

which have been introduced because of the theoretical risk of prion transmission. They recommend the cleaning of these holders with alcohol wipes to decontaminate them between patients. They should be aware that alcohol does not inactivate prions; in fact it fixes proteins, including prions, in a viable form to inert material. Therefore, alcohol cleansing prolongs the infectivity of prions on instruments. Re-usable tonometer prism heads should never be cleaned with alcohol wipes for the same reason.

Although the disposable tonometer holders have no direct contact with patients, they should be cleaned in the same way as recommended for re-usable tonometer prisms (eg, by immediate immersion in sodium dichloroisocyanurate 1 g/l). This minimizes any theoretical risk of prion transmission.

Conflict of interest

The author declares no conflict of interest.

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Sir,
Reply to Beare

We thank Beare¹ for his interest in our article. It must be remembered that our study was originally an audit of handwashing in the general ophthalmology clinic.² Through this we showed that the holder used in TONOSAFE can act as a reservoir for micro-organisms such as *Staphylococcus*, transferred there by normal doctor-patient interaction. This transfer was presumed to be via the clinician's fingers from the patient's face, which is a known route of MRSA transmission.³ We also highlighted that this 'disposable' product is not truly single use.

TONOSAFE is manufactured and packaged with one holder designed to be used only with 20 disposable prisms (5 holders with every 100 prisms). It has been our clinical observation that these holders are often used greatly in excess of this, and are rarely disinfected between cases, clinics, or even overnight. This is probably because disposable devices should not require cleaning, as they are, by definition, single use. The idea

for our study was generated by the multiple colonies and variety of micro-organisms grown following random plating of one such holder. It was in this context that we suggested cleaning with alcohol wipes between patients to remove the micro-organism load from the holder. It could be argued that these results can be replicated by swabbing any equipment used in regular ophthalmic examination.⁴ In keeping with surveys of the normal ocular flora, we made it clear in our article that these micro-organisms were unlikely to be of pathological significance in the healthy patient.^{5,6}

Nevertheless, we thank Beare for his helpful comments regarding cleaning and the theoretical risk of prion transmission. Hopefully, our study has indirectly raised the issue regarding overuse of the TONOSAFE holder and, in doing so, helped to prevent continuation of this practice.

Conflict of interest

The author declares no conflict of interest.

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Sir,
Pink hypopyon caused by *Klebsiella pneumoniae*

Pink hypopyon had been reported in cases of *Serratia marcescens* endophthalmitis¹ and leukaemia uveitis.² We report for the first time the presentation of a pink hypopyon caused by *Klebsiella pneumoniae*.

Case report

A 38-year-old woman experienced progressive blurred vision in the right eye for 2 days. One week earlier, she had had intermittent fever and a sore throat. She was treated with oral prednisolone 25 mg bid and topical steroid OD.

She was afebrile at the time of examination. Her visual acuity was 20/200 OD and 20/20 OS. A 1.5-mm pink hypopyon with diffuse chemotic conjunctiva, fine fibrinous exudates on the lens, and grade III vitreous opacities was found in the right eye (Figure 1a). Laboratory tests showed a white cell count of $10 \times 10^3/\mu\text{l}$, 2% atypical lymphocytes, and 1% band.

Aqueous and vitreous aspirations and intravitreal injections of vancomycin (1.0 mg/0.1 ml) and ceftazidime (2.25 mg/0.1 ml) were performed on suspicion of infectious endophthalmitis. The aqueous aspirate showed numerous neutrophils, polymorphonuclear cells, and a few bacilli (Figure 1b). The patient was hospitalized and given intravenous vancomycin 500 mg every 6 h and ceftazidime 500 mg every 12 h. Systemic antibiotic treatment was replaced by ceftriazone 1 g every 12 h after a systemic survey revealed an abscess of 3.72 cm at segment 5 of the liver. Sonography-guided percutaneous drainage of liver abscess was performed on

the second day of admission. However, panophthalmitis (Figure 1c) developed and her vision rapidly deteriorated to negative light sense. On day 3, endogenous Klebsiella pneumonia endophthalmitis was established on the basis of vitreal aspirate and liver abscess culture. Scleral melting developed and perforated at the inferior nasal sclera on day 10, and evisceration was performed. The patient was discharged after liver abscess was completely absorbed 3 weeks after admission.

