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Sir,
**Endogeneous endophthalmitis caused by
*Sporobolomyces salmonicolor***

Endogenous endophthalmitis is intraocular infection resulting from haematogenous spread from a remote source. We report a case of endophthalmitis caused by *Sporobolomyces salmonicolor* in a reasonably healthy woman. To the best of our knowledge, *S. salmonicolor* endophthalmitis has not been previously reported.

Case report

A 31-year-old lady presented with a 3-day history of decreased vision in the left eye. She had been treated 2 years previously for pelvic inflammatory disease. Her visual acuity was 6/4 in the right eye and 6/18 in the left. The right eye was normal. The left eye showed fibrinous exudates in anterior chamber, posterior synechiae, and vitritis. She was commenced on oral prednisolone and intensive topical steroids, and a cycloplegic. FBC, ACE levels, anti-Toxoplasma Ab titre, Lupus anticoagulant, ANCA, and X-rays of the chest and sacro-iliac spine were reported normal. With little improvement over 2 weeks, vitreous biopsy and intravitreal injection of amikacin 400 µg, vancomycin 1 mg, amphoterecin 5 µg, and

dexamethasone 400 µg was performed. Vitreous sample showed pink colored yeast-like organism, possibly *Rhodoturela*. She was started on Tab. fluconazole 200 mg twice a day. Vitreous sample was sent to a tertiary microbiology department where the yeast was identified as *S. salmonicolor*. Sensitivity recommended the use of voriconazole 200 mg twice a day which was continued for 2 months. Improvement was seen within a week. Six months from presentation, the vitreous cavity remains clear on no antifungals with a final visual acuity of 6/12.

Comment

Risk factors for endogenous fungal infections include bacterial sepsis, corticosteroid therapy, immunosuppression, intravenous drug abuse, malignancy, alcoholism, and haemodialysis.

Sporobolomyces, a yeast closely related to *Rhodoturela*, is commonly isolated from environmental sources, such as air, tree leaves, and orange peels. The natural habitats are humans, mammals, birds, the environment, and plants. Infections that have so far been reported due to *Sporobolomyces* are lymphadenitis,¹ dermatitis,² cerebral infection, and fungemia.³ Although *Rhodotorula*-related endophthalmitis has been reported,^{4,5,6,7} ophthalmic infection caused by *Sporobolomyces* has not been previously reported.

Our patient had no obvious predisposing risk factors except for previous pelvic inflammatory disease which may have been a source. The low level of suspicion led to the use of systemic steroids prior to the use of systemic antifungal therapy and this may have contributed to the slightly prolonged course. It is therefore important to maintain a high level of suspicion and attempt to identify any possible infective pathogen in cases with unusual presentation.

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Sir,
Persistent unilateral myopia following blunt trauma

Myopia after blunt ocular trauma is usually transient, resolving within weeks of the injury, and may be caused by ciliochoroidal oedema and thickening of the crystalline lens.¹ This condition is distinct from bilateral accommodative spasm occurring after closed head injury, which may involve one or more elements of the near synkinesis and has variable periods of recovery.^{2,3} Here, we report a case of unilateral traumatic myopia that had not resolved 3 months after blunt ocular injury.

Case report

A 28-year-old woman had been struck in the left eye by hard, baseball-sized ball and presented with ocular pain and reduced vision. Her unaided acuities were 20/20 OD and counting fingers OS, but the injured eye improved to 20/30 with a -6.50 sph/ -0.50 cyl $\times 90^\circ$. Cycloplegic retinoscopy and refraction revealed 20/30 vision OS with a plano/ -0.50 cyl $\times 90^\circ$ correction. The pupils were equal and reactive to light and accommodation. The anterior segments were clinically normal. The intraocular pressures were 10 mmHg OD and 12 mmHg OS, and the fundi were normal. Axial length was 24.18 mm in the right eye and 24.05 mm in the left. The anterior chamber depth was 2.85 and 2.94 mm and lens thickness was 3.68 and 4.60 mm in the right and left eyes, respectively.

After 3 months, the refractive findings were unchanged, and she was prescribed cyclopentolate 1% daily.

Discussion

Closed head trauma may cause bilateral accommodative spasm in young adults, which may be permanent.² In

addition, blunt ocular injury may cause a bilateral pseudo-myopia,⁴ which may be secondary to ciliary oedema and spasm.¹ In our patient, the increased lens thickness was probably due to the induced accommodation. Given that the anterior chamber depth was greater in the injured eye, it is unlikely that the induced myopia was caused by anterior displacement of the lens iris diaphragm. To our knowledge, this form of traumatic myopia has not been previously reported to last more than several weeks. In this case, the pseudo-myopia was still present 3 months after the injury. Symptoms were relieved by cycloplegics.

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Sir,
Plexiform neurofibroma masquerading as a persistent chalazion—a case report

Neurofibromatosis Type 1 (NF1) is an autosomal dominant disorder that commonly presents with