cataract surgery at our tertiary referral centre in Northern Taiwan, and whether there were differences from findings in other regions. We found that *Pseudomonas aeruginosa* was the most commonly isolated organism ($n=13$, 38.2%), and that 12 of 13 patients (92.3%) achieved the final VA worse than 5/200. We agree that details on presenting and final VA of *Staphylococcus aureus* and other negative bacterial cultures might have provided more information in our study. As we focused our findings on *P. aeruginosa* and their VA outcome, we provided the data concisely.

Using ceftazidime instead of amikacin led to a higher rate of antibiotic susceptibility in our study. Thus, concerns have emerged that ceftazidime may positively influence future treatment outcome in acute postoperative bacterial endophthalmitis after cataract surgery among the population in Northern Taiwan. We treated our patients with a regimen of intravitreal vancomycin and amikacin rather than vancomycin and ceftazidime. We thus concluded that the use of regimen (vancomycin and amikacin) still provides good coverage in our region.

On the basis of the results of antibiotic susceptibility in our study, one might argue that ceftazidime is better than amikacin in Northern Taiwan. A change in antibiotic sensitivity has been reported over the past two decades.[3] It definitely needed to be periodically surveyed. However, there was in fact not enough clinical evidence in our study for the claim by Drs Benjamin Pijl and Niels Crama.

Obviously, further investigation should continue to provide information about post-cataract endophthalmitis. We appreciate Drs Benjamin Pijl and Niels Crama's interest and thank them for giving us an opportunity to consider an important point that we had not fully expressed.

Conflict of interest
The author declares no conflict of interest.

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Sir,

OCT III imaging of whiplash maculopathy

I read with interest the remarkable description of whiplash maculopathy in a 24-year-old woman following a motor vehicle accident.[1] The authors point out that the patient noted a paracentral scotoma within hours of the accident. During the examination and on visual field testing 6 months later, a nasal parafoveal annular whitish lesion was noted and the scotoma could be documented by visual field assessment with laser beam and a Maddox cross, and quantified Octopus automated perimetry (10° centromacular field). Furthermore, the authors describe a change on optical coherence tomography (OCT) at the vitreoretinal interface.

After a careful review of the imaging, including the OCT, I note an additional finding that may be a more likely cause of the scotoma in this patient. The OCT image demonstrates a severe disorganization of the inner segment–outer segment (IS–OS) retinal pigment epithelial (RPE) layer signals. Parafoveally, on the side closest to the visual field images in the composite figure, and presumably representing the nasal macula, the outer retina-RPE layers are not separately visible. Specifically, the IS–OS junction is obscured in this area, while it is distinctly visible elsewhere on this OCT image.

The integrity of the IS–OS junction has increasingly become recognized as important for visual function. Reports in several conditions have shown that abnormalities in this layer are associated with poor visual function in the abnormal region, with decreased measured acuity or corresponding scotomata.[2–4]

Reinterpretation of the OCT image would thus suggest that the cause of the scotoma in this case of whiplash maculopathy may be disruption of the outer segment architecture, and not a small area of increased reflection at the vitreoretinal junction. This interpretation is supported by the findings of Parsons *et al* in an autopsy case of whiplash maculopathy, which demonstrated the pathologic features of retinoschisis between the photoreceptor nuclei and the intact, but folded, photoreceptor inner and outer segments and RPE detachment.[5] This alternative interpretation of the OCT image may more plausibly explain the scotoma in this patient and in whiplash maculopathy in general.

Conflict of interest
The author declares no conflict of interest.