Comment

Klebsiella pneumonia endophthalmitis accounts for 60% of cases of endogenous endophthalmitis in East Asia.³ Hepatobiliary infection is the most common source of bacteraemia. Rapid progression in clinical course was observed in this patient, which was initially misdiagnosed as uveitis. Klebsiella is not known to produce the red pigment, prodigiosin, which is produced by Serratia species. We speculate that this pink hypopyon is caused by Klebsiella pneumonia that tends to be destructive and leads to extensive necrosis and haemorrhage.⁴

In conclusion, pink hypopyon could be the initial presentation of Klebsiella pneumonia endophthalmitis, which subsequently causes a fulminant clinical course in

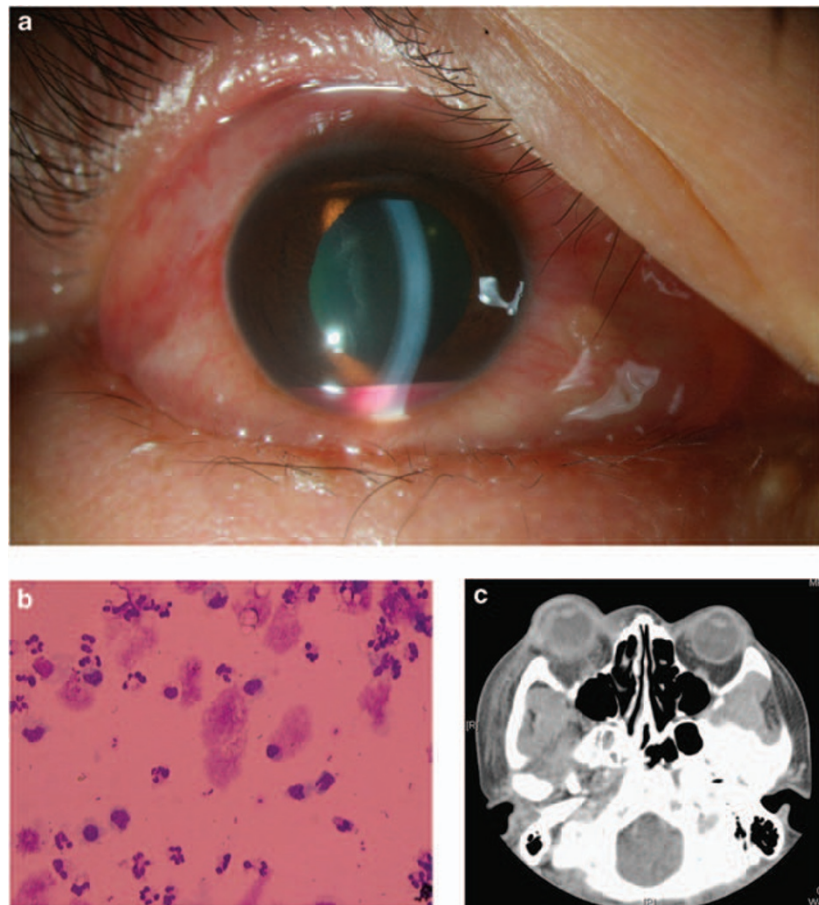


Figure 1 (a) Slit lamp examination of the right eye at initial examination showing pink hypopyon with conjunctival injection and chemosis. (b) Photomicrograph of the anterior chamber aspirate shows numerous neutrophils and bacilli. (c) Orbital CT revealed panophthalmitis and right orbital cellulites with preseptal and retroorbital involvement.

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