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Sir,

Primary retinal detachment surgery

Thank you for giving us the opportunity to comment upon the letter by Scott and colleagues on success rates following primary retinal detachment surgery. The authors' comment on aiming for 0% failure rate following primary surgery, although unachievable at this time, is something that we should aspire for. The goal should be set high as in the present day the vast majority of retinal detachment surgery is carried out in specialist vitreoretinal units. In addition to achieving anatomical success, functional results should also be considered. The referral service arrangements should be such that patients with macula-on detachment are dealt with on an urgent basis to reduce the risk of macula-on detachment becoming macula-off while awaiting transfer to the specialist unit. Such an arrangement presently exists in the North Trent region benefiting this group of patients.

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Sir,

Intravitreal triamcinolone acetonide in Eales' disease: a case report

Eales' disease is commonly seen in young individuals in Indian subcontinent. It manifests as retinal periphlebitis and in many instances progress to retinal ischaemia and neovascularization.[1] The clinical manifestation and management depends upon the stage of the disease. Corticosteroids are the mainstay of treatment in active periphlebitis stage.

We report about a patient of Eales' disease treated with intravitreal triamcinolone acetonide (IVTA) where oral corticosteriod was contraindicated because of co-existing peptic ulcer.

Case report

A 23-year-old man was seen at our institute with complaints of reduction of vision in the right eye since 1 month. On examination, the best-corrected visual acuity was 20/30, N6 in the right eye and 20/20, N6 in the left eye. The anterior segment examination was normal in both eyes and intraocular pressure was 14 mmHg in both eyes. The fundus examination of the right eye showed mild vitreous haze, hyperaemic disc, active periphlebitis, perivascular exudates, and intraretinal haemorrhages in the inferior and superonasal quadrants (Figure 1a). The left eye fundus was normal. Haematological investigations for complete blood count, erythrocyte sedimentation count, random blood sugar, serology for syphilis, ELISA for HIV, antinuclear antibody test, basic coagulation profiles were within normal limits. Mantoux test and chest X-ray were normal. The fundus fluorescein angiography (FFA) of the right eye showed staining of the vessels with late extravasation of the dye, areas of capillary nonperfusion in all quadrants, late staining of the disc and an area of neovascularization in the inferonasal quadrant (Figure 1b). The left eye angiogram was normal. Central macular thickness was 260 μm on optical coherence tomography (OCT). Oral corticosteroids were ruled out in the presence of peptic ulcer.

He received intravitreal triamcinolone injection of 4 mg in 0.1 ml in right eye under aseptic conditions. He was regularly followed up every month. At 3 months follow-up, the best-corrected visual acuity improved to 20/20,N6 and the intraocular pressure was 20 mmHg in the right eye. The fundus examination showed regressed periphlebitis seen as sclerosed vessels (Figure 2a). The FFA showed shunt vessels temporal to the fovea, capillary nonperfusion zones in all quadrants and stable area of neovascularization. There was no late extravasation of the dye (Figure 2b). The central macular thickness had regressed to 210 μm as measured by OCT. At 4 months follow-up, the best-corrected visual acuity and intraocular pressure were maintained. The fundus examination showed regressed periphlebitis (Figure 3a). The FFA showed regression of neovascularization in the inferonasal quadrant. Late extravasation of the dye was absent (Figure 3b).

Comment

Natural course of Eale's disease is variable.[1] Untreated periphlebitis may lead to retinal neovascularization. Systemic and periocular corticosteroids are the main stay of treatment in inflammatory stage of Eales' disease.[1] Although oral corticosteroid achieves effective intraocular concentration, it is associated with systemic complications. Patients with history of peptic ulcer may experience aggravation of symptoms even with conventional dose of oral corticosteroid.[2] The intraocular concentration and dissolution rate of corticosteroid across the sclera is variable following periocular adminstration.[3] IVTA delivers the desired concentration of the drug without extraocular side effects.[4] The long half-life of IVTA is beneficial for various retinal conditions including uveitis.[5] In our patient, regression of active periphlebitis, neovascularization, and macular oedema was observed clinically, angiographically, and by OCT. Visual acuity improved and intraocular pressure was maintained.

To conclude, IVTA can induce regression of periphlebitis in Eales' disease. Further case–control studies are required to validate IVTA-induced regression. IVTA could be a primary option in management of selected cases in Eales' disease with or without contraindication of oral corticosteroid.

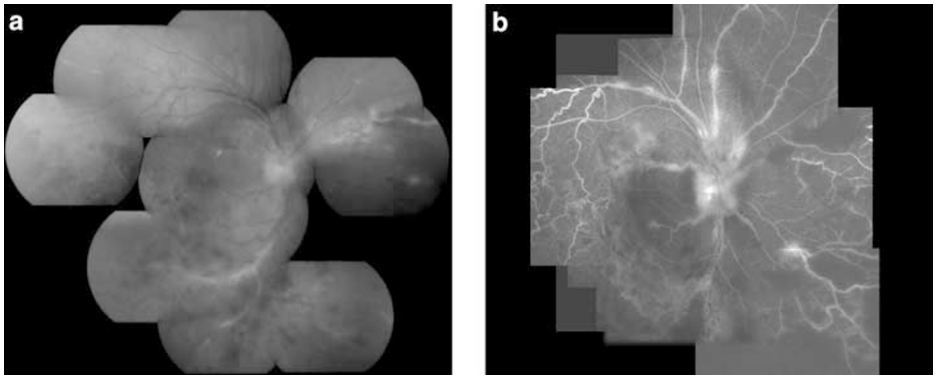

Figure 1 (a) Fundus photograph of the right eye showing active periphlebitis. (b) Fundus fluorescein angiogram of the right eye showing staining of the vessels with extravasation of the dye and an area of neovascularization in the inferonasal quadrant.

