome (IUES) associated with unilateral acute angle closure (AAC) in a pseudophakic patient.[1]

The authors propose that the case occurred in the absence of pupil block, however, the anterior segment OCT image presented shows iris convexity implying pupil block. We note that no posterior synechiae were seen clinically, however, the B-scan ultrasound images suggest adhesions between the posterior iris and the anterior capsule, consistent with seclusio pupillae. Pseudophakic pupil block with synechiae not visible at the pupillary margin can occur.[2] Furthermore, the case resolved with pupil dilation and medical intraocular pressure control supporting a pseudophakic pupil block mechanism.

The association of uveal effusion with AAC is well recognized and has been reported to occur in up to 58% cases of acute primary angle closure.[3] As stated by the authors, IUES is a diagnosis of exclusion; and is typically associated with serous retinal detachment.[4] No serous retinal detachment is seen in the case presented.

Their case is certainly unusual with respect to the fact that AAC occurred with an IOL placed in the capsular bag with presumed correct orientation. We would suggest the authors consider prophylactic peripheral laser iridotomy in their case to reduce the risk of a repeat AAC episode.

Conflict of interest
The authors declare no conflict of interest.

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Sir,

Response to Day and Foster

We value the interest Day and Foster[1] have expressed in our case.[2] The reported cases of seclusio pupillae in