

Figure 1 Fundoscopic photograph on the day of injury revealed vitreous hemorrhage and the site of laser injury on the inferior retina (a). Three days following the exposure, fundoscopic photograph revealed the laser injury with retinal edema around it (b).

In recent years, 1064-nm Q-switched Nd:YAG cosmetic laser therapy for the removal of age and sun spots has become popular especially in China. In contrast to previously reported cases,^{1,2} the location of the injury was not at the macula. The most important factor in determining the functional damage to the retina is the location of the retinal injury. Lesions to the periphery of the eye may not cause symptoms or affect the vision.

The importance of inflammation and oxidative stress in laser injuries has been suspected but not studied in detail. Current medical treatment for retinal laser injuries is systemic administration of anti-inflammatory and antioxidant drugs, typically corticosteroids^{3,4} and vitamins, that are believed to limit retinal injury, reduce vision loss, and promote recovery.⁵

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Multifocal chorioretinitis caused by *Bartonella henselae*: imaging findings of spectral domain optical coherence tomography during treatment with trimethoprim-sulfamethoxazole

We report a case of cat scratch disease with manifestation of multifocal chorioretinal lesions and we document the imaging findings through spectral domain optical coherence tomography (SD-OCT) during the course of the disease from early presentation until the resolving of symptoms.

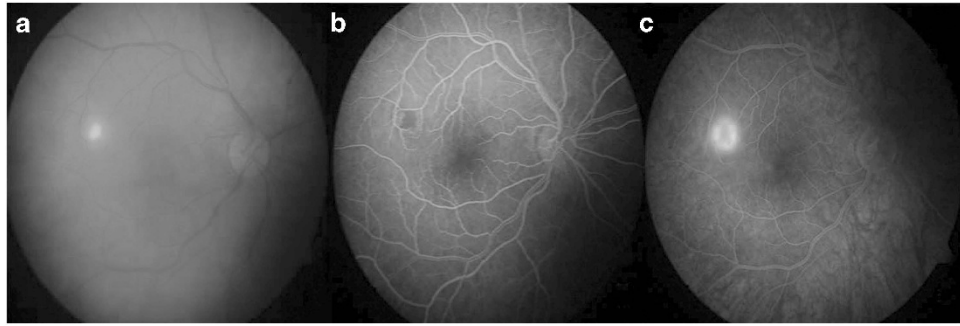


Figure 1 (a) Colour fundus photograph taken at presentation and indicating one of the retinal lesions. (b, c) Fluorescein angiography images where late hyper-fluorescence was observed from the focal lesion. No signs of optic nerve head involvement or vasculitis were observed. A full colour version of this figure is available at the Eye journal online.

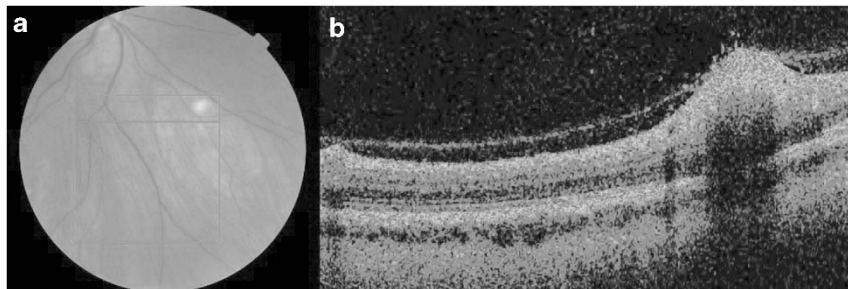
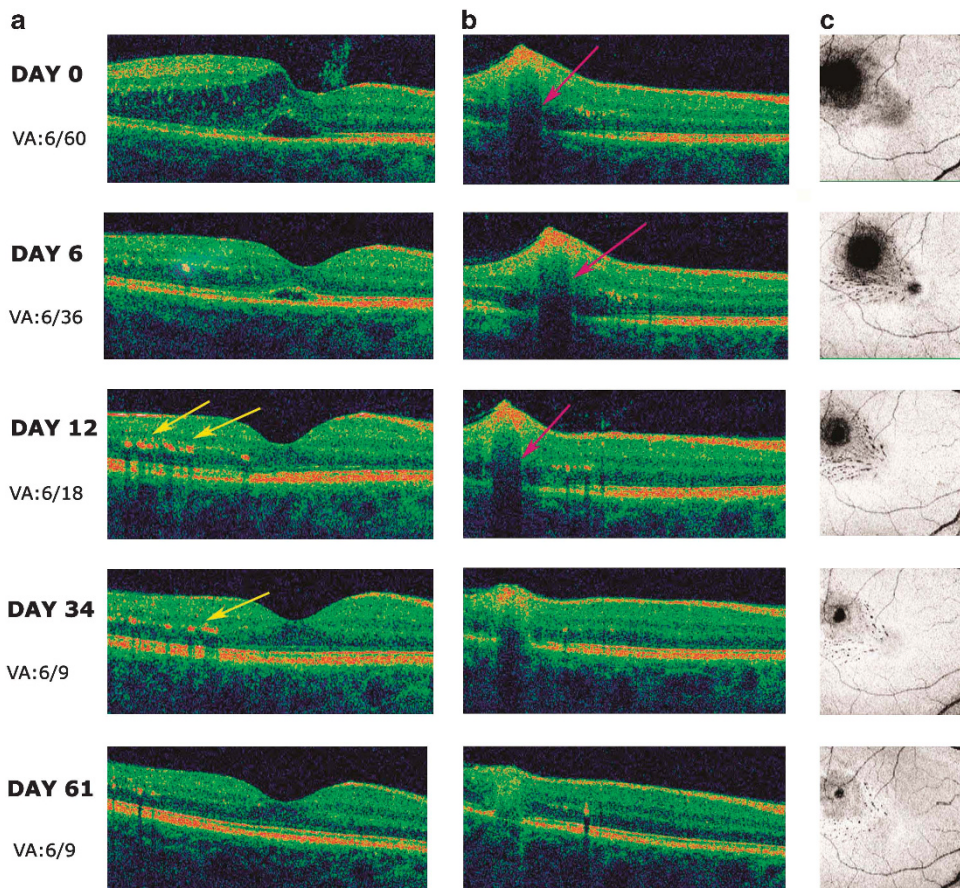


Figure 2 The second focal lesion of the retina. Colour fundus photograph (a) and OCT image (b). A full colour version of this figure is available at the Eye journal online.



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 hyperfluorescence 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.