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 condition[1] 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 amoxycillin and vancomycin; the latter anitbiotic is known to be effective against enterococci[7] and can be given intravitreally or intravenously. There has been a report of an enterococcal endophthalmitis being sensitive to ampicillin[7] 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 amoxycillin 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

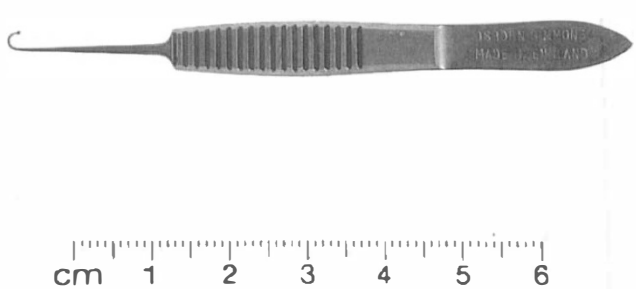

Fig. 1. *New forceps with 'J'-shaped curve and flattened tips.*

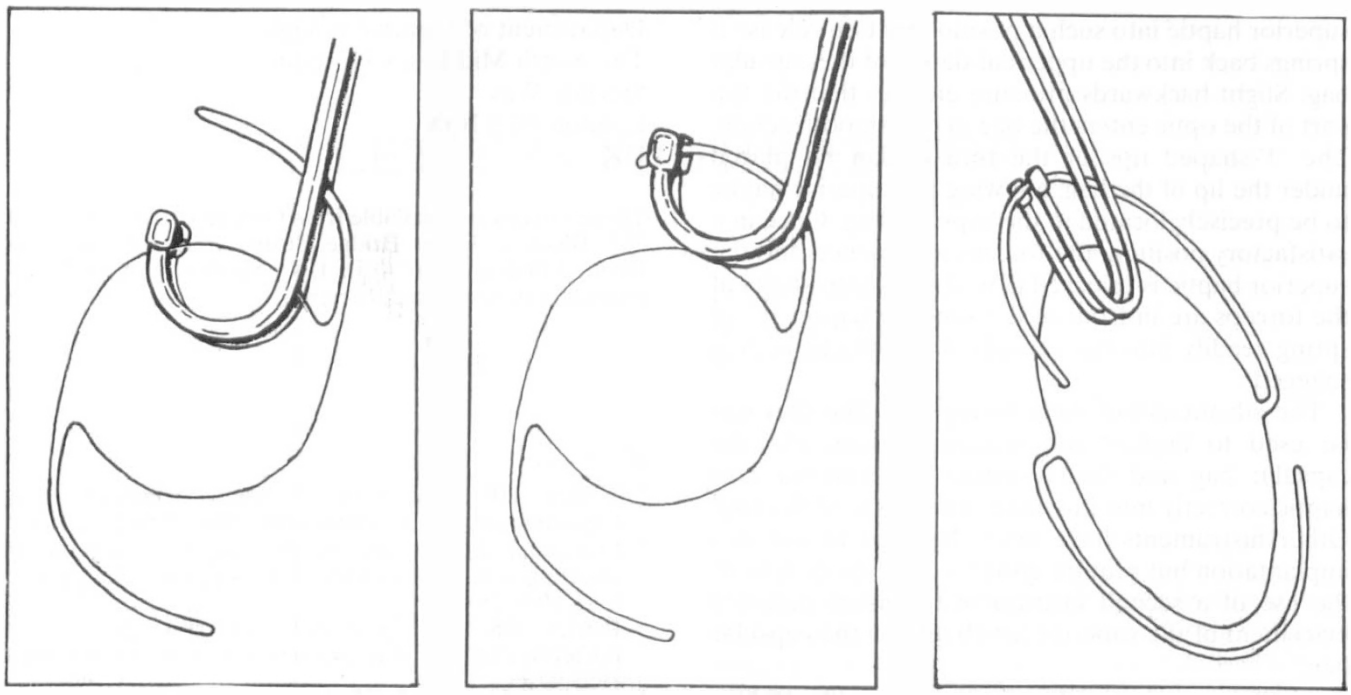

Fig. 2. *The forceps are used to grasp the lens, which is then inserted into the capsular bag. The forceps are then removed (left). Next the forceps are reintroduced closed, above the superior haptic (middle and right). The forceps are then opened and the tips used to grasp the outer third of the haptic. Gently pushing the forceps forwards and slightly backwards places the intraocular lens inside the capsular bag.*

of these lenses can be compressed against the optic. This manoeuvre shortens the length of the lens implant allowing it to be inserted with greater ease through the hole in the anterior capsule. Such techniques are not possible with one-piece lenses as the haptics are stiffer and fracture when compressed to such a degree.

