

Sir,
Preseptal cellulitis: an unusual presentation of *Trichophyton interdigitale* in an adult

Preseptal cellulitis typically affects children and is usually secondary to infections around the face and cranium.¹ We report an unusual case associated with vesicular hand lesions resulting from *Trichophyton interdigitale*. This has been reported in only two children² and should be considered in adults with skin lesions.

Case report

A 43-year-old man working in a pet shop developed painful right periorbital rash, photophobia, and blurred vision since a week. Initial treatment with Daktacort ointment and Ferofenedine tablets for 1 week was ineffective.

A delineated erythematous lesion involved the right eyelids and cheek (Figure 1a). Apart from chemosis, conjunctival discharge, and reduced vision of 6/18, the

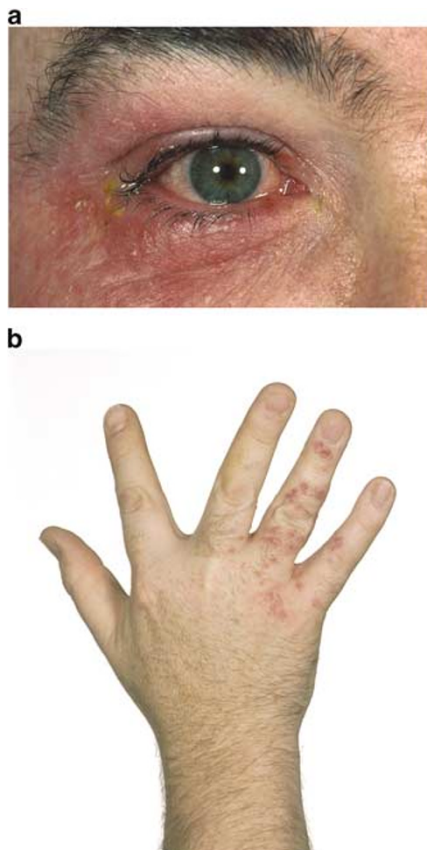


Figure 1 (a) Preseptal cellulitis of the right eye showing chemosis and an erythematous rash of the lids (a week after initial antibiotic treatment). (b) Vesicular lesions with erythematous ulcerated margins on the dorsum of the right hand involving the middle, ring, and little finger.

ocular examination and movements were normal. No infection, immunodeficiency, or allergy was identified. A week after oral Flucloxacillin and Chloramphenicol ointment, the rash persisted with reduced corneal sensation, while the chemosis resolved. Painful vesicles with ulcerated margins appeared over the dorsum of his right hand (Figure 1b). Herpes simplex blepharoconjunctivitis was suspected and treated with Aciclovir 3% ointment but the lesions spread to his palm. Dermatologists considered animal fungus infection or fish-tank granuloma in view of his occupation. Identical lesions were found on the hand and eyelids and scrapes from his hand isolated fungal elements on a potassium hydroxide slide with cotton blue stain. Dermatophyte agar isolated *Trichophyton mentagrophytes* variety *interdigitale* (Figure 2). Having failed to respond to antibacterial and antiviral agents, the lesions dramatically resolved in 3 weeks with topical Daktarin and oral Itraconazole (200 mg twice-a-day and then once-a-day for 10 days each).

Comment

In 1937 Hubert classified preseptal cellulitis.³ The main causative organisms are *Pneumococcus*, *Staphylococcus*, *Mucormycosis*, and *Aspergillus*.^{4,5} Our case however, isolated *Trichophyton* which is a common dermatophyte causing tinea.⁴ Dermatophytes have low infectivity and virulence with anthropophilic, zoophilic,^{4,6} and phytophilic transmission.⁷ Tinea is difficult to diagnose as seen in four children misdiagnosed with bullous impetigo.⁸ Skin scrapes and cultures are important for early diagnosis. Infections respond to a variety of antifungal agents including clotrimazole and

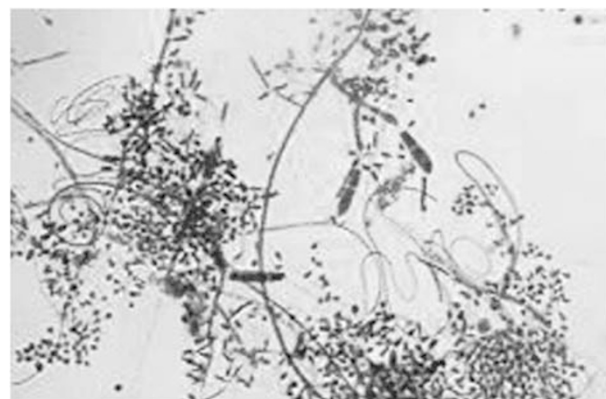


Figure 2 Culture showing numerous microconidia, macroconidia, chlamydoconidia, and spiral hyphae in *T. mentagrophytes* var. *interdigitale*. (Courtesy of Mycology Online: Department of Microbiology and Immunology, Mycology Unit, Adelaide Women's and Children's Hospital, Adelaide, Australia).

miconazole.⁸ Triazole and itraconazole may have better efficacy with shorter treatment time.⁹

Dermatophyte infections can masquerade as bacterial, viral preseptal cellulites, or allergic dermatitis and should be considered in resistant cases. To our knowledge this is the first case of *T. interdigitale* infection causing preseptal cellulitis in an adult.

Acknowledgements

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Sir, Partial posterior capsulectomy through an anterior approach: an intraocular lens retaining technique in the management of presumed *Propionibacterium acnes* endophthalmitis

Delayed onset endophthalmitis caused by *Propionibacterium acnes* is a well-recognized complication of cataract surgery.^{1–3} Several reports have shown that intraocular antibiotic injection (IOAB), capsulectomy (partial or total) combined with vitrectomy, with or without intraocular lens (IOL) removal are associated with the least recurrence rates.^{4–6} The technique of performing partial posterior capsulectomy (PPC) through the anterior segment, without pars plana vitrectomy (PPV) has not been described. We herein describe a technique of performing PPC through the anterior segment using intraocular forceps and scissors.

Case report

An 82-year-old female was referred for cataract surgery. Best corrected visual acuities were 6/24 in both eyes. She underwent an uncomplicated superior clear corneal phacoemulsification with implantation of a multifocal silicone IOL (Allergan, SA 40N) in the right eye (RE). At the end of the surgery, subconjunctival injection of gentamicin and betnesol was administered. Postoperatively she was treated with topical antibiotics and steroids for 4 weeks and at discharge the vision was 6/6, N₁₀.

After 12 months, she presented with pain and photophobia of the RE. Visual acuity was 6/36, due to severe anterior chamber (AC) inflammation. There was no keratic precipitates, hypopyon, or intracapsular plaque, and the IOL was well-centered. The fundal reflex was bright with no evidence of vitritis. Late postoperative uveitis was diagnosed and topical steroids were prescribed. As the intraocular inflammation was not responding, a sub-Tenon's injection of methyl prednisolone acetate was administered, following which the vision transiently improved to 6/18. As the uveitis persisted, the possibility of delayed onset endophthalmitis was considered.

She underwent an AC paracentesis with intracameral injection of vancomycin (1 mg in 0.1 ml) and cefazidime (2 mg in 0.1 ml) in the operating room. Gram stain and culture of the AC aspirate showed no microorganisms. The intracameral injection was repeated 2 weeks later, with the same antibiotics injected in to the capsular bag. This procedure displaced the IOL, leaving the optic in the sulcus and haptics within the bag.