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Sir,
***Streptococcus pneumoniae* meningitis following
postoperative endophthalmitis**

Postoperative bacterial endophthalmitis is usually
confined to the eye. Metastatic spread to the meninges is
very rare and could have a devastating outcome.

Case report

An 87-year-old man presented with one day history of
severe pain and reduced vision in his left eye 3 days
following uneventful cataract surgery under topical
anaesthesia. He previously had successful right cataract
surgery and bilateral ptosis correction. His medical
history included Hypertension and Aortic Valve
replacement.

His visual acuity was 6/60 in the affected eye.
Examination revealed corneal epithelial and stromal
oedema, +3 cells in the anterior chamber and raised
intraocular pressure (45 mm Hg). A red reflex was
present but no fundus details were visible.

Intravitreal injections of Tetracycline (1 mg) and
Ciprofloxacin (0.2 mg) were administered. Oral
Ciprofloxacin and topical Tetracycline, Ciprofloxacin,
Dexamethasone, Ketorolac, and Atropine were commenced.

The AC tap and vitreous tap grew *Streptococcus
pneumoniae*, which was sensitive to Chloramphenicol but
resistant to Ciprofloxacin. Hence topical Ciprofloxacin
was substituted by Chloramphenicol.

Two days later, he developed tonic-clonic seizures and
reduced GCS (10/15). An urgent CT of Head did not
reveal any intracranial haemorrhage. His bloods showed
WBC 26.5, Neutrophils 24.4, and CRP 168. A lumbar
puncture showed RBCs $1600 \times 10^6/l$, WBCs $2500 \times 10^6/l$
(Neutrophils 95%, Lymphocytes 5%); pneumococcus was
positive on PCR.

He was diagnosed with pneumococcal meningitis.
Intravenous Ceftriaxone 2 gm BD given for 2 weeks
resulted in resolution of meningitis. His final visual
acuity dropped to 3/60.

Comment

Postoperative endophthalmitis is a dreaded complication
of cataract surgery. Prompt diagnosis and treatment with
intravitreal and intensive topical antibiotics is required to
salvage vision.¹ Systemic antibiotics may have a role in

prevention of systemic spread of infection. Systemic
spread to involve meninges has been reported² once but
is extremely rare.

Our patient developed meningitis despite receiving
oral Ciprofloxacin because the offending organism was
resistant to this drug. He was successfully treated under
guidance of microbiology results.

Patients with endophthalmitis should be observed
closely for signs or symptoms of metastatic spread.
Although postoperative bacterial endophthalmitis is
typically confined to the eye, this case report indicates
that the infection can spread to the central nervous
system. The treatment of endophthalmitis (including
systemic antibiotics) should be guided by microbiology
to ensure that the antibiotics administered are effective.

Conflict of interest

The authors declare no conflict of interest.

References

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Sir,
**Longitudinal sectioning of temporal artery biopsy
specimens**

Despite increasing interest in the use of various imaging
modalities such as ultrasound, magnetic resonance
imaging, and positron-emission tomography, temporal
artery biopsy remains the gold standard in the diagnosis
of giant cell arteritis (GCA).¹ Given that GCA can lead
to profound irreversible blindness and other devastating
complications, every effort must be made to ensure
a correct diagnosis is made in each and every case.

Case report

We report a case of an 88-year-old patient referred
with suspected GCA. A temporal artery biopsy was
performed. Macroscopically, the specimen had a
segmented, earthworm-like appearance. The 22-mm-long
specimen was processed *in toto* and sectioned in the
longitudinal plane at six levels, ~120 μ m apart. This
demonstrated patchy focal inflammation, predominantly
in the outer media, with 'skip areas' of 3–5 mm of
uninflamed artery (Figure 1). The inflammatory infiltrate
consisted predominantly of mixed mononuclear