approach, but sits *side saddle*, with his thighs parallel to the long axis of the operating table and facing the head end (Figure 1d). The optical axis of the microscope is inclined about 60° towards the horizontal, and the globe is tilted a little more superotemporally than usual to optimize the red reflex if present.

We have used this positioning for about 10 patients now. All patients had intracameral anaesthesia and some required capsular staining and pupil stretching. All but one had uneventful surgery. One patient needed anterior vitrectomy, which was not significantly more difficult than usual. We would not expect the risk of endophthalmitis to be any different from that of a temporal section. Although the surgeon had to take the weight of his arms a little more than usual, he found this posture to be far superior to the alternative of standing.

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Şir,

Infective crystalline keratopathy secondary to nontuberculous mycobacterium (*Mycobacterium abscessus*) in a non-traumatized eye

We report a rare case of infective crystalline keratopathy (ICK) secondary to non-tuberculous mycobacterium.

Case report

A 55-year-old Pakistani myopic gentleman with primary open-angle glaucoma was taking three ocular hypotensive drops in his right eye. He complained of discomfort in his right eye. Examination revealed pseudoproptosis, inferior punctate staining, and filamentary keratitis more in the right eye. Lubricants and punctal plugs were applied. As symptoms deteriorated, he was changed to preservative-free (PF) drops and started doxycycline 100 mg o.d. with lid hygiene for posterior blepharitis.

Two weeks later, while in Pakistan, a dendritic ulcer in the right eye was treated with occ-acyclovir 3%. On returning the following week, disciform keratitis developed with no epithelial defect. Mild inflammation was present, and therefore, g-Predsol 0.5% PF t.d.s., g-chloramphenicol, and oral acyclovir 400 mg (5 \times /day) were started.

There was a marked improvement in his condition. However, after 5 weeks of reducing g-Predsol, he developed bacterial keratitis. Steroids were stopped and hourly g-ofloxacin 0.3% was commenced. Cultures showed fast-growing non-tuberculous mycobacterium (*Mycobacterium abscessus*) sensitive to amikacin and clarithromycin, but resistant to ciprofloxacin/ chloramphenicol/vancomycin/erythromycin/ cefotaxime/penicillin/rifampicin/imipenem/ gentamicin. Despite intensive topical g-amikacin 1.25% monotherapy, the ulcer grew with stromal crystalline keratopathy at the edges (Figure 1a and b). Clarithromycin 500 mg b.d. and g-clarithromycin 1% were added. g-Clarithromycin was poorly tolerated and g-amikacin was recommenced.

Gradual deterioration with eventual perforation occurred. Therapeutic penetrating keratoplasty was performed. Crystalline keratopathy due to *M. abscessus* recurred while on topical g-dexamethasone 0.1%, g-chloramphenicol, and oral clarithromycin and acyclovir. The patient obtained g-gatifloxacin 0.3% from the United States, which was effective with resolution at 4 weeks.

Comment

Less than 30 cases of non-tuberculous mycobacterial ICK have been described.^{1,2} Previous surgery or trauma is





Figure 1 (a) Right cornea. (b) Magnified right cornea: midstromal crystalline keratopathy at the edges of the epithelial defect.

commonly associated with it. *Candida* has also been found to be a cause of post-surgical ICK.³ This is the first reported case of non-tuberculous mycobacteria without iatrogenic or accidental corneal trauma. Similarly,⁴ we found fourth generation fluoroquinolones effective in treatment and recommend first line use for these cases. As *M. abscessus* can be found in soil and water, patients at risk of infection should be warned of hygiene to prevent the severe consequences of ICK.

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Sir

Operating microscope use in scleral buckling Correspondence

Raman *et al*¹ advocate the use of the operating microscope for scleral buckling surgery. Iatrogenic scleral perforation is a recognized complication of scleral buckling surgery, and the authors elucidate manoeuvres that may decrease the likelihood of this intraoperative complication.

Time is of the essence when surgery is required to repair a macula-attached retinal detachment, as progression of the detachment to the macula will influence visual outcome significantly.² When nonelective scleral buckling surgery is undertaken for these patients, ideal surgical facilities may not be available to the surgeon—for example, the eye operating room might be unavailable, while the general operating facility is more accessible. In the absence of the operating microscope under such circumstances, the surgeon will have to rely on loupes or the naked eye to pass partial thickness scleral sutures.

The authors suggest the use of the non-dominant hand for passing scleral sutures in certain positions to access parts of the scleral quadrants. In our view, the use of the non-dominant hand leads to considerable loss of control and proprioception, increasing the possibility of an iatrogenic perforation. Also, the frequency of scleral buckling surgery has decreased somewhat, following the universal adoption of extracapsular cataract extraction techniques.^{3,4} This has diminished the opportunity for trainee surgeons to develop ambidexterity for scleral suturing manoeuvres.

The authors assert that using the operating microscope promotes comfort and good posture, since the surgeon remains seated 'all the time' during the operation. We believe that scleral buckling surgery is necessarily a dynamic operation in which the surgeon can remain seated only some of the time, because indirect ophthalmoscopy must still be performed at various points during the surgery when the surgeon will stand and the microscope will be removed from the field.

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Sir,

Use of the operating microscope for scleral buckling We thank Drs Singh and Stewart for their interest in our paper.

We agree that time is definitely the essence for operating on an unstable super-temporal macula on rhegmatogenous retinal detachment. The objective of our paper¹ was to advocate the routine use of the operating microscope when it is available for buckling surgery. Not having access to the operating microscope in a scenario as described will definitely make it difficult to achieve the objective as suggested in our paper. In this situation, a loupe would be a superior alternative to surgery performed with the naked eye.

We assume that the authors probably mean to say that, with the universal adoption of phacoemulsification, cataract surgery trainee surgeons do not get adequate practice in suturing techniques.

This is quite true and makes it a compelling argument for suturing under the operating microscope, as there is greater stereopsis and magnification and less likelihood