LETTERS TO THE EDITOR

Paraneoplastic non-caseating granulomatous inflammation of the eyelid

EDITOR,—Periocular granulomatous inflammation is most commonly due to a chalazion or sarcoidosis, and more rarely to allergic granulomatosis (Churg-Strauss), Erdheim-Chester disease, Wegener's granulomatosis, and necrobiotic xanthogranuloma. When no cause for this inflammation can be found, it may be called idiopathic non-infectious granulomatous inflammation¹ or orbital sarcoid.² We report a case in which this idiopathic inflammation appeared to be associated with squamous cell carcinoma of the lung.

CASE REPORT

A 77-year-old man presented with a 2½ year history of non-tender inflammation of the left upper eyelid (Fig 1). There was no history of injury to the eyelid. A chest x ray showed an abnormality that was thought to be due to overprojection. Systemic steroids reduced the inflammation temporarily. After referral to our hospital, extensive clinical and laboratory investigations were performed. Computed tomography scanning showed the lacrimal gland to be of normal size. Tests for tuberculosis, other infectious diseases, and systemic inflammatory disease were negative. An incisional biopsy of the eyelid revealed a non-caseating, granulomatous inflammation without foreign body material or acid fast bacilli. In a few granulomas some B cells could be demonstrated immunohistochemically (Fig 2). A new chest x ray revealed a coin lesion of the right upper lobe and a lobectomy was performed. Histopathological examination of the specimen showed a poorly differentiated squamous cell carcinoma of the lung without signs of lymph node metastasis or sarcoidosis. Systemic corticosteroids and non-steroidal anti-inflammatory drugs had no significant effect on the inflammation in the

Figure 1 Frontal view of the patient. Note left upper lid swelling.

Figure 2 Immunohistochemical stain (L26) showing admixture of B cells in granulomas (×200).

eyelid. Some more tissue was removed for cosmetic reasons, and the histopathology was similar to the first specimen.

COMMENT

The association of granulomatous inflammation (especially in lymph nodes) and malignancy has been noted before.²⁻⁶ The pathogenesis of this malignancy associated