

Response to comments on: Relapse of acute lymphoblastic leukemia presenting as masquerade uveitis with hypopyon in a child

We read with great interest the reply by Evereklioglu *et al.*^[1] to our photo essay. Firstly, we would like to sincerely thank the authors for raising very valid points and for their detailed analysis. We agree with the authors that the term "pseudohypopyon" should have been used for describing the case. Since at the first presentation, the anterior segment precipitation appeared similar to hypopyon, we erroneously used the term in our manuscript throughout, even after the diagnosis of masquerade was confirmed. We express our gratitude to Evereklioglu *et al.*^[1] for rightly pointing it out and stand corrected on this matter. As regards the presence of ciliary congestion in the case, it was, in fact, present in the case in certain quadrants, along with diffuse conjunctival congestion. As the photograph has been taken with the lid pulled upward (not giving a proper view of superior and inferior limbus), the documentation does not do justice to the clinical features. Posttreatment, it is clear that no congestion in the conjunctiva or the perilimbal area (superior limbus not visible) is present. Masquerade syndromes are typically characterized by convex anterior chamber (AC) precipitate, absence of posterior synechiae, and absence of ciliary congestion. In our unique case, the presence of ciliary congestion in the perilimbal area in certain quadrants and the AC reaction of 3+ were two confounding factors. However, we did keep masquerade syndrome as the first differential diagnosis in mind and that is the reason why pediatrician's review and magnetic resonance imaging (MRI) were advised. We agree with the authors that the sediment does have a pinkish hue, and also, the point that the AC reaction might be due to irritation of uveal tissues seems valid. We, however, failed to elicit the mobility of AC sediment during clinical examination and it is a key point that will be remembered for future cases of such nature. The patient was already receiving topical steroid and cycloplegic eyedrops from a previous prescription with another ophthalmologist, and only topical antiglaucoma drugs were further added from our side. The differentiating features between hypopyon of inflammatory origin and tumoral pseudohypopyon have

been very proficiently outlined by Evereklioglu *et al.*^[1] in their manuscript, which should be known to all ophthalmologists. We commend the authors for their thorough scrutiny and thank them for pointing out the subtle shortcomings in our manuscript. All their comments are well received and will definitely be of great benefit while dealing with such cases in the future.

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1. Evereklioglu C, Arda H, Sener H, Polat OA, Horozoglu F. Comments on: Relapse of acute lymphoblastic leukemia presenting as masquerade uveitis with hypopyon in a child. *Indian J Ophthalmol* 2023;71:2314-5.

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Access this article online	
Quick Response Code:	Website: https://journals.lww.com/ijo
	DOI: 10.4103/IJO.IJO_3338_22

Cite this article as: Rehman O, Das D, Magdalene D, Bhattacharjee K, Deka D, Singh S, *et al.* Response to comments on: Relapse of acute lymphoblastic leukemia presenting as masquerade uveitis with hypopyon in a child. *Indian J Ophthalmol* 2023;71:2316.