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Sir,

Response to Shah *et al*

We thank Shah *et al*[1] for their interest in the Portsmouth Glaucoma Refinement Scheme.[2] The scheme also uses Van Herick grading for anterior chamber depth—all patients with a Van Herick peripheral limbal anterior chamber depth of less than 25% of corneal thickness were referred to the virtual clinic for assessment by an ophthalmologist. Approximately 10% of all of those accepted from the Refinement Scheme virtual clinic to HES (from a total of 11 out of 100 referred to the virtual clinic, from our audit) were due to narrow angles suspected through Van Herick grading. Of these, 25% subsequently required laser peripheral iridotomy, slightly higher than the 17% positive predictive value, for the suggestion of occludable angles by an initial Van Herick test, outlined by Foster.[3]

Conflict of interest

The authors declare no conflict of interest.

References

1 Shah B, Campbell P, Ford C, Goyal S, Lim KS. Re: The Portsmouth-based refinement scheme: a role for virtual clinics in the future? *Eye* 2013; **27**(7): 892–893.
2 Trikha S, Macgregor C, Jeffery M, Kirwan J. The Portsmouth-based refinement scheme: a role for virtual clinics in the future? *Eye* 2012; **26**: 1288–1294.
3 Foster P. Advances in the understanding of primary angle-closure as a cause of glaucomatous optic neuropathy. *Commun Eye Health* 2001; **14**(39): 37–39.

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Sir,

Identification of Epstein–Barr virus in a case of aggressive retinochoroiditis

We describe isolation of Epstein-Barr virus by aqueous PCR in a case of fulminant retinochoroiditis with prominent choroidal effusions as an atypical feature.

Case report

A sixty-five-year-old woman with primary open-angle glaucoma and previous bilateral augmented trabeculectomies presented with a painful, red left eye with decreased vision. She had been diagnosed with aplastic anaemia 1 year previously and was undergoing systemic immunosuppression (mycophenolate mofetil) in preparation for an anti-thymocyte globulin transfusion, receiving long-term prophylactic ciprofloxacin, acyclovir, and itraconazole. At presentation she had neutropaenia (0.07×10^9/l), thrombocytopaenia (13×10^9/l), and low reticulocytes (3×10^9/l).

Visual acuity in the right eye was 6/6, while the left was light perception. A left afferent pupillary defect was present with anterior uveitis and hypotony (intraocular pressure right eye 11 mm Hg, left 7 mm Hg). There was no associated blebitis. Fundal examination revealed vitritis, focal retinitis (Figure 1) and localised choroidal effusions (Figure 2). A diagnosis of retinochoroiditis was made.

Empirical intravenous acyclovir 10 mg/kg tds was commenced along with topical dexamethazone 0.1% and

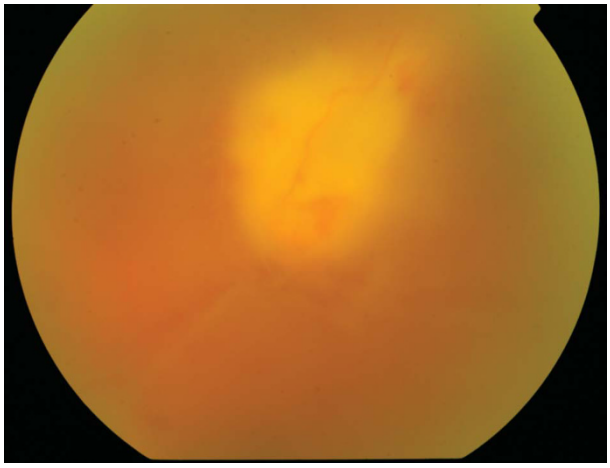

Figure 1 Focal retinitis with haemorrhagic arteriolitis in the region of the superotemporal vascular arcade. The view is partially obscured by marked vitiritis.

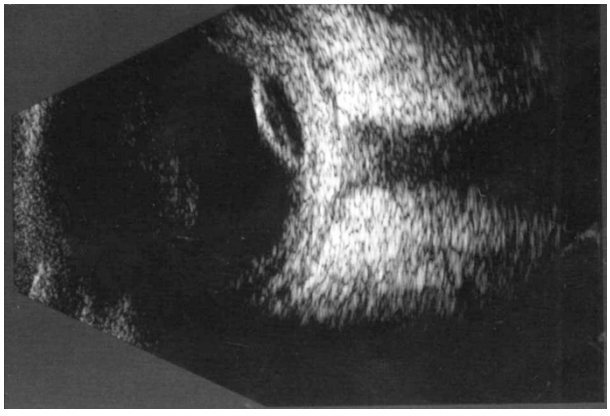

Figure 2 Localised choroidal effusion at presentation.