displayed on the iPhone. Because the magnitude of this difference was similar for both reviewers and no bias in the other ratings was observed, we believe this occurred because the advantages of the iPhone's display (eg, higher dot pitch and brightness) outweighed its disadvantages (eg, lower resolution and smaller screen area). The factors contributing to this difference warrant additional investigation. It also remains to be seen whether relevant abnormalities found on the computer display would also be found on the iPhone display under routine conditions. This was not studied directly because currently no iPhone software exists to transfer and review a large number of photographs grouped by patient. However, our results support the iPhone's display as a potential component in a telemedicine network. We are not suggesting using the iPhone to screen for subtle conditions (eg, diabetic retinopathy) or as a replacement for in-person ophthalmologic consultation. Rather, we believe the iPhone, and similar devices, in combination with nonmydriatic photography can complement ophthalmologic consultations in settings such as the emergency department.5 by allowing for rapid and remote identification of obvious conditions affecting the posterior pole such as papilledema and malignant hypertension.

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Intravitreal Daptomycin in a Case of Bilateral Endogenous Endophthalmitis

Bacterial endophthalmitis is a devastating intraocular infection that, in its most severe form, can result in complete loss of vision in the affected eye. In patients with endogenous bacterial endophthalmitis, 69% have a final visual acuity worse than counting fingers.1 Visual outcomes are directly related to the infecting bacteria, with eyes infected with coagulase-negative Staphylococcus faring much better than those infected with Staphylococcus aureus, Streptococcus, and gram-negative organisms.2 With the emergence of drug-resistant bacteria, increasing the arsenal of safe and effective antibiotics for treatment is of particular importance. We report a case of bilateral endogenous methicillin-resistant S aureus endophthalmitis treated successfully with intravitreal injections of daptomycin.

Report of a Case. A 69-year-old previously well woman who was retired, married, and caregiver to her chronically ill husband was taken to the emergency department by her daughter with an acute onset of confusion, disorientation, and generalized malaise. Her medical history included a remote history of angina, intermittent pleurisy, a total abdominal hysterectomy with bilateral salpingo-oophorectomy, and cataract surgery in the left eye. Her only medication was estrogen replacement. There was no illicit drug use, recent dental work, or indwelling venous catheter. The patient was admitted to the hospital for workup of altered mental status and eventually found to have bacterial endocarditis with methicillin-resistant S aureus. The bacterial isolate had an intermediate resistance to vancomycin hydrochloride (minimum inhibitory concentration, 4-8 µg/mL). Magnetic resonance imaging of the brain showed multiple bilateral acute ischotic changes, and echocardiography revealed mitral valve endocarditis.

The ophthalmology service was consulted for evaluation of the patient's blurred vision. At initial examination, the patient's visual acuity was at least counting fingers OU and intraocular pressures were normal. Findings on anterior segment examination at the bedside were nor-
mal except for a few posterior synechiae in the right eye, moderate nuclear sclerotic cataract in the right eye, and a well-centered posterior chamber intraocular lens in the left eye. No hypopyon was noted. There was a moderate vitreous haze in both eyes with a small area of retinitis along the superior temporal arcade of the left eye. Otherwise, the optic nerve, macula, and periphery were grossly normal in each eye. Given the clinical setting, a diagnosis of bilateral endogenous endophthalmitis was made.

The patient’s initial general health and mental state precluded both vitrectomy and intravitreal injection. She was treated with topical atropine, prednisolone, and vancomycin. Two days after the initial examination, intravitreal daptomycin (200 µg/0.1 mL) was administered without complication. She was also receiving intravenous daptomycin for endocarditis treatment. During the week following injection, the vitreous cleared completely in both eyes and the retinitis resolved. The patient required no further ocular intervention. At follow-up 2 months after the initial injection, visual acuity was 20/20 OU.

Comment. Daptomycin is a lipopeptide antibiotic that causes concentration-dependent depolarization of the bacterial cytoplasmic membrane, which inhibits protein synthesis. Since its introduction in 2003, it has been used to treat complicated skin and soft-tissue infections, endocarditis, and osteomyelitis. A recent safety and efficacy study showed that daptomycin can be administered safely in a dose of 200 µg in adult belted rabbits, and daptomycin killed 99.9% of gram-positive bacteria within 6 to 8 hours. Another report showed that therapeutic intravitreal concentrations greater than the minimum inhibitory concentration for methicillin-resistant *S. aureus* can be achieved following intravenous administration of daptomycin. The bactericidal activity of daptomycin and the ability to cross the blood-ocular barrier make it a useful alternative to vancomycin and fluoroquinolone antibiotics.

To our knowledge, this is the first report of intravitreal daptomycin being used to successfully treat bacterial endophthalmitis. Future studies evaluating the safety and efficacy of daptomycin in treating endophthalmitis are warranted.

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Conjunctival Pediatric Follicular Lymphoma

 Conjunctival lymphomas constitute 30% of adnexal lymphomas, affect women slightly more than men with median ages of 55 and 63 years in 2 series (<1% occurring in the first 2 decades), and carry a favorable prognosis. Among childhood systemic lymphomas, only 1% to 2% are pediatric-type follicular lymphomas (PFLs); these lesions are also rarely seen in young adults. Pediatric-type follicular lymphomas occur predominantly in boys, are frequently localized (36%-79%), have isolated lymphadenopathy and stage I disease, and are most commonly found in the head and neck region. We describe a dramatic epibulbar, globose, well-circumscribed conjunctival PFL that was considered clinically to be a pyogenic granuloma in a young man. The distinguishing clinical and immunohistochemical features of adult follicular lymphoma and PFL are described.

Report of a Case. A 21-year-old man had a 5-month history of a slowly growing epibulbar lesion in the left eye. His medical history was otherwise unremarkable. Visual acuity was 20/50 OS. The external examination findings were notable for a mobile, 7-mm–elevated, salmon-colored, globose medial conjunctival mass bordering the plica (Figure 1A). An excisional biopsy was performed. Histopathologically, there was a lymphoproliferative process with ill-defined follicular regions (Figure 1B and C). Expression of CD20 (B lymphocytes) was heavily positive in lymphoid follicles; thin rims of CD3-positive T lymphocytes further accentuated the follicular architecture. Staining was positive for CD10 and negative for BCL-2 in the follicular centers (Figure 2). Immunostaining for Ki-67 disclosed 75% positivity. A loose scaffolding of CD23-positive dendritic cells was noted in the follicles, and small BCL–2-positive lymphocytes were present at the base of the excision. The lesion was characterized as grade 3A (>15 centroblasts/high-power field with admixed centrocytes). Polymerase chain reaction for immunoglobulin gene rearrangement revealed a clonal population. Findings on the systemic workup with total-body computed tomographic scanning and hematologic studies were unremarkable. Postoperatively, the operative site healed well; the patient declined any further local or systemic treatment. No evidence of recurrence has developed after 8 months of follow-up.

Comment. Pediatric-type follicular lymphoma is composed of a mixture of round centroblasts and, to a lesser extent, smaller cleaved centrocytes in the germinal center. Clinical aggressiveness of PFL is directly correlated with increasing numbers of centroblasts and the in-