

It would also be interesting to know which oral antibiotic prophylaxis was chosen in those cases that displayed enterococci in their conjunctival flora.

As no intraocular samples were taken, it remains unclear how the authors arrive at the conclusion that the 'risk of intraocular contamination... was increased 1.6 and 2.5 times in those over 85 and 90...'.

Conflict of interest

The authors declare no conflict of interest.

References

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AR Nestel

North Devon District Hospital, Barnstaple, UK
E-mail: achimnestel@gmail.com

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Sir, Response to Nestel

We thank Dr Nestel¹ for his interest in our study.² We found some associations between the pathogenic conjunctival bacteria and the systemic co-morbidities of patients undergoing cataract surgery, which was the main purpose of the study. Among these associations, we found that enterococci prevalence is associated with age and diabetes. Owing to the current wide use of intracameral cefuroxime for the cataract surgery prophylaxis,^{3,4} we introduced the example of the postoperative endophthalmitis (PE) caused by enterococci for illustrating the implications of our findings in the management of patients carrying conjunctival bacteria resistant to a particular prophylaxis, such as the enterococci to cefuroxime, as Dr Nestel pointed. The systemic co-morbidities associations with other bacteria (for instance multi-resistant *Staphylococcus*) could also help in choosing a prophylaxis.

Table 1 Increasing potential risk of intraoperative contamination by enterococci according to age in patients operated on for cataract

Age groups (years)	Patients	Enterococci	%	OR	CI (95%)
18–65	1264	11	0.87		
66–85	6597	148	2.24	2.61	1.41–4.84
86–90	377	11	2.92	3.42	1.47–7.96
91–98	95	5	5.26	6.33	2.15–18.61

Abbreviations: CI, confidence interval; OR, odds ratio.

The answers to other comments are as follows:

- In the study design, polymyxin B plus trimethoprim eye drops is an empirical prophylaxis for all patients, except those having conjunctival pathogen bacteria resistant to these antibiotics, such as enterococci. We try not to increase the resistance to first-line antibiotic treatments.
- The occurrence of four PE cases in the first year of the study period² was before using intracameral cefuroxime. This fact could point to streptococci as the most likely cause, as there was no case of Streptococci-PE in the ESCRS groups treated with cefuroxime,⁵ and no others prophylactic measures had changed in our study.
- The oral antibiotic for patients with conjunctival enterococci was chosen in accordance with their susceptibility tests;⁶ quinolones being the first choice, if possible.
- Finally, the 'potential' risk of intraocular contamination by enterococci, in patients over 85 years, was calculated with respect to the conjunctival enterococci prevalence of patients younger than 86 years (Supplementary Table 3).² This information is extended in Table 1.

Conflict of interest

The authors declare no conflict of interest.

References

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M-E Fernández-Rubio¹, T Cuesta-Rodríguez²,
J-L Urcelay-Segura² and C Cortés-Valdés²

¹Ophthalmic Institute Laboratory, Department of Ophthalmology, 'Gregorio Marañón' University General Hospital, Madrid, Spain

²Department of Ophthalmology, 'Gregorio Marañón' University General Hospital, Madrid, Spain
E-mail: mfernandezr.hgugm@salud.madrid.org

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Sir, Endogenous *Serratia marcescens* endophthalmitis: an atypical presentation

Endogenous endophthalmitis is an uncommon but potentially blinding condition caused by hematogenous microbial spread from an extraocular focus. *Serratia marcescens* is an aerobic, Gram-negative bacillus that is commonly associated with nosocomial infections of the respiratory and urogenital tract in susceptible

individuals.^{1–3} It is a rare but devastating cause of endogenous endophthalmitis due to its multi-drug resistant nature, resulting in blindness or enucleation in a majority of reported cases.^{1–3} Herein, we report a case of endogenous *Serratia marcescens* endophthalmitis with a ciliary body abscess presenting initially as acute angle-closure glaucoma, leading to difficult diagnosis. This is the third reported case of an irido-lenticular abscess in a background of endogenous endophthalmitis.

Case report

A 78-year-old Chinese woman presented with acute right ocular pain, redness and blurred vision for 2 days, associated with nausea and vomiting. Past medical history was notable for diabetes and dengue hemorrhagic fever 8 days prior requiring platelet transfusion.

On examination, she was afebrile, with right wrist swelling from phlebitis following recent venous catheterization. Right ocular examination showed upper eyelid non-erythematous edema with mild proptosis, a mid-dilated pupil with a grade 3 reverse relative afferent pupillary defect, and intra-ocular pressures (IOP) of 38 mm Hg. Visual acuity (VA) was counting fingers at 3 feet. Slit-lamp examination findings are shown in Figure 1a.

Biochemical investigations showed normal blood counts with polymorphonuclear neutrophil predominance (79%). ESR and CRP levels were elevated. Blood and urine cultures were negative. B-scan ultrasonography and magnetic resonance imaging findings are shown in Figures 1b and c. Maximum anti-glaucoma therapy, topical Tobramycin 0.3%, and intravenous Ceftazidime and Vancomycin were initiated, with subsequent addition of topical Moxifloxacin 0.5%, Cefazolin 50 mg/ml, and Natamycin 5%.

The eye deteriorated, with persistently elevated IOP, increasing hypopyon and fibrin in the anterior chamber (AC), and a decrease in VA to no light perception. Antibiotics were switched to Meropenem, Daptomycin, and Doxycycline for phlebitis being a possible focus. Ocular cultures were not obtained due to a flat AC and an uncooperative patient.

The eye developed severe infective signs after 7 days (Figure 2a). Repeat B-scan findings are shown

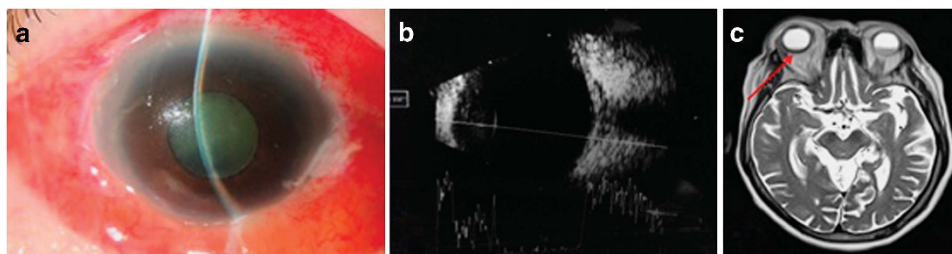


Figure 1 Findings at initial presentation. (a) Slit-lamp photograph of the right eye showing chemosis and conjunctival injection, corneal edema, and flat anterior chamber with fibrin pupillary plaque. (b) B-scan ultrasonography of the right eye showing clear vitreous and 'T-sign' without retinal detachment. (c) MRI of orbits and brain showing orbital inflammation, scleral enhancement, and optic nerve enhancement (red arrow), with no ciliary body, choroidal, or intracranial abscesses.