

## LETTER TO EDITOR

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# Frequency of Bacterial Samples from Patients with Chronic Acquired Nasolacrimal Duct Obstruction

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Dear Editor,

We read with interest the article by Shahrakiet et al. regarding the frequency of bacterial samples from patients with chronic acquired nasolacrimal duct obstruction (CANDO) (1). The clinical importance of microbial causes of CANDO and pattern of drug resistance is widely recognized as a key part of the treatment strategy in these patients. Similar to the results of previous studies, the authors found that in patients with CANDO, a great variety of bacterial pathogens can be isolated (2-4). Shahrakiet et al. found that 46.7% of all samples were negative – normal, and only 6.7% were marked with gram positive bacteria. In the results from previous studies, negative cultures were found in 17.8% of patients in Thailand (4), 15.6% in Nepal (3) and only 10% in United States (5). Additionally, in most of previous studies gram positive bacteria were the most predominant in culture positive specimens, from 64.9% to 78.5% (2-4). Thus, Pornpanich et al. found that in patients with longer duration of the CANDO symptoms, gram negative cultures become more common (2). Therefore, these differences might be a result of prolonged previous usage of different local and systemic antibiotics in the present group, which could result in changed bacterial profile and fungal superinfection. However, Shahrakiet et al. (1) found no presence of the fungus in their samples, which could be positive in up to 14.9% of samples (3). Consequently, the bacterial resistance profile in this study is a bit different from other studies, which might be misleading for the future readers. This is particularly applies to overall low sensitivity and high resistance (36.7%) to vancomycin in this study, which is important aid in most dif-

ficult ophthalmic cases (5). Furthermore, the outcome of dacryocystorhinostomy, as a successful procedure for the treatment of nasolacrimal obstruction associated with dacryocystitis, significantly depends on possible bacterial and fungal superinfection (6). For these reasons, we would kindly ask the authors to present the data for duration of the symptoms, history of previous antibiotic usage, percentage of positive fungus cultures, and the final prognosis regarding the possible operative treatment. These findings will significantly contribute to the papers scientific value and contribution. Overall we agree with Shahrakiet et al. that variety of bacteria can cause CANDO, and identification of bacterial contamination can be a great help in the treatment process. Other systemic and ocular risk factors should be carefully monitored too.

- Conflict of Interest: none declared.

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