

Reply to editor comment on *Alternaria chartarum* sclerokeratouveitis: A new fungus cause

Dear Editor,

It was good to read the comments regarding our article on "*Alternaria chartarum* sclerokeratouveitis: A new fungus cause."^[1] In this relation, the authors of the letter to the editor have pointed out some observations, which we want to answer:

1. The first question was about B scan findings. Infectious sclerokeratouveitis can have vitreous inflammation, without being endophthalmitis. The incidence of endophthalmitis associated with infectious keratitis is around 20%^[2,3] and the risk is greater if the patient has $\geq 50\%$ vitreous opacities in ultrasound B, but these features are neither sensitive nor specific and diagnosis of endophthalmitis is mainly based on clinical assessment.^[4] Without exception, serial ultrasound monitoring is recommended.
2. Related to the use of systemic steroids, the patient arrived at our hospital with a high dose of prednisone, which was tapered and maintained in addition to antifungals. It is important in the diagnostic approach to emphasize that if a patient does not respond to a high dose of steroids, an infectious origin must be suspected. In infectious scleritis, steroids play an important role in controlling inflammation, preventing destruction, preserving vision, and helping with pain management. However, steroids in infection can suppress host immunological responses, allowing invaded microorganisms to progress and worsen the disease.^[5] Besides steroids, our patient had other risk factors for infectious scleritis: diabetes mellitus and pterygium surgery. Hence, prescribing oral steroids depends on the clinical picture and evolution, taking into consideration pros and cons.
3. Regarding the surgical technique used, in eyes with infectious endophthalmitis and in early stages of keratitis/scleritis-related endophthalmitis, pars plana vitrectomy is the best treatment option.^[3]

In our patient, to perform a vitrectomy in an eye with poor visualization of intraocular structures because of corneal opacification, evisceration was indicated because of various factors: First, it could be challenging to suture a temporal prosthesis in a lytic sclera and after performing a corneal-scleral graft; second, thinking about the success of the scleral graft; third, it was essential to eliminate the infection; and finally, a poor visual prognosis since, from admission the patient, visual acuity was counting fingers that unfortunately decreased to light perception.

Diagnosis and management of infectious scleritis is always a challenge. Oral steroids can be prescribed under certain conditions, always after the specific treatment for the causative pathogen is started, assessing benefits and risks. We hope we have resolved the questions posed and we are open to further comments.

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Conflicts of interest

The authors declare that there are no conflicts of interest of this paper.

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