# LETTERS TO THE JOURNAL

Sir,

**Subhyaloid Haemorrhage with Fluoxetine**

We report a case of subhyaloid haemorrhage which occurred in a patient receiving fluoxetine (Prozac; Dista). The drug is known to cause disorders of platelet function and bleeding. This case is the first description in the literature of subhyaloid haemorrhage, although there have been reports of 'eye haemorrhage' reported to the drug's manufacturer.

*Case Report*

A 51-year-old woman was started on 20 mg fluoxetine daily for mild depression. There was no past medical history of note and in particular there was no history of abnormal bleeding, hypertension or diabetes. She had no recent or concurrent medical treatment. One week later she noticed floaters and flashing lights in her right eye, followed by loss of vision in that eye. There was mild discomfort around the eye but she felt otherwise well.

When examined there was no meningism and blood pressure was 140/80 mmHg. The only abnormal findings were impaired visual acuity (finger counting) in the right eye with a large subhyaloid haemorrhage involving the macula and haemorrhages along the vessels. The fundus and acuity in the left eye were normal.

Fluorescein angiography confirmed the subhyaloid haemorrhage but showed no evidence of vasculitis. A computerised tomogram scan of the brain, plasma glucose, renal and liver function tests, autoantibody screen, plasma viscosity and blood count (including platelet count) were normal apart from a slightly high mean corpuscular volume. Serum vitamin $B_{12}$ and folate levels were normal. The fluoxetine was stopped and she was treated with ethamsylate. The haemorrhages slowly resolved and visual acuity returned to normal.

It was considered unethical to rechallenge with fluoxetine so we cannot attribute with certainty this adverse event to the drug. However, we found no other cause for the haemorrhage, which occurred soon after the start of treatment with fluoxetine and has improved since withdrawal of the drug.

*Discussion*

The serotonin reuptake inhibitor fluoxetine is a widely prescribed antidepressant. It reduces platelet stores of serotonin, inhibits platelet aggregation and prolongs the bleeding time without causing thrombocytopenia.[1,2] Serious haemorrhagic complications, including one case of death resulting from haemorrhage, have been attributed to fluoxetine.[3,4] Dista Products Ltd, the manufacturer of fluoxetine, informed us that 'during clinical trials [with the drug] eye haemorrhage was reported rarely'.

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Sir,

**Patient Perceptions of Cataract Surgery Pre-operatively**

Cataract surgery is the most commonly performed intraocular operation. Awareness of patients' perceptions, anxieties, expectations and knowledge regarding the procedure is essential if ophthalmologists are to assist patients in providing informed consent. It is the duty of the surgeon to provide a description of the proposed treatment and the potential risks associated with it.

We present the results of a survey investigating patient perceptions of cataract surgery pre-opera-

 

tively. Two hundred consecutive patients attending the pre-operative assessment clinic were invited to complete a confidential questionnaire. This was done before the pre-operative education programme for two reasons: first, to establish the understanding patients have of cataract surgery, and second, to identify misconceptions they may have regarding the procedure. This information could be used to enhance the effectiveness of patient education. Patients who had undergone previous intraocular surgery were excluded. To minimise the bias inherent in questionnaires, all questions included a 'Don't know' option.

All 200 patients asked to complete the questionnaire did so. One hundred and thirty-two were female and 68 were male (mean age 69.8 years; range 39–88 years). The perceived anatomical locations of a cataract were: anterior surface of the eye (37.5%), behind the eye (14%) and intraocular (19.5%). Common misconceptions concerning cataract surgery included: it is performed by laser (35%); an intraocular lens is not inserted (22%); the eye is taken out of the orbit (6%); the cataract is scraped off the anterior surface of the eye (31%). Five per cent of patients were expecting the unlisted eye to be operated upon, and 1.5% did not know which side had been scheduled for surgery.

The results raise the issue of informed consent and how much technical information a patient requires pre-operatively. It has been reported that too much technical knowledge can be anxiety-provoking.[1,2] However, problems relating to informed consent are a factor in 25% of medico-legal claims concerning cataract surgery in the United States.[3] This reflects the frequent disparity between the surgeon's and the patient's recollection of the pre-operative discussion. O'Malley *et al.*[1] showed that cataract patients retained only 37% of pre-operative information when tested post-operatively. This further emphasises the need for the ophthalmic surgeon to identify misconceptions patients have regarding cataract extraction in order that they may be clarified prior to surgery.

The provision of a detailed written informed consent form at the time of listing, which is to be signed in the presence of the doctor at the pre-operative assessment clinic, has been shown to greatly enhance patient knowledge of the procedure.[4] Concerns arising from such information could be specifically addressed before surgery, thereby ensuring the patient is indeed providing informed consent.

In conclusion, this survey reveals a poor understanding of the term 'cataract' and basic misconceptions regarding the surgical procedure among patients. Ophthalmologists should be aware of patient perceptions in this area.

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Sir,

**_E. coli_ Endophthalmitis**

Endogenous bacterial endophthalmitis is a rare event. The causative bacteria usually reported are gram-positive, i.e. *Staphylococcus aureus* or *Streptococcus* species.[1] Endophthalmitis due to gram-negative organisms such as *E. coli* is being increasingly reported. We report a case of endogenous endophthalmitis due to *E. coli*.

*Case Report*

A 72-year-old insulin-dependent diabetic woman was referred with a 5 day history of rapid and painful loss of vision in the right eye, severe headaches and malaise. The patient was lethargic and dehydrated but afebrile. The right eye had no perception of light, while she could perceive hand movements with her buphthalmic left eye. The right eye was proptosed and immobile with grossly swollen lids. There was corneal oedema, a hypopyon and a very shallow anterior chamber. Intraocular pressure was more than 60 mmHg. There was no fundal reflex and posterior segment evaluation by B-scan ultrasonography revealed low-intensity spikes in the vitreous cavity and choroidal and scleral thickening. CT scanning showed extensive soft-tissue swelling of the orbit, no extraocular muscle enlargement and gas in the anterior chamber. The sellar region and cavernous sinus were normal (Fig. 1). Relevant laboratory findings were a leucocyte count of 16400/mm$^3$, a plasma viscosity of 1.98, a blood urea of 12.2 mmol/l and a plasma glucose of 11.0 mmol/l. Urine microscopy showed more than 50 leucocytes/h.p.f. and gram-negative bacilli.

The patient was treated with intravenous penicillin, flucloxacin and ciprofloxacin and topical fortified