

Comment

Orbital cellulitis is potentially a life- and sight-threatening condition needing immediate ophthalmology/ENT management. In 90% of cases, orbital cellulitis is secondary to sinusitis. In small number of patients, bacteraemia is the culprit. Reports suggest *Staphylococcus* species are increasingly becoming resistant to methicillin both nosocomial and community-acquired infections (CA-MRSA). A recent study from the National Health and Nutrition Examination Survey found the incidence of *S. aureus* colonization in the US population to be 31.6% and the incidence of MRSA carriers to be 0.84%.¹ Mathias *et al*² showed that orbital cellulitis is preceded by boil/chalazia in CA-MRSA cases. CA-MRSA carries PVL gene, which is a cytotoxin that destroys cells.³ Several studies suggest that CA-MRSA is an important emerging cause of orbital cellulitis.⁴ Our case is unusual because the patient developed not only fulminant orbital cellulitis following a CA-MRSA skin infection but also secondary pleural effusion.

We believe in cases of orbital cellulitis not responding to conventional antibiotic regime, clinicians should consider the possibility of infection from PVL producing *Staphylococcus aureus* and institute appropriate treatment.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgements

We thank Mr Colin Hutchinson (consultant ophthalmologist) and Dr David Brikenhead (consultant microbiologist).

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Meeting presentation: Not previously presented.

Eye (2013) **27**, 108–109; doi:10.1038/eye.2012.233;
published online 26 October 2012

Sir, Response to Tatham and Brookes

We were pleased that the Scientific Journal of the Royal College of Ophthalmologists recognizes that immediate sequential bilateral cataract surgery (ISBCS) now merits open discussion in the pages of the August 2012 edition of your journal.

We read with interest the submission by Tatham and Brookes,¹ but could not follow their logic. Their paragraph 1 seems to summarize all the published peer-reviewed evidence in favor of ISBCS. However they state that the interest in ISBCS is fueled by economic benefits. In fact, many jurisdictions financially penalize bilateral cataract surgery, and in many countries it is a money-losing proposition for the surgeon. Almost all the articles referenced by Tatham and Brookes discuss the medical benefits to the patients, which are considerable, but not economic benefits.² We would also like to encourage health care providers/financing bodies to take in account patient benefits and logistical and economic effects for the social system as a whole when deciding upon the reimbursement of ISBCS.

Paragraph 2 waves the shroud of ‘bilateral blindness’, but omits that bilateral simultaneous ophthalmic surgery is common, and the risk of bilateral infection has been shown to be extremely small in bilateral cataract surgery.³ LASIK, blepharoplasties, ptosis, and squint surgery are all commonly performed bilaterally, and bilateral simultaneous retinal surgery is not that rare.

In paragraphs 3 and 4, they effectively summarize the recommendations of our Society (see www.isbcs.org), for which we thank them, as good advice deserves repetition. However, in paragraph 5, they state that ISBCS may be ‘logistically difficult’. We disagree; if ISBCS is a regular event, then there are no logistical problems. Setting up for cases of ISBCS is much easier than for double the number of single eye cases. They then turn to the question of endophthalmitis, stating that diabetes is a risk factor. This does not appear to be the opinion of The Royal College of Ophthalmologists, who do not mention it in their document ‘Cataract Surgery Guidelines’ published September 2012. Curiously, they also state that if one eye develops endophthalmitis, there is less chance of both being involved by deferring second eye surgery. We know of no evidence to support this statement. As it is known that most cases of endophthalmitis emanate from the patient’s own flora, it is questionable whether delaying the second eye reduces the risk for that eye. Furthermore, they refer to diabetes and blepharitis as risk factors, and while we agree that this is widely believed, and many increase precautions in the presence of these conditions, we again know of no published data on which to base these suppositions.

