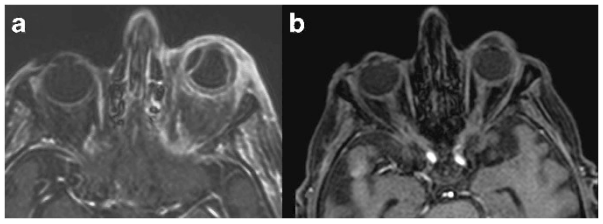

Figure 1 (a) Magnetic resonance imaging (MRI) demonstrating right eye proptosis, swelling of the extraocular muscles, and the orbital fat, which all led to the diagnosis of orbital cellulitis. In addition, the exudative retinal detachment (ERD) is depicted in the MRI scan. Sinusitis is also evident. (b) MRI on day 10 post initiation of treatment demonstrating complete resolution of orbital cellulitis and no signs of ERD.

blood tests gradually normalized. Complete resolution of the ERD was evident (Figure 1b). VA improved to 6/36.

Comment

Orbital cellulitis is an extremely rare cause of ERD. The only published reports[4,5] refer to a 12-year-old boy who sustained ERD due to orbital cellulitis originating from an eyelid abscess and a 56-year-old with Down's syndrome; the source of infection remained unclear. In our case the MRI findings and the purulent nasal discharge were consistent with ethmoid sinusitis leading to cellulitis. The bacteria responsible for causing the infection are MRSA as the patient was hospitalized, and the nasal aspirate cultures were positive for MRSA. In all cases including ours treatment of cellulitis was followed by rapid resolution of the ERD.

Our case illustrates the uncommon but possible occurrence of ERD in the course of orbital cellulitis. Although the incidence is rare, it may pose diagnostic and therapeutic dilemmas, but it should be considered, especially in immunocompromised patients. Our case illustrates that medical management with strong antibiotics can lead to resolution without surgical intervention even in the presence of sinusitis.

Conflict of interest

The authors declare no conflict of interest.

References

1 Cannon PS, Mc Keag D, Radford R, Ataullah S, Leatherbarrow B. Our experience using primary oral antibiotics in the management of orbital cellulitis in a tertiary referral centre. *Eye* 2009; **23**: 612–615.
2 Ferguson MP, McNab AA. Current treatment and outcome in orbital cellulitis. *Aust N Z J Ophthalmol* 1999; **27**: 375–379.
3 Gariano RF, Kim CH. Evaluation and management of suspected retinal detachment. *Am Fam Physician* 2004; **69**: 1691–1699.
4 Malhotra M. Orbital cellulitis with exudative retinal detachment. *Br J Ophthalmol* 1957; **41**: 317–319.
5 Farhil P, Kurup S, Abdelghani WM. Orbital cellulitis associated with combined retinal and choroidal detachments. *Eye* 2007; **21**: 1009–1010.

E Farah, G Kalantzis, I Papaefthimiou, C Koutsandrea and I Georgalas

Department of Ophthalmology, 'G.Gennimatas' Hospital of Athens, University of Athens, Athens, Greece
E-mail: igeorgalas@yahoo.com

Eye (2014) **28,** 109–110; doi:10.1038/eye.2013.243; published online 15 November 2013

Sir,
Liver failure following antituberculosis (ATT) chemotherapy for presumed tuberculous uveitis

We read with great interest the paper by Manousaridis *et al*,[1] which adds to the publication by Sanghvi *et al*,[2] with respect to presumed tuberculous (TB) uveitis in the United Kingdom, and we would commend both sets of authors for these well-presented case series. In the latter[2] it was recommended that a full 6-month course of Anti-TB therapy (ATT) be commenced in all patients with uveitis and latent TB, in whom other causes of uveitis have been ruled out. We present a case of acute liver failure secondary to ATT in one such patient.

Case report

A 41-year-old Indian lady presented to Leicester Royal Infirmary Eye Casualty with gradual reduction in vision with floaters and was found to have bilateral granulomatous pan-uveitis. The best-corrected visual acuity was 6/36 in both eyes, and there were multiple choroidal tubercles (Figure 1) with leakage on fluorescein angiography. Quantiferon-TB gold testing was positive.

The Infectious Diseases Unit found no evidence of other active systemic TB and the patient was started on Rifater (rifampicin, isoniazid, pyrazinamide), Moxifloxacin 400 mg, and Pyridoxine 10 mg. After 28 days, the patient was admitted to a tertiary liver centre ITU with acute liver failure presumed secondary to ATT and subsequently developed severe autoimmune haemolysis presumed secondary to rifampicin. The ATT was stopped and the patient recovered. The patient declined any further ATT. The visual acuity at her last visit was 6/9 in each eye with low-dose topical steroid.

