References

1 Karia N, Laidlaw A, West J, Ezra E, Gregor MZ. Macular hole surgery using silicone oil tamponade. *Br J Ophthalmol* 2001; **85**(11): 1320–1323.
2 Kumar V, Banerjee S, Loo AV, Callear AB, Benson MT. Macular hole surgery with silicone oil. *Eye* 2002; **16**(2): 121–125.
3 Michael H, Goldbaum MD, Brooks W, McCuen II MD, Hanneken MD, Stuart K *et al*. Silicone oil tamponade to seal macular holes without position restrictions.*Ophthalmology* 1998; **105**: 2140–2148.
4 Freeman WR, Azen SP, Kim JW, Kim JW. Vitrectomy for the treatment of full thickness stage 3 or 4 macular holes. Results of a multicentered randomized clinical trial. The Vitrectomy for treatment of Macular hole treatment study group. *Arch Ophthalmol* 1997; **115**: 11–21.
5 Tornambe PE, Poliner LS, Grote K. Macular hole surgery without face-down positioning. *Retina* 1997; **17**(3): 179–185. [Comment in: *Retina* 1998; **18**(1): 84-86; discussion 86–88. A pilot study].
6 Simcock PR, Scalia S. Phacovitrectomy without prone posture for full thickness macular holes. *Br J Ophthalmol* 2001; **85**(11): 1316S–1319S.
7 Thompson JT, Smiddy WE, Glaser BM, Flynn HW Jr, Hanhan A, Murphy RP. Intraocular tamponade duration and success of macular hole surgery. *Retina* 1996; **16**: 373–382.
8 Madreperla SA, Geiger GL, Funata M, de la Cruz Z, Green WR. Clinicopathologic correlation of a macular hole treated by cortical vitreous peeling and tamponade. *Ophthalmology* 1994; **101**: 682–686.

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Sir,

Metastatic endogenous endophthalmitis secondary to *Staphylococcus aureus* iliopsoas abscess

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Endophthalmitis after haematogenous spread or septicaemia accounts for 10% of all cases of endophthalmitis.[1] Among the well-recognized causative microorganisms, *Staphylococcus aureus* is a common pathogen,[1–4] often resulting in bilateral endophthalmitis.[1,2,5] We present an unusual case of metastatic endogenous endophthalmitis secondary to *S. aureus* iliopsoas abscess.

Case report

A 45-year-old man presented with a 1-week history of a red, painful left eye with gradual reduction of vision. Left visual acuity was 6/36 and examination revealed a large subretinal mass in the superior periphery with surrounding exudative retinal detachment and vitreous and anterior chamber cells.

Previous ophthalmic history was unremarkable. Previous medical history included alcoholism, splenectomy without subsequent antibiotic coverage, partial pancreatectomy 15 years ago with subsequent insulin-dependent diabetes mellitus (poorly controlled), angina, and a 6-month history of anorexia, weight loss, and severe right loin pain requiring oral morphine for pain relief.

Medical examination revealed tenderness and fullness at the right renal angle, significantly accentuated by palpation of the right iliac fossa and by passive right hip extension. His temperature chart showed a low-grade remittent fever.

Laboratory investigation showed neutrophilic leucocytosis (WBC 18.3×10^9 cells/l, neutrophils 14.6×10^9 cells/l), raised ESR (120 mm/h) and CRP (145 mg/l), and high blood glucose and HbA1c.

After obtaining blood and urine cultures, he was started on intravenous meropenem 2 g q.i.d. A vitreous biopsy was performed and intravitreal vancomycin 1 mg and ceftazidime 2 mg were given. An abdominal ultrasound and a CT scan (Figure 1) confirmed the presence of an iliopsoas abscess. Pus (500 ml) was drained percutaneously and its culture grew a fully sensitive *S. aureus*. His treatment was subsequently modified to oral rifampicin 600 mg b.d. and clindamycin 450 mg q.i.d. Vitreous, blood, and urine cultures were negative. His iliopsoas abscess source was not identified.

After 1 week, the patient was afebrile, his backache had improved, and the left eye was comfortable with visual acuity 6/36. A repeat CT scan at 2 weeks showed that the iliopsoas abscess had collapsed, while left visual acuity was 6/12, anterior chamber and vitreous were quiet, and the subretinal infiltrate and the exudative retinal detachment had resolved. The same oral antibiotic

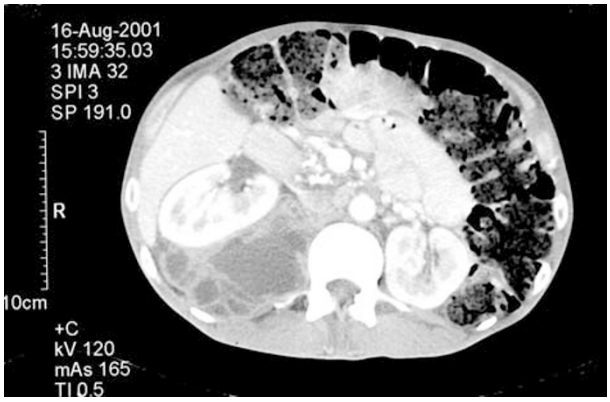

Figure 1 CT scan showing right large iliopsoas abscess, with anterior displacement of the right kidney.

regime was continued for 3 months. After 9 months, his left visual acuity was recorded as 6/24.

