Certain associations such as between cylindromas and apocrine cystadenoma are expected, as they are sweat gland proliferations. Similarly, basal cell and squamous cell carcinomas are malignant proliferations of keratinocytes and have similar histogenesis. However, most collision tumours occur by chance, and are not derived from similar cell lines nor share pathogenic mechanisms.

The coexistence of two or more neoplasms in a single cutaneous specimen is unusual and can be diagnostically misleading if only one of the two is discovered. Biopsy reports must always be questioned in the light of the clinical history and examination. Unless histopathological diagnoses are considered alongside the clinical appearance of the original lesion, which may be altered by surgery, the anomaly may not be questioned.

It is essential therefore that new lesions be photographically documented prior to any intervention. This will aid in the patient's future management particularly in situations where the patient is reviewed by a different clinician at subsequent visits. This objective tool is especially important in cases where the clinical appearance does not correlate well with histological findings. Performing a large incisional biopsy will also maximize the chance of identifying multiple lesions.

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Sir,

Serratia marcescens endophthalmitis secondary to pneumonia

A 56-year-old female was admitted to ITU with postoperative pneumonia secondary to *Serratia marcescens* treated with Imipenem 750 mg b.i.d. i.v. She underwent bowel resection for Crohn's disease 1 week prior to her pneumonia. A month later, she arrested and became comatosed despite resuscitation. She deteriorated, developing renal failure requiring haemofiltration. *S. marcescens* was grown from sputum and blood cultures and Teicoplanin 400 mg b.i.d. i.v. was started. After 24 h, she developed an acute right red eye.

On examination, there was an afferent pupillary defect, corneal oedema, and hypopyon. There was no fundal view (Figure 1). Examination of her left eye was unremarkable. A diagnosis of endogenous endophthalmitis was suspected and a vitreous tap performed with Ceftazidime 2.25 mg, Vancomycin 1 mg, and Amphotericin 5 μg given intravitreally. In addition, she was given hourly G Cefuroxime 5% and G Gentamicin 1.5%. *S. marcescens* sensitive to Ceftazidime was isolated from her vitreous and a repeated intravitreal injection of Ceftazidime and Vancomycin were given 72 h later. There was little ocular or systemic improvement and despite aggressive treatment she eventually died of multiple organ failure. An autopsy was declined.

Endogenous endophthalmitis (EE) accounts for 10% of all endophthalmitis.[1] Fungi are the most common causal pathogen[2] followed by bacteria.[1,3] Risk factors include systemic immunosuppression, sepsis, major surgery, indwelling catheters, and prolonged antibiotic therapy.[2] The overall prognosis is poor with useful vision preserved in only 40%, 6 and 7–15% patients die from septicaemia.[4,5]

Identifying the underlying cause is paramount. Conjunctival swabs poorly reflect intrinsic eye infection and vitreous tap/biopsy[6] should be performed and intravitreal antibiotics administered.

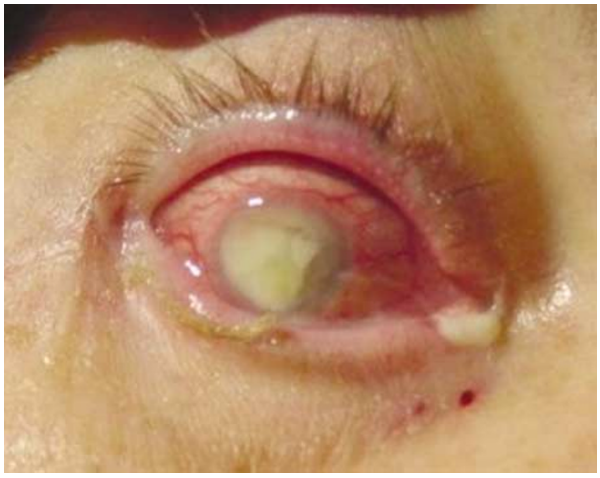

Figure 1 Right eye of patient showing scleral injection, corneal oedema, and hypopyon.

S. marcescens is multiresistant Gram-negative bacillus that can produce a red pigment causing a pink hypopyon.[7] To our knowledge, this is the first reported case of *S. marcescens* pneumonia as a primary source for EE (the lung is the most common site for these pathogens[8]). Despite appropriate systemic and intravitreal antibiotics, the visual outcome was poor and the patient eventually died. As the incidence of EE (especially Gram-negative infections) appears to be rising,[3] then this aggressive organism may become a more common cause for this devastating condition.

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Sir,

Tractional retinal break and rhegmatogenous retinal detachment consequent to branch retinal vein occlusion

Traction on neovascular tissue causing tractional retinal breaks and consequent rhegmatogenous retinal detachment is an infrequent complication of branch retinal vein occlusion (BRVO). We report a case which was successfully managed with barrier laser photocoagulation.

Case report

A 73-year-old man presented to ophthalmic casualty with history of sudden painless loss of vision in the left eye. There was no significant ophthalmic history and he suffered from hypertension. Visual acuities were 6/6 in right eye and hand movements in left eye. Anterior segment examination was normal; there was no fundus view due to dense vitreous haemorrhage. B-scan confirmed vitreous haemorrhage and flat retina.

Vitreous haemorrhage cleared 2 months later and visual acuity improved to 6/6 in the affected eye. Fundoscopy revealed a large posterior horseshoe retinal tear at 2 O'clock position with surrounding localised retinal detachment above the superotemporal retinal vessels. There was an avulsed neovascular frond attached to posterior hyaloid face and ghosting of superotemporal blood vessels suggesting an old BRVO (see Figure 1).

Barrier laser photocoagulation was performed surrounding the area of retinal detachment. After 6 months the patient's vision was stable with no progression of retinal detachment or development of further complications.

Comment

BRVO may be associated with a number of complications including macular oedema, epiretinal membrane, retinal neovascularisation, vitreous haemorrhage, retinal breaks, and rhegmatogenous retinal detachment. Retinal breaks