

encouraging initial results. We would be interested to know some further details of their results.

- (1) We note that during the follow-up period described none of the 14 eyes had any retinal problems postoperatively. We would be interested to know how many of these patients had a pre-existing posterior vitreous detachment (PVD) preoperatively and how many needed a PVD induced during vitrectomy. Inducing a PVD during surgery is a well-known risk factor for retinal tear formation and retinal detachment during vitrectomy. Conversely a pre-existing PVD would reduce the risk of these patients suffering retinal problems either with vitrectomy surgery or cataract surgery alone.
- (2) Combining cataract extraction with lens implantation and three port pars plana vitrectomy has been found to induce a myopic shift in the actual postoperative refraction from the predicted postoperative refraction.^{2,3} Suzuki *et al* have reported a spread between predicted and actual refractions of -0.05 ± 1.18 D in a combined surgery group and $+0.55 \pm 1.32$ D in a cataract surgery alone group. We note that Uhlmann and Wiedemann¹ found a mean postoperative refraction of -0.7 ± 1.6 D. We would be interested to know whether there was any myopic shift in their study between the predicted and the actual refractions. This would be an important finding to be aware of in, what is primarily, a refractive procedure.
- (3) Shioya *et al* have also reported a difference in the postoperative refraction in patients having gas tamponade and those who did not have gas tamponade. In eyes without gas tamponade, the refractive error was $+0.14 \pm 1.11$ D as compared to the eyes with gas tamponade in whom the refractive error was -0.36 ± 1.22 D. It was proposed that the gas tamponade pressed the intraocular lens forward and caused the myopic shift. We would be interested to know from the authors if any of their patients had gas tamponade following vitrectomy.

References

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S Manvikar and D Steel

Sunderland Eye Infirmary, Sunderland UK

Correspondence: S Manvikar
Tel: +44 191 565 6256;
Fax: +44 191 227 5246.
E-mail: sridharm@hotmail.com

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Sir,
Don't forget Gonococcus!

Genitourinary infection by *Neisseria gonorrhoeae* is well recognised, but ocular infection in adults is rare,^{1,2} especially in the developed world. With a 139% increase in the number of new cases of gonorrhoea in the UK between 1995 and 2003,³ the incidence of adult gonococcal keratitis can be expected to rise. Unlike *Pseudomonas*, *Neisseria gonorrhoeae* is able to penetrate intact corneal epithelium^{4,5} resulting in aggressive invasion and high risk of rapid corneal perforation. Early diagnosis and treatment is essential to reduce the risk of blinding complications. We report a case of severe gonococcal keratitis in an HIV positive patient.

Case report

A 52-year-old Caucasian male presented with a 1-week history of a painful red right eye and lid swelling. He had been treated at a walk-in primary care facility with oral flucloxacillin and topical fusidic acid before being referred with worsening symptoms and visual loss. Of note, he was HIV positive for 20 years with no history of AIDS defining illnesses. On highly active antiretroviral therapy (HAART), he was systemically well with a CD4 count >400 cells/mm³ and undetectable viral load. His past ocular history was unremarkable and he did not wear contact lenses. Three years before he had been treated for gonorrhoea but had no recent genitourinary symptoms.

On examination, visual acuities were perception of light right eye and 6/6 left eye with marked right lid oedema and copious mucopurulent discharge. There was

