After the surgery, topical levofloxacin, cefmenoxime hemihydrochloride (six times/day) and minocycline hydrochloride (200 mg/day) were prescribed. Microbiological cultures of the conjunctiva identified *Nocardia* species. The symptoms gradually decreased, but, 6 weeks later, they worsened again. Two more similar treatments were necessary to eliminate the symptoms completely. No recurrences were observed in the 10 months thereafter.

Nocardia sp. are aerobic, gram-positive, filamentous bacteria found in soil. They can be contracted by inhaling contaminated dust or by contamination of a wound with soil containing *Nocardia*. Although *Nocardia* can cause infection in healthy persons, it mainly affects immunocompromised hosts, such as patients on chronic steroid therapy or those undergoing cancer treatment. Typically, *Nocardia* infection has a late onset, and is chronic and indolent; its signs and symptoms are similar to those of low-virulence organisms (Haripriya et al. 2005).

Our patient was on chronic systemic and local steroids for Bechet's disease. He also had poorly controlled diabetes mellitus.

Our observations indicate that ophthalmologists should be aware that posterior subtenon TA injections can cause orbital infections, especially in subjects who are immunocompromised.

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Corneal oedema and acute anterior uveitis after two doses of travoprost

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Editor,

Glaucoma is a chronic disease and requires longterm treatment. The ideal medication should be effective and should have minimal side-effects in order to increase patient compliance and allow the patient to continue the therapy. Recently, prostoglandin analogues have revolutionized the medical treatment of glaucoma. Their advantages include potent effect and once-a-day dosing. Frequent side-effects of travoprost include conjunctiva hyperaemia, increases in iris pigmentation and eyelash changes (Hollo 2007). Periocular pigmentation, damage to the blood–aqueous barrier and cystoid macular oedema are rare adverse reactions (Del Hierro Zarzuelo et al. 2004). This report describes a patient who experienced acute iritis and corneal oedema after using only two doses of travoprost.

A 70-year-old caucasian woman was admitted to the ophthalmology clinic suffering from redness, discomfort and blurriness in her left eye of 3 days' duration. She had been diagnosed with primary open-angle glaucoma in both eyes in 2005. After timolol/dorzolamide combination therapy for 1 year, travoprost was added to the left eye as a second antiglaucoma medication on November 3rd, 2006. Her symptoms began after only two doses of travoprost, on November 5th, 2006.

Ophthalmic examination showed the subject's best corrected visual acuity (VA) to be 20/25 in the right eye and 20/80 in the left. Slit-lamp findings included grade 2 conjunctival hyperaemia, diffuse corneal folds, minimal central corneal oedema, 2 + cell and flare in the anterior chamber in the left eye, and nuclear sclerosis in both eyes. Fundus examination showed the cup : disc ratio to be 0.4 in both eyes. Intraocular pressure (IOP) was 27 mmHg RE and 21 mmHg LE. Central corneal thickness was 561 μm RE and 629 μm LE. We suspected travoprost of causing these clinical manifestations. Therefore, the patient was advised to cease using travoprost in the left eye and to continue the bilateral timolol/dorzolamide combination therapy. Ten days later the patient's discomfort resolved and VA improved to 20/25 LE. The diffuse corneal folds and corneal oedema completely resolved and the anterior chamber flare resolved substantially. The subject's IOP measured 26 mmHg in both eyes. Pachymetry measurement of the central cornea dropped to 550 μm LE. As the patient's IOP was still high, latanoprost was added to the timolol/dorzolamide combination therapy and the glaucoma was well controlled medically.

Uveitis and iritis are rare adverse effects of travoprost and are most common with latanoprost (Kumarasamy & Desai 2004; Suominen & Valimaki 2006). Faulkner & Burk (2003) published a case of acute anterior uveitis and corneal oedema after five

doses of travoprost. We are unaware of previous reports of these findings after only two doses of travoprost. This is probably a rare adverse effect. However, given the increase in the number of patients treated with travoprost in the past few years, it is more likely that the incidence of this effect is higher than has been reported. We aim to raise awareness among clinicians and patients of possible adverse effects of topical travoprost therapy that have previously not been well known. Physicians should consider this issue when prescribing these medications.

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