CORRESPONDENCE

γδ T cells in aqueous humour from untreated idiopathic uveitis patients

EDITOR—It is now well established that many lymphocytes are present in the anterior chamber secondary to a blood–ocular barrier breakdown, that most of them are of the T cell lineage,1 and that in some instances they are activated, as shown by the expression of membrane bound high affinity interleukin 2 receptors.2 To the best of our knowledge, however, no studies have determined whether cells bearing the γδ T cell receptor heterodimer populate the anterior intraocular fluid in both normal and pathological conditions. By using an immunofluorescence staining technique and two direct enumerating monoclonal antibodies (mAbs) (a phycoerythrin conjugated anti-CD3 mAb (RD1; Coulter Immunology, Hialeah, FL) and a fluorescein conjugated panreactive γδ T cell reagent (anti-TCR δ; T Cell Sciences, Cambridge, MA) we carried out two colour cytofluorimetric analyses. In 12 untreated idiopathic uveitis patients (six with Vaux, Char DH, Garovoy MR. Lymphocyte subpopulations in uveitis. Arch Ophthalmol 1986; 104: 233-6. 2 Scheinberg MA, Beijerin M, Silva MH, Mata IM. Interleukin 2 receptor membrane bound and in soluble form in the aqueous humor and peripheral blood of patients with acute uveitis. J Rheumatol 1992; 19: 1362-3. 3 Bertotto A, Gerli R, Spinozzi F, Muscat C, Scalini F, Castellucci G, et al. Lymphocytes bearing the γδ T cell receptor in acute Brucella melitensis infection. Eur J Immunol 1993; 23: 1777-80. 4 Gerli R, Aega E, Bertotto A, Tognelli R, Flenzi L, Spinozzi F. Analysis of T cells bearing different TCR γδ subtypes in γδ T cell receptor in patients with systemic autoimmune diseases. J Rheumatol 1991; 18: 1504-10. 5 Liveritt J, Dick A, Cheng YF, Scott GB, Forrester JV. Retinal antigen specific lymphocytes, TCR-γδ T cells and CD5+ B cells cultured from the vitreous in acute sympathetic ophthalmia. Autoimmunity 1993; 45: 257-66. 6 Spinozzi F, Aega E, Bistoni F, Travetti A, Migliorati G, Moraca R, et al. T lymphocytes bearing the γδ T cell receptor are susceptible to steroid-induced accelerated cell death. Immunology 1995 (in press).

History of ophthalmalmy

EDITOR—I have for some time now been very much enjoying the series ‘History of ophthalmalogy’ which appears in your journal, written by the estimable Fiona Roman. While not going so far as to say that it is the best thing in your columns, it certainly comes close to this and I am constantly amazed and diverted by the extraordinary pieces of information Ms Roman manages to dig up and provide to your readers.

Is it possible for us to know a little more about M. S. [Mr. Smith] historian or an ophthalmologist (or both) and may we at some point hope to see some of her articles in a more permanent form such as a book?

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Reply

EDITOR—I thank John P Lee for his comments. I myself am fascinated by the detailed reports which can be found on all aspects of medical history, particularly where they give a hint of the personalities and attitudes behind them.

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Chronic lymphatic leukaemia in the elderly

EDITOR—We recently encountered an 82-year-old woman with stage one chronic lymphatic leukaemia (CLL) who presented 3 days after an uncomplicated cataract surgery with endophthalmitis. Streptococcus pneumoniae was cultured from the aqueous humour. These patients are susceptible to bacterial infections and pneumococcal infection is known to be a particular problem.1 CLL is the most common leukaemia of the elderly which means patients are likely to present for cataract surgery. We believe consideration should be given to anti-pneumococcal antibiotics. We are aware of a case of ophthalmia with endophthalmitis in a patient with CLL and this may be another link between CLL and endophthalmitis. The endophthalmitis may be due to local sensitization with such a virulent organism. Subconjunctival vancomycin before surgery would be a suitable choice as it will achieve therapeutic aqueous levels and is active against the pneumococcus.2 We believe that in patients who have had endophthalmitis in the first eye or who have hypogammaglobulinemia (IgG <50% of the lower limit of normal) additional antibiotic prophylaxis may need to be taken for the second eye. Consultation with an immunologist may be helpful as these patients can benefit from intravenous immunoglobulin. This has been shown to decrease the likelihood of infection in at risk patients.3

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Xerophthalmia in Rwandan refugees

EDITOR—In July 1994 the influx of Rwandan refugees into the Ngara district of Tanzania was catastrophic. There were new arrivals every day. The newcomers were in worse general condition than previous waves of refugees. During the same period a case of