Letters to the Editor

Pseudomonas arthropathy in an older patient

SIR—The case report by Keynes et al. [1] published in Age and Ageing suggested that only one case of *pseudomonas aeruginosa* septic arthritis affecting elderly people is currently in existence in the literature. May I point out that, in addition to the one case mentioned by the author [2], there are several such cases in the literature as highlighted below.

Vickers and Price reported a case of recurrent septic arthritis due to *pseudomonas aeruginosa* involving two different joints [3]. Similarly Dan et al. reported two episodes of infectious arthritis due to *pseudomonas aeruginosa* separated by a 6-year interval [4], and Grieco reported five cases, of whom two cases were aged 65 and 75 years [5].

In a retrospective study of patients hospitalised with septic arthritis between 1979 and 2002, Gavet et al. reported septic arthritis in two patients between the ages of 60 and 80 years to have been caused by pseudomonas [6]. In another retrospective study of 52 patients with septic arthritis of the wrist diagnosed between 1994 and 2004, Rashkoff et al. reported two to have been due to pseudomonas, although the age of those two cases was not reported by the authors [7].

There are also reports of other pseudomonal joint infections. MacFarlane and Oppenheim, for instance, reported a case of recurrent, and persistent, septic arthritis due to *pseudomonas putida* in a neutropenic patient aged 66 years [8]. Also Matteson and McCune reported a patient with osteoarthritis developing knee sepsis due to *pseudomonas cepacia* following intra-articular corticosteroid injection [9].

Septic arthritis due to pseudomonas is not very common, but does exist. It particularly affects intravenous drug users, immunodeficient patients, patients with infections elsewhere, patients with chronic coexistent diseases as well as arthritic joints and patients receiving frequent broad-spectrum antibiotics [10]. The elderly, with multiple pathology, prone to have these last four characteristics and are at risk.

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Visual impairment following stroke: do stroke patients require vision assessment?

SIR—We have read with interest the article by Rowe et al. [1] published in Age and Ageing and will like to make the following comments. There are people who do not get referred or assessed by orthoptist for various reasons. These are listed below:

(i) People discharged to nursing homes are less likely to be referred to the service.
(ii) The lack of awareness by the stroke team looking after the patient to refer to orthoptist.
(iii) Patients fail to attend the clinic because they have been informed their visual field defect may not improve, hence, they may not see the need to attend.
(iv) Patients with disability may find it difficult to attend several clinic visits.

Our recommendations are as follows: Each hospital should establish a close link with orthoptists. All patients
who present with visual field loss should be referred to an ophthalmologist with interest in neuroophthalmology. All patients who are driving, following a stroke, should have a formal visual field assessment. The DVLA requirements are no missing areas larger than a blind spot in a 40 × 120 degree matrix of 4 mm², 1.0 asb target and only static perimetry acceptable as a DVLA field [2]. Visual field assessment should be done about 2 weeks after a stroke, because recovery of a complete hemianopia occurs in the first 10 days after which further recovery is unlikely [3]. Some of these patients will be eligible to be registered partially sighted. This entitles them to benefits, such as attendance allowance, disability allowance, incapacity benefit, pension credit and concession for TV licenses. They will only be eligible for these benefits if seen by an ophthalmologist.

The pathway for patients with visual impairment following a stroke could be as follows:

(i) Visual field impairment.
(ii) If driving, advice not to drive for 4 weeks.
(iii) Formal visual assessment if driving.
(iv) Refer to low vision clinic.
(v) Consider referral to voluntary organisation (e.g. FOCUS) [4].

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Reply

SIR—We agree that there are many reasons why stroke patients are not referred to, or examined by, orthoptists. This further supports the need for improved organisation of referral pathways from the stroke team to eye services and for referral pathways within ophthalmology to ensure full assessment of these individuals. This also highlights the great need for health promotion so that patients, caregivers and members of the stroke team are clearly aware of the importance of onward referral to orthoptists. The message that much can be done to aid visual disability must be given regardless of whether it is thought that a visual defect may or may not improve. Even one clinic visit can make substantial inroads into the required assessment and management of visual disability.

We agree in part with the recommendations suggested by Drs Ijaola and Kausar. Our further recommendations are:

Each hospital must establish a close link with Orthoptists. All patients with any suspected visual difficulty should be referred to Orthoptists who can assess the visual status of the patient and make onward appropriate referrals within ophthalmology as required [1]. Often patients referred direct to ophthalmology are not seen by a neuro-ophthalmologist and thus may not access the full range of advice and/or management that would be provided from a specialist service.

All stroke patients who wish to return to driving should have a quantified visual field assessment using an Estermann programme [2]. We agree that the first visual field assessment should be undertaken not only within 2 weeks of the stroke onset but also at 3 months as visual field recovery can take place over a longer time span [3]. A 3-month assessment provides a better indication of visual status which is better suited to providing information for the process of Certification of Visual Impairment (this registration process may only be signed by an ophthalmologist).

Visual impairment includes eye movement and alignment disorders, visual perceptual difficulties and low vision in addition to visual field impairment [4]. Therefore, we suggest the following pathway:

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