the literature. We wish to bring this observation to the notice of ophthalmologists prescribing latanoprost 0.005% so that patients undergoing treatment may be informed of its new side effects.

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Sir,

Intralenticular abscess caused by *Stenotrophomonas maltophilia*

The non-fermentative Gram-negative bacillus *Stenotrophomonas maltophilia* has increased in profile in recent years as a significant nosocomial pathogen with rapidly rising clinical importance.[1] We describe a case of intralenticular abscess resulting from this organism, which has not, to our knowledge, been previously reported.

Case report

A 27-year-old woman was referred from a provinicial ophthalmology department with right uveitis for further assessment and management. She had first presented to that centre 16 months earlier with right iritis, after which initial investigations and treatment were never completed, the symptoms resolved, and she did not re-present for follow-up. Four weeks previously she had given birth to a normal-term infant. She had lived in a rural setting for 4 years.

Two weeks before tertiary referral, there had been a rapid onset of photophobia, right eye ache and redness. She was admitted to the provincial hospital for 2 days, treated with dexamethasone 1% eyedrops 2-hourly and atropine 1% eyedrops 8-hourly. The patient stated that she initially improved but then worsened. Betamethasone was injected subconjunctivally.

Anterior segment activity was recorded as increasing despite treatment, and a dense exudative and inflammatory membrane had formed across the pupil. Iris bombe had developed and YAG iridotomy was attempted. Erythrocyte sedimentation rate at the provincial centre was 46 mm/h.

On examination at admission to Royal Brisbane Hospital, the Snellen visual acuity was light perception in the right eye and 6/5 in the left. There was a right relative afferent pupillary defect. In the right eye there was 3+ conjunctival injection, and mild corneal epithelial oedema. The anterior chamber was very shallow with areas of iris–endothelial contact. There was a fibrinous exudate across the anterior chamber forming a pupillary membrane. Mild iris bombe was present. Intraocular pressure in the right eye was 22 mmHg. No red reflex was visible and there was no fundal view. B-scan ultrasonography showed clear vitreous and no detectable retinal detachment. Pathology tests screening for causes of uveitis were performed showing no positive results. On examining the left eye, no abnormalities were noted.

Treatment was commenced with prednisolone 1%/phenylephrine 0.12% eyedrops half-hourly and atropine 1% eyedrops 6-hourly with oral prednisone 80 mg daily. There was decreased pain and decreased redness but a fibrin plaque persisted with leakage of lens material into the anterior chamber. Blood vessel growth was noted on the anterior surface of the lens.

Surgery was performed with removal of the dense, fibrinous pupillary membrane, and an anterior capsulotomy was made with aspiration of liquid pus. No lens fragments were identified. Intravenous vancomycin and ceftazidime were commenced. Microscopy of the lens aspirate showed Gram-negative rods.

A three-port pars plana vitrectomy was performed the next day, with debulking of a fibrinous exudate on the posterior hyaloid face. Three peripheral retinal tears were noted, and there were scattered satellite lesions on the retinal surface. A 360° scleral buckle was placed and endolaser performed. Amikacin 400 μg and vancomycin 2 mg were given intravitreally.

Subsequently, *Stenotrophomonas maltophilia* was grown, and after consultation with the infectious diseases unit, ceftazidime 2 mg was given intravitreally. Intravenous sulphamethoxazole 240 mg/trimethoprim 1.2 g t.d.s. was substituted for the vancomycin when the culture and sensitivities were completed.

Post-operatively, the retina remained flat with the aqueous cells clearing and the vitreous gradually becoming less hazy. At about 1 month post-operatively the patient was discharged back to the provincial centre. At this stage, the macula looked healthy with no oedema and visual acuity in the right eye was count fingers. Six months later, best corrected visual acuity in the right eye had improved to 6/36.

Comment

Stenotrophomonas maltophilia is primarily a free-living, aerobic plant pathogen that is also isolated in soil and water. Of particular note is its isolation on contact lenses and lens care systems.[2] Previously known as *Pseudomonas maltophilia* and then *Xanthomonas maltophilia*, it has been documented as the causative agent in conjunctivitis, corneal ulceration in contact lens wearers, keratitis (including in a corneal graft), infected scleral buckle, orbital cellulitis, dacryocystitis, preseptal cellulitis and endophthalmitis.[2–4]

In ocular infections and elsewhere this organism is becoming a more important nosocomial pathogen, particularly in the debilitated and immunosuppressed. Difficulty in distinguishing between colonisation and infection by *S. maltophilia* fostered the belief, particularly in the early days after its discovery, that it had limited pathogenicity.[2] Since its first description in 1960, it has shown a steady increase in its isolation rate in diagnostic laboratories, now being the second most common pseudomonad (after *Pseudomonas aeruginosa*) found in clinical specimens.[2]

Intralenticular abscess is an extremely uncommon clinical infection. The route by which the organism gained access to the lens capsule is obscure; however, risk factors would be the previous iritis, and the bacteraemia associated with recent childbirth. The patient denied and there was no evidence of ocular penetration or any intraocular injection of drugs.

Penicillins and cephalosporins are generally agreed to exhibit poor activity against *S. maltophilia*; however, ceftazidime has been shown to possess reasonable activity against it.[1] Susceptibility of this organism to fluoroquinolones is variable.[2] Trimethoprim–sulphamethoxazole has been found to be active against most strains of the bacterium, and in some cases may be an adequate treatment for this type of infection. Choice of antibiotic should be strongly based on culture and sensitivity results on a case-by-case basis. The authors were fortunate to be able to consult infectious diseases colleagues in order to individualise treatment for this organism with highly variable antimicrobial susceptibilities.

This case highlights the increasing context of this opportunistic organism and patterns of resistance that can make treatment difficult.

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Sir,

Transient phacodonesis after circling buckle procedure for rhegmatogenous retinal detachment

The pathomechanisms involved in producing phacodonesis have not all been firmly established. We present a patient who was admitted to our department due to severe ocular pain 9 days after a circling buckling procedure for rhegmatogenous retinal detachment in that eye. Ocular examination revealed severe phocodonesis, with ciliary body effusion on ultrasound biomicroscopy. Systemic steroid therapy resulted in prompt resolution of ocular pain with reabsorption of ciliary effusion as well as disappearance of the phacodonesis.

Case report

A 35-year-old highly myopic (–11.00 dioptre) male was evaluated due to visual deterioration in his right eye, which had a corrected visual acuity of counting fingers. The anterior segment was normal. Funduscopy revealed inferior macula-off retinal detachment.

The right eye underwent a circling buckling procedure of 360° and drainage of subretinal fluid, after which visual acuity was 1/36 and intraocular pressure was 10 mmHg, with no other change in the anterior segment. Funduscopy revealed a high 360° buckle indentation and an attached retina. The patient was discharged with topical steroids and atropine 1% twice daily.