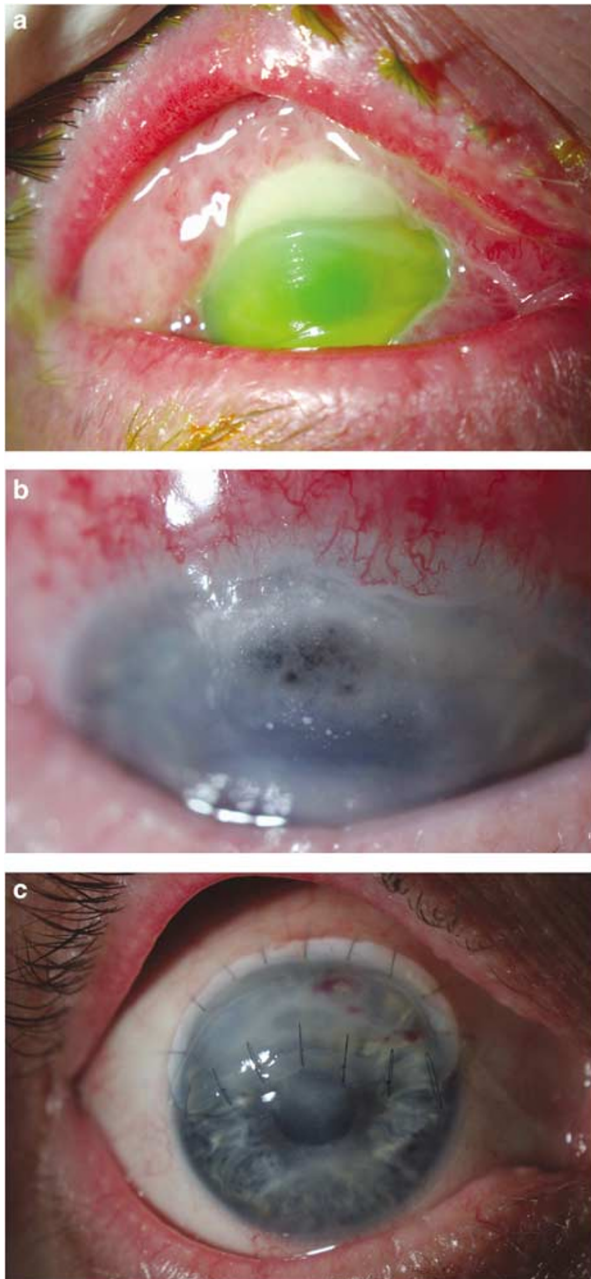


Figure 1 (a) Right eye at presentation. (b) Superior corneal thinning with impending perforation. (c) Lamellar tectonic patch graft at 2 months.

severe conjunctival injection and chemosis with a dense full thickness white infiltrate involving the upper third of the cornea, marked corneal thinning and subtotal corneal epithelial loss (Figure 1a). The anterior chamber was shallow with a fibrinous uveitis but no hypopyon. A B-scan ultrasound showed clear vitreous and flat retina. The left eye was healthy.

Microbiology specimens were obtained and he was treated empirically for microbial keratitis with

g.ofloxacin 0.3% 1 hourly, g.cefuroxime 5% 1 hourly, g.cyclopentolate 1% tds to the right eye, and oral ciprofloxacin 750 mg bd. Cultures grew beta-lactamase negative *Neisseria gonorrhoeae* sensitive to fluoroquinolones, cephalosporins, and chloramphenicol. A single dose of intramuscular ceftriaxone 250 mg was given according to UK National Guidelines for the treatment of gonorrhoea.⁶

The severity of the infection resulted in necrosis of a substantial volume of corneal stroma that required gentle debridement by lamellar keratectomy to reduce inflammation and allow epithelial regrowth. Topical dexamethasone 0.1% qds was added to his treatment. By day 11, despite clinical improvement and corneal reepithelialisation, a microperforation developed in the thinned cornea superiorly. A bandage contact lens assisted in maintaining the anterior chamber but progressive superior corneal melting occurred (Figure 1b), requiring a large limbal-lamellar tectonic patch graft (12 × 5 mm) to preserve ocular integrity. Immunosuppression was necessary to minimise further corneal melting and to reduce the risk of graft rejection. In our patient, high dose systemic steroids were not contraindicated by his HIV status, although close collaboration with HIV physicians was required. At 2 months postoperatively, his visual acuity was 6/60 with a quiet eye and clear lamellar graft (Figure 1c). Further visual rehabilitation involving penetrating keratoplasty is planned.

Comment

Ocular Gonococcal infection typically occurs in neonates and in sexually active adults. Gonococcal ophthalmia neonatorum, which was once the leading cause of blindness in European infants, is now rare due to antenatal screening and antibiotic treatment. Adult ocular Gonococcal infection is fortunately also rare, with transmission usually being by autoinoculation or direct inoculation from the genital secretions of an infected partner.¹ The treatment of *Neisseria gonorrhoeae* has been complicated by increasing antibiotic resistance, but in our patient the strain was sensitive to most antibiotics including chloramphenicol, the most commonly used first line topical antibiotic in the UK. Lamellar corneal patch grafts are effective in restoring ocular integrity following corneal perforation,⁷⁻⁹ and their use has recently been described in a case of Gonococcal keratitis with severe corneal melting leading to descemetocoele formation without corneal perforation.¹⁰

Ocular Gonococcal infection must be considered in all patients with mucopurulent keratoconjunctivitis and lid swelling, especially in those with known or at risk of exposure to sexually transmitted diseases. Don't forget *Gonococcus*!

