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Sir,

Response to Comment on: How common is inflammatory marker-negative disease in giant cell arteritis?

We thank Dr Kermani *et al*[1] for their interest in our article.

In response to their comments on our report[2] we acknowledge the inadvertent omission of two recent articles,[3,4] both of which emphasise the occurrence of CRP-negative disease seen in giant cell arteritis (GCA). Our case is clearly described as 'CRP-negative disease', and in addition to this we review inflammatory-marker-negative disease in GCA, as it is appropriate and informative in this context.

The threshold for an abnormal CRP result is ill defined. Indeed various receiver operating characteristic curves for CRP have been published, illustrating the trade-off of sensitivity and specificity at various threshold settings. Also, different laboratories express the parameter as either mg/l or mg/dl, which can be a source of confusion in clinical practice. Hayreh *et al*[5] use a level <24.5 mg/l (2.45 mg/dl) as a cut-off for normal in the context of GCA.

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Sir,

An unusual case of orbital cellulitis

Orbital cellulitis is an ophthalmic emergency that may lead to both life- and sight-threatening complications. We report the case of a child who presented with orbital cellulitis secondary to self-inflicted periocular and facial lacerations during sleep. He regained normal visual function after propitious ophthalmic and psychiatric intervention.

Case report

A 6-year-old boy presented with a 2-day history of painful protrusion of the left eye.

On examination, multiple fresh and old scratch marks were seen over his face. The left eye showed lacerated wounds on the lids, axial proptosis, ptosis, and conjunctival chemosis (Figure 1). Vision was 6/12. Extraocular movements were restricted. Pupils and retinal examination were normal. Computerized

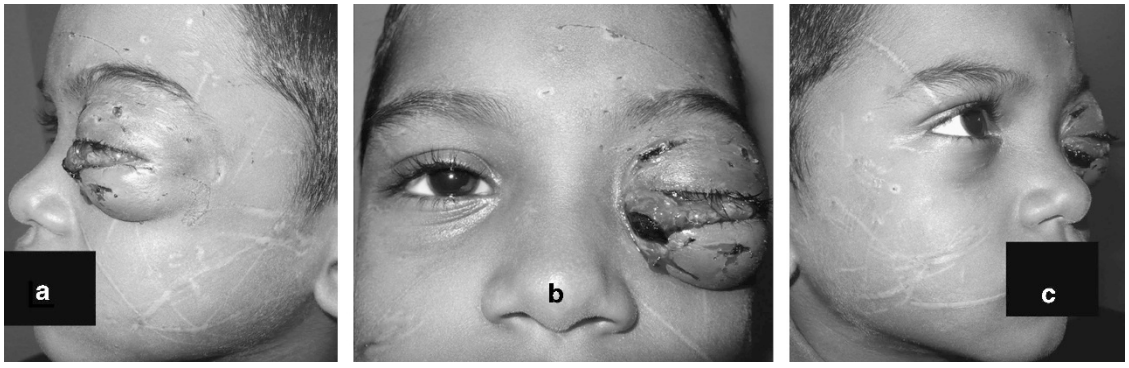

Figure 1 Clinical photographs showing (a) right lateral; (b) frontal; (c) left lateral views of the patient with facial scratch marks and left eye ptosis, proptosis, and periocular lacerations.

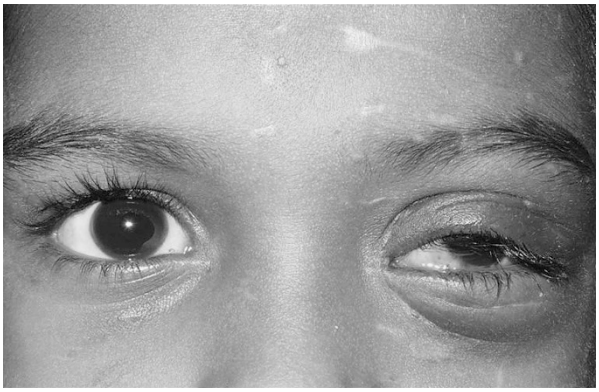

Figure 2 Clinical photograph after treatment.

tomography scan showed diffuse inflammation of the left orbit. Paranasal sinuses and brain study were normal. Based on these findings the diagnosis of orbital cellulitis secondary to self-inflicted periocular injury was made.

Clinical improvement was noted after 48 h of intravenous antibiotics (Figure 2).[1] Psychiatric evaluation revealed attention deficit/hyperactivity disorder (ADHD) with night terrors. The child was prescribed Methylphenidate and Clonazepam for his ADHD and parasomnia, respectively. He was advised to wear gloves during sleep.

Currently, at 9 years of age, he is not using either medications or gloves. He has not had any episodes of self-injury for the past 2 years.

Comment

Parasomnias, defined as undesirable behavioral events during sleep, for example, nightmares, sleep terrors, and sleep walking, are common in the general population. Disorders of arousal, like sleep terrors, are the most common parasomnia seen in boys aged 5–7 years.[2]

The child may sit up, scream, and appear frightened, with increased pulse and respiratory rates and sweating. For most children, treatment is not necessary. Adhering to good sleep routines will usually reduce the frequency of events.[3] If sleep terrors cause an injury, parents/guardians need to be educated about creating a safe environment for the child.[4] The etiology of orbital cellulitis in the pediatric age group is varied, ethmoid sinusitis being the commonest.[5] To our knowledge, this is the first reported case of orbital cellulitis secondary to self-inflicted trauma due to parasomnia in a child. However, in any case of trauma in a child, non-accidental injuries should be ruled out. In case of parasomnia, it is important to prevent further episodes by psychotherapy and protective measures.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgements

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Sir,

Central corneal haze after wedge resection following penetrating keratoplasty and photorefractive keratectomy

Arcuate keratotomy is a common procedure after keratoplasty, but can induce central corneal haze in eyes with a history of PRK. Herein, we report on a patient with the history of uncomplicated penetrating corneal transplantation with uncomplicated PRK, who developed central corneal haze 6 months after wedge resection.[1]

Case report

A 34-year-old man with keratotconus underwent penetrating keratoplasty in the right eye in 1993 and arcuate keratotomies (AK) for high astigmatism in 2000. A PRK for a refraction of $-1.0\times-2.0/140^{\circ}$ without mitomycine C (MMC) was done in 2005.

Postoperative course was uncomplicated including a clear cornea and uncorrected distance visual acuity (UDVA) was 0.2 logMAR 6 months after PRK. The patient's vision decreased 5 years later again due to inferior corneal steepening and wedge resection (two opposite 60° AK in the 6.0-mm central optical zone with six compression sutures using 10-0 nylon) was performed to treat irregular astigmatism.