In paragraph 6, the authors turn to economics and turnover. Our experience is the reverse of their suppositions; we can easily add one or two eyes to

a 4-h operating list when the majority of cases are ISBCS as opposed to unilateral surgery. The time saved is in moving patients in and out of theater and redundant paperwork. The comments on time from listing to surgery, and time from first to second eye surgery is likely to be very variable for multiple reasons. However, we are aware that within 16 miles of the authors' hospital the current waiting time for cataract surgery routinely exceeds 6 months.

In the final two paragraphs, the authors equate bilateral endophthalmitis with bilateral blindness. This extraordinary assumption would imply no treatment of this complication, which seems unlikely. Our experience is that the modern management of endophthalmitis leaves many eyes with useful, (and often excellent) vision, and to assume blindness shows a rather alarmist approach. In these closing paragraphs, the authors muse on 'Should bilateral same day cataract surgery routinely be offered to all?' We accept that they may have been asked to opine on this specific question, and may indeed have used the narrowness of the question to reply. We believe that ISBCS should be offered routinely to all appropriate patients, and that full consent and explanation of options should be offered. We believe that there are patients who should not have such surgery, but with increasing experience with ISBCS, as with any other procedure, the surgeon discovers that fewer and fewer patients fall into the routine exclusion group. However, ISBCS is currently routinely NOT offered to appropriate patients in the UK, and many other countries, despite peer-reviewed published evidence of effectiveness, economy, and very low risk. We would suggest that many patients would benefit if more ophthalmologists would remember to consider this option when listing patients for surgery.

Conflict of interest

The authors declare no conflict of interest.

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Eye (2013) **27**, 109–110; doi:10.1038/eye.2012.240;
published online 16 November 2012

Sir,
Reply to Claoué et al

We agree with many of the comments of the International Society of Bilateral Cataract Surgeons (iSBCS) and welcome the debate regarding what is best practice for patients and society.¹ However, many of the arguments made in this response have already been made in the 'Bilateral same-day cataract surgery should routinely be offered to patients – Yes' article,² accompanying our No argument.³

First, the common ground. We agree that there may be circumstances where immediate sequential bilateral cataract surgery (ISBCS) is in the best interests of the patient. We also agree that surgeons should not be financially penalised for ISBCS. When we state that interest in ISBCS is fuelled by potential economic benefits, it is the economic benefits for the social system as a whole to which we refer.

We also agree that the publications we reference show some medical benefit of ISBCS, however our argument is that the medical benefits are primarily transient if second eye surgery is performed. For example, attainment of normal stereopsis and binocular summation of visual acuity may be achieved more quickly with ISBCS but will also be achieved with an interval between surgeries. We are not aware of any publications discussing ISBCS that do not also discuss convenience and economy, and these issues are rightly discussed in our article.

We do not agree that other bilateral ocular procedures should be used as a model for ISBCS. It is perhaps misleading to liken ISBCS to bilateral ptosis or squint surgery, and even to bilateral retinal surgery, where the risk benefit ratios may be quite different to cataract surgery.

We agree that the evidence regarding potential risk factors for endophthalmitis is limited. However we prefer to err on the side of caution and treat patients' blepharitis prior to cataract surgery. Furthermore, the question of risk factors for endophthalmitis affects the suitability of an individual patient for ISBCS more than the wider debate, as to whether ISBCS is appropriate in the first place.

The authors refer to the waiting time for cataract surgery, which varies from region to region. A long wait between first and second eye cataract surgery is not ideal. However, if ISBCS were to be widely adopted, it is conceivable that the waiting time for first eye cataract surgery may actually increase due to the additional time required for the bilateral surgical procedure.

Mention is also made of the low incidence of endophthalmitis following ISBCS, however, much of this evidence is retrospective. A previous paper based on a survey of ISBCS surgeons stated that as 'each case represented a memorable event for the surgeon and it is unlikely that omissions were made in data collection'.⁴ When introducing a new procedure into practice a more robust prospective evaluation would be better.

The precautions recommended by the iSBCS to reduce the risk of endophthalmitis should be commended, however, as they state, most cases of endophthalmitis emanate from the patient's own flora. Therefore