healthy individuals. A pink hypopyon should raise suspicion of Enterobacteriaceae, either Klebsiella or Serratia, infection, which needs prompt systemic survey and appropriate antibiotic treatment.

Conflict of interest
The authors declare no conflict of interest.

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Sir,
Unnecessary harassment of consenting adults

The rising importance of impact factors seems to correspond with reduced case report publication in the ophthalmic literature, reflected by journals changing their 'Instructions to authors'.[1] The impact on the doctor–patient relationship of the publication process has not been considered in the ophthalmic literature. We wished to evaluate ophthalmic journals' author instructions to compare their approach regarding patient consent for publication.

Case report
We identified 10 journals with which we had previous personal experience of article submission. These were Ophthalmology, Survey of Ophthalmology, Archives of Ophthalmology, British Journal of Ophthalmology, American Journal of Ophthalmology, Journal of Cataract and Refractive Surgery, Eye, and Cornea, British Medical Journal, and Lancet. All 10 journals state that written informed consent for the publication of clinical details and photographs must be obtained.[2,3] Some specify that reviewing or processing cannot proceed until written consent is submitted. All state that publication will not occur without written consent. In all, 50% have their own journal-specific consent form. Such forms would need to be posted to patients for their own reading and signing, unlike the hospital forms, which are explained to the patient at the time of consent. For comparison, our own hospital consent form for photography has three sections and specifically requires consent for taking and storage of images, image use in teaching, and image use for publication.

Comment
This current system means patients can end up being repeatedly contacted for their written permission every time an article is resubmitted to another journal. This is unnecessary and such harassment can damage the doctor–patient relationship. We have experienced withdrawal of consent on one occasion directly due to this. We echo calls for the journal editors to have a standard universal consent form.[4,5] If this is unrealistic, accepting the form that the patient signed happily with informed consent when their images were first recorded would enable processing or review of the paper, and the journal-specific form could be signed on acceptance for publication. This would ensure the patient would only need to be re-contacted once, thus preventing any unfair and unnecessary harassment of patients for written consent.

Conflict of interest
The authors declare no conflict of interest.

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Sir,
Paradoxical vascular–fibrotic reaction after intravitreal bevacizumab for retinopathy of prematurity

Retinopathy of the prematurity (ROP) is the main cause of childhood blindness in developing countries, largely

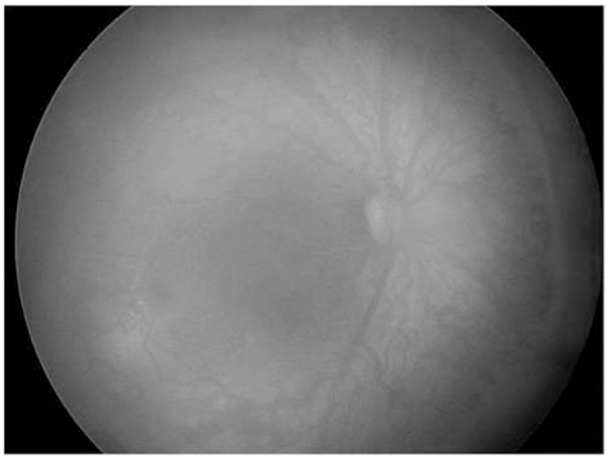

Figure 1 Image of the right eye obtained before treatment show ROP stage 3, zone II, plus disease.

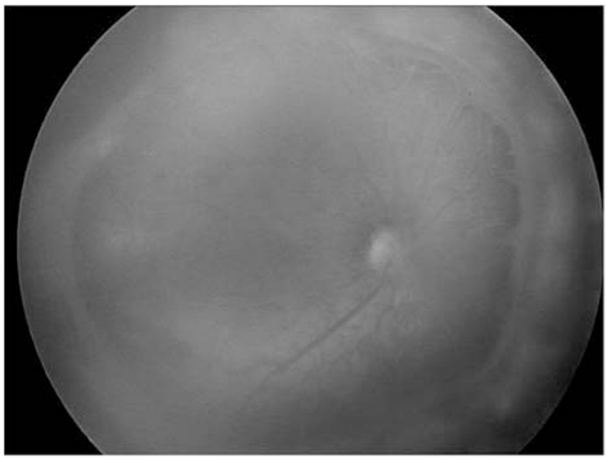

Figure 2 Fundus image of the same eye obtained 1 day after diode laser ablation and intravitreal bevacizumab; notice how plus disease decreased and the elevated membrane.

because of the lack of efficient programmes for its detection and treatment. The use of antiangiogenic agents in cases of advanced ROP has been suggested even though the long-term ocular and system side effects of using these medications in premature babies are unknown.[1,2] We report a case of advanced ROP treated with laser ablation and intravitreal injection of bevacizumab (Avastin, Genentech, San Francisco, CA USA), after which the vascular response was paradoxical with significant fibrosis and subsequent traction.

Case report

A 1350-g male baby, born at 31 weeks of gestation, was discharged from neonatal intensive care unit and referred to ophthalmological evaluation at 36 weeks postmenstrual age (PMA) without a specific time for follow-up recommendation. The baby's first ophthalmic examination was performed 4 weeks later (40 weeks PMA). Funduscopic examination showed circumferential ROP stage 3 in zone II with severe plus disease in both eyes (Figure 1). Information was provided to the parents about the baby's poor visual prognosis, options, advantages, and disadvantages of treatment, and the informed consent was obtained. Under general anaesthesia, photocoagulation with diode laser (810 nm, 3310 burns right eye, and 3405 burns left eye using 200 mW and 200 mS) as well as intravitreal application of 0.4 mg of bevacizumab was performed . Twenty-four hours after the treatment, the plus disease showed some signs of resolution with diminished vascular activity, increased fibrous activity in the region of the ridge (Figure 2). At one week, vascular activity had markedly decreased and the proliferative membrane showed marked fibrous component (Figure 3). At day 8, a vitrectomy was performed in the left eye because of progressive stage 4a. In the right eye, a fibrous ring was noted on day 14 (Figure 4).

