practice, especially where evidence clearly contradicts opinion.

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S Prasad

Arrowe Park Hospital, Arrowe Park Road, Upton, Wirral CH60 6RT, UK
E-mail: sprasad@rcsed.ac.uk

Eye (2007) **21,** 1008–1009; doi:10.1038/sj.eye.6702812; published online 6 April 2007

Sir,

Reply to Scott and Kirkby

The authors agree with Kirkby and Scott that in the management of macula-on retinal detachment, there should not be 'undue delay' and that the surgery should occur in a 'timely fashion'. But of course these are very vague terms. Undue delay in one case might be reasonably timely in another.

The whole point of the MORD (macular-on retinal detachment) study[1] was to try to determine what degree of surgical delay is acceptable in these cases, and what interval to surgery would be considered 'timely'.

It is the authors' contention that immediate surgery may not be indicated in all cases.

The MORD study has limitations because it was not constructed as a randomised controlled trial, but it might be considered as paving the way for such a trial, and that would then answer the concerns of vitreoretinal surgeons regarding what is 'timely' and what actually constitutes 'undue delay'.

Reference

1 Ho SF, Fitt A, Frimpong-Ansah K, Benson MT. The management of primary rhegmatogenous retinal detachment not involving the fovea. *Eye* 2006; **20**: 1049–1053.

SF Ho[1,2], A Fitt[1], K Frimpong-Ansah[1] and MT Benson[1,2]

[1]Birmingham and Midland Eye centre, Birmingham, UK
[2]Birmingham Heartlands and Solihull Hospital, Birmingham, UK
E-mail: s_ho2@yahoo.com

Eye (2007) **21,** 1009; doi:10.1038/sj.eye.6702811; published online 6 April 2007

Sir,

Orbital cellulitis associated with combined retinal and choroidal detachments

Orbital cellulitis may have sight- and life-threatening consequences.[1] We report an atypical manifestation of this condition. A 56–year-old woman with Down syndrome was referred for assessment of OD choroidal detachment. This was detected on a computed tomography (CT) scan carried out for evaluation of worsening periorbital swelling, purulent discharge, and chemosis of 4 days duration while on topical tobracmycin and dexamethasone. Patient had malaise; however, there was no history of maxillofacial infections, fever, chills, trauma, or recent surgeries. There was no history of epiphora. Besides history of bilateral cataract surgeries a few years earlier, ocular history was unremarkable.

On examination the vital signs were normal. OD was proptotic with limited lateral gaze, inability to fix and follow, and a relative afferent pupillary defect. Sensation at CN V1 and V2 distribution was decreased but present. She was able to fix and follow by OS. The intraocular pressures were 32 mmHg OD and 23 mmHg OS. There was significant pain with retropulsion, right eyelid erythema, swelling, chemosis, and purulent discharge. The right lacrimal apparatus was difficult to assess given severe periorbital swelling. The right cornea, anterior chamber, and iris were unremarkable. She was pseudophakic OU. Funduscopic examination OD revealed an exudative retinal detachment, optic nerve head swelling, and an annular, opposing choroidal detachment. Ultrasound confirmed the choroidal detachment. No masses were noted by ultrasound. OS was essentially normal. No ocular bruits were detected. The patient was admitted and placed on intravenous ceftriaxone, vancomycin and metronidazole. Topical moxifloxacin and timolol were initiated. Topical prednisolone q.i.d. was used to relieve chemosis. Orbital CT scans with contrast revealed right choroidal detachment, retro-bulbar fat stranding extending to the orbital apex, and enhancement of the optic nerve sheath. The head CT was normal. The cavernous sinus filled normally, the superior ophthalmic vein calibres were normal, and the sinuses were clear (Figures 1 and 2). Within hours of admission, the patient developed lethargy, cool, clammy skin and a right pupil-involving cranial nerve III palsy. The patient was unable to complete magnetic resonance imaging of the head. Heparin was initiated to prevent a cavernous sinus thrombosis. Conjunctival and blood cultures were negative but they were done after antibiotic use. The right eyelid culture grew heavy *Staphylococcus aureus* sensitive to the administered antibiotics. Symptoms improved by the 4th day of treatment. Her complete blood counts were normal initially; however, the white count components and haemoglobin level gradually decreased. The hemoglobin and absolute neutrophils were below normal levels but eventually normalized. The anticoagulation was maintained and intravenous ceftriaxone was continued for the next 5 weeks coincident with the resolution of the retinal/choroidal detachments. The patient was able to fix and follow with no afferent pupillary defect or ophthalmoplegia. The optic nerve