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**Sir,
Re: Spontaneously resolved exudative retinal detachment caused by orbital cellulitis in an immune compromised adult**

We thank the authors for presenting a very interesting case of orbital cellulitis and exudative serous retinal detachment with excellent MRI scans showing orbital pathology.¹ The authors suggest orbital cellulitis as a possible cause of the retinal detachment. The hematological tests suggest that the patient may have had a septicemia, with elevated ESR, C-reactive protein level, and a neutrophilic leukocytosis. Septicemia is well known to cause serous retinal detachments.

We wonder if the serous retinal detachment described in this case report was caused by the septicemia resulting from the primary infection, and if blood cultures were done to exclude this possibility.

Conflict of interest

The authors declare no conflict of interest.

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**Sir,
Response to Perera and Ali**

We would like to thank Perera and Ali¹ for their interest in our case report and their useful comments. It is true that serous retinal detachments can occur in patients suffering from septicemia or disseminated intravascular coagulation (DIC).^{2,3}

In our case,⁴ an 89-year-old immunocompromised patient presented with fever and elevated inflammatory markers (that is, raised ESR, C-reactive protein and neutrophilic leukocytosis), but the blood cultures that were performed were negative for any microorganism. Additionally, culture of nasal aspirates revealed methicillin-resistant *Staphylococcus aureus* and *Warneri-Staphylococcus*, which were consistent with ethmoid sinusitis leading to orbital cellulitis and subsequent exudative retinal detachment.

Conflict of interest

The authors declare no conflict of interest.

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**Sir,
Maculopathy following extended usage of Clomiphene citrate**

Clomiphene citrate (CC) is a selective estrogen receptor modulator mostly used for treatment of infertility associated with polycystic ovarian disease.¹ Unlike Tamoxifen, which is also a selective estrogen receptor

modulator, maculopathy has not been reported in association with CC in previous reports.²⁻⁴

Case report

A 33-year-old woman developed progressive visual impairment and headaches within the last 6 months. Her visual acuity was 20/200 OU. Color vision was normal. Fundus examination showed atrophic changes at the macula (Figure 1). She had no prior history of systemic or familial retinal disease, and her medical records confirmed that she had 20/20 vision OU 3 years ago.

She denied usage of systemic agents that may induce maculopathy, but reported using CC (100 mg/day,

5 days per cycle). She kept using CC by her own for 3 years without visiting her gynecologist for infertility treatment. Cranial MRI showed no intracranial pathology. Fluorescein angiography (FA) revealed RPE defects with perifoveal macular staining (Figure 2). The headaches subsided within 3 months after cessation of CC; however, visual impairment and macular changes were persistent during a 2-year follow-up.

Discussion

CC has potential systemic side effects and ≥ 6 cycles of therapy is not usually recommended for ovulation induction.¹ Several dose-related ocular side effects have been defined, such as blurred vision, scotomata,

Figure 1 Color fundus appearance of the patient showing oval-shaped macular atrophy in both eyes.

Figure 2 FA shows the central area of retinal pigment epithelial atrophy giving a bull's eye appearance to the macula in both eyes. There was no leakage from these areas at the later phases.

diplopia, photophobia, temporary visual impairment, and retinal vein occlusion.^{2,3} Although these adverse ocular effects generally disappear within a few days to weeks following discontinuance of therapy, shimmering after-images (palinopsias) and photophobia have been reported to be symptomatic in three cases for 2–7 years.³

Maculopathy associated with CC was not reported in previous series. Our case was taking CC by her own for an overextended period and developed irreversible visual impairment with maculopathy. Although CC has a similar molecular structure to tamoxifen,⁴ CC-associated retinopathy differs from tamoxifen retinopathy as there are no blocking crystals in FA, but atrophic maculopathy. Our case indicates that CC may induce irreversible retinal damage and visual deterioration if used for an overextended period.

Conflict of interest

The author declares no conflict of interest.

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Sir, Eyelid nodule in a child: a chalazion or idiopathic facial aseptic granuloma?

Chronic, painless facial nodules in children, which may be misdiagnosed as chalazions if located on eyelids are subject of a new entity called ‘idiopathic facial aseptic granuloma’ (IFAG). IFAG is a dermatological disorder characterized by solitary eyelid nodules or accompanying facial nodules located on the cheeks with an unknown etiology.¹ The role of trauma and insect bite has been discussed.² Nodules include a discharge of pus. Cultures are negative, except in cases of superinfection.

Figure 1 Eyelid nodule of IFAG.

Eyelid nodules resemble nodules of meibomian cysts (chalazions) (see Figure 1). Ultrasonography of IFAG nodules shows a well-demarcated hypoechoic lesion located in dermis only.³ But chalazions—which are due to meibomian gland inflammation—are located inside eyelid tarsus.⁴ IFAG nodules are thought to be related to a granulomatous process surrounding an embryological residue, rather than inflammation of meibomian glands.¹ Chalazions are not accompanied by facial nodules unless they are related to rosacea.⁴ IFAG lesions on eyelids are often self limited and heal without any scar,¹ whereas surgical management is necessary in most cases of chalazia, especially for the large ones.

Characteristic appearance of the eyelid nodules and accompanying facial lesions are typical for IFAG. But coexistence of facial and eyelid nodules is also a common feature for ocular rosacea. These two diseases demonstrate major differences despite this overlapping clinical picture. As a major difference, conjunctival hyperemia, blepharoconjunctivitis, or keratitis-like ocular manifestations are typical for rosacea and very rarely seen with IFAG.¹ Oral antibiotic regimens like oral clarithromycin or erythromycin fasten the healing process,⁵ unlike ocular rosacea, which always necessitates systemic antibiotic treatments—even surgical interventions in unresponsive cases.

Despite these differences, some authors assume it to be early childhood rosacea,¹ whereas some others regard it as rosacea's granulomatous form.⁶

Ophthalmic and dermatological evaluation in IFAG is important, as these cases are recommended to be followed up for pediatric rosacea development—although the association is not exactly verified. Associated with rosacea or not, we believe that awareness of this new dermatological disorder by the ophthalmologists is the most important point, to avoid unnecessary surgical interventions, because of its good response to oral antibiotics.

Conflict of interest

The authors declare no conflict of interest.