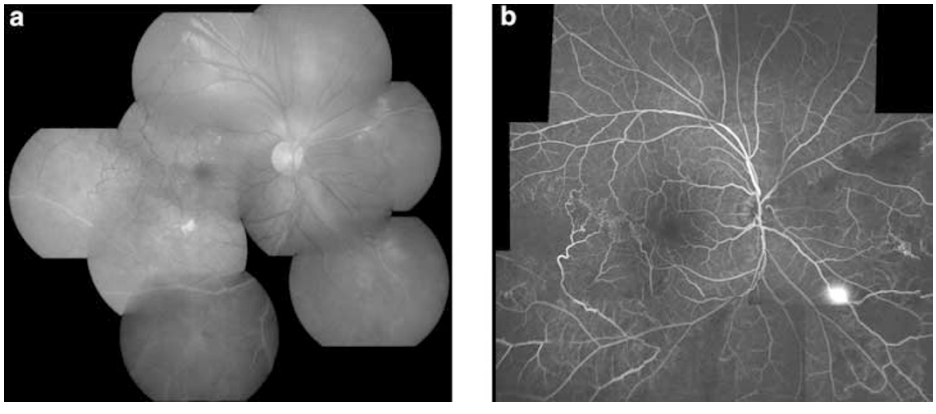

Figure 2 (a) Fundus photograph of the right eye showing resolved periphlebitis. (b) Fundus area fluorescein angiogram of the right eye showing staining of the vessels and stable area of neovascularization in the inferonasal quadrant.

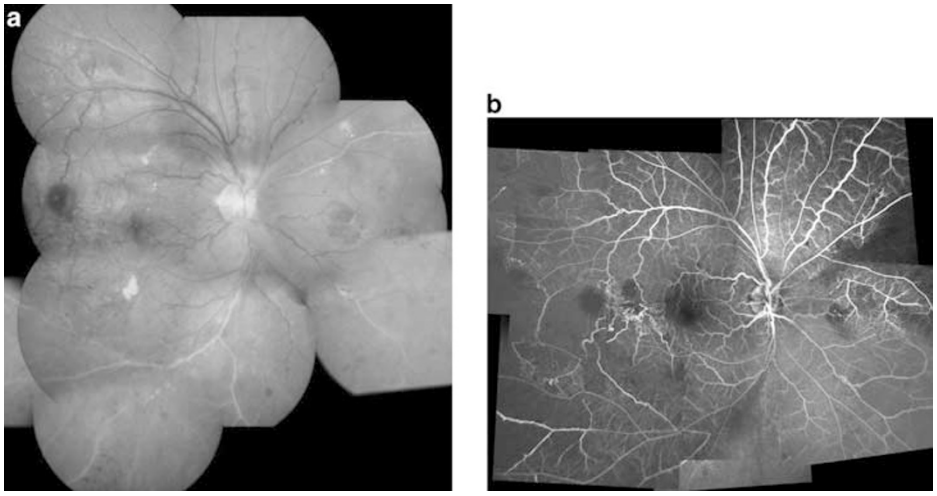

Figure 3 (a) Fundus photograph of the right eye showing persistence of resolved periphlebitis. (b) Fundus fluorescein angiogram of the right eye showing a regressed neovascularization in the inferonasal quadrant.

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Sir,

Acute postoperative *Morganella morganii* panophthalmitis

Endophthalmitis is an uncommon but serious complication of intraocular surgery, often resulting in severe visual loss.[1] The endophthalmitis may progress to panophthalmitis if medical or surgical therapy cannot control the infection.

Strains of the *Morganella* genus are a rare cause of panophthalmitis following trauma and cataract surgery.[2] We describe a patient who developed fulminant *Morganella morganii* panophthalmitis following vitrectomy with resultant loss of vision. To our knowledge, this is the first reported case of *M. morganii* panophthalmitis.

Case report

A 46-year-old Taiwanese male had sudden loss of vision in right eye for a day due to vitreous haemorrhage. On day 1 after pars plana vitrectomy, the fundus was visible and the retina was well attached. Unfortunately, his visual acuity decreased to no light perception, and severe ocular pain with eyelid swelling developed rapidly within 2 days after the operation. He was transferred to our hospital on day 4. On presentation, the patient eyelid appeared to be severely swollen and haemorrhagic chemosis was noted. Mucopurulent pus exuded from the right eye. Acute postoperative panophthalmitis was diagnosed. Haemogram revealed leukocytosis (16 700/μl) with neutrophils predominant by 80.9%. Pars plana vitrectomy with anterior chamber irrigation and