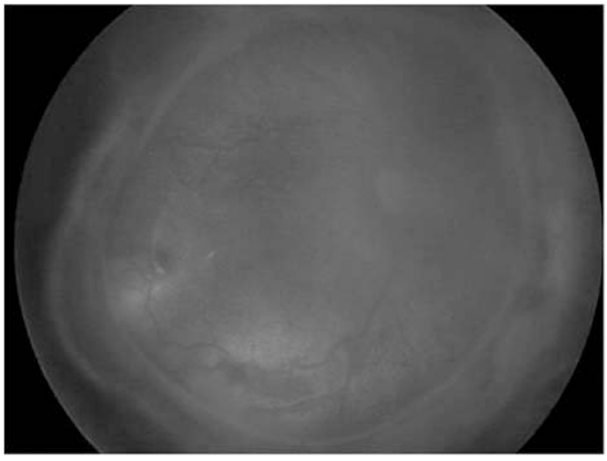

Figure 3 Fundus image of the same eye obtained 1 week after treatment show plus disease residual and vitreous organisation at the edge.

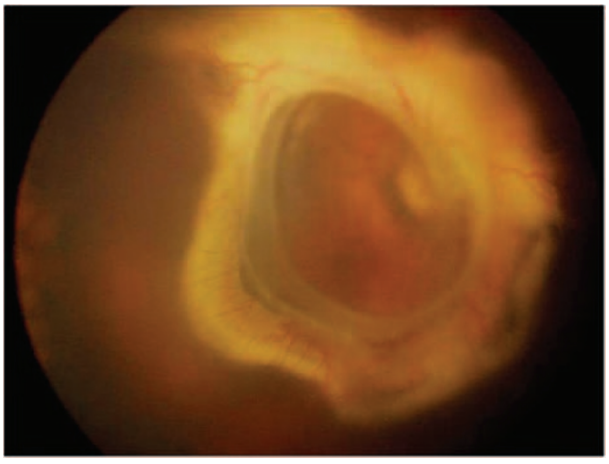

Figure 4 Fundus image of the right eye obtained 14 days after treatment show a ring-shaped fibro-tractional membrane.

Comment

In the majority of the cases treated with laser, the involution of the vascular component (plus disease) correlates to the activity of the fibrovascular ridge of

stage 3.[3] However, in the case reported here, the tractional component progressed even without the appearance of vascular activity. This finding is not unique when using intravitreal bevacizumab in vascular retinopathies. Fibrosis, 7 days after intravitreal bevacizumab, had been reported in eyes with proliferative diabetic retinopathy,[4] as well as acute contraction of the fibrovascular membrane in ROP.[5] Kong *et al* reported in a pathologic study that intravitreal bevacizumab in zone I, stage 2 plus ROP did not show inflammation, necrosis, or degeneration.[6] Contraction of large fibrovascular membranes (stage 3, more than 6 h extension) may well lead to a tractional retinal detachment as shown in this case and in two cases in a series by Kusaka *et al*.[1,5]

Antiangiogenic therapy had been proposed as a valuable resource in the treatment of advanced cases of acute phase ROP; however, we must remember that such use is off-label, and long-term ocular and systemic side effects in this population are unknown.[2,6,7] The value of the current report is pointing out that the development of a tractional retinal detachment is a potential complication of such therapy. Postsurgical evolution of these cases differs from the cases treated only with photocoagulation.

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Sir,

Intravitreal bevacizumab for choroidal neovascularization associated with a retinochoroidal coloboma

Choroidal neovascularization (CNV) secondary to colobomas are rare and have been treated with laser photocoagulation, photodynamic therapy (PDT), or merely observed.[1–4] To the best of our knowledge, this is the first report of treatment of CNV secondary to a coloboma with intravitreal anti-vascular endothelial growth factor therapy.

Case report

A 36-year-old man presented with reduced vision in the right eye of 1-month duration. The left eye had microphthalmos. His best-corrected visual acuity (BCVA) was 6/36 OD. Clinical evaluation of the right eye revealed an inferior retinochoroidal coloboma, extending up to the inferior disc margin and macula. Active subfoveal CNV with submacular haemorrhage was noted (Figure 1a), which was further evidenced by fluorescein angiography (FA) (Figure 1b) and optical coherence tomography (OCT) (Figure 1c). The patient opted for and was administered 1.25 mg of intravitreal bevacizumab (Avastin, Genentech, San Francisco, CA, USA).

One month later, the patient presented with an improved BCVA of 6/24 OD. Fundus examination, FA, and OCT revealed partially regressed CNV, and the patient was re-treated by injecting intravitreal bevacizumab in the right eye. At the final review, a year later, his BCVA was 6/9 OD and the CNV was noted to have completely regressed clinically, angiographically, and tomographically (Figures 1d–f).

Comment

CNV, a rare complication, usually develops at the junction between the normal retina and the coloboma, as also observed in our case.[1] Bruch's membrane disruption and retinal pigment epithelium displacement at the margin of the coloboma allow migration of choroidal neovascular tissue into the subretinal space at this site.[1] The paucity of reports coupled with the age at presentation varying from the first to the seventh decade has led to the specific trigger for neovascularization remaining unestablished.[1]