Case report

A 37-year-old woman presented at our emergency Eye Department complaining of blurred vision in her right eye for a period of 1 week. Visual acuity was 6/60 in the affected eye and 6/9 in the left eye. There was a history of contact with cats and dogs. Patient reported also cough and fatigue during the past week. Slit-lamp examination revealed mild inflammatory reaction in the anterior chamber and central vitreous haze. Biomicroscopy revealed two white focal chorioretinal elevated lesions superiorly temporarily to the fovea (Figure 1) and in the inferonasal peripapillary area (Figure 2). OCT revealed hyper-reflective inner retina layers in the lesions casting a shadow on the posterior retinal layers and choroid (Figure 3, purple arrows) and the presence of intraretinal and subretinal fluid causing neurosensory detachment (Figure 3). FFA demonstrated late hyperfluoresence from the focal lesions (Figure 1). Interestingly, exudation around the fovea appeared 12 days after the initial presentation (Figure 3, yellow arrows).

Treatment with trimethoprim-sulfamethoxazole 160/800 mg twice/day was prescribed. The serology tests were negative for toxoplasmosis and strongly positive for *Bartonella henselae* (IgM: 80 and IgG: 512).

Four weeks after the initiation of the treatment VA was 6/9 in the affected eye with no signs of active inflammation while the exudates had resolved and the focal lesions appeared to have pigment in their margins.

Comment

In our case, cat scratch disease was initially strongly suspected and presented without the involvement of optic nerve head but with an initial presence of multiple exudates, a finding more common than previously believed.[1–5] Serology tests confirmed the diagnosis and following treatment VA had progressively increased, with intraretinal and subretinal fluid accumulation resolving dramatically within days and hyper-reflectivity on OCT at primary lesions was diminished. OCT showed noticeable correlation with clinical findings and may have a significant role in the diagnosis and follow-up of patients with cat scratch disease.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Complete dehiscence of a DALK graft after early suture removal

Deep anterior lamellar keratoplasty (DALK) involves removal of the diseased anterior layers of the corneal stroma and preserves the healthy Descemet membrane (DM) and endothelium of the host. As the DM is kept intact in DALK surgery, it is arguable that the healing is faster and the wound more durable compared to penetrating keratoplasty (PK). The main drawback of DALK is the occurrence of a high amount of postoperative astigmatism. Although sutures after PK are removed over a period of 1–2 years, early suture removal after DALK can be carried out to combat high postoperative astigmatism. We describe a case of complete dehiscence of a DALK graft after early suture removal.

Case report

A 40-year-old man with advanced keratoconus underwent DALK in his left eye (OS) using the big bubble technique.[1,2] After a successful centration of the host cornea, an 8.00-mm Hessburg–Barron suction trephine was used to trephine through the anterior corneal stroma. No perforation of the DM was noted during surgery. The stromal dissection was completed up to the DM. An 8.25-mm donor button, without the DM and endothelium, was sutured on to the host bed using single running suture technique. Postoperatively, dexamethasone and chloramphenicol eye drops were given every 2 h. Visual acuity 24 h after surgery was

Figure 3 OCT and infrared fundus images corresponding to each day of the follow-up during the course of disease. Column a comprises OCT (3D OCT-1000, Topcon Corporation, Tokyo, Japan) images from the fovea where intraretinal and subretinal fluid diminished after 12 days while exudates (yellow arrows) were visible in the OCT after that time point. Column b presents images from the foveal focal area where hyper-reflectivity of the inflamed lesion casts a shadow in the OCT (purple arrows). Column c presents infrared images of the fovea where the sites of lesion and exudates are evident.

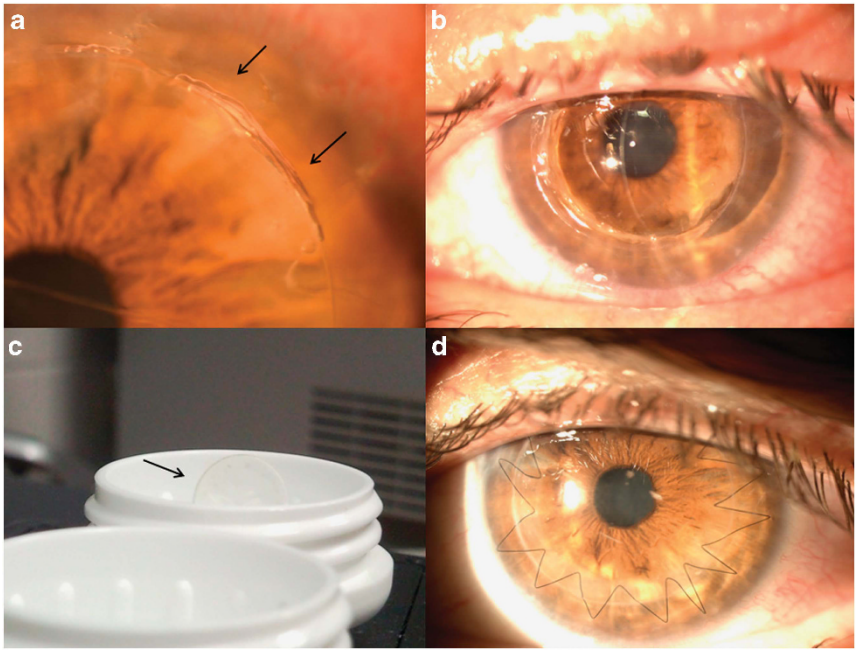

Figure 1 (a) Slit lamp photograph shows a surgical wound dehiscence located at 1–2 o'clock hours after suture removal. (b) The clinical appearance seen through slit lamp photograph reveals the absence of the whole donor graft and the DM exposed. Note the anterior chamber is deep and formed. (c) The contact lens case shows the graft inside. Slit lamp photograph 1 month after the second DALK is shown in (d).

