

Comment

Eales' disease characterized by perivascular sheathing, peripheral retinal nonperfusion, and neovascularization, predominantly affects young males.^{1,2} Bilateral involvement is present in 80–90% of patients.¹ In this case, other conditions such as sarcoidosis, tuberculosis, syphilis, systemic lupus erythematosus, and primary HIV infection, which could be associated with a similar clinical picture were ruled out.

Macular involvement in the form of cystoids macular oedema and macular pucker has been reported in Eales' disease;³ however, premacular subhyaloid haemorrhage was present in this patient during the active inflammatory stage. Premacular haemorrhage produces profound visual loss, which may be prolonged and cause permanent macular changes. Nd:YAG laser hyaloidotomy has been described as an effective procedure for management of premacular haemorrhages.^{4,5} The present case also had immediate clearing of the premacular haemorrhage and early recovery of vision after Nd:YAG laser hyaloidotomy (Figure 1). No retinal or choroidal damage was observed.

To conclude, premacular subhyaloid haemorrhage can be present in Eales' disease, which can be managed effectively with Nd:YAG laser posterior hyaloidotomy.

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Sir, Two non-infectious forms of endophthalmitis after intravitreal triamcinolone and cataract extraction

Intravitreal triamcinolone acetate (IVTA) has been used to treat resistant macular oedema associated with diabetes, vascular occlusion, and uveitis.¹ Three forms of endophthalmitis have been described with IVTA use: infectious, sterile, and pseudoendophthalmitis. We report the occurrence of sterile endophthalmitis and pseudoendophthalmitis in the same eye after IVTA.

Case report

A 62-year-old male non-diabetic patient with a 10-year history of idiopathic anterior uveitis OU developed cystoid macular oedema (CME). He required topical steroids and four subtenon's triamcinolone injections OU. In October 2006, the patient received the first IVTA (4 mg) for recalcitrant CME OD. The CME cleared but his vision remained 20/100 because of the posterior subcapsular cataract. Focal zonular weakness was noted during the cataract surgery. A capsular tension ring and an acrylic intraocular lens were placed in the bag. The case concluded with an IVTA (4 mg).

Six hours after surgery, a 0.5-mm hypopyon was noted with a mixture of fibrin and cells (Figure 1). Visual acuity was *hand movement* and intraocular pressure (IOP) of 52 mmHg. Initial treatment included topical gatifloxacin, timolol/dorzolamide, and brimonidine. On postoperative day 2, aspirates from the anterior chamber and vitreous cavity were sent for culture; intravitreal vancomycin, and ceftazidime were given at the same time. The culture remained negative. On postoperative day 6, a bright white crystalline material was found above the original cream coloured hypopyon (Figure 2). Over the next week, the layered hypopyon cleared (Figure 3). The macula did not develop oedema, and visual acuity was 20/20 at 10 months after surgery.

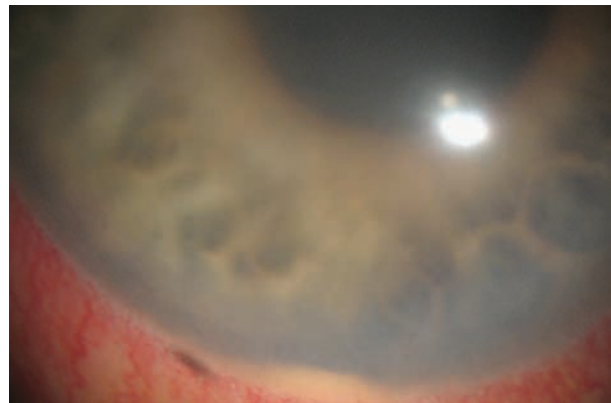


Figure 1 Sterile endophthalmitis. A 0.5-mm hypopyon was noted 6 h after surgery. Visual acuity was hand motions and the intraocular pressure was 52 mmHg.

