been used in combination with the transpupillary approach to compensate for the lack of solidity. There is also the fact that the quality of the CCD camera is not yet satisfactory. However, if surgeons recognize these weak points and adapt the intraocular endoscopic system appropriately, this instrument could surpass expectations and provide more safe and useful techniques for surgery. Our presenting techniques will also be helpful, especially in RRD and/or PVR patients with anterior segment problems, which are frequently occuring in severe cases.

References

1 Eguchi S, Araie M. A new ophthalmic electronic video endoscope system for intraocular surgery. *Arch Ophthalmol* 1990; **108**: 1778–1781.
2 Yaguchi S, Kora Y, Takahashi H, Fukado Y, Yamanaka A, Kusakabe M *et al*. A new endoscope for ophthalmic microsurgery. *Ophthalmic Surg* 1992; **23**: 838–841.
3 Kreiger AE. Wound complications in pars plana vitrectomy. *Retina* 1993; **13**: 335–344.
4 Imamura Y, Minami M, Ueki M, Satoh B, Ikeda T. Use of perfluorocarbon liquid during vitrectomy for severe proliferative diabetic retinopathy. *Br J Ophthalmol* 2003; **87**: 563–566.
5 Bourke RD, Cooling RJ. Vascular consequences of retinectomy. *Arch Ophthalmol* 1996; **114**: 155–160.

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Sir,

Reply to T Sandinha *et al*

I read with interest the article written by T Sandinha *et al*.[1] I would like to make the following comments.

In the case 1 reported, the conjunctival pedicle appears very vascular even though the initial surgery was performed 2 months ago. The peripheral cornea was vascularised in the corresponding quadrant, contrary to what the authors had claimed in their article. This amount of peripheral corneal vascularisation would work against the success of any future corneal transplant surgery. An amniotic membrane graft or a tectonic corneal graft would have been a better choice for such a corneal perforation involving the visual axis. In the event of nonavailability of donor material, temporary glueing of the perforation or even a scleral autograft could have been carried out.

However, I agree that Superior forniceal conjunctival advancement pedicles could be used in peripheral corneal perforations such as the case 2 described in the article.

Reference

1 Sandinha T, Zaher SS, Roberts F, Devlin HC, Dhillon B, Ramesh K. Superior forniceal conjunctival advancement pedicles (SFCAP) in the management of acute and impending corneal perforations. *Eye* 2006; **20**: 84–89.

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Sir,

Panophthalmitis secondary to infection with *Citrobacter koseri*

We present a case of visual loss due to *Citrobacter koseri* panophthalmitis.

Case report

An 86-year-old retired taxi-driver was seen in clinic with a right full thickness macular hole. He was noted to have a small right lower lid cyst, the contents of which were digitally expressed. He underwent elective phacoemulsification, vitrectomy, insertion of silicone oil