

**Sir,
Reply to Dr Grzybowski**

We thank Dr Grzybowski for his interest in our manuscript. His comments¹ are consistent with those that we mentioned in the paper: 'a significant increase in the antibiotic resistance of the isolated specimens from ocular flora' and 'a greater rate of endophthalmitis with the use of topical antibiotics'.² As we stated in our manuscript, we reviewed the articles that have been published in the literature from January 2005 to November 2012.²

After our manuscript was in press, several reports, including those discussed by Dr Grzybowski, were published describing the use of antibiotics in intravitreal injections. Although high-quality prospective randomized clinical trials comparing the rate of post-injection endophthalmitis have not been conducted, there is a growing body of evidence that shows that the routine use of antibiotics before or after intravitreal injections should be discouraged.³⁻⁵

It is noteworthy that the use of pre- and/or post-injection antibiotics may still be considered in selected conditions such as eyes with external ocular diseases, nasolacrimal drainage problems, or history of endophthalmitis, as well as monocular patients.

Once again we thank Dr Grzybowski for his comments, which have allowed us the opportunity to respond.

Conflict of interest

The authors declare no conflict of interest.

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**Sir,
Myopic macular retinoschisis with microvascular anomalies**

Myopic macular retinoschisis is found in eyes with pathological myopia. It is a precursor to both myopic macular holes and rhegmatogenous retinal detachment.¹⁻³ This report describes a novel vascular finding in this setting, which offers support to the theory that paravascular anomalies contribute to the pathogenesis of this condition.

Case report

A 45-year-old ethnic-Chinese lady presented with central visual disturbance in the right eye. Her corrected acuity was 6/9 in both eyes and the refraction was -8.0 dioptres in the right eye and -10.0 dioptres in the left eye. The anterior segments were normal in both eyes. Fundoscopy of the right eye revealed fine radial striae at the fovea and subtle cystic spaces. Temporal to the macula there were a number of saccular aneurysm-like structures and a 200° wide-field image of the retina demonstrated that there was no peripheral retinoschisis. (Figure 1) A fluorescein angiogram highlighted these lesions, together with disrupted retinal capillaries. No leakage was demonstrated. (Figure 2) Optical coherence tomography (OCT) confirmed the presence of macular retinoschisis in the right eye (Figure 3).

Comment

The OCT features of this syndrome can be varied but typically include: columnar bridging structures within the schisis cavity, and a variable degree of vitreo-retinal traction including ILM dehiscence.^{1,4} Both of these findings were present in our patient.

Recently, OCT imaging has demonstrated that the contour of larger retinal vessels may also be altered in patients with myopic macular retinoschisis, but to date disruption of the retinal microcirculation has not been described.⁵ In our patient the blood filled spaces appeared to be dilated capillary terminals and not extravasated blood. This suggests