Editorial: Endophthalmitis following cataract extraction

Endophthalmitis following cataract extraction varies in reported incidence from a minimum of around 0·1%1 to 0·66%.2 There is some doubt about the benefit of preoperative antibiotics but probably a consensus in favour of using them. One author even resorted to intravenous chloramphenicol,3 but since only 520 cases were studied only 0·5 cases of endophthalmitis would have been expected, throwing doubt on the author’s claim of success.

Attempts have been made to single out patients most at risk, formerly by conjunctival culture and even by culturing the intracapsularly removed lens,4 but since many of the infections have occurred in the face of sterile cultures, and others have been due to what are normally regarded as harmless commensals,5,6 it seems that preoperative cultures have little to offer.

Reports have recently been published suggesting that endophthalmitis behaves somewhat differently when an intraocular lens (IOL) has been used. Infection by organisms normally thought to be of low virulence such as Propionibacterium acnes have been implicated,7 and the infection has pursued a peculiar clinical course, characterised by apparent complete cure followed by repeated severe relapses. I have just such a case at the moment which has remitted completely three times while on metronidazole and Maxitrol (neomycin, polymyxin B, dexamethasone). It is quiescent at the moment, but I am waiting with trepidation for the fourth attack.

As pointed out in the article in this issue by Griffiths, Elliot and McTaggart foreign material is known to adhere to implanted foreign material, including heart valves and other indwelling devices. It has also been pointed out8 that in cataract cases Propionibacterium acnes endophthalmitis has been reported only in patients with an IOL. The present paper by Griffiths and colleagues demonstrates elegantly how staphylococci can adhere like limpets to IOLs and furthermore somewhat alarmingly thereby increase their resistance to antibiotics.

The authors put a brave face on it, suggesting certain measures which may help to minimise the dangers, but it is clear that there is a problem here which will not just go away. No one, as far as I am aware, has shown that there is a genuine increased incidence of endophthalmitis due to the increased use of IOLs or whether the incidence is the same but the clinical behaviour different. One’s clinical impression is certainly not of an obvious increase in postoperative endophthalmitis, but of course clinical impressions can be misleading. However, one certainly hopes that in this case it is correct.

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References
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