highlight the importance of prompt diagnosis, referral, and subsequent intervention in children with suspected CNS relapse of their leukaemia.

Conflict of interest
The authors declare no conflict of interest.

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Sir,
Iritis, ptosis, and sequential severe loss of vision in a patient with essential thrombocytosis

We describe a patient with signs of partial third nerve palsy, severe iritis, and loss of vision due to essential thrombocytosis.

Case report
A 60-year-old man was referred from the neurologists by whom he had previously been treated under suspicion of TIAs.

Initially, visual acuity was 6/6 in both eyes. At presentation, a ptosis on the left eye was observed, but otherwise the eye examination was unremarkable. After a couple of months, he developed several episodes of aggressive iritis, with various forms of keratic precipitates. He had posterior synechiae and markedly increased intraocular pressure (IOP). He had no corneal oedema, pain, or photophobia. Uveitis investigation and MRI of the orbits were normal.

At that time, repeated blood tests showed an elevated platelet count ($\sim 80 \times 10/l$). A bone marrow biopsy was performed and essential thrombocytosis was diagnosed.

He was continuously treated with hydroxyurea as well as venesection and the iritis is more readily controlled—but vision has slowly deteriorated. Two years after diagnosis, vision is now restricted to counting fingers with a pale optic disc on fundoscopy. No retinal changes have been observed, and no neovascularisations have been seen on the iris. The ptosis is unresolved and eye movements are normal.

Essential thrombocytosis causes multiple vascular occlusive disease and some groups have reported vascular retinal occlusions in essential thrombocytosis.[1,2] To our knowledge, iritis has never been reported in essential thrombocytosis, and only one previous report has described a partial third nerve palsy in essential thrombocytosis.[3]

Comment
As essential thrombocytosis is not a leukaemic or carcinoid disease, it is unlikely that iritis is due to an autoimmune reaction, but more so due to an ischaemic reaction. Cells in the anterior chamber have been described in ocular ischaemic syndrome.[4] The patient also suffered from an unspecific constant burning periocular pain—possibly of ischaemic origin.

It is concluded that the patient, because of essential thrombocytosis, suffered from multiple minor ischaemic events in the central nervous system, including a partial third nerve palsy and severe ocular ischaemia, which has caused iritis and slow progressive optic neuropathy.

Conflict of interest
The authors declare no conflict of interest.

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Sir,
Alcohol cleansing prolongs the infectivity of prions on instruments

Lockington *et al*[1] rightly raise the issue of microbial contamination of disposable tonometer prism holders,

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 Beare[1] 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 pneumonia

Pink hypopyon had been reported in cases of Serratia marcescens endophthalmitis[1] and leukaemia uveitis.[2] We report for the first time the presentation of a pink hypopyon caused by Klebsiella pneumonia.