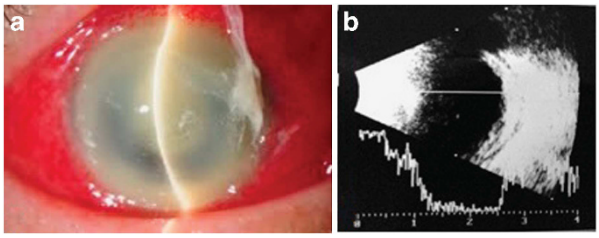

Figure 2 Findings 7 days following presentation. (a) Slit-lamp photograph of right eye showing peripheral corneal melting, a deep stromal ring with thinning, an early central abscess in a flat anterior chamber, and central whitening due to white cataract covered with fibrin and pus. (b) B-scan ultrasonography of right eye showing progressively thickened posterior choroid and sclera, vitreous haze, and a superior retinal detachment despite broad-spectrum intravenous antibiotic therapy.

in Figure 2b. It was eviscerated due to intractable pain. Intraoperatively, a thickened opaque cornea and localized ciliary body pus collection were found, from which *Serratia marcescens* was isolated. Cultures showed resistance to Ampicillin and Cephalothin, with sensitivity to Cefipime, Ertapenem, Gentamicin, Ciprofloxacin, and Levofloxacin.

Comment

This is a case of ciliary body abscess secondary to endogenous endophthalmitis, presenting initially as acute angle-closure glaucoma. Negative blood/urine cultures, lack of ocular cultures, deterioration despite broad-spectrum antimicrobials, and late deep vitreous involvement[4] made diagnosis difficult. An ultrasound biomicroscopy should have been used to detect ciliary body abscesses[5] had the patient not been in severe pain.

Serratia marcescens is a Gram-negative rod-shaped Enterobacteriaceae known to cause nosocomial catheter-related bacteremia in immunocompromised individuals.[1–3] Ophthalmologists should suspect atypical infections in such patients,[1–3] and for *Serratia marcescens* endophthalmitis, initiate aggressive intra-vitreal aminoglycoside therapy.[1–3]

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Spontaneously resolved exudative retinal detachment caused by orbital cellulitis in an immunocompromised adult

Exudative retinal detachment (ERD) may result from the accumulation of fluid in the subretinal space because of hydrostatic factors (eg severe acute hypertension), inflammation, or neoplastic effusions.[1] ERD generally resolves with successful treatment of the underlying disease, and visual recovery may be excellent.[1–3]

Case report

An 89-year-old male with chronic myeloid leukemia (CML) was referred with new onset RE pain and severe reduction of vision 1 week after admission for his CML. He was febrile (39 °C), anemic, and presented generalized malaise. He had bilateral age macular degeneration (AMD) that was worse in the RE.

On examination there was RE proptosis with limited lateral gaze, significant pain with retropulsion, right eyelid erythema and swelling, chemosis, and purulent discharge (Figure 1a). Visual acuity (VA) was light perception in the RE and 6/9 in the LE. The intraocular pressures were 34 mm Hg in the RE and 17 mm Hg in the LE. Fundoscopy revealed a RE ERD with shifting fluid, in the absence of PVD or retinal tears.

On full blood count there was neutrophilic leucocytosis (WBC 22.79 $\times 10^3/\mu$l; 94.2% neutrophils). C-reactive protein was 128 mg/l and ESR 106 mm/h. Culture of nasal aspirates revealed methicillin staph aureus (MRSA) and Warneri-Staph.

The patient was placed on intravenous (vancomycin, cefurixime, and metronidazole) and topical antibiotics. Symptoms improved by the fifth post-treatment day and

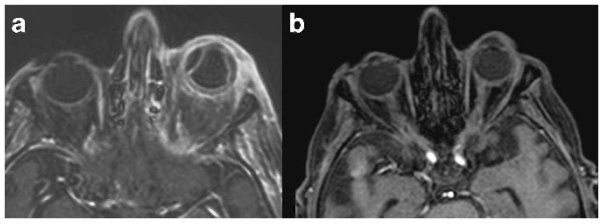

Figure 1 (a) Magnetic resonance imaging (MRI) demonstrating right eye proptosis, swelling of the extraocular muscles, and the orbital fat, which all led to the diagnosis of orbital cellulitis. In addition, the exudative retinal detachment (ERD) is depicted in the MRI scan. Sinusitis is also evident. (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.

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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