Instruments have been designed to position the superior haptic of one-piece lenses inside the capsular bag.[3,4] However, this is only after the lens has been introduced into the capsular bag with standard lens-introducing forceps.

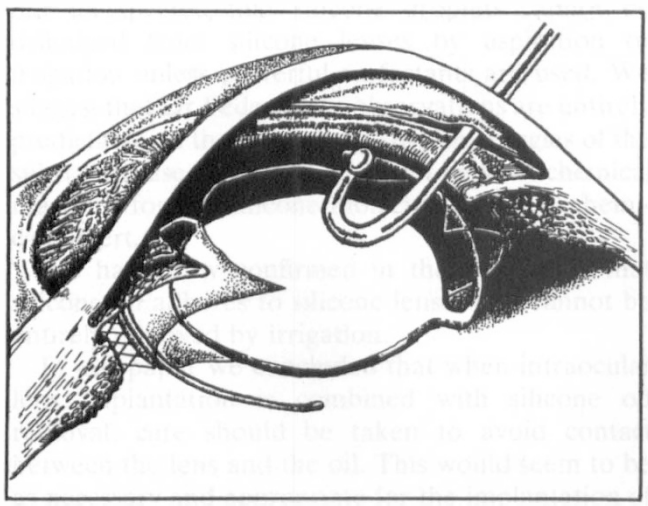

Fig. 3. *The tip of the superior haptic is gently manoeuvred around the lip of the capsular bag and then released. Accurate placement is assured.*

The new lens-introducing forceps presented here have been specifically designed to overcome these problems. Firstly, the forceps can be used to insert the inferior haptic of the lens in the capsular bag. They are then used to place the superior lens haptic exactly under the lip of the capsular bag, allowing accurate lens placement every time. The forceps can be used to implant both one-piece and three-piece lenses. The forceps have been used for both extracapsular cataract surgery and phacoemulsification, in over 100 cases.

Method of Use

The 'J'-shaped forceps (Fig. 1) are made from stainless steel. The straight shafts have a length of 18 mm and curve to end with semicircular tips. The ends of the forceps are slightly flattened to provide a secure grip.

In use, the forceps are used to grasp the top of the lens (Fig. 2, left), inserting the inferior haptic into the capsular bag. At this stage the superior haptic is still protruding through the wound. The forceps are then withdrawn. The shafts of the closed forceps are then placed in front of the superior haptic and into the anterior chamber in front of the optic (Fig. 2, middle). Next the forceps are opened slightly while being withdrawn from the eye, until the tips encounter the superior haptic. This is then grasped at the junction of the outer and middle third (Fig. 2, right). The forceps are advanced again, pushing the lens into the capsular bag. The forceps carry the

superior haptic into such a position that on release it springs back into the upper cul-de-sac of the capsular bag. Slight backwards pressure ensures that the top part of the optic enters the bag in one smooth action. The 'J'-shaped tips of the forceps can be placed under the lip of the bag, allowing the superior haptic to be precisely located in the capsular bag. Once in a satisfactory position, the forceps are opened and the superior haptic is released (Fig. 3). As both shafts of the forceps are in front of the superior haptic, it can spring readily into the capsular bag without getting snagged.

The advantages of these forceps are that they can be used to implant the intraocular lens into the capsular bag and then position the superior lens haptic correctly into the upper cul-de-sac of the bag. Other instruments have been designed to aid lens implantation but require either a three-piece lens or the use of a second instrument to ensure accurate placement of the superior lens haptic in the capsular bag.

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These forceps are available from Osborn & Simmons, Unit 213, Block J, Tower Bridge Business Square, Clements Road, London SE16 4EF, UK. Neither surgeon has a financial interest in the forceps.

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