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Sir,
**Microbial profile and antibiotic susceptibility
of culture-positive bacterial endophthalmitis**

I read the interesting paper by Melo *et al.*,¹ highlighting the threats posed by bacterial endophthalmitis and the importance of microbiological susceptibility surveillance for its treatment. I would like to share my point of view regarding the concern of increasing antimicrobial resistance arising from this study. As the most important factor to avoid permanent damage of retina is an early appropriate antibiotic therapy, systemic and intravitreal are the preferred route of antibiotic administration for endophthalmitis. Intravitreal injection is a key component of clinical management of exogenous endophthalmitis. It warrants predictable intravitreal levels, especially for hydrophilic antibiotics, such as aminoglycosides, beta-lactams, and glycopeptides, diffusion of which from plasma to vitreous cavity is insufficient to achieve target-site concentration attainment.² However, systemic therapy is required for endogenous endophthalmitis, in which bacteraemia is followed by ocular seeding, to avoid further embolic complications. Pharmacodynamics of conventionally administered systemic antimicrobials show that intravitreal levels vary substantially, but remain below the MIC for many ocular pathogens in most cases. Indeed, very few drugs (mostly lipophilic antibiotics) achieve appropriate concentration within the vitreous cavity, where targeted exposure is required. Inappropriate administration of antimicrobials has been shown not only to worsen clinical outcomes, but also to drive resistance—and meticillin resistance often means quinolone or multidrug resistance.^{2,3} Even if antimicrobial susceptibility testing remains to be of great value for epidemiology and surveillance, optimised management of endogenous endophthalmitis should no longer rely only on static definitions, such as susceptible, intermediate, and resistant,⁴ but requires now the inclusion of pharmacodynamic indices into prophylactic and therapeutic protocols and the integration of different fields of expertise—ophthalmic surgery, infectious diseases, microbiology, and clinical pharmacology—to promote antimicrobial stewardship. Improving patient safety is a multifaceted task requiring multidisciplinary

and organisational commitment.⁵ The appropriate antibiotic, administered to the target site, in the right concentration, in a timely manner could be both one therapeutic challenge and one goal for the future. In my opinion, it would be more worthwhile attempting to improve the management of such a severe infection through demanding, but shared efforts, rather than passively recording a progressive increase of antimicrobial resistance, too often coupled with unsatisfying clinical outcomes.

Conflict of interest

The author declares no conflict of interest.

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Sir,
Spectral domain optical coherence tomography macular cube scans and retinal pigment epithelium/drusen maps may fail to display subretinal drusenoid deposits (reticular pseudodrusen) in eyes with non-neovascular age-related macular degeneration

As subretinal drusenoid deposits, also known as reticular pseudodrusen, carry an increased odds ratio for the development of choroidal neovascularization (2.6),¹ the recognition of this finding is warranted in clinical evaluations of non-neovascular age-related macular degeneration (AMD).

Imaging subretinal drusenoid deposits requires optical coherence tomography (OCT) resolutions adequate to determine the retinal pigment epithelium (RPE) position relative to drusen and OCT algorithms that include subretinal structures. As the low reflectance of retinal tissue limits OCT resolution, subretinal drusenoid deposits are more easily detected with high-resolution