

Figure 1 (a; Left). Four days after initiation of ATT: intense vitritis with the area of chorioretinitis adjacent to an area of previous scarring. (b; middle). One week after the addition of systemic steroids: resolution of vitritis and scarring of area of chorioretinitis. (c; right). One month after initial presentation: complete resolution of vitritis and scarring up of area of chorioretinitis.

Case report

A 77-year-old woman with biopsy-proven tuberculous cervical lymphadenitis was started on rifampicin, isoniazid, pyrazinamide, and ethambutol. Pretreatment screening showed normal vision in her left eye. The right eye had been phthisical for 10 years, with no light perception. Reduced vision (6/120) developed in the left eye 4 days after starting ATT, with 2+ anterior chamber cells, 3+ vitreous cells, and multiple areas of retinitis with sheathed vessels adjacent to pigmented chorioretinal scars. (Figure 1a).

Mycobacterium tuberculosis (TB) DNA was identified using PCR from a vitreous tap. DNA from CMV, HSV, VZV, or *Toxoplasma gondii* was not detected. Syphilis serology was non-reactive.

The diagnosis of TB chorioretinitis, with paradoxical worsening following ATT (ie, JHR) was made. Addition of oral prednisolone 25 mg once daily resulted in prompt resolution of vitritis and scarring of the area of chorioretinitis within 1 week (Figure 1b). Oral prednisolone was tapered over the next month, with further resolution of vitritis and chorioretinitis (Figure 1c) and the final best-corrected visual acuity was 6/45.

Comment

Systemic manifestation of JHR (fever, headache, and sweating) is most commonly associated with treatment of syphilis,¹ but has also been described in leptospiral infection² and Lyme disease.³ Ocular manifestations are less common, but has been described as retinal vasculitis in Whipple's disease.⁴ Proposed mechanisms include endotoxin release from the death of organisms, delayed hypersensitivity, and decreased suppressor mechanisms.

In systemic TB, JHR has been described as worsening of intracranial tuberculoma, meningeal disease, tuberculous meningeal radiculitis, pleural effusion, and abdominal TB.⁵

We believe that the rapid worsening of vitritis and chorioretinitis following initiation of ATT in our patient and the prompt improvement with corticosteroid represent the JHR. Although only anecdotal report of ocular JHR in tuberculous seropigorous choroiditis exists,⁵ this is the first reported case of JHR manifesting as ocular

symptoms following initiation of ATT. This case highlights the importance of the awareness of JHR and the importance of appropriate and timely use of systemic steroids.

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Eye (2009) **23**, 1472–1473; doi:10.1038/eye.2008.204; published online 4 July 2008

Sir, Orbital cellulitis and cavernous sinus thrombosis secondary to necrobacillosis

Necrobacillosis, the septicaemic disease caused by *Fusobacterium necrophorum*, is a rare and potentially fatal disease. The original description of Lemierre¹ included fever, rigors, arthritis, and pulmonary infarct occurring after an episode of sore throat. The mortality and morbidity is commonly due to thrombotic complications and septicaemia. We report a case of *F. necrophorum* septicaemia causing orbital cellulitis and cavernous sinus thrombosis in a healthy young female patient.

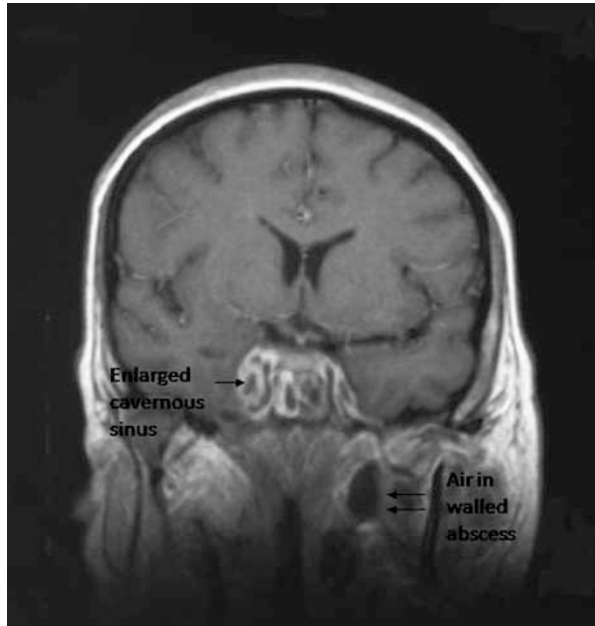


Figure 1 Coronal MRI (T1, post-gadolinium) image showing enlarged right cavernous sinus and left parapharyngeal abscess.

Case report

A 23-year-old female patient was admitted to the infection unit with high fever (40°C) left facial swelling, right proptosis, diplopia, and decreased vision for 2 days. She had been treated with clarithromycin for a sore throat 3 weeks before presentation. Examination revealed visual acuity of 6/24 on the right and 6/5 on the left, proptosis (26 mm OD, 22 mm OS), conjunctival chemosis, and painful limitation of gaze.

CT scan revealed a left-sided parapharyngeal abscess with a right-sided cavernous sinus thrombosis. Throat examination revealed a parapharyngeal abscess abutting the epiglottis. She underwent emergency left tonsillectomy with drainage of the abscess and was commenced on high-dose intravenous benzyl penicillin with metronidazole.

On the third day of admission, she developed left arm weakness and a right facial palsy. The MRI scan revealed diffuse swelling of right hemisphere with swollen right cavernous sinus and enhancement of adjacent sphenoid sinus (Figure 1). Blood and aspirate culture grew *F. necrophorum* sensitive to penicillin, metranidazole, and clindamycin. She received 4 weeks of the appropriate intravenous antibiotics and had a full recovery.

Comment

F. necrophorum is a Gram-negative anaerobic commensal of human oropharynx. Its pathogenesis is attributed to endotoxin, lipopolysaccharide, and haemolysin. The lipopolysaccharide is shown to aggregate platelets and thought to be responsible for thrombotic complications of Lemierre's disease.² *F. necrophorum* septicaemia tends to occur after a sore throat.³ Antibiotic therapy is the

mainstay of treatment. Most species are susceptible to penicillin, cephalosporin, metronidazole, clindamycin, tetracycline, and chloramphenicol.⁴ In our case, the organism was sensitive to penicillin and metronidazole. Prolonged aggressive treatment and debridement are necessary.⁵ Culture of blood and aspirate from the abscess seems valuable in isolating the organism. *F. necrophorum* infection must be considered in any case of orbital cellulitis with other coexisting focus of infection or venous thrombosis.

References

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Eye (2009) 23, 1473–1474; doi:10.1038/eye.2008.202; published online 4 July 2008

**Sir,
 Bacterial contamination of the disposable prism holder during routine tonometry for intraocular pressure**

The theoretical risk of prion transmission has led to the widespread use of disposable prism tonometers.¹ This has led to the marketing of products such as TONOSAFE (Haag-Streit UK), who state in their product information that 'disposable prisms are convenient, effective method of reducing the risk of cross infection between patients and eliminating the need to clean and disinfect prisms.'² The actual prisms have been shown to enable accurate pressure measurement and to be sterile.^{3,4} The potential risk of transmission of microbial contamination of the holder for disposable applanation prisms has yet to be reported (see Figure 1).

Case report

In the light of this, an audit of handwashing was performed during a general ophthalmology checkup. This involved plating of ophthalmologist's fingers, after handwashing, following the interaction with patients.