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Sir,
Minimising the risk of iatrogenic intraocular damage

Saha and Price report a case of severe intraocular damage due to a Rycroft cannula flying loose during cataract surgery,¹ and suggest that the routine use of luer-lock syringes will reduce the risk of this. Similar adverse events have been reported previously.² The most important measure that can preclude such unfortunate occurrences is to handle all syringes bimanually while undertaking any intraocular manoeuvres. One hand controls the barrel and the plunger, and the other hand firmly grasps the hub of the cannula or needle at its attachment to the syringe. The second hand can thus feel a cannula giving way, if this were to occur, and prevent it flying loose into the eye. I have also found that the bimanual grasp improves the control and manipulation of the tip.

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Sir,
Correlation of lipid layer thickness measurements with fluorescein tear film break-up and Schirmer's test

I read with interest the article by Isreb *et al.*,¹ where they have positively correlated the lipid layer thickness with fluorescein tear film break-up time (FBUT) and Schirmer's test (STA).

Meibomian gland dysfunction (MGD) is a fairly common condition, and the reported prevalence at one study was 38.9%.² It is easy to guess therefore that it is one of the major causes of dry eye syndrome. It is therefore quite a useful study, and I would like to convey my appreciation to all the authors.

Meibum (Meibomian gland secretion) contains hydrocarbons, sterol esters, wax esters, triglycerols, free cholesterols, free fatty acids, and polar lipids (in decreasing order of abundance). Meibum melts at 35°C and is thus liquid at the surface of the eye.³ This property of the lipid layer is utilized in the treatment of dry eyes using hot compresses.⁴

The normal lipid layer thickness is stated to be ideally more than 120 nm, however, will a thickness of less than 60 nm alone with normal FBUT and STA be sufficient for a diagnosis of dry eye.²

Tandem scanning confocal microscopy is another modality for the assessment of the tear film and is thought to be more accurate than the method used by the authors. It would be nice to know the authors' opinion on this.

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Sir,
Use of voriconazole in candida retinitis

Candida retinitis is a sight-threatening ocular infection that frequently occurs as a complication of candidemia. Voriconazole is a recently introduced broad-spectrum antifungal drug. To the best of our knowledge, its use in candida retinitis and candida endophthalmitis has not been reported before.

Case report

A 39-year-old 'terminally ill' woman with known systemic candidiasis secondary to central venous line infection was referred to the ophthalmic 'on call team'. She complained of bilateral simultaneous visual deterioration of 1-week duration. Her past medical history included hyperactive thyroid associated with paroxysmal atrial fibrillation. She had recently undergone major gastrointestinal surgery for extensive small bowel infarction and developed postoperative sepsis. Ocular examination included bedside visual acuity (VA), intraocular pressure measurement using Perkins tonometer, direct ophthalmoscopy, and indirect ophthalmoscopy. Slit-lamp examination was not possible. Her corrected VA was 5/60 in the right eye and 6/60 in the left eye. Anterior segment examination was unremarkable with absence of a relative afferent pupillary defect and normal intraocular pressures. Fundus examination of both eyes revealed multiple, creamy white retinal lesions at the posterior pole (Figures 1 and 2). The overlying vitreous appeared clear, although detailed slit-lamp evaluation was not possible. A diagnosis of bilateral candida retinitis was made. Candida had been cultured from her blood, urine and sputum samples; however, information on drug sensitivities was not available at the time of treatment. Over the next few days, both general and ocular condition deteriorated despite high doses of intravenous fluconazole (800 mg daily for 2 weeks), therefore it was decided to use oral Voriconazole (4 mg/kg bodyweight) instead.

After 2 days, the retinal lesions were seen to decrease in size. The patient was reviewed daily and 2 weeks later the lesions were significantly smaller in size. The same consultant ophthalmologist who had examined the

patient prior to treatment with voriconazole noted the post-treatment clinical improvement. Unfortunately, the patient demised due to cardio-respiratory arrest and further follow-up including photographic documentation of clinical improvement following use of voriconazole was not possible.

Comment

Candidiasis is an opportunistic infection of intravenous drug users and debilitated patients. Ocular candidiasis can result from either haematogenous spread or direct inoculation and is characterised by anterior and/or posterior segment inflammation. Candida retinitis is characterised by small, round, white slightly elevated lesions that enlarge and extend into the vitreous cavity-forming floating white colonies. Endophthalmitis

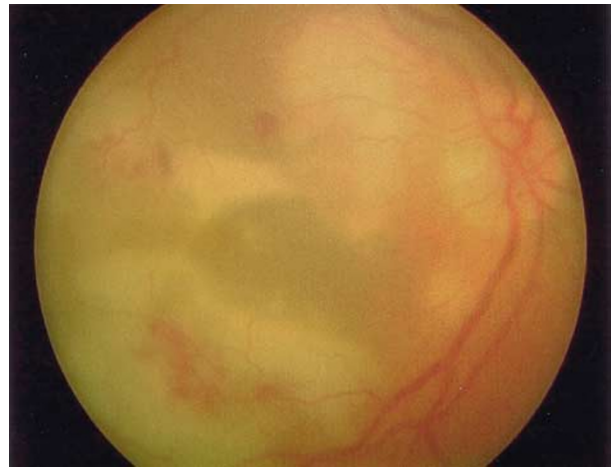


Figure 1 Right eye fundus photograph showing multiple areas of candida retinitis with associated haemorrhages at posterior pole.

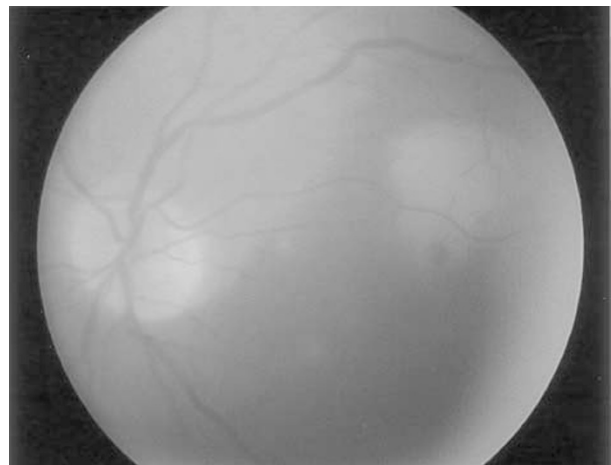


Figure 2 Left eye fundus photograph.