



Figure 2 Left. Axial orbital computerized tomography (CT) scan showing bilateral proptosis due to an increased orbital fat volume. Right. Coronal CT scan also shows an (old) fracture of the right orbital floor.

Hashimoto's disease. As the classical FES occurs in obese, middle-aged men, it is surprising that spontaneous globe luxation is not encountered more frequently.

While bilateral proptosis due to an increase of orbital fat without extraocular muscle enlargement may be features of thyroid-associated orbitopathy (TAO), there was no orbital inflammation or other characteristic signs and symptoms suggestive of this disorder.

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Sir, Precautions in ophthalmic practice in a hospital with a major acute SARS outbreak: an experience from Hong Kong

Chan *et al*¹ report their experience in ophthalmic practice during an outbreak of SARS. First of all I would like to point out the authors' wrong affirmation on two issues. Firstly, their hospital was not the only one in Hong Kong, not to say in the world, that had gone through the largest outbreak of SARS. Our hospital, which has an Ophthalmology Department, admitted more than 100 suspect and probable SARS cases during the outbreak in 2003. Secondly, they claimed that ophthalmologists in Hong Kong had abandoned direct ophthalmoscopy. I wonder if they have ever taken a survey to make such a comment. Many ophthalmologists in Hong Kong have been and are still using direct ophthalmoscope.

The authors seem to share their experience in ophthalmic patients' management during the outbreak of SARS in Hong Kong. However, their suggestion on the management of clinical admission was in contrary to the public hospital management policy at the time of SARS outbreak. All clinical admissions were cancelled in the midst of SARS as part of the infection control measures and for the purpose of saving beds for the SARS cases. In their flow chart (Figure 1),¹ they admit emergency eye patients to an infection triage ward for physicians'

assessment but for clinical admission, patients are only screened by a resident with clinical history taking only. I do not see why there should be a difference and why emergency cases cannot be screened by residents before admission to the appropriate ward. For a suspected case in the out-patient clinic, the authors advocated attending the patient in the last time slot. It is very unusual to leave the suspected case in the crowded clinic for an unnecessary long period of time to increase the risk of cross-infection. The usual practice is to see the patient in a special room as early as possible and to discharge the patient to the appropriate destination.

The authors placed too much emphasis on the personal protective equipment (PPE). Although PPE plays an important role in the prevention of infection, the authors only mentioned lightly and failed to highlight the importance of the proper technique in donning and sequential removal of the PPE in areas designed for such purposes. There is a high risk of being infected during removal of the PPE especially when they have been contaminated with the SARS coronavirus. It is therefore extremely important for the hospital to provide, besides adequate stock of PPE, proper and adequate areas for putting on and removal of PPE, training courses and regular refresher courses for the technique, as well as audit on the practice of the proper technique.

It is interesting to know what PPE was used by the authors in their wound revision operation on the suspected SARS case. The use of enhanced PPE including positive air-powered respirator is advised when operating on a suspected SARS case.² Although not impossible, it is certainly painstaking to use the operating microscope and the indirect ophthalmoscope after wearing the respirator and its helmet.

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Sir,
Precautions in ophthalmic practice in a hospital with a major acute SARS outbreak: an experience from Hong Kong

We would like to thank Dr Lai for the invaluable comments. Some of the issues raised are interesting and we will take this opportunity to make further clarifications.

In our article, we said ‘...Being the Ophthalmology Department of the only hospital in the world that has just gone through the largest outbreak of SARS, we would like to share our strategy, measures and experience of preventing SARS infection’. This statement was based upon scientific evidence available at the early stage of SARS outbreak in 2003. Subsequent careful epidemiological and infection control study had shown that the principle index case responsible for SARS outbreak in Hong Kong community came from Prince of Wales Hospital. Moreover, Prince of Wales Hospital, Hong Kong was vetted to be the only hospital with the largest number of SARS cases under intensive care during *early outbreak*.^{1,2} SARS is a highly infectious disease. It is not surprising that once there is a community outbreak, all the regional hospitals of the territory will have to tackle the multiplying suspect/probable cases. United Christian Hospital did admit a number of suspect and probable SARS cases, but significant number of them represented mutant strains during the second wave of ‘super-spreading’ infection.²

Concerning the issue about direct ophthalmoscope, we were referring to the special and temporary infection control measure during the SARS outbreak in substituting direct ophthalmoscope by other safer examination techniques such as binocular indirect ophthalmoscope or fundus photography (‘In real life, the ophthalmic practices in the midst of the SARS outbreak have been changed. The ophthalmologists in Hong Kong have abandoned the direct ophthalmoscopic examination in view of its short working distance. In ultrahigh risk patients proven to have SARS, safer and easily accessible investigative tools...’).³ It is conceivable that continuous usage of direct ophthalmoscope will constitute an imminent threat for SARS infection via droplets spread.³