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Sir,

Evolution and management of macular hole secondary to type 2 idiopathic macular telangiectasia

Full-thickness macular holes (FTMHs) have been rarely documented in type 2 idiopathic macular telangiectasia (IMT2); and are generally considered poor candidates

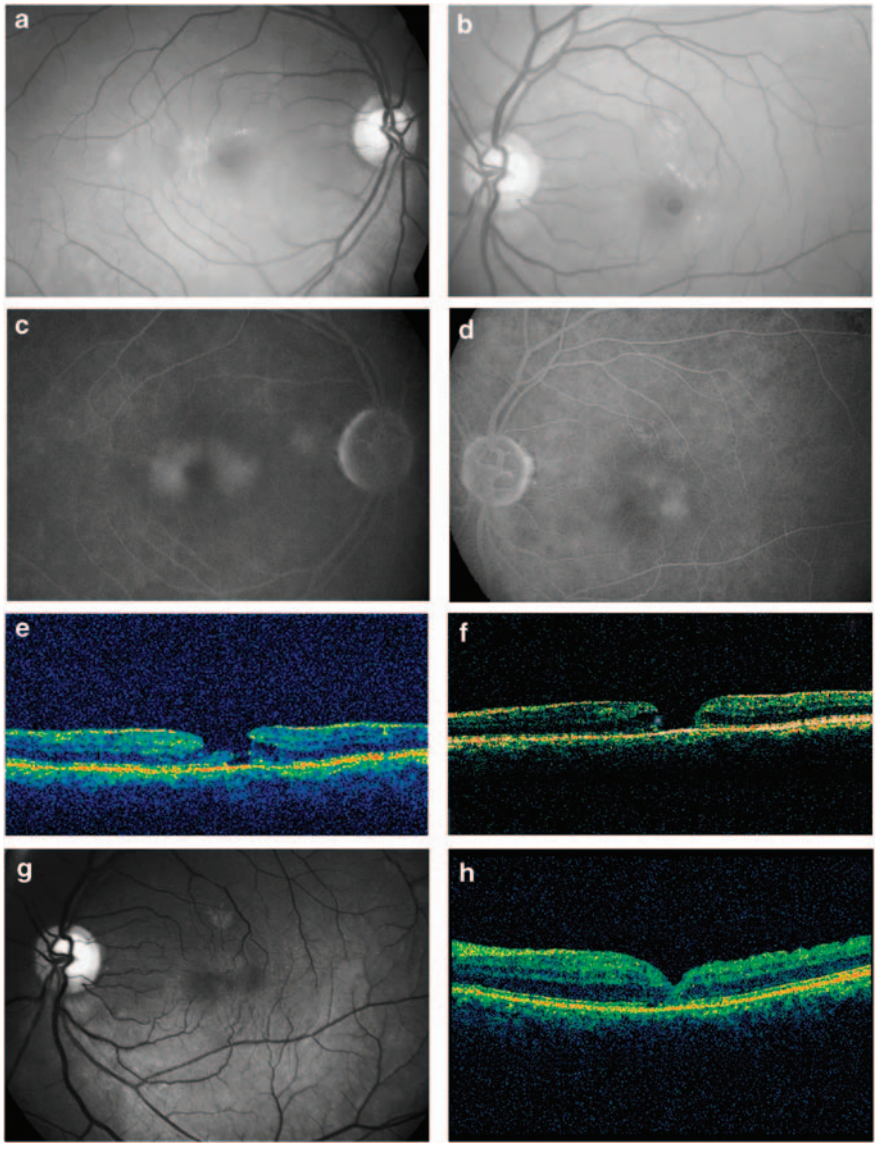

Figure 1 (a and b) Fundus examination of both the eyes reveals a loss of foveal transparency and intra-retinal crystals suggestive of idiopathic macular telangiectasia type 2. The left eye also shows a FTMH, which was preceded by an inner lamellar defect. (c and d) Late-phase fluorescein angiogram shows typical parafoveal hyperfluorescence from the telangiectasia in both eyes. (e and f) Horizontal OCT scan of the left eye initially showed an lamellar macular hole, which dehisced into a FTMH after 14 months. (g and h) Fundus view and OCT scan at 11 months after surgery show complete closure of the macular hole without any residual neurosensory degeneration.