especially if there is presence of a vegetative foreign body, prompt wound closure with simultaneous removal of IOFB with systemic and intravitreal antibiotics should be the preferred practice pattern for most ophthalmologists.⁵ Second sitting removal of IOFB should be considered only in patients with significantly large corneoscleral wounds that may leak during vitrectomy and in cases with associated retinal detachment requiring complex vitreoretinal surgery.⁵

Conflict of interest

The authors declare no conflict of interest.

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R Agrawal and A Laude
Department of Ophthalmology, Tan Tock Seng
Hospital, Singapore, Singapore
E-mail: rupesh_agrawal@ttsh.com.sg

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Sir, Response to Comment on 'Predictive factors and outcomes of posterior segment intraocular foreign bodies'

We appreciate the comments of Dr Agrawal and Dr Laude¹ on our paper.² Indications of enucleation in four cases of our reviewed study were no light perception vision with extensively exposed uveal and retinal tissues accompanied by multiple facial bone injuries. Owing to the development of ophthalmic instruments and surgical techniques, primary ocular repair is the aim of penetrating ocular injuries in clinical practice. However, severe ocular injuries in some conditions may result in irretrievable reconstruction. Although the current trend

leans toward evisceration because of the rarity of sympathetic ophthalmia and better cosmetic outcome compared with enucleation, the preference of these procedures is still controversial.^{3,4} Savar *et al*⁵ reported 51 and 5 enucleation and evisceration cases among 660 traumatized eyes, respectively. In contrast, Toit *et al*⁶ reported primary enucleation in 3 eyes and evisceration in 491 eyes, respectively. The decision should be considered for selected cases based on the different conditions of the patients.

We reported the delay in IOFB removal because of timing limitation by referral or consultation in the setting of no prophylactic intravitreal antibiotic injections unless there were signs of endophthalmitis. The management of intraocular foreign body has been reviewed. The decision to administer intravitreal antibiotics should be considered in high-risk setting.^{7,8} Consequently, the acceptable endophthalmitis rate of 9.1% in this study may depend on domestic type of injury and prophylactic systemic antibiotic application with no intravitreal antibiotic injections. However, the definite role of giving intravitreal antibiotic prophylaxis in eyes suffering from different types of IOFB had not been explored in this limited data study.

We realize the importance of meticulous primary ocular repair procedures and the removal of foreign bodies in the available situations to get rid of possible complications. The data from prospective or a retrospective cohort study in the future may provide more evidence in some controversial points.

Conflict of interest

The authors declare no conflict of interest.

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J Choovuthayakorn, L Hansapinyo, N Ittipunkul, D Patikulsila and P Kunavisarut

Department of Ophthalmology, Faculty of Medicine,
Chiang Mai University, Chiang Mai, Thailand
E-mail: janjitc@yahoo.com

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Sir,
Angioid streaks with severe macular dysfunction and generalised retinal involvement due to a homozygous duplication in the *ABCC6* gene

Pseudoxanthoma elasticum (PXE, OMIM no. 264800) is a recessive disorder characterised by dystrophic

calcification of elastic fibers in connective tissues with primary involvement of the skin. Mutations in the *ABCC6* gene on chromosome 16p13.1, encoding an ATP-binding cassette transmembrane transporter protein, are associated with PXE.¹ Ocular manifestations ranging from angioid streaks, disc drusen, peau d'orange and focal chorioretinal comettial lesions are seen, although these do not appear to affect visual function. Visual loss can occur secondary complications such as choroidal neovascularization from angioid streaks or choroidal rupture from minor ocular trauma. Approximately 10–15% of patients develop various forms of pattern macular dystrophy.² Retinal function was thought to be unaffected in PXE;³ until recently, a small number of electrophysiological studies demonstrated generalised retinal dysfunction associated with PXE on electroretinogram (ERG).^{4,5} We report the unusual ophthalmological presentation of a patient with a novel *ABCC6* mutation.

Figure 1 (a, b) Fundus photographs of the right (a) and left (b) eyes, showing early macular abnormalities with RPE mottling. The optic disc and peripheral retina were unremarkable. (c, d) Fundus photographs of the right (c) and left (d) eyes taken 5 years later, showing visible angioid streaks originating from the optic discs. The macular abnormalities have progressed with marked RPE atrophy. (e, f) Histological analysis of the skin biopsy showed fragmentation of basophilic elastic fibres and confirmed the diagnosis of PXE.