Comment

Hepatotoxicity is the most common iatrogenic disease in TB[3] with an incidence between 1 and 10% worldwide,[4,5] and 4% in the United Kingdom.[6] The benefits of ATT clearly outweigh the risks for active TB. However, this is not true in cases of latent TB and NICE guidance highlights those patient groups most likely to benefit from ATT.[7] In the series of patients reported,[1,2] those who benefited most in terms of visual acuity from ATT had

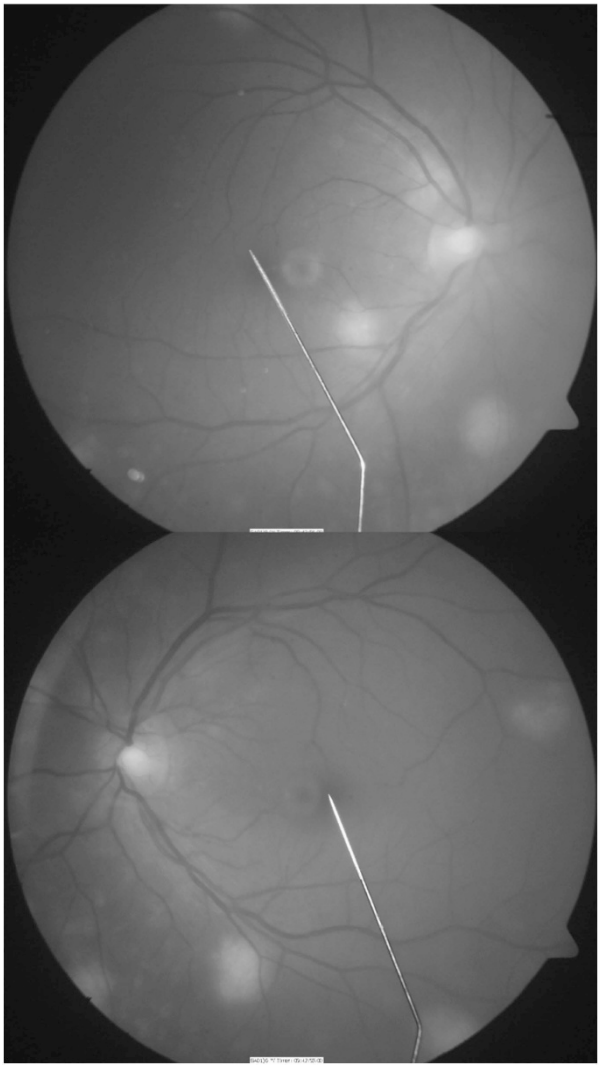

Figure 1 Choroidal tubercles in both eyes.

active TB and received systemic or periocular steroid. Furthermore, ATT may not be curative of the uveitis.[3] We therefore recommend some caution when considering ATT in patients with presumed TB uveitis and latent TB.

Conflict of interest

The authors declare no conflict of interest.

References

1 Manousaridis K, Ong E, Stenton C, Gupta R, Browning AC, Pandit R. Clinical presentation, treatment, and outcomes in presumed intraocular tuberculosis: experience from Newcastle upon Tyne, UK. *Eye* 2013; **27**: 480–486.
2 Sanghvi C, Bell C, Woodhead M, Hardy C, Jones N. Presumed tuberculous uveitis: diagnosis, management, and outcome. *Eye* 2011; **25**: 475–480.
3 Iseman MD, Albert R, Locks M, Raleigh J, Sutton F, Farer LS. American Thoracic Society. Medical Section of the American Lung Association. Guidelines for short-course tuberculosis chemotherapy. *Am Rev Respir Dis* 1980; **121**: 611–614.
4 Gangadharam PRJ. Isoniazid, rifampin and hepatotoxicity. *Am Rev Respir Dis* 1986; **133**: 963–965.
5 Parthasarathy R, Raghupati SG, Janardhanam B, Ramachandran P, Santha T, Sivasubramanian S *et al*. Hepatic toxicity in South Indian patients during treatment of tuberculosis with short-course regimens containing isoniazid, rifampicin and pyrazinamide. *Tubercle* 1986; **67**: 99–108.
6 British Thoracic Association. A controlled trial of six months chemotherapy in pulmonary tuberculosis. First report: results during chemotherapy. *Br J Dis Chest* 1981; **75**: 141–153.
7 National Institute for Health and Care Excellence. Clinical diagnosis and management of tuberculosis, and measures for its prevention and control. CG117. Available at: http://guidance.nice.org.uk/CG117.

MJ Wakefield and P Kumar

Ophthalmology Department, Leicester Royal Infirmary, Leicestershire, UK
E-mail: mjwakefield_uk@hotmail.com

Eye (2014) **28,** 110–111; doi:10.1038/eye.2013.226; published online 18 October 2013

Sir,
Reply to Wakefield and Kumar

We would like to thank Wakefield and Kumar[1] for their useful comments. It is true that the exact association between latent TB and uveitis is not known. In our series, all patients with presumed intraocular TB and active TB elsewhere received standard anti-tuberculous therapy (ATT). Patients with presumed intraocular TB and latent TB were generally offered ATT, but this was done after careful consideration of individual risk/benefit. Indeed, as we state in our article, two patients with latent TB and presumed intraocular TB received no ATT, because we estimated that the risks of treatment outweighed any potential benefit in them.[2]

ATT has well-recognized systemic and ocular adverse effects. On the other hand, it is known that ATT can eliminate latent TB and decrease a person's lifetime risk of developing active TB by 90%.[3] Moreover, administering corticosteroid or immunosuppressive therapy for severe intraocular inflammation without the coverage of ATT may cause re-activation of systemic TB, resulting in severe disseminating TB or even panophthamlitis.[4,5] In a large series of patients with presumed intraocular TB and latent TB combination treatment with corticosteroids and ATT reduced the risk of developing recurrence of the uveitis by approximately two-thirds compared to