diagnosis of sarcoid associated optic neuropathy was made.

Treatment with oral prednisolone 80 mg daily resulted in resolution of her disc swelling and retinal vascular changes with modest improvement in her visual field. Her systemic symptoms abated.

Comment

Our patient had several risk factors for TB. She is Asian-Indian and had developed night sweats and an unusual inflammatory optic neuropathy with severe visual loss shortly after her return from living in a part of the world where TB is endemic. Thus, it was important in terms of her clinical management to distinguish between sarcoidosis³ and TB⁶⁻⁷ as reliably as possible. Although she had a marked BAL lymphocytosis and elevated CD4/CD8 ratio, both of which are associated with sarcoidosis, these measures may also be increased in TB.⁸ We believe that flow cytometric analysis can help here by providing on one sample not only BAL T cell data but also an indication of pulmonary IFN- γ production in response to mycobacterial antigen (PPD). While strongly positive in almost all cases of active pulmonary or extrapulmonary TB,⁴ the PPD test appears to be negative in sarcoidosis.

Other reported antigen specific T cell based TB assays have used blood.⁹ We think that these might be less sensitive than tests using either BAL or body fluids from sites of active TB.¹⁰ Given we are proposing that a negative result assists in distinguishing sarcoidosis from TB it is likely to be quicker and more effective to use BAL as a single, sensitive test than an algorithm where one moves from TST through blood tests to BAL analysis if the preceding step is negative.

Although our data require validation, we think our findings may have application in cases where the clinical diagnosis is equivocal, laboratory tests are unhelpful, and the need for appropriate, specific treatment is urgent.

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MAILBOX

Polymicrobial keratitis

We read with great interest the clinical report by Pate *et al* in which bacterial co-infection in keratomycosis was reported by smear, culture, or both.¹ We have seen in our own practice in a series of 110 cases of infectious keratitis (unpublished data) between 2001 and 2005, six cases of bacterial co-infection in keratomycosis. Five of them were smear positive and one case was only culture positive for bacteria. In all these cases, the mycotic element was septate fungus—*Fusarium* spp, and not yeast as reported by these authors. We had suspected polymicrobial keratitis clinically in all these cases because of certain distinctive features at presentation. The typical raised dry infiltrate with hyphate margins, which is so characteristic of keratomycosis, was modified into wet looking necrotic infiltrate in some areas; epithelial defect overlying the infiltrate showed extension beyond the infiltrate in some areas. Treatment in all these cases is incomplete if a thorough microbiological investigation is not done. Clinical judgment does not suffice to treat microbial keratitis in many cases; rather we advocate laboratory support.

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NOTICES

Managing human resources

The latest issue of *Community Eye Health* (No 56) assess the use of human resources in the delivery of eye care. For further information please contact: Journal of Community Eye Health, International Resource Centre, International Centre for Eye Health, Department of Infectious and Tropical Diseases, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK (tel: +44 (0)20 7612 7964; email Anita.Shah@lshtm.ac.uk; url: ; online edition: www.jceh.co.uk). Annual subscription (4 issues) UK £28/US\$45. Free to developing country applicants.

8th EUNOS Meeting – 2007

The 2007 European Neuro-ophthalmology Society meeting (EUNOS; www.eunos.web.org) will be taking place in Istanbul, Turkey on 26-29th May 2007. For further information please visit www.eunos2007.org or contact Pinar Aydin aydinp@eunos2007.org

Teaching courses on Retinal and Vitreous Surgery

Several teaching courses on Retinal and Vitreous Surgery have been organised throughout 2006 and 2007 around the world in association with the International Faculty. For further information on each of these courses please contact Ingrid Kressig, Univ.-Augenkl. Theodor-Kutzer-Ufer 1-3, 68164 Mannheim, Germany; email: Ingrid.kressig@augen.ma.uni-heidelberg.de; website: <http://kressig.uni-hd.de/>.

EVER 2006

The EVER 2006 meeting will take place in Vilamoura, Portugal on 4-7th October 2006. For further information please contact the EVER Office, Kapucijnenvoer 33, 3000 Leuven, Belgium; website www.ever.be

Prevention of Blindness Fellowship Programme

Applications are invited for BCPB Fellowships to start in 2007. The aim of the Fellowships is to fund research and training in prevention of blindness for high caliber clinicians and scientists from the UK and overseas. Projects must further the goals of VISION 2020: THE RIGHT TO SIGHT, the elimination of avoidable blindness. In 2007, the BCPB seeks to fund one Fellow from the UK and one Fellow from a low-income country to undertake projects that focus on Africa.

Priority will be given to applicants who:

- Demonstrate that their project is innovative and increases knowledge of the causes of blindness and/or its prevention in line with the priorities of VISION 2020
- Demonstrate the ability and ambition to pass on their skills in blindness prevention

The fellowships will be worth up to £60,000pa for 2 or 3 years. Applications must be submitted jointly by the Fellowship candidate and the supervisor at the host institution in the UK.

For full information and an application form, see www.bcpb.org or contact Jackie Webber at BCPB, 59-60 Russell Square, London WC1B 4HP or by email: info@bcpb.org. Closing date for applications is 30 September 2006.