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Sir,

Reply to Z Youssef *et al*

We appreciate the interest shown by the authors Youssef *et al* in our article[1] titled 'Orbital cellulitis after peribulbar anaesthesia for cataract surgery'. They point out that the orbital cellulitis in our case could well be an allergic reaction to hyaluronidase used during peribulbar anaesthesia. They felt that sensitisation to hyaluronidase occurred as a consequence of peribulbar block to the fellow eye operated previously, resulting in a type 1 hypersensitivity reaction on peribulbar block to the second eye. This is a possibility; however, we note that all three cases reported by Youssef *et al* were apyrexial, there was lack of purulent discharge, and orbital cellulitis presented 1–2 days postoperatively after uncomplicated peribulbar anaesthesia. Their patients spontaneously resolved without antibiotic treatment. In our patient, symptoms and signs suggestive of infection were presence of purulent discharge from the affected eye and leucocytosis on blood testing. There was occurrence of trauma to periorbital soft tissues during the peribulbar block, which could possibly have resulted in access of skin flora to the orbit and cellulitis. The inflammation settled only after a course of broad-spectrum intravenous antibiotics.

We note that in the cases reported by Minning *et al*[2] and Taylor *et al*,[3] the allergic reaction occurred within minutes of the retrobulbar block, was associated with local pruritis and the oedema responded to intravenous administration of diphenhydramine hydrochloride. Kirby *et al*[4] have also reported allergic reaction following use of hyaluronidase. Their patient developed periorbital oedema and chemosis within minutes of administration of local anaesthetic. Systemic symptoms such as sweating, nausea, and hypertension were also seen. In our patient, the ocular examination was unremarkable on the first postoperative visit and periorbital oedema developed 2 days following injection of the local anaesthetic. There were no systemic or local signs suggestive of an allergic phenomenon in our patient. Hence, we feel that in our case the diagnosis was orbital cellulitis and not an allergic reaction to hyaluronidase.

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Sir,

A hypopyon is a sign of post-trabeculectomy endophthalmitis or not?

We read with interest the case reported by Tan *et al* in July 2003 issue of *Eye*. The author presented one of the first cases of late bleb-related endophthalmitis caused by group B Streptococcus.[1] As the authors emphasized, delayed-onset endophthalmitis usually occurs in the leaking bleb and most of the cases were caused by *Staphylococci* or *Streptococci*.[2,3] and fewer cases by fungus.[4] However, other forms of organisms occasionally causes hypopyon and mimic bacterial endophthalmitis. We present an atypical case of acute retinal necrosis syndrome (ARNS) mimicking bleb-related endophthalmitis after trabeculectomy.

A 76-year-old woman complained of a visual disturbance in her right eye for the previous 7 days. She had suffered from shingles around the right eye. She had experienced chronic recurrent iridocyclitis with secondary open-angle glaucoma for the last 10 years and had received trabeculectomy 3 years ago in the right eye.

Best-corrected visual acuity was light perception in the right eye. The right conjunctiva was severely injected.

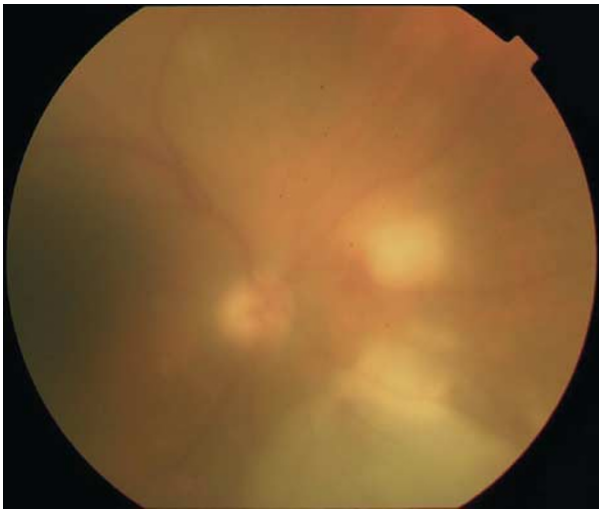

Figure 1 Fundus photograph of the right eye at 2 days after pars plana vitrectomy. Several exudative lesions with white vessels were observed at the nasal and inferior midperipheries of the fundus.

Marked cells and flare with angle hypopyon were present in the anterior chamber. A thin-walled bleb existed at the upper side of the conjunctiva. However, no opaque or leakage was seen in the bleb. The fundus was invisible because of extreme vitreous opacity.

A pars plana vitrectomy was conducted with a tentative diagnosis of bleb-related endophthalmitis. The retina was mostly intact and several exudative lesions with white vessels were observed at the nasal and inferior mid-peripheries of the fundus (Figure 1). Suspecting of a viral infection, vitreous humour was sampled. Whereas the culture examination resulted in no bacterial growth, varicella-zoster virus (VZV)-specific DNA was detected by polymerase chain reaction (PCR). The patient was diagnosed as ARNS caused by VZV.

Intravenous infusion of acyclovir of 750 mg/day and oral corticosteroid of 40 mg/day with topical corticosteroid were initiated. The white-exudative lesions gradually subsided and became necrotic degeneration. Visual acuity improved up to 160/200 in the right eye 2 months after vitrectomy.

To our knowledge, this is the first description of ARNS mimicking bleb-related endophthalmitis. We should be aware that viral infection could masquerade clinical features resembling a bacterial endophthalmitis.

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Sir,

Time taken to do external and endoscopic endonasal dacryocystorhinostomy (DCR) surgery

We read with interest the article by Malhotra *et al*[1] on 'A consideration of the time taken to do dacryocystorhinostomy (DCR) surgery'. In the article, they reported and compared the surgical time and success rates of external, endoscopic endonasal surgical