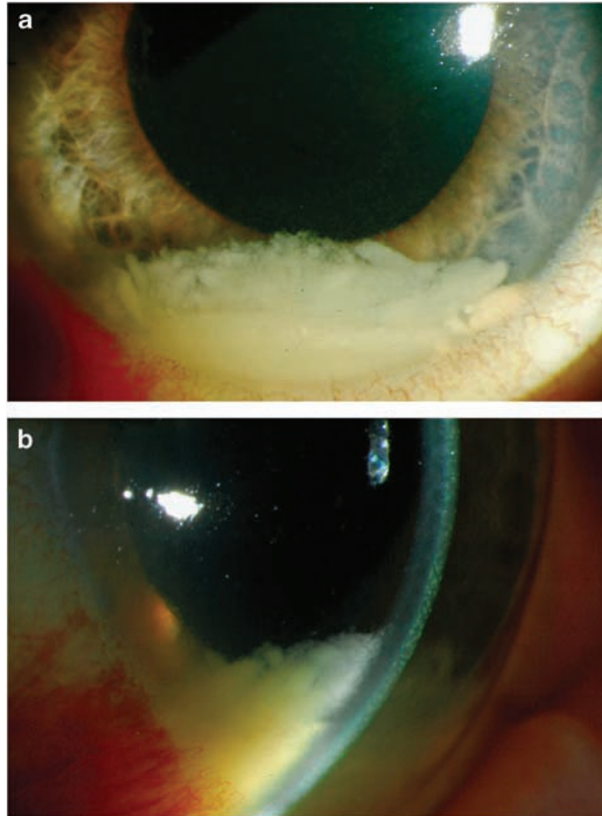


Figure 2 Pseudoendophthalmitis on top of sterile hypopyon. On postoperative day 6, a bright white crystallin material was found just above the original cream-colored hypopyon. This was felt to represent triamcinolone crystals that moved anteriorly. Pseudoendophthalmitis above the original sterile endophthalmitis in diffuse illumination (a) and with slit-beam illumination (b).

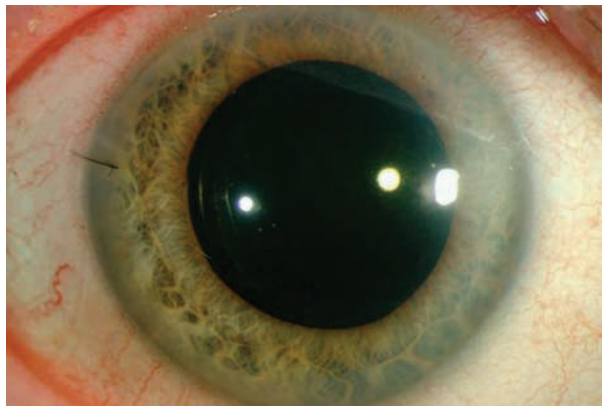


Figure 3 Clinical resolution. By postoperative day 16, the hypopyon and triamcinolone crystals in the inferior angle cleared.

Comment

This case illustrates two non-infectious forms of endophthalmitis associated with IVTA in the same eye.

First, a rapid sterile endophthalmitis resulted from an acute reaction to either triamcinolone or its vehicle components.² This inflammatory reaction may be similar to that of toxic anterior shock syndrome (TASS). Our patient with chronic uveitis developed this when the IVTA was combined with a cataract surgery. Previous intraocular surgery and uveitis have been reported to be risk factors for sterile endophthalmitis.^{2,3} Subsequently, he developed pseudoendophthalmitis, which results from the anterior migration of triamcinolone crystals.^{4,5} In our patient, loose zonules may have contributed to the anterior migration. The patient's findings were not typical of infectious endophthalmitis, given the rapidity of the hypopyon and lack of pain. However, the dramatic rise in IOP is uncommon in non-infectious endophthalmitis. Given the atypical presentation, aspirates were taken for culture. To the best of our knowledge, this is the first report of sterile endophthalmitis and pseudoendophthalmitis in the same eye.

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Sir,
Lymphoepithelial carcinoma of the lacrimal sac

Lymphoepithelial carcinoma (LEC), which often occurs in nasopharynx, is a rare entity in ocular adnexa. Only two cases involving lacrimal gland and one case involving nasolacrimal duct have been reported.^{1–3} We