Comment

In two recent systematic reviews of endogenous endophthalmitis, two-thirds of patients had predisposing factors or underlying illnesses, including diabetes mellitus, valvular heart disease, recent abdominal surgery, intravenous drug abuse, renal failure, malignancy, asplenia, indwelling catheters, burns, and immunocompromised states.[1,3] Diabetes mellitus is one of the commonest concurrent medical conditions, being present in 40% of cases.[1,2]

In the West, the commonest source of endogenous endophthalmitis was found to be endocarditis.[2,4] Other common reported sources include pulmonary and urinary tract infections, skin and wound sepsis, meningitis, septic arthritis, and intra-abdominal sepsis.[1–4] Hepatobiliary tract infection is a particularly common source in the East Asian population.[1]

Endogenous endophthalmitis associated with iliopsoas abscess has not, to the best of our knowledge, been described previously. Iliopsoas abscess, in the absence of pancreatitis, is uncommon.[6] Patients usually present with fever, hip or abdominal pain and WBC, ESR and serum urea nitrogen level elevation, while blood cultures are positive in 71%.[7] This potentially life-threatening condition is usually associated with gastrointestinal, renal, or spinal disease.[6] CT is the imaging study of choice.[6,7] In many cases, the source of this infection is not identifiable.[6–8] The predominant bacterial isolate from patients with primary iliopsoas abscesses is *S. aureus* (75–90% of cases).[6,7]

Reported positive vitreous cultures from cases of endogenous bacterial endophthalmitis vary between 36%[1] and 74%.[2] Early recognition and prompt and intense intravenous antibiotic therapy with broad-spectrum antibiotics at the maximum recommended dose are the keys to successful treatment.[3,4] Intravitreal antibiotics are also crucial in the management of severe bacterial endogenous endophthalmitis, while surgical intervention may be beneficial in selected cases.[4] Only 30% of the eyes achieve final visual acuity of counting fingers or better and 17% are enucleated.[1,3] Better final visual outcomes were reported when the disease was 'focal' on presentation: either a discreet uveal, subretinal or retinal infiltrate (such as in our case) or confined to the anterior segment.[3,4]

This case illustrates that iliopsoas abscess should be considered as a potential infectious source in the case of endogenous endophthalmitis. It may run a chronic course with insidious symptoms and is a potentially life-threatening entity, its diagnosis being therefore very important. Antibiotic coverage against *S. aureus* is mandatory when this condition is suspected.

References

1 Wong JS, Chan TK, Lee HM, Chee SP. Endogenous bacterial endophthalmitis: an east Asian experience and a reappraisal of a severe ocular affliction. *Ophthalmology* 2000; **107**(8): 1483–1491.
2 Okada AA, Johnson RP, Liles WC, D'Amico DJ, Baker AS. Endogenous bacterial endophthalmitis. Report of a ten-year retrospective study. *Ophthalmology* 1994; **101**(5): 832–838.
3 Greenwald MJ, Wohl LG, Sell CH. Metastatic bacterial endophthalmitis: a contemporary reappraisal. *Surv Ophthalmol* 1986; **31**(2): 81–101.
4 Chee SP, Jap A. Endogenous endophthalmitis. *Curr Opin Ophthalmol* 2001; **12**(6): 464–470.
5 O'Brien CJ, Kyle GM. Metastatic *Staphylococcus aureus* endophthalmitis: a case report. *Br J Ophthalmol* 1988; **72**(3): 189–191.
6 Paley M, Sidhu PS, Evans RA, Karani JB. Retroperitoneal collections—aetiology and radiological implications. *Clin Radiol* 1997; **52**(4): 290–294.
7 Santaella RO, Fishman EK, Lipsett PA. Primary *vs* secondary iliopsoas abscess. Presentation, microbiology, and treatment. *Arch Surg* 1995; **130**(12): 1309–1313.
8 Costen MTJ, Harrison A, Crick MPD. Bilateral reactive subretinal abscesses following *S. pyogenes* septicaemia. *Eye* 2001; **15**: 561–562.

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Sir,

Dermatochalasis: a potential pitfall in botulinum rejuvenation

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Since the first publication of the cosmetic use of botulinum toxins by Carruthers and Carruthers, the use of botulinum toxin has gained popularity as a safe and reversible method of achieving periorbital rejuvenation.[1] While ptosis and subcutaneous haematoma are recognised as complications other unwanted effects of treatment can occur.[2] This letter describes two cases