Sir,
Uveitis-like syndrome and iris transillumination after the use of oral moxifloxacin

We have read with interest the article of Wefers Bettink-Remeijer *et al.*,¹ who described a case series of five patients presenting an acute iris depigmentation, masquerading as uveitis, following moxifloxacin treatment. They suggest that this new syndrome is multifactorial and that moxifloxacin use is one of the precipitating factors. In our clinic, we have followed up a patient with a similar history who had also a possible additional risk factor.

Case report

A 36-year-old man presented to our department for acute bilateral pain and vision impairment. Ten days earlier he was treated in another institution with topical steroids for a bilateral mild uveitis that occurred 2 weeks after treatment with moxifloxacin (Avelox) for otitis. Symptoms did not improve and the patient was given oral and subconjunctival steroids with a topical beta-blocker. However, the situation continued to get worse and the patient came to our clinic. His visual acuity was 1/10 in both eyes. Slit lamp examination showed fine pigment keratic precipitates, many pigment granules, and few non-pigmented cells in the anterior chamber. Intraocular pressure was 46 mm Hg in both eyes. The angles were open but heavily pigmented. The iris was intensively depigmented (Figure 1). OCT of the angles demonstrated a concave iris (Figure 2). Steroids were stopped, antiglaucomatous therapy and oral acetazolamide were prescribed, but the clinical picture remains uncontrolled. An anterior chamber tap was performed and PCR for herpes viruses was negative. After the tap, the amount of pigment in the anterior chamber decreased significantly but IOP remain elevated despite strong anti-glaucomatous medication. Finally, IOP could be controlled after laser iridoplasty, which normalised the shape of the iris.

Comment

As predicted by the authors, our case report further confirms that moxifloxacin can induce the development of a pseudouveitis characterised by an acute depigmentation of the iris. In addition, this case also suggests that a concave

Figure 1 Anterior chamber color picture demonstrating intense iris depigmentation.

Figure 2 OCT of the angles before (top) and after (bottom) laser iridoplasty.

shape of the iris could be another triggering element. In this setting, IOP might be dangerously elevated and laser iridoplasty recommended.

Conflict of interest

The authors declare no conflict of interest.

Reference

- 1 Wefers Bettink-Remeijer M, Brouwers K, van Langenhove L, De Waard PW, Missotten TO, Martinez Ciriano JP *et al.* Uveitis-like syndrome and iris transillumination after the use of oral moxifloxacin. *Eye* 2009; **23**: 2260–2262.

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Sir,
Responding letter

I have read with great interest the report of the additional patient seen by François Willermain *et al.*¹ in Bruxelles. There are, however, some differences between their patient and the patients we have described in our case series.² None of our patients had visible pigment in the chamber angle. None of our patients had an alteration of

visual acuity. None of our patients needed more than a short course of steroid drops. Although we do not know which other factors are causing the development of depigmentation of the iris, in none of our patients a concave iris has been the primary factor. Gonioscopy did not reveal pigmentation of the chambre angle. In addition, in pigment glaucoma the pattern of translucency of the iris differs from the pattern seen here, which is similar to the pattern in our patients. In any patient with iris translucency it is wise to evaluate the concavity of the iris by gonioscopy, but it is also possible that in this patient the subconjunctival steroid injection is one of the factors for developing glaucoma.

Conflict of interest

The author declares no conflict of interest.

References

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- 2 Wefers Bettink-Remeijer M, Brouwers K, van Langenhove L, De Waard PW, Missotten TO, Martinez Ciriano JP *et al*. Uveitis-like syndrome and iris transillumination after the use of oral moxifloxacin. *Eye* 2009; **23**: 2260–2262.

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Sir, Intravitreal ranibizumab for choroidal neovascularisation secondary to pathologic myopia: 12 month results

We read with interest the article 'Intravitreal ranibizumab for choroidal neovascularisation secondary to pathologic myopia: 12 month results'. We noted that the study group was very diverse with regard to age and incorporated people with myopia ranging from -5 to -18 D. We would like further clarification whether Monés *et al*¹ used refraction as the only assessment of myopia. We believe that some of the more elderly patients may have had a myopic shift related to lenticular changes. The axial length would have given further support to determine the true pathological myopia, and we are interested to know whether this was measured. The number of injections of ranibizumab is very low compared with that often reported for age-related macular degeneration and choroidal neovascularisation. For example, a recent study² on the frequency of injections needed stated 5.2 as the mean number of injections *vs* 1.52 in this article. Of interest is the finding by Ruiz-Moreno *et al*³ that three monthly injections was an appropriate regimen to manage choroidal neovascularisation, as disease activity in pathological myopia is sometimes difficult to predict in-between injections.

Conflict of interest

The authors declare no conflict of interest

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Sir, Reply to Rajendram *et al*

We deeply appreciate the comments from Rajendram *et al*¹ regarding our article 'Intravitreal ranibizumab for choroidal neovascularisation secondary to pathologic myopia: 12 month results'.² We agree that myopia cannot be assessed accurately only with refraction. In some patients lenticular changes could contribute to a certain amount of myopia. Axial length was not used in this study. However, patients had to have retinal abnormalities consistent with pathological myopia (such as lacquer cracks, peripapillary atrophy, etc).

Regarding the frequency of injections, the main characteristic of myopic choroidal neovascularization in comparison with age-related macular degeneration is the very different dynamics of CNV progression. Myopic CNV is more likely to respond with less injections needed and with improvement in vision. As reported in this study, the loading phase does not seem to be necessary and could represent an overtreatment for many patients. The recurrence is unpredictable; some patients may never have it, while many patients may not have it for several months. This justifies the pro re nata regimen. Owing to the potential specific risk of myopic eyes, it seems advisable to reduce the number of injections as possible. We once again thank Rajendram *et al* for their interest and comments.

Conflict of interest

The authors declare no conflict of interest

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- 1 Costa-Gomes N, Rajendram R, Horgan SE. Intravitreal ranibizumab for choroidal neovascularisation secondary to pathologic myopia: 12 month results (Correspondence). *Eye* 2010; **24**: 1420 (this issue).