pupillae, homocystinuria, Weill–Marchesani syndrome, sulfite oxidase deficiency, and hyperlysinemia. In addition to the investigations included in our report, she reported no family history of Marfan syndrome, nor of any other family members with her condition, including her two school-aged children. In addition, no clinical evidence of pseudoexfoliation, retinitis pigmentosa, buphthalmos, megalocornea, chronic uveitis (other than that associated with her condition), or ocular syphilis, nor aniridia was seen.

To our regret, we did not perform any genetic studies, and our patient may have separate mutations resulting in both SWS and isolated ectopia lentis. Indeed, that is likely, given the paucity of reports associating ectopia lentis and SWS. However, reports of unilateral isolated ectopia lentis are similarly rare;[4] this entity is usually familial and bilateral, at least those due to known genetic mutations.[5] We welcome further research into the pathogenetic mechanisms of ectopia lentis.

Conflict of interest
The authors declare no conflict of interest.

References

1 Chandra A, Aragon Martin JA, Child AH, Arno G, Charteris DG. Alternative diagnoses with ectopia lentis. *Eye* 2012; **26**: 481.
2 Moore DB, Reck SD, Chen PP. Angle closure glaucoma associated with ectopia lentis in a patient with Sturge-Weber Syndrome. *Eye* 2011; **25**: 1235–1236.
3 Cameron DJ, Streeten BW. Pathology of the lens. In: Albert DM, Miller JW, Azar DT, Blodi BA (eds). *Principles and Practice of Ophthalmology*, 3rd edn. Elsevier: New York, 2008.
4 Simon JW, Cotliar JM, Burke LW. Familial unilateral ectopia lentis. *JAAPOS* 2007; **11**: 620–621.
5 Yu R, Lai Z, Zhou W, Ti DD, Zhang XN. Recurrent FBN1 mutation (R62C) in a Chinese family with isolated ectopia lentis. *Am J Ophthalmol* 2006; **141**: 1136–1138.

DB Moore and PP Chen

Department of Ophthalmology, University of Washington, Seattle, WA, USA
E-mail: pchen@uw.edu

Eye (2012) **26,** 481–482; doi:10.1038/eye.2011.307; published online 2 December 2011

Sir,
Endophthalmitis following vitrectomy

We read with interest the article by Patel and Rahman,[1] whose study involved an online survey aimed at members of the Britain & Eire Association of Vitreoretinal Surgeons (BEAVRS) to disclose their experience with endophthalmitis following smaller gauge vitrectomy surgery. Two cases of endophthalmitis following 4944 transconjunctival 23G vitrectomy operations were noted, providing an estimate for the incidence of 1 in 2472.

As the authors highlight, this remains an estimate due to the low response rate (31%) and lack of documentary evidence. However, it is reassuring that this study has not revealed a dangerously high rate for this severe complication as sutureless vitrectomy has now become the mainstay in an increasing number of vitreo-retinal centers.

Previous studies have differed greatly with respect to the estimated incidence of endophthalmitis following sutureless vitrectomy—exemplified by the study at Wills Eye Hospital[2] finding the rate to be more than 12 times higher than that following sutured vitrectomy and contrasting with another American collaborative study[3] that recently found no increased rate of endophthalmitis following sutureless surgery. These studies are limited by their retrospective nature and coverage of a relatively small catchment area.

In order to establish a more reliable incidence for endophthalmitis following vitrectomy in the United Kingdom, we have currently completed 15 months of prospective, national surveillance (in association with the British Ophthalmic Surveillance Unit, BOSU), and received 18 reports of endophthalmitis following vitrectomy—14 of which meet our case definition. Given that data from the Hospital Episode Statistics disclose that ~20 000 pars plana vitrectomies are performed each year, this provides an approximate incidence of 1 in 1800 before adjusting for underreporting (yet to be established with the use of validation centers). This framework that BOSU helps to provide is well suited to rare complications providing prospective surveillance across a large geographical area. National surveillance for this complication terminates in May 2012 and we urge all UK ophthalmologists to report cases to us via BOSU or directly to jonathanpark@nhs.net in order to investigate this disastrous complication thoroughly.

Conflict of interest
The authors declare no conflict of interest.

References

1 Patel KC, Rahman R. Incidence of post-operative endophthalmitis following 23-gauge transconjunctival sutureless vitrectomy in the United Kingdom: a survey. *Eye* 2011; **25**: 956.
2 Kunimoto DY, Kaiser RS. Incidence of endophthalmitis after 20- and 25- gauge vitrectomy. *Ophthalmology* 2007; **114**: 2133–2137.
3 Scott IU, Flynn Jr HW, Acar N, Dev S, Shaikh S, Mittra RA *et al*. Incidence of endophthalmitis after 20-gauge vs 23-gauge vs 25-gauge pars plana vitrectomy. *Graefes Arch Clin Exp Ophthalmol* 2011; **249**: 377–380.

JC Park[1], B Ramasamy[2], RH Ling[1] and S Prasad[2]

[1]West of England Eye Unit, Royal Devon & Exeter NHS Foundation Trust, Exeter, UK
[2]Wirral University Teaching Hospital NHS Foundation Trust, Wirral, UK
E-mail: jonpark777@gmail.com

Eye (2012) **26,** 482; doi:10.1038/eye.2011.329; published online 16 December 2011