ERG abnormalities together with antiretinal antibodies suggest a paraneoplastic origin like melanoma-associated retinopathy (MAR). In our patient with no antiretinal antibodies and a normal ERG, MAR syndrome is unlikely.[6]

The vitelliform lesions of our patient may resemble other disorders with vitelliform lesions like acute exudative polymorphous vitelliform maculopathy[7] (AEPVM) or adult vitelliform macular dystrophy[8] (AVMD). Both diseases show normal ERG and no antiretinal antibodies. However in contrast to our case, AVMD patients show a solitary subretinal lesion in the fovea. AEPVM consists of bilateral vitelliform lesions and visual loss, which resolve within several months, accompanied by subnormal ERG and EOG. Neither one has associations with ocular or systemic malignities.

Fundus configuration as well as the course of the mentioned diseases are quite different from that of our patient.

Although our patient had a normal ERG and no antiretinal antibodies, the association of vitelliform lesions with metastatic choroidal melanoma suggests a paraneoplastic origin.

The pathogenesis of paraneoplastic retinopathy is poorly understood. Further studies are required for a better understanding of the aetiology.

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Sir,

Peripheral corneal ulceration as a complication of silicon punctal plug: a case report

Punctal plugs (PP) insertion is an effective and reversible method to treat dry eye syndrome (DES) and some other ocular surface diseases. Non-absorbable plugs made of silicon are the most commonly used types and are relatively safe with minimal complications.[1] We report a case of corneal ulcer secondarily to localized irritation from a fragmented cap of silicon PP in a patient with DES.

Case report

A 55-year-old man is presented to emergency eye clinic with a watery, sore, and red left eye. He gave a history of having silicone PPs inserted into both eyes 5 years earlier. Examination showed a peripheral corneal ulcer, 2×1 mm in size at 8 O'clock, separated from the limbus by a zone of clear cornea in his left eye. A provisional diagnosis of marginal keratitis was made and treatment with topical antibiotic and steroid combination was initiated. After 2 weeks with an interim follow-up visit, the patient reported little improvement in his symptoms and was still found to have active corneal ulceration. Slit-lamp examination revealed that on adducting his left eye, the ulcerated corneal margin comes into direct contact with the cap of the lower lid PP (Figure 1a–d). The cap was seen partially broken and hence was removed. Complete resolution of the ulcer was observed a week later.

Comment

The most popular PP design was first described by Freeman in 1975.[2] This style of PP has a wide disc-shaped top/cap that sits level on the punctal opening to prevent plug migration into the canaliculus. Conjunctival irritation caused by this exposed part of PP may warrant plug removal in a small number of treated patients (1.5%).[3] However, apart from spontaneous PP extrusion and loss (40% by 6 months),[4] other complications are rare and include bacterial conjunctivitis and punctal granuloma formation.

In literature, peripheral corneal ulceration has not been described in association with silicone PP. Although co-existing ocular surface disorder may have initiated the corneal ulceration in our case, the intermittent irritation by the edge of the fragmented PP top may have played a major role in maintaining it.

PP design with no exposed part (intracanalicular) theoretically eliminates local irritation; however, such design is associated with canaliculitis and dacryocystitis.[5] Among others, these complications should be addressed in future designs of PP. For early

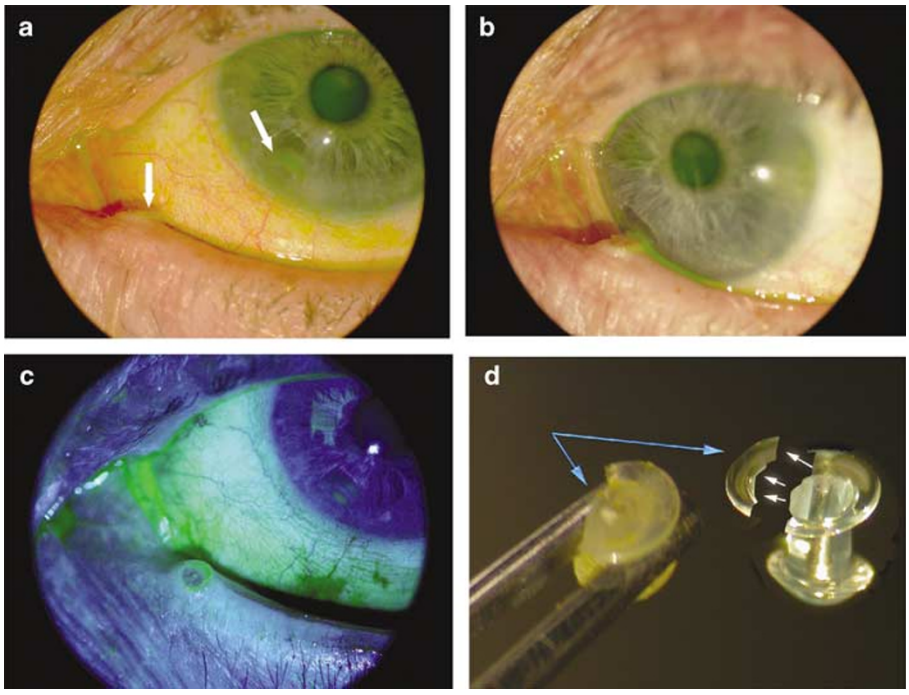

Figure 1 White arrows point to the PP and the corneal ulcer (a), coming in direct apposition on adduction (b). The lower lid is pulled to show PP broken cap (c). The whole plug is shown after removal (d, left), compared to an illustrated new plug with a torn lip (d, right).

diagnosis of PP-associated complications, careful examination of the punctum area is necessary in patients presenting with red eye and a history of PP insertion.

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Sir,

Bilateral Group A streptococcal endogenous endophthalmitis following routine gynaecological surgery

When a patient is referred with a sticky, painful eye soon after an operation on a region of the body remote from the eye, and they are systemically unwell, a diagnosis of endogenous endophthalmitis should be considered. If after examining the eye endophthalmitis seems possible then blood cultures should be taken.

Case report

A previously healthy 62-year-old woman with no past ocular history was admitted with abdominal pain and red, painful eyes 2 days following a routine hysteroscopy for investigation of postmenopausal bleeding. The visual acuities were hand movements in each eye and the conjunctivae were injected with an accompanying pseudomembrane formation. Both corneas were opaque and the left was necrotic inferiorly.

Bilateral hypopyons were present, iris detail was obscured and no red reflex could be seen in either eye (Figures 1 and 2). On systemic examination, the patient was confused, pyrexial, septicaemic, and hypovolaemic. A *B*-haemolytic group A streptococcus was isolated on blood culture and a diagnosis of streptococcal bilateral endogenous endophthalmitis was made.

Treatment was commenced with topical ofloxacin and cefuroxime 5%, and oral ciprofloxacin 750 mg bd. Intravitreal amikacin 0.4 mg and vancomycin 1 mg was administered twice within the first 72 h. No organism was identified from the vitreous biopsy specimens. At 3 months following presentation, the right eye