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 non-elective 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 paper[1] 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

for scleral perforation, particularly for trainee surgeons. Ambidexterity can be achieved with practice over a period of time under an operating microscope.

Back problems related to posture adopted during surgery are due to bending and leaning over the operating site when standing. This is again minimal with the use of operating microscope, required only during break localization and cryopexy.

We strongly believe that using the microscope will result in better trained, more dexterous vitreoretinal surgeons, with less risk of inadvertent scleral perforation during surgery and less prone to back problems in later life.

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Sir,

Combined treatment of a juxtapapillary retinal capillary haemangioma with intravitreal bevacizumab and photodynamic therapy

The treatment of juxtapapillary retinal capillary haemangioma (RCH) raises difficulties because of the vicinity to the optic nerve. As juxtapapillary RCHs are frequently located at the temporal site of the disk,[1,2] chronic leakage often threatens the macula.[3] Photodynamic therapy (PDT) with verteporfin has shown to succeed in shrinking RCH, but repeated treatment often resulted in poor functional results.[2,3] We report on a case of juxtapapillary RCH, successfully treated with a combination of intravitreal bevacizumab and PDT.

Case report

A 58-year-old patient complained about diminished vision since 2 days. Visual acuity (VA) was RE: 20/200 and LE: 20/25. Ophthalmoscopy revealed an elevated mass overlying the temporal half of the optic nerve with invasion of the peripapillary area and macular exudation (Figure 1). Fluorescence angiography showed early hyperfluorescence of the tumour vessels. Perimetry revealed a centrocoecal scotoma. Systemic staging was unremarkable.[1]

Informed consent was obtained in accordance with IRB approval. Two days after the intravitreal injection of 1.25 mg bevacizumab, a decrease in exudation was seen. VA increased to 20/40. Two weeks later, PDT (verteporfin

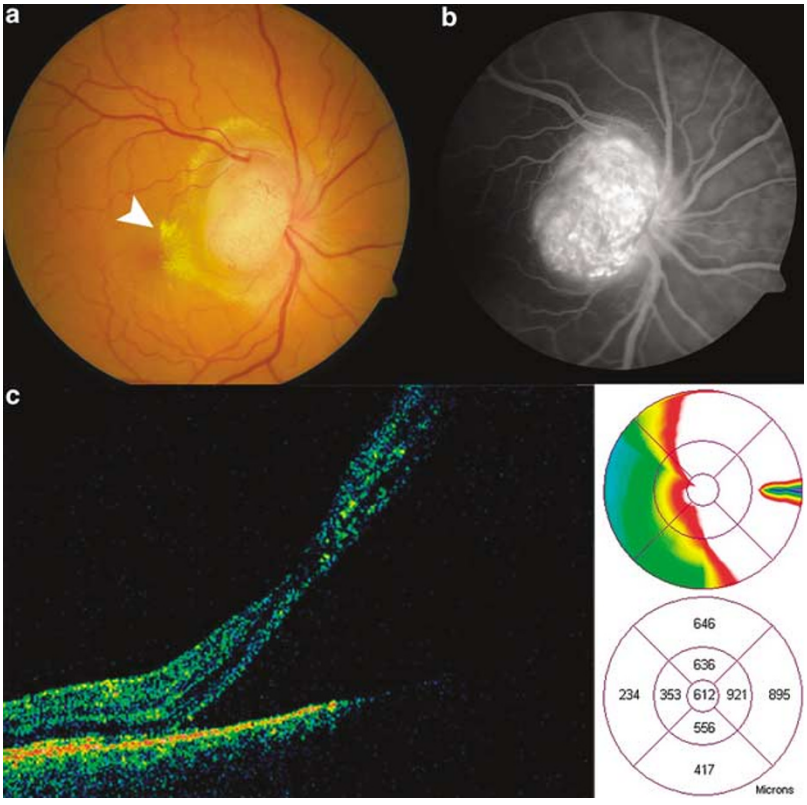

Figure 1 (a) Fundus photograph demonstrates the endophytic growth of the juxtapapillary capillary haemangioma and the concomitant exudation involving the fovea (white arrow). (b) Fluorescein angiography showed early hyperfluorescence of the prominent tumour. (c) Initial optical coherence tomography showing horizontal section through the fovea (left) and retinal thickness map (right).