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AC Day, YD Ramkissoon, S George and MC Corbett

The Western Eye Hospital, London, UK

Correspondence: A Day, Ophthalmology, Western Eye Hospital, 153–173 Marylebone Road, Marylebone, London, NW1 5QH, UK
Tel: +44 207 886 3265;
Fax: +44 207 886 3229.
E-mail: alex@acday.co.uk

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Sir,
Homonymous hemianopia and exotropia: an important management issue

We report a case of comorbidity of exotropia with homonymous hemianopia in whom a careful preoperative assessment helped avoid an unexpected surgical outcome.

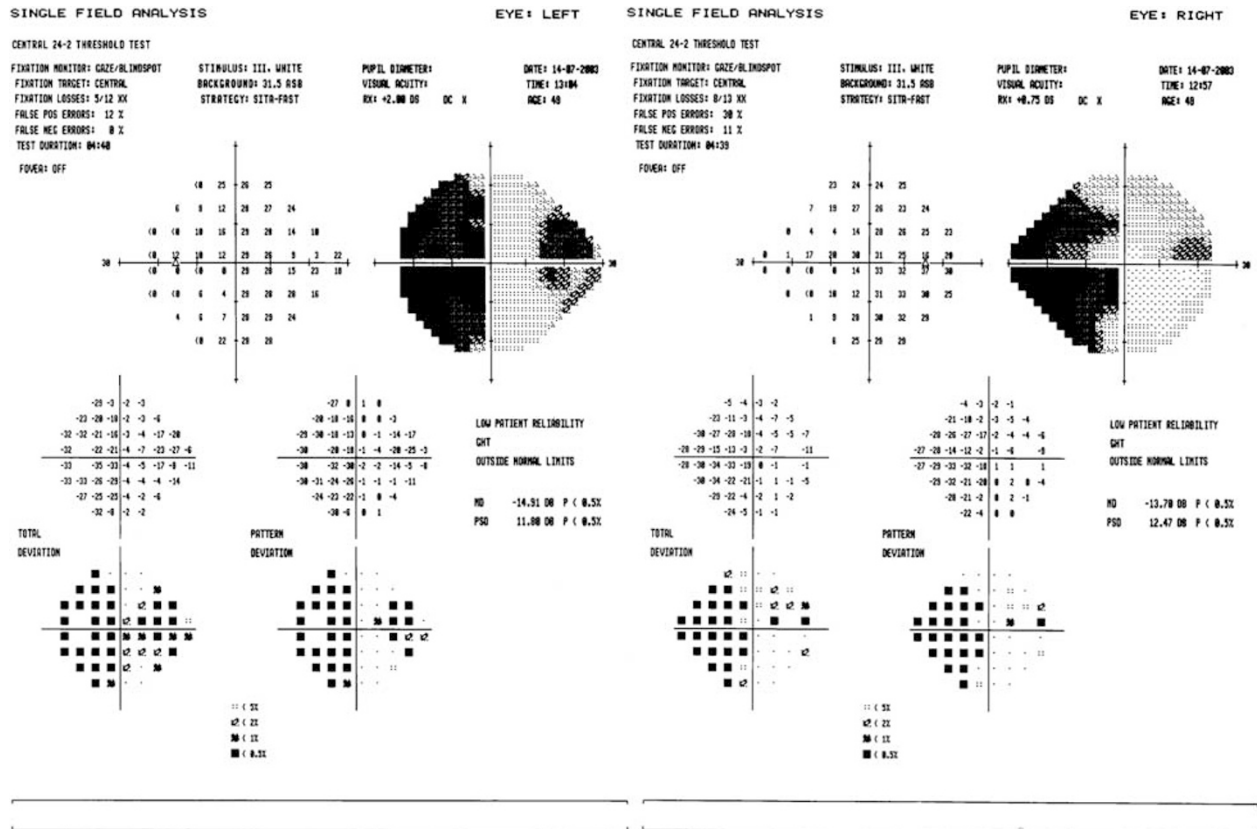


Figure 1 Left homonymous hemianopia.