E Tay¹, T Aung^{1,2} and I Murdoch¹

¹Moorfields Eye Hospital, London, UK

²Singapore National Eye Centre, Singapore, Singapore

Correspondence: E Tay,
Tel: +44 207 253 3411.
E-mail: dr_eugenetay@yahoo.com

Meeting presentation: Presented at SERI-ARVO, Singapore, February 16–19, 2005.

Disclosure: None for all authors.

Conflict of interest: None for all authors.

Eye (2006) **20**, 625–627. doi:10.1038/sj.eye.6701948;
published online 3 June 2005

Sir,
With regards to 'Endophthalmitis' (Editorial, *Eye* 2004, 18, 555–556)

Contemporary early cataract extraction for glare, blurring, and 'nuisance' vision, etc. together with the advent of clear lens replacement for high hypermetropia and hypermetropic with presbyopia (RSM Meeting 2003) makes the consequences of endophthalmitis even more important for the individual patient. Ms Seward pertinently remarks 'prevention remains the most important factor' and as described, the statistically valid evidence base for prophylaxis is still developing.

In the meantime an experience based and rational approach may contribute:

Use of the unique vancomycin as a prophylactic, risks resistance development in a potentially MRSA Hospital environment. In the eyes of nonophthalmologists, it may reduce ophthalmology to a rogue speciality. All prophylaxis transgresses one of medicines most accepted principles: 'treat effectively in dosage and duration to avoid resistance.'

The evidence would have to be extremely strong to justify its routine use. It is not.

Conjunctival sac iodine and intracameral cephaloridine, etc. may well reduce the incidence of endophthalmitis but how long do their effects last?

One of three eyes lost in the first 30 years of cataract surgery (AK) was due to *Streptococcal faecalis* in a padded patient who had soiled the bed from top to bottom overnight. Postoperative exogenous infection certainly occurs and not only from blepharitis, natural lid flora or a vulnerable conjunctival sac with a blocked tear duct: in the days of routine use of sutures many surgeons had

occasion to witness abscess tracking through suture leading to endophthalmitis.

Nowadays, entrance of organisms through the iatrogenic portal of entry can occur until epithelialisation is complete. As this occurs mainly in the first 24 h it is worth considering the protective value of postoperative ointment in the eye together with subconjunctival antibiotic and a pad.

OCC chloramphenicol would induce bacteriostasis and entrapment of organisms. With subconjunctival antibiotics, a significant part of the vulnerable entrance period would coexist with a bacteriolytic concentration of antibiotic in the anterior chamber. Also, any organism carried in with the inert, organism proliferation enhancing foreign body implant, would be exposed to a sustained hostile bacteriolytic environment, while in their weakest numbers, and before any protective host exudative reaction occurs.

Many eyes may well be thus saved, while an evidence base is secured for each of the several precautions necessary for each of the several risk factors.

It is interesting that the evidence base for prophylactic antibiotics (local and systemic) is extremely thin, when joints are replaced. They are, however, routinely used by our Orthopaedic colleagues.

If prophylaxis with subconjunctival antibiotics is accepted on the rationale above there are strong theoretical reasons to suggest a 'Kanski cocktail' approach, not only for the range of cover but also with the overlap to remove adaptation and resistance to individual antibiotics.

The magnitude of the catastrophe of endophthalmitis is not only in numbers. The loss of normal or slightly abnormal eyes in contemporary surgery has to be compared with 'mature' cataract and 6/24 eyes of previous eras.

Finally, it may also be interesting to ascertain whether the routine use of postoperative steroids in modern avascular surgery increases the incidence of endophthalmitis from usually nonpathogenic organisms.

HA Khatib, AG Karseras

MDA Clinic, 65 Cardiff Road, Llandaff,
Cardiff CF5 2AA, UK

Correspondence: AG Karseras,
Tel: +44 29 20 56 3004;
Fax: +44 29 20 56 7846.
E-mail: laservision@mdaclinic.co.uk

Eye (2006) **20**, 627. doi:10.1038/sj.eye.6701980;
published online 1 July 2005