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Sir,  
**Refractive lens exchange combined with pars plana vitrectomy to correct high myopia**

Thank you for the interesting discussion concerning our pilot study.

As described none of the patients had retinal problems postoperatively. Vitreous body status was not taken into account as inclusion criteria. However, we can report that nine eyes had a pre-existing posterior vitreous detachment (PVD) preoperatively and five eyes needed a PVD induced during vitrectomy. Actually, inducing a PVD during surgery is a risk factor for retinal tear formation.<sup>1</sup> However, only undetected or improperly managed retinal breaks lead to postoperative retinal detachment. The assumption is that the surgeon is experienced in surgery of the anterior and posterior segment of the eye.

We are familiar with the study of Suzuki *et al.*<sup>2</sup> and Bilinska *et al.*<sup>3</sup> The spread between predicted and actual refractions was  $-0.05 \pm 1.18$  D in the combined surgery group and  $+0.05 \pm 1.32$  D in the cataract surgery group. The actual refractive errors in the combined surgery group were found to shift toward myopia when compared with the controls.<sup>2</sup> However, the actual refractive errors in the combined surgery group showed nearly no spread between predicted and actual refraction

( $-0.05 \pm 1.18$  D). In contrast, the cataract surgery group showed a hyperopic shift.

We measured a mean postoperative refraction of  $-0.7 \pm 1.6$  D. As slight myopia was targeted as postoperative result ( $-0.5$  to  $-1.0$  D; using the IOLPC-5-formula by Haigis).<sup>4</sup> Thus, we found no myopic shift between predicted and actual refractions for our group with combined surgery. We had no group with patients undergoing RLE without PPV for comparison of the shift between combined surgery and cataract surgery alone.

None of the eyes in our study needed a gas tamponade following vitrectomy. We therefore did not expect to find a myopic shift due to gas tamponade, which can press the intraocular lens forward.

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Sir,  
**Refractive lens exchange combined with pars plana vitrectomy to correct high myopia**

We read with interest the article by Uhlmann and Wiedemann,<sup>1</sup> and congratulate the authors on their

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.<sup>2,3</sup> Suzuki *et al* have reported a spread between predicted and actual refractions of  $-0.05 \pm 1.18$  D in a combined surgery group and  $+0.55 \pm 1.32$  D in a cataract surgery alone group. We note that Uhlmann and Wiedemann<sup>1</sup> found a mean postoperative refraction of  $-0.7 \pm 1.6$  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  $-0.36 \pm 1.22$  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.

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Sir,  
**Don't forget Gonococcus!**

Genitourinary infection by *Neisseria gonorrhoeae* is well recognised, but ocular infection in adults is rare,<sup>1,2</sup> especially in the developed world. With a 139% increase in the number of new cases of gonorrhoea in the UK between 1995 and 2003,<sup>3</sup> the incidence of adult gonococcal keratitis can be expected to rise. Unlike *Pseudomonas*, *Neisseria gonorrhoeae* is able to penetrate intact corneal epithelium<sup>4,5</sup> 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/mm<sup>3</sup> 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