the corneal epithelium, superficial stroma, and Descemet membrane bilaterally. Fundus examination revealed no pigmentation. Dental, oral mucosal, skin, and nail pigmentation were evident (Figure 1F). The diagnosis of argyrosis was confirmed by conjunctival biopsy. It was possibly due to occupational inhalation of silver.

The Scheimpflug image displayed hyperreflectivity corresponding to corneal pigment accumulation areas at the superficial layers (Figure 2A and B). Histopathologic examination of the incisional biopsy material revealed subepithelial extracellular silver particles in the lamina propria, which supported the diagnosis of argyrosis (Figure 2C and D). Systemic evaluation results were normal except for the presence of fatty degeneration of the liver.

**Comment.** The most common health effects with prolonged exposure to silver are the development of a characteristic irreversible pigmentation of the skin (argyria) and/or the eyes (argyrosis). Affected areas include hands, eyes, and mucous membranes in most patients. Discoloration of the ocular surface is the main ocular evidence in these patients. A direct relationship was shown between the amount of discoloration and total exposure time. If fine particles of silver are rubbed into the eyes, localized argyrosis may develop over time. Generalized argyria is recognized by a widespread pigmentation of the skin, eyes, and nails and may occur when silver compounds are applied to mucosal surfaces, inhaled, ingested, or injected into the body. Similarly, our patient had conjunctival, corneal pigmentation as well as skin, nail, and dental pigmentation resulting from occupational contact. Although the exact mechanism for black tears is not very clear, we believe that mechanical inoculation (rubbing into the eyes) is the cause. The pigmentation resulting from silver deposits is irreversible. Chelation therapy and dermabrasion are ineffective in removing silver deposits from the body. There is no known effective treatment for argyria. Besides argyria and argyrosis, exposure to soluble silver compounds may lead to other toxic effects such as liver and kidney damage, irritation of the eyes, skin, respiratory tract, and intestinal tract, and changes in blood cells. In systemic evaluation, only fatty degeneration of the liver was detected in our patient.

Melanodacryorrhea is extremely rare, and our review of the literature for melanodacryorrhea and argyrosis yielded no results. In the case of melanodacryorrhea, argyrosis should be taken into consideration in the differential diagnosis.

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**Acanthamoeba Endophthalmitis Following Penetrating Keratoplasty for Acanthamoeba Keratitis**

We report a case of culture-positive *Acanthamoeba* endophthalmitis in a patient with a history of *Acanthamoeba* keratitis. To our knowledge, there is only 1 previous report in the English literature.

**Report of a Case.** A 61-year-old female soft contact lens wearer had a 10-day history of progressively worsening pain, redness, and blurred vision in the left eye. Her visual acuity was 20/20 OD and 20/40 OS. She was initially diagnosed with possible herpes simplex keratitis. Over the next 2 months, she was treated with topical trifluridine, prednisolone acetate, and oral famiclovir. Her symptoms continued to worsen, and her visual acuity decreased to counting fingers.

Two months later, she was seen at our center. She had significant pain and her visual acuity was hand motions. Examination revealed multiple epithelial defects and diffuse anterior keratitis with a ring infiltrate. Confocal microscopy revealed probable *Acanthamoeba* cysts. Corneal scrapings were performed for culture. Treatment with trifluridine, prednisolone, and famclovir was discontinued, and treatment with propamidine isethionate, polyhexamethylene biguanide, chlorhexidine gluconate, neomycin sulfate, and atropine sulfate eyedrops was started.

Over the next 4 months, there was fluctuation of the keratitis and anterior chamber inflammation, with a persistent epithelial defect. Treatment was continued with various anti-*Acanthamoeba* agents without resolution. Because of a concern for impending perforation, a therapeutic penetrating keratoplasty was performed. Histological analysis of the corneal button demonstrated widespread *Acanthamoeba* cysts, including at the margin of resection (Figure 1).

Fifteen days later, the patient reported seeing a “white dot in her cornea.” Visual acuity was 20/400. The corneal graft was clear but the anterior chamber had 4+ cells with a hypopyon (Figure 2). She was seen in consultation by a retina specialist and began treatment with oral prednisone for presumed sterile inflammation. The inflammation initially improved and the prednisone dosage was decreased. However, 2 days later, the hypopyon increased in size and a vitreous tap with injection of antibiotics was performed. The oral prednisone dosage was increased as well. The inflammation initially improved.

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Acanthamoeba of the eye. Additionally, there are 2 cases of systemic Acanthamoeba was via direct extension through the interior of the eye. It was concluded that the spread of infection with secondary ocular involvement. A case of sterile panophthalmitis from Acanthamoeba keratitis without pathological or culture evidence has also been described. A study to determine why Acanthamoeba keratitis does not spread intraocularly was published. It was found that the trophozoites could progress beyond the Descemet membrane and endothelium, but in the anterior chamber a neutrophilic response rapidly cleared the organisms. Our patient had intraocular inflammation with a hypopyon. Acanthamoeba was isolated from the vitreous culture with no other organisms isolated. Intraocular spread was likely due to direct extension from the cornea. As our patient developed endophthalmitis secondary to Acanthamoeba keratitis, this should be considered in patients with intraocular inflammation associated with Acanthamoeba keratitis.

Comment. Acanthamoebae are ubiquitous protozoans found in various aquatic habitats. They are known to cause keratitis in contact lens wearers. They have rarely been reported to cause intraocular infection. There is 1 pathologically confirmed case of chorioretinitis associated with Acanthamoeba keratitis. The patient underwent 4 penetrating keratoplasties, followed by enucleation. Analysis of the pathological specimen revealed cysts consistent with Acanthamoeba throughout the globe. It was concluded that the spread of Acanthamoeba was via direct extension through the interior of the eye. Additionally, there are 2 cases of systemic infection with secondary ocular involvement.

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Depression Despite Anti–Vascular Endothelial Growth Factor Treatment of Age-Related Macular Degeneration

Anti–vascular endothelial growth factor (VEGF) treatment has dramatically reduced the risk of severe vision loss in patients with age-related macular degeneration (AMD). Although about 30% of active-treated subjects in clinical trials gained 15 or more letters in visual acuity and 50% demonstrated improved mental health, many patients did not improve to this extent and...