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*Eye* (2011) **25**, 529–530; doi:10.1038/eye.2010.214;  
published online 14 January 2011

Sir,  
**Acute endophthalmitis after cataract surgery at a referral centre in Northern Taiwan: review of the causative organisms, antibiotic susceptibility, and clinical features**

We read with interest the study by J-H Cheng *et al*<sup>1</sup> describing the bacterial isolates and treatment outcomes of endophthalmitis after cataract surgery at a referral centre in Northern Taiwan. However, there are a few issues that we would like to discuss, especially regarding the information on presenting and final visual acuity (VA) specified to the causative organisms, and the choice of the intravitreal antibiotics.

As the authors state, the poorer visual outcome in their study (only 7 (11.9%) of the 59 patients had a final VA of >20/40) may indeed be partly explained by the high percentage of more virulent organisms. Unfortunately, detailed information on both the presenting VA and the final VA for all types of bacterial cultures is not provided, except for the information that 1 (7.7%) out of the 13 patients with a bacterial culture of *Pseudomonas aeruginosa* achieved a final VA better than 5/200.

The presenting VA and final VA for the 8 patients with a culture of *Staphylococcus aureus* and the 25 patients with a negative bacterial culture would be of special interest, as the quantities of these groups make them major determinants in the overall final VA. In literature, the percentage of patients achieving a final VA >20/40 range from 20.0 to 45.0% for *S. aureus* and from 55.3 to 58.3% for a negative bacterial culture.<sup>2–4</sup> As known from previous studies, presenting VA is a major determinant in final treatment outcome.<sup>2,5</sup> Details on presenting VA and final VA, especially for *S. aureus* cultures and negative bacterial cultures, may therefore provide essential information on the poor overall outcome in their study and would improve the ability to compare their data with previous studies.

Regarding optimal antibiotic treatment, the authors correctly emphasize the importance of geographical variations as well as the need for periodic susceptibility

testing to anticipate (changes in) the microbiological spectrum and antibiotic sensitivities. Surprisingly however, they state that the use of vancomycin and amikacin still provides good coverage for pathogens after cataract surgery in their region, despite the fact that their own data do not support this statement. Their reported susceptibility to amikacin was 89.5% for Gram-negative isolates and 90.9% for Gram-positive isolates, compared with 94.7 and 100% susceptibility to ceftazidime. Using ceftazidime instead of amikacin may positively influence the future treatment outcome in acute postoperative bacterial endophthalmitis after cataract surgery for the population in Northern Taiwan.

#### Conflict of interest

The authors declare no conflict of interest.

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*Eye* (2011) **25**, 530; doi:10.1038/eye.2010.213;  
published online 21 January 2011

Sir,  
**Response to Pijl and Crama**

We thank Drs Benjamin Pijl and Niels Crama<sup>1</sup> for their instructive comments regarding our article.<sup>2</sup> Benjamin Pijl and Niels Crama highlighted the following introductory statement: 'The information of presenting and final visual acuity (VA) specified to the causative organisms and the choice of the intravitreal antibiotics.'

The aim of our paper was to show the spectrum of bacterial isolates that caused endophthalmitis after