Sir,
Response to Wong *et al*.

We thank Drs Wong, Lee and Shunmugam[1] for their interest in our paper.[2]

Dr Wong *et al* state that the number of cases with less than 2 months of tamponade is disproportionally low. The reason for the unequal distribution is that we consider 3 months as the minimum period of tamponade. This potentially introduces confounding, as the reason for early silicone oil removal could be related to worse outcome. Thus, although we revealed a statistically significant influence of tamponade duration, further study is needed to determine a causal relation, preferably using a controlled design, comparing equally sized groups. We thank Dr Wong *et al* for pointing out an error in the manuscript. The number of cases with tamponade of less than 2 months was not 10, as stated in the paper, but was 14. Of these 14 cases, 6 redetached, which amounts to 43% as depicted in the paper correctly.

Dr Wong *et al* describe a perceived discrepancy between the exclusion of cases with clinically apparent macular pucker and the performance of membrane peeling. The peelings performed were for membranes located outside the macula, for instance, along the retinectomy edges. The indication for peeling of these membranes was not standardized, and was mainly dependent on intraoperative assessment of the presence of traction after staining by membrane blue. The underlying idea was that prophylactic removal of dormant retinal traction could improve the outcome.

Our study was a retrospective, uncontrolled case series. The objective was to describe the transition from a two-port to a three-port technique. The reason for our transition was our hypothesis that the ability to perform an internal search could identify more retinal breaks, and that membrane removal could release dormant peripheral traction. Despite these theoretical advantages of the three-port technique, our results could not show any influence on outcome. Because of the retrospective, uncontrolled design of our study, there is plenty of room for confounding. But unless better equipped studies can show better results from a more expensive technique, we still feel that adherence to the traditional technique of oil removal is preferable.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Post-traumatic endophthalmitis

We read with interest the survey on post-traumatic endophthalmitis by Flynn and co-authors.[1] The authors have described the use of systemic or intravitreal antifungal agents in so-called 'suspected fungal endophthalmitis'. Before instituting antifungal treatment, distinguishing fungal from bacterial post-traumatic endophthalmitis is important because the treatments are different and prophylactic antifungal treatment can be toxic both systemically or locally.[2–4] A clinical feature that suggests fungal infection is a delayed onset of inflammation after injury.[2–4] Literature search has reported that all post-traumatic cases of fungal endophthalmitis became symptomatic between the first and fifth weeks after injury, with minimal discomfort to the patient.[3,4] In the absence of microbiological diagnosis, clinical signs suggesting infection include slow indolent smouldering intraocular inflammation associated with a relatively quiet eye, which may or may not be associated with the presence of an inflammatory mass in the vitreous or anterior chamber that is described as a 'fungal ball', or white vitreous 'snowball', or 'string of pearls'. More often than not, the patients with fungal endophthalmitis may have only minor discomfort.[2–4]

Similarly, not all clinicians agree with the routine use of intravitreal antibiotics in prophylaxis.[5] In patients with open globe injuries and traumatic endophthalmitis, there is always a risk of associated retinal detachment or choroidal detachment. Pre-operative B-scan is not routinely done in eyes with open globe injury and hence intravitreal injection can pose an additional risk of injection going inadvertently into subretinal or suprachoroidal space. On the other hand, it is important to realize that no large, randomized, prospective study has explicitly demonstrated a decrease in incidence of post-traumatic endophthalmitis with prophylactic antibiotics in eyes without IOFBs. For ruptured globes without IOFBs, until a prospective study shows a clear benefit from a prophylactic treatment protocol, one approach might be to treat all open globe injuries with systemic (oral/intravenous) and topical antibiotics for a few days. Intravitreal antibiotics prophylaxis can be used selectively in eyes with contaminated injuries, greater wound length, or delayed primary closure of the wound, and after ruling out retinal detachment or suprachoroidal haemorrhage, because such cases have an increased risk of endophthalmitis.[6]

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Outer retinal structural anomaly due to frameshift mutation in *CACNA1F* gene

X-linked congenital stationary night blindness (CSNB) is associated with mutations in nyctalopin[1] (*NYX*;CSNB1A) or in the α1 subunit of L-type voltage-gated Ca^{2+} channel[2] (*CACNA1F*;CSNB2A). We report for the first time, optical coherence tomography (OCT) features consistent with abnormal synapses in the outer nuclear layer (ONL) in a molecularly confirmed case of CSNB2A.

Case report

A 15-year-old-male presented with history of nonprogressive nyctalopia and diminution of distance vision since childhood. Nystagmus was first noted in infancy, but it gradually improved. On examination, he had no nystagmus. The best-corrected visual acuity was 20/40 and 20/30 in the right and left eyes, respectively; he had mild red–green color deficit. Fundus evaluation

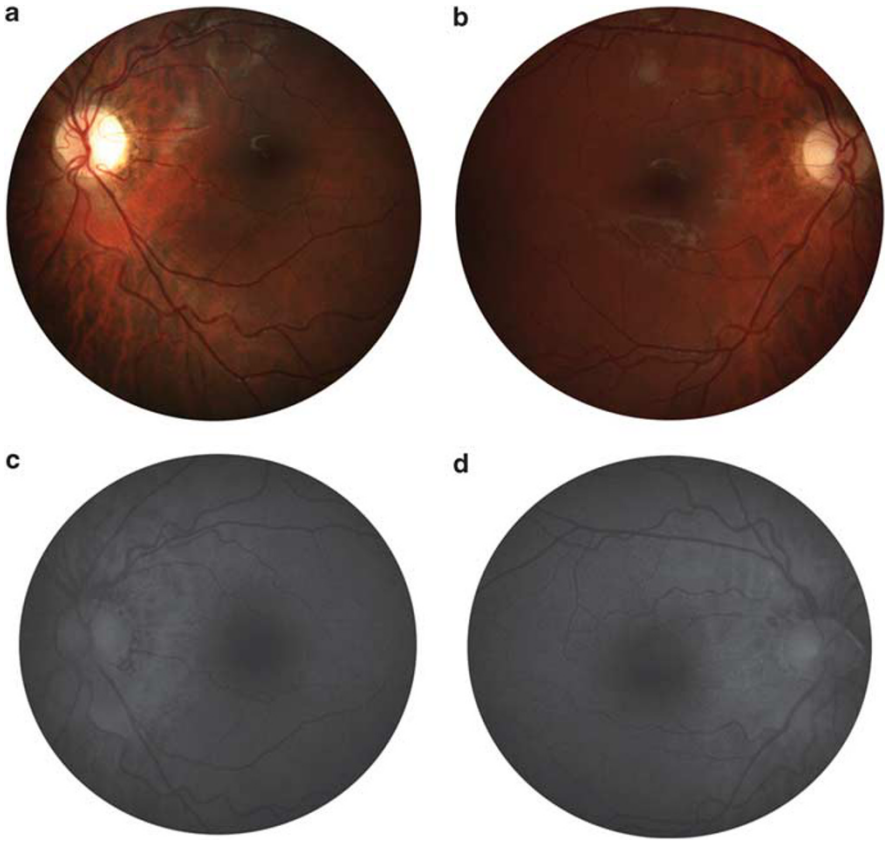

Figure 1 Fundus photographs (a, b) and fundus autofluorescence images (c, d) from either eye of the patient was normal.