

incurred to the NHS. A box of 20 Minims is priced at £11.68 in our trust and this will cost the NHS 58 pence per patient.<sup>2</sup> We found that the application of proxymethacaine 0.5% drops on paper fluorescein strips in the form of Fluorets by Chauvin can be a safe and cost-effective way to stain the cornea. Each box of 100 strips costs £6.64, which is equivalent to £0.07 for usage per patient. The cost of a vial of proxymethacaine 0.5% is £0.51 (£10.19 for a box of 20 vials), and if used for 10 patients, £0.05 for each patient. The total cost of using the paper Fluorets with proxymethacaine is 12 pence per patient. This is 5 times less than the cost per vial of Minims containing proxymethacaine 0.5% and fluorescein 0.25%. Apart from this, they are portable, do not need refrigeration when not in use, are environmentally friendly, and are easier to open compared with the Minims pack available.

#### Conflict of interest

The authors declare no conflict of interest

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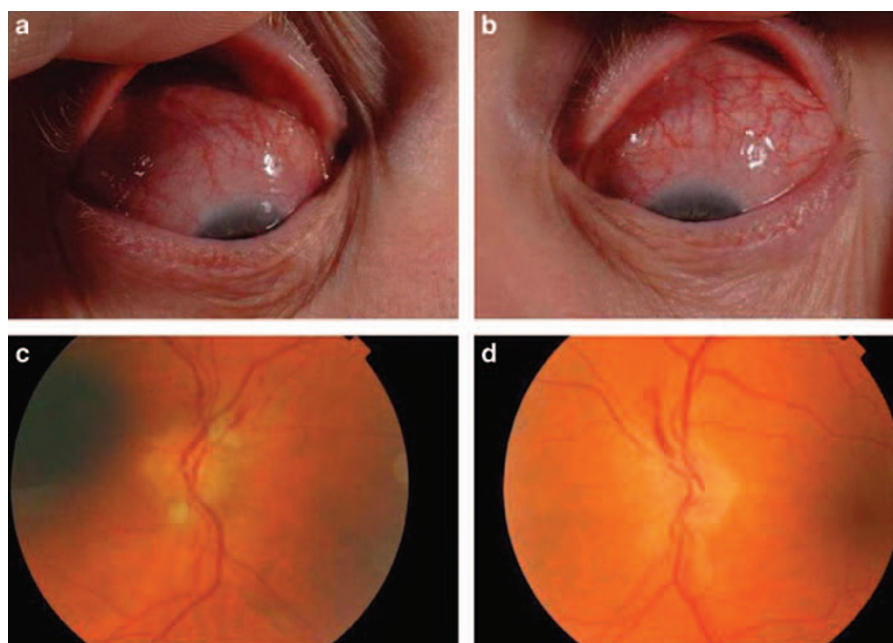
#### Sir, Bilateral disc swelling associated with posterior scleritis

We read with great interest Sandfeld *et al's*<sup>1</sup> recent correspondence regarding bilateral papillitis in ocular toxoplasmosis. Although they highlight that only a few microorganisms are required to incite a detrimental inflammatory response in the optic nerve, they argue that the relatively preserved visual function in their case tends to refute this hypothesis. We agree and feel that the simultaneous, symmetrical, and bilateral nature would also refute this hypothesis. The serology confirms an active toxoplasma infection, but we wonder what the proposed mechanism for the disc swelling in both eyes was. We would be interested to find out whether they performed a B-scan to rule out a posterior scleritis, which we feel could explain the clinical picture. We describe a similar presentation of bilateral disc swelling with normal visual function secondary to posterior scleritis.

#### Case report

A 59-year-old Caucasian man presented with bilateral, painful red eyes of 3 weeks duration. The functions of the pupils, colour vision, and optic nerve were all normal. His corrected visual acuities were 20/20 bilaterally.

Examination revealed bilateral diffuse anterior scleritis with quiet anterior chambers (Figure 1a and b) and bilateral disc swelling (Figure 1c and d). His CRP and ESR were raised (41 and 97, respectively), ANA was weakly positive and IgG was mildly raised. The rest of his autoimmune screen and his urine dip were normal. CXR revealed probable longstanding right basal atelectasis.



**Figure 1** (a, b) Anterior segment images showing diffuse anterior scleritis. (c, d) Fundus view illustrating disc oedema and associated haemorrhages.

Neuroimaging failed to demonstrate any intracranial or orbital lesions although the paranasal sinus mucosa was thickened, consistent with sinusitis. B-scan ultrasound confirmed the diagnosis of posterior scleritis, showing a diffuse posterior scleral thickening (2.4 mm). High-dose prednisolone (1 mg/kg) led to resolution of the disc swelling over the following week. The steroid doses were tapered and steroid-sparing immunosuppressants commenced.

#### Comment

Posterior scleritis is a rare condition notorious for its non-specific presentation leading to frequent misdiagnosis.<sup>2-4</sup> Despite the negative c-ANCA, the likely systemic association in this case was thought to be 'limited' Wegener's granulomatosis, although the steroid-sensitive nature of the condition would seem to contradict this.

Posterior scleritis may be associated with disc swelling in up to 17% of patients.<sup>5</sup> Although visual loss is typically severe, posterior scleritis may also occur with normal vision. B-scan ultrasound is *the* key investigation in diagnosing the condition; it is non-invasive and readily available in most eye units. As in the previous case of toxoplasmosis and bilateral disc swelling, adjuvant signs should be closely examined for, as in this case the anterior scleritis suggested the diagnosis and in the former case the vitritis suggested the inflammatory aetiology.

#### Conflict of interest

The authors declare no conflict of interest.

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#### Sir, Response to 'Bilateral disc swelling: papillitis or posterior scleritis?'

We read with high interest the case report by Dr Stead *et al*,<sup>1</sup> who describe a patient with bilateral optic disc swelling associated with anterior and posterior scleritis, presumably related to localized Wegener's granulomatosis, despite the absence of biological or pathological evidence of the latter condition.

Although we perfectly agree with the general comment that B-scan is a key examination to diagnose posterior scleritis, we strongly feel that our recently reported patient<sup>2</sup> had bilateral papillitis, rather than posterior scleritis. The patient, who presented with painless bilateral visual loss and no redness in the eye, had central scotomas and decreased colour perception. Except bilateral optic disc oedema, fundoscopy and fluorescein angiography disclosed no retinal or retinochoroidal involvement.

Pain, redness in the eye, anterior scleritis or uveitis, and retinal or retinochoroidal involvement (panuveitis, retinal folds, serous detachment, uveal effusion syndrome, etc) are the most important clinical signs indicating posterior scleritis.<sup>3,4</sup> None of those signs were detected in our case with confirmed toxoplasmosis, which is known to cause only rarely scleritis.<sup>5</sup> In addition, an orbital MRI with contrast disclosed no posterior scleral thickening or retrobulbar oedema, which is often seen in posterior scleritis with orbital CT or MRI.<sup>6</sup>

In the complete absence of all these clinical and radiological signs, we felt that posterior scleritis was unlikely to be present in our patient, although we cannot formally rule out some scleral involvement, which was undetectable by a thorough orbital MRI. In conclusion, we agree with Dr Stead *et al* that a B-ultrasonography should be performed in patients with clinical signs indicating the possibility of posterior scleritis, although this was probably not the case in our patient.

#### Conflict of interest

The authors declare no conflict of interest.

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