

pressure increase being the primary cause of the visual loss.

Acetazolamide or osmotic diuretics may help the situation but an orbital decompression in the form of a lateral canthotomy and inferior cantholysis should be the treatment of choice.⁶ This type of orbital decompression works by increasing the space available, thus reducing the orbital pressure.

If there are signs of optic nerve compromise in the form of a visual loss, field defect or an afferent pupil defect in a situation of acute retrobulbar haemorrhage, an immediate orbital decompression in the form of a lateral canthotomy and inferior cantholysis should be considered. In a situation of retrobulbar haemorrhage following retrobulbar anaesthetic injection it is obviously difficult to assess optic nerve function, but if there are any signs of increased orbital pressure it may be safer to do a lateral canthotomy and inferior cantholysis. Further investigations need to be done in the individual situation, based on the history and clinical manifestations, to find the aetiology of the retrobulbar haemorrhage. Once the eye settles down it is relatively easy to repair the lateral canthus by an approach similar to the one described for an ectropion.⁷

This case demonstrates the need for urgent surgical intervention in an acute retrobulbar haemorrhage compromising the optic nerve, and also shows the dramatic recovery of optic nerve function following immediate intervention.

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Sir,

Endophthalmitis Caused by *Enterococcus faecalis*

We present a case of post-operative endophthalmitis caused by *Enterococcus faecalis*. Few cases of enterococcal endophthalmitis have been reported and we review the likely source of infection, when the diagnosis should be suspected and the treatment options available.

Case Report

A 68-year-old woman underwent uneventful right endocapsular cataract extraction with intraocular lens implantation. Post-operative recovery was uneventful until on the third post-operative day she had a rapid onset of pain, photophobia, lid swelling and a rapid decline in her visual acuity. She presented to the eye department the same day, when examination revealed a visual acuity of perception of light (PL) in the operated eye (compared with 6/18 unaided on the first post-operative day) The anterior chamber had a 40% hypopyon, there was no red reflex and no view of the retina could be obtained. A diagnosis of an infective endophthalmitis was made and a vitreal tap was performed with instillation of amikacin and vancomycin. Further to this a subconjunctival injection of vancomycin and gentamicin was given and the patient was commenced on intravenous vancomycin and gentamicin as well as g. gentamicin forte and g. cefuroxime hourly. A Gram stain revealed Gram-positive cocci and the treatment regime continued.

Over the next 48 hours the hypopyon remained static and the vision remained at PL with no red reflex; the patient declined to have a vitreoretinal opinion as she did not want to undergo further surgery. Three days after her initial presentation *Enterococcus faecalis* was grown from her vitreous tap. The organism was found to be resistant to gentamicin but was sensitive to amoxycillin and vancomycin.

One week after presentation her vision had declined to no perception of light (NPL), the hypopyon had decreased but no retinal view was obtainable. The treatment was slowly tapered over the next few months and to date the eye is comfortable but remains NPL.

In her past medical history, she was diagnosed as hyperthyroid in 1974 with marked exophthalmos, but this had been stable for many years. In early 1992 she underwent a successful left extracapsular cataract extraction with a resulting visual acuity of 6/5 unaided and no post-operative problems following that procedure. Later in 1992 she had been admitted

with an acute cholecystitis and subsequently undergone a laparoscopic cholecystectomy some months later. She had persistent abdominal pain following this and in early 1994 she underwent exploration of a recurrent umbilical sinus; the sinus was excised and a small gallstone was found at its base.

Discussion

Endophthalmitis following surgery is a rare condition¹ and there have only been a few cases in the literature of *Enterococcus* being the causative organism.²⁻⁷ *Enterococcus faecalis* is normally found in the urinary and gastrointestinal tract;⁷ it is a group D *Streptococcus* (now called enterococci) and usually only weakly pathogenic.² The organism is strongly resistant to bile, commonly being found in chronic biliary obstruction, and is a not uncommon cause of sub-acute bacterial endocarditis.²

Enterococcal endophthalmitis of both endogenous and exogenous origin has been described. Uchio *et al.*² described an endogenous infection following biliary surgery in a diabetic – who also developed a bacterial endocarditis. Exogenous infections usually occur after cataract extractions^{2,4,7} and the source of the organism may not be obvious.⁷ It is interesting to note that our patient underwent surgery for cholecystitis in 1992 and a chronic umbilical sinus with a gallstone was excised a few months prior to her endophthalmitis.

The organism that was cultured from our patient was sensitive to amoxicillin and vancomycin; the latter antibiotic is known to be effective against enterococci⁷ and can be given intravitreally or intravenously. There has been a report of an enterococcal endophthalmitis being sensitive to ampicillin⁷ and it has been shown that intravenous ampicillin can produce effective concentrations in the aqueous but not the vitreous.⁸ Intravitreal ampicillin has been shown to be of benefit in the treatment of endophthalmitis.⁹ The effect of vitrectomy on this case could not be assessed since she refused surgery.

The prognosis of enterococcal endophthalmitis is poor: visual acuity, even when the infection resolves, is usually very poor and there have been two reported cases of secondary glaucoma^{4,7} and a subsequent enucleation.⁷ Interestingly, the endogenous case did relatively well, with a final visual acuity of around 6/24 after vitrectomy, intravenous piperacillin and minocycline and immunoglobulin.²

Conclusion

Enterococcus faecalis endophthalmitis is a rapidly blinding condition. It is a rare ocular pathogen but should be treated aggressively with a combination of gentamicin or vancomycin and amoxicillin or ampicillin intravitreally and intravenously. When a patient with either an endogenous or exogenous

endophthalmitis has a recent history of chronic biliary obstruction the possibility of *Enterococcus* being the causative organism should be borne in mind.

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Sir,

New Forceps for Implanting Intraocular Lenses

Several techniques have evolved for intraocular lens insertion. A prerequisite of many of these is the use of a three-piece lens,^{1,2} as the flexible superior haptic



Fig. 1. New forceps with 'J'-shaped curve and flattened tips.