infection can be the initial manifestation of sepsis. In addition, the visual outcome of septic metastatic endophthalmitis caused by *K. pneumoniae* was worse than counting fingers in more than 80% of patients with affected eyes in most series.[3–5] Therefore, more aggressive treatment may be needed. In our patient, although the primary focus of infection was obvious and urgent treatment was also given, the visual prognosis is still disappointed.

In the past, septic metastatic endophthalmitis caused by *K. pneumoniae* was considered to be rare. Before 1980, only one patient was reported in the literature.[6] However since 1981, more than 40 cases have been described, mainly in Taiwan, with 61% diabetes mellitus, 68% of patients having suppurative liver disease, and 16% having urinary tract infection as the primary focus of infection.[7] To date, the primary foci from skin infection was only noted in three patients. Okada *et al*[2] reported two cases of septic metastatic endophthalmitis from skin cellulitis. One resulted from skin burn with *Staphylococcus aureus* infection and another was skin abscess owing to intravenous drug abuse, in which the infectious organism was not identified. However they did not mention whether these patients were diabetic mellitus. Wong *et al*[8] reported one diabetic patient of septic metastatic endophthalmitis from foot abscess with *S. aureus* infection. Therefore, to the best of our knowledge, this is the first case of septic metastatic endophthalmitis resulting from scalp furuncle with *K. pneumoniae* infection described in diabetic patient.

In conclusion, the physician must take into account that diabetic patients could have a metastatic infection to eyes when with skin infection.

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Sir,

Bilateral vitreous haemorrhage associated with dengue fever

We read with interest the report by Nainiwal *et al*[1] of a 14-year-old girl with bilateral vitreous haemorrhage associated with dengue haemorrhagic fever (DHF). The authors suggested that if a patient with DHF was to present with bilateral vitreous haemorrhage, severe headache and myalgias after the initial fever and rashes have subsided, a misdiagnosis of Terson's syndrome could be made. Terson's syndrome is vitreous haemorrhage occurring in association with subarachnoid haemorrhage. From the report, it is unclear if the authors have satisfactorily excluded subarachnoid haemorrhage in their patient. There was no mention of any detailed neurological examination or imaging of the brain performed on the patient to suggest that intracranial pathology has been excluded.

Although rare, DHF has been associated with subarachnoid haemorrhage.[2] A sudden increase in intracranial pressure from subarachnoid haemorrhage can rupture the epipapillary and peripapillary capillaries, resulting in Terson's syndrome. In a systematic review by McCarron *et al*,[3] 24 out of 181 (13%) patients with subarachnoid haemorrhage assessed prospectively had vitreous haemorrhage. Rarely, there may be no neurological symptoms or signs in Terson's

syndrome at the initial presentation.[4] Computed tomography has a high sensitivity (91–98%) for the detection of subarachnoid haemorrhage, although it cannot unequivocally exclude subarachnoid haemorrhage.[5]

In summary, while we agree that it is possible for vitreous haemorrhage to occur in DHF, we wish to highlight that Terson's syndrome could be a plausible explanation for the occurrence of vitreous haemorrhage in DHF and this life-threatening condition should not be overlooked.

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Sir,

Late traumatic scleral flap dehiscence following trabeculectomy

We report the case of a patient who suffered a blunt ocular injury 13 years after a trabeculectomy with postoperative 5-fluorouracil (5-FU) injections, which resulted in dehiscence of the scleral flap causing acute hypotony and choroidal detachment. To our knowledge, this consequence of ocular trauma has not been described previously.

Case report

A 62-year-old female patient was seen in the Eye Emergency Department following a fall, in which she struck her right eye on the side of a car door. She was myopic and had undergone radial keratotomy (RK) in 1990. In 1992, she developed a right rhegmatogenous retinal detachment, which was repaired with cryotherapy and a scleral buckle. A diagnosis of chronic glaucoma was made in 1987, and in 1993, she underwent a right trabeculectomy followed by four 5 mg 5-FU subconjunctival injections to suppress the fibrovascular healing response. She developed a diffuse microcystic bleb, with an intraocular pressure (IOP) of 15 mmHg. In 1997, she underwent extracapsular cataract extraction with implantation of a posterior chamber intraocular lens.

The retina in the right eye redetached in 2001 and she underwent a posterior vitrectomy and replacement of the posterior chamber implant with an Artisan iris fixation intraocular lens. Her vision stabilised at 6/12 OD, with an IOP of 16 mmHg in the presence of a diffuse filtration bleb.

On presentation following the injury, the visual acuity was 'counting fingers' OD and 6/9 OS. A right relative afferent pupillary defect was present. The cornea was clear, with evidence of previous surgery (RK). She had a large diffuse bleb extending 6 o'clock hours (Figure 1). The anterior chamber was deep with a microhyphaema and a stable intraocular lens. The IOP was measured at 0 mmHg and dilated examination of the fundus showed retinal folds and choroidal detachment