counting fingers in the operated eye. Slit lamp exam (SLE) revealed corneal edema. No leaks were observed. The graft–host junction was well apposed. The follow-up during subsequent weeks revealed an improvement of the graft edema and astigmatism. The videokeratography revealed 4.5 diopters of astigmatism after 4 months. Continuous suturing was removed, but during the procedure an opening of the surgical wound located at 1–2 o'clock hour corresponding to the suture knot was noted (Figure 1a). A contact lens was placed. Close follow-up and antibiotics were recommended. Five days later patient presented with loss of vision, foreign body sensation and redness. The patient denied any trauma or additional mechanical damage. He also referred: '*Doctor, I had to remove my contact lens because of discomfort*'. Inside the contact lens case the graft was found (Figure 1c). SLE revealed the absence of the whole donor graft with DM exposed (Figure 1b). Anterior chamber was stable; no signs of infection or perforation were visible. The digital tonometry (gently) was used to estimate intraocular pressure. The ocular tone was apparently normal, but it is well known that this method is notoriously unreliable. The patient was hospitalized and emergency DALK surgery was performed with the placement of a new 8.25-mm graft. The second surgery was uneventful. Immediate follow-up was also free of complications (Figure 1d). One year after surgery, the best-corrected visual acuity was 20/25 in his OS.

Discussion

Mannan *et al*[1] reported a case of spontaneous wound dehiscence after DALK. The sutures were removed by the end of 5 months and the patient developed spontaneous 270° wound dehiscence.

In DALK, suture removal time should be ~6 months after surgery.[2–6] The wound healing in the present case has not been probably completed earlier, therefore extensive wound dehiscence may be observed even after minimal mechanical force. Another interesting fact derived from this case is the resistance of DM. The globe remained stable only with 10–12 μm of corneal thickness.

Postoperative medical and nonmedical cares must be strictly followed to reduce complications and improve the result of surgery.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Patient experience of the transition from Xalatan to generic latanoprost

We write in response to Mr Dubois and Ms Titcomb regarding the controversy over the switch from Xalatan to generic latanoprost.[1,2] We prospectively studied our patients' experience and the impact of generic use on our population. We also investigated the potency of generics versus Xalatan.

Patients with ocular hypertension and primary open angle glaucoma treated with Xalatan monotherapy were recruited between March and September 2012. At baseline visit, intraocular pressure (IOP) was recorded, and a questionnaire designed to acquire information on practical issues regarding drop application, side effect profile, and patient preference, was issued. At review in clinic (between 3 and 6 months later), IOP was recorded and questionnaires were collected.

Sixty-five patients were recruited, of whom 48 were women, with an average age of 75 ± 9.02 years. Fifty-one completed questionnaires, of whom 76% were using generics.

Patients found Xalatan easier to instil ($X^2 = 14.96$; $P < 0.001$), more comfortable in the eye ($X^2 = 10.82$; $P < 0.01$), and easier to open ($X^2 = 9.80$; $P < 0.01$). There was no statistical difference in hyperaemia caused by Xalatan or generics ($X^2 = 2.46$; $P > 0.1$).

Generic bottles failed to last a month for 20% patients (nonspecific to different manufacturers). Patients commented that: multiple drops fall at a time or drops run down their face; bottles fail to last a month, causing distress at the perceived wasting of resources; bottle is difficult to open or cannot be used with a dispensing aid.

Overall, 75% of patients preferred Xalatan and 22% wished to recommence Xalatan.

IOP data were complete for 45 eyes, with no statistical difference between Xalatan and generics ($t = 1.37$; $P > 0.01$); however, individual patients had reduced control of IOP on generic latanoprost (Figure 1).

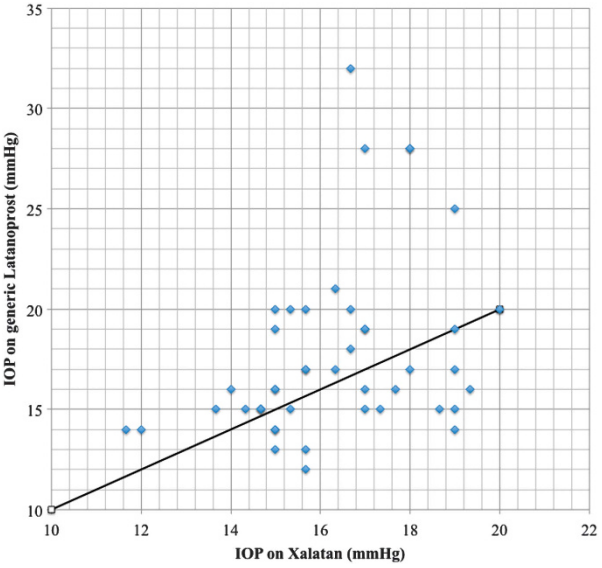

Figure 1 Comparison of IOP on Xalatan and generic latanoprost with solid line indicating identical pressures.

Our study provides confirmation of the points raised in Mr Dubois and Ms Titcomb's articles and clarifies our population's experience. Our patients prefer Xalatan and tolerate it better. The debate of IOP control cannot be concluded with this small study as, although the population has statistically insignificant changes of IOP, individual patients lose control. This will ultimately have impact on the clinician's time, patient management, and the economy of glaucoma care.

Conflict of interest

The authors declare no conflict of interest.

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