Chronic Anterior Uveitis Following Bacille Calmette–Guérin Vaccination

To the Editors:
I am writing in response to the case report “Chronic Anterior Uveitis Following Bacille Calmette–Guérin Vaccination: Molecular Mimicry in Action?” published in the July/August 2008 issue. The authors describe an interesting potential side effect of the bacille Calmette–Guérin (BCG) vaccine in a 13-year-old girl and have postulated molecular mimicry as the mechanism. They have rightly stated that side effects from routine BCG vaccination, although rare, can occur. They have encouraged ophthalmologists to be aware of the described associations of what they term a “commonly used vaccine” and have alluded to the use of the BCG vaccine as part of childhood immunization schedules.

I would like to draw attention to the United Kingdom’s 2006 National Institute of Clinical Excellence Guidelines on Tuberculosis. The Department of Health no longer recommends BCG vaccination for school children between the ages of 10 and 14 years. In fact, since approximately 2001, England and Wales have met the accepted international criteria for the cessation of universal vaccination in a low-prevalence country. The United Kingdom “Schools BCG Programme,” which was developed in the 1950s, has now been deemed as not cost-effective.

The incidence of reported tuberculosis cases in southeastern England (where the published case was based) in 2006 was 8.5 per 100,000. This would suggest an area of low risk, and as such the girl should not have received the BCG vaccine as part of a routine childhood immunization schedule. In fact, current guidance suggests that in such areas of low incidence the BCG vaccine should be routinely offered to neonates who: (1) were born in an area of high incidence (as defined by HPA3); (2) have one or more parents or grandparents who were born in a high-incidence country; or (3) have a family history of tuberculosis in the past 5 years.

The authors do not state why the girl received the BCG vaccine or her ethnicity. This may change the complexion of the case described. I wonder whether she may have been identified and received the BCG vaccine as part of the contact tracing of a close index case of tuberculosis as opposed to receiving the vaccination routinely. She may have had some contact with the mycobacterium itself prior to the vaccine, which could have triggered an immune response. It would therefore be interesting to note whether she received a Mantoux test prior to the BCG vaccination if indeed she was identified as part of the contact screening of an active case of tuberculosis.

REFERENCES

James M. Duckers, MB Chb, MRCP
University of Wales Hospital of Medicine
Cardiff, United Kingdom

Reply:

We thank Dr. Duckers for his interest in our case report highlighting the previously unreported complication of bilateral anterior uveitis following bacille Calmette-Guerin (BCG) vaccination. The patient described was a previously healthy, 13-year-old white girl with no history of tuberculosis and no contact with a known case of tuberculosis. She received the BCG vaccine in early 2005, following a negative Heaf test, as part of the then routine vaccination schedule employed in her region of the United Kingdom.

Dr. Duckers correctly states that subsequent guidance from the United Kingdom Department of Health led to a change of national policy on BCG vaccination from one of routine school-age provision to a more selectively targeted program. This will certainly have changed the demographic profile of those now receiving BCG vaccination in the United Kingdom and will...
reduce the number of patients in whom this proposed, apparently rare, complication may be recognized.

Notwithstanding this change in United Kingdom national vaccination policy, we hope that our case report will continue to be of interest and benefit to an international readership because BCG vaccination remains a commonly used, important, and life-saving component of tuberculosis control measures in many endemic parts of the world.²

REFERENCES

Alexander Spratt, MBBCh, MRCOphth
Anthony J. Vivian, FRCS, FRCOphth
West Suffolk Hospital NHS Trust
Bury St. Edmunds, United Kingdom

Excision of Persistent Pupillary Membrane Using a Suction Cutter

To the Editors:

There have been multiple reports of use of laser, Vana’s scissors, or microvitreous scissors for the excision of visually significant persistent pupillary membranes. Oner et al.¹ reported using vitreous scissors. Other investigators have reported inadvertent damage to the lens capsule leading to cataract while using scissors² and potential risk of iridodialysis.

We have found the use of a 20-gauge suction cutter useful for the excision of these membranes. The blunt tip of the cutter protects the lens capsule against any damage. Well-controlled suction and cutting achieves precise excision of the membrane, maintaining the anterior chamber depth. We have successfully cut the persistent pupillary membranes using the vitreous cutter with high suction (typically 200 mm Hg) and low cut rate (20 to 40 per minute to help engage the membrane). With this technique, damage to the lens capsule is unlikely. Care should be taken to keep the cutting port faced up throughout the surgery.

REFERENCES

Mihir Kothari, MS
Kruti Mody, MBBS
Aditya Jyot Eye Hospital
Mumbai, Maharashtra, India

doi: 10.9999/01913913-20090505-16