As suggested by some authors,[5] the electromyography of all patients was assessed preoperatively for confirmation of absence of anomalous lateral rectus innervation. No patients had anomalous lateral rectus innervation.

Figure 2A shows preoperative and postoperative photographs of a case with left type 1 Duane syndrome. For this patient, the preoperative MRD was 9.0 mm and the postoperative MRD was 9.5 mm. We did not determine an increase in globe retraction on adduction for the left eye.

Some authors reported that vertical rectus transposition surgery in cases of Duane's retraction syndrome may worsen globe retraction or up- or downshoots.[6,7] However, other studies have determined that globe retraction or up- or downshooting did not worsen.[8,9] We did not notice any worsening of retraction or shoots in our patients on follow-up.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Enterococcus casseliflavus endophthalmitis due to metallic intraocular foreign body

Enterococccus casseliflavus infection has been rarely implicated in ophthalmic infections. We report a case of *E. casseliflavus* exogenous endophthalmitis due to a metallic intraocular foreign body (IOFB).

Case report

A healthy 54-year-old male presented with a 3-day history of left eye pain and blurred vision after a metal chip entered his left eye during hammering. As the accident occurred overseas, there was a 3-day interval from injury to presentation.

Visual acuity of the left eye was hand movement with a left grade 4 reverse relative afferent pupillary defect. Slit lamp examination findings are shown in Figure 1. Computed tomography of orbits confirmed a 3×6 mm metallic IOFB impacted in the retina inferiorly.

He underwent left corneoscleral laceration repair, phacoemulsification (with no intraocular lens implanted), 20G vitrectomy, IOFB removal through the corneal incision with the aid of an intraocular magnet, intravitreal vancomycin (1 mg/0.1 ml) and ceftazidime (2.25 mg/0.1 ml), and silicone oil injection. Postoperatively, topical cefazolin, gentamicin, and atropine were commenced. Vitreous culture grew

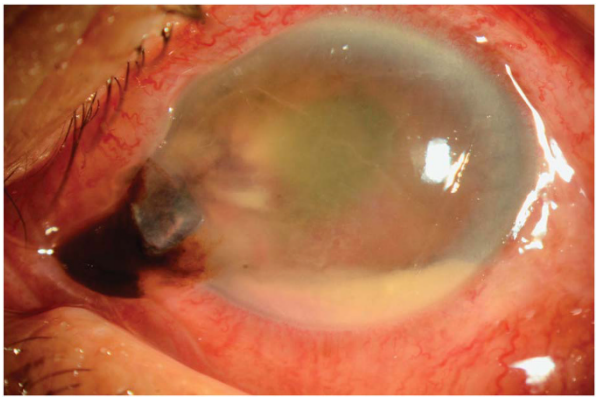

Figure 1 Slit lamp examination of the left eye showed conjunctival chemosis, corneal oedema, and an inferonasal corneoscleral laceration with iris prolapse. The anterior chamber was shallow with a fibrinous reaction and a 1.6-mm hypopyon.

E. casseliflavus susceptible to penicillin (demonstrable synergism with aminoglycoside) and linezolid but resistant to vancomycin. He completed 6 weeks of systemic antibiotics therapy, which consisted of 19 days of intravenous amoxicillin, linezolid, and gentamicin, followed by oral amoxicillin. At postoperative month 2, visual acuity in his left eye improved to 6/90.

Comment

E. casseliflavus is commonly found in the gastrointestinal tract of livestock.[1] Although it has been implicated in a variety of human infections, we found no previous report of *E. casseliflavus* endophthalmitis due to IOFB. Two cases of *E. casseliflavus* endophthalmitis have been reported: an endogenous endophthalmitis due to enterococcal bacteraemia[2] and an endophthalmitis associated with a horse tail injury; however, no entry site was found.[3] In exogenous endophthalmitis, the success of treatment is dependent on adequate vitreous clearance during vitrectomy and appropriate antibiotic therapy postoperatively. Cephalosporins and quinolones have good eye penetration but are ineffective against *E. casseliflavus*. Vancomycin and high-dose penicillins may penetrate the eye during active inflammation, but the concentration achievable is not previously studied. The *E. casseliflavus* in our patient showed low-level vancomycin resistance, but remained susceptible to penicillins.[4] Previous reports of *E. casseliflavus* endophthalmitis were treated with vitrectomy with intravitreal vancomycin and ceftazidime[2,3] and topical gentamicin.[2] Our patient had a reasonably good outcome with the postoperative use of appropriate triple systemic antibiotics. We added linezolid as it has satisfactory eye penetration.[5] Early diagnosis, prompt surgical intervention, and sensitivity-guided systemic antibiotics can result in an improved visual outcome in this otherwise devastating condition.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

The absence of focal choroidal excavation in children and adolescents without retinal or choroidal disorders or ocular trauma

Focal choroidal excavation (FCE), is an unusual excavation of the choroid that has been observed on optical coherence tomography (OCT) image.[1–5] Although FCE was previously thought to have a congenital etiology,[2] recent evidence suggests that some cases of FCE are acquired.[5] To address whether the origin of FCE is congenital or acquired, investigating the presence of FCE in children is necessary because the choroid in children is relatively free from latent pathology that may contribute to the development of acquired FCE. The purpose of the present study was to identify the presence or absence of FCE in children, adolescents, and young adults.

This retrospective study included 1697 eyes from 858 subjects <40 years of age who visited the pediatric ophthalmology or neuro-ophthalmology clinic. To identify FCE, horizontal and vertical spectral domain OCT crosshair scan images centered at the center of the fovea were reviewed. All individual images consisting of a macular volume scan was additionally reviewed.

The mean age was 15.1 ± 11.2 years (range, 3–39 years). A FCE was identified in three eyes (0.18%) of three subjects (0.35%). The first subject (Figure 1a, a 19-year-old male) had a history of unilateral chorioretinitis of unknown origin 10 years before OCT examination. The second subject (Figure 1b, a 26-year-old female) had no history of any intraocular disorder. The third subject (Figure 1c, a 38-year-old male) had a history of blunt ocular trauma 2 years before OCT examination.

The major limitation of the present study was that this study was performed with patients visited pediatric ophthalmology and neuro-ophthalmology clinic. Thus, our patients may not accurately represent the general population.

In conclusion, the extremely low prevalence of FCE in this cohort in which the majority of subjects were free from retinal or choroidal disorder, along with the absence of FCE in children and adolescents may suggests that the congenital type of FCE is rare and the majority of FCEs found in adults are likely to be acquired type. A population-based study of young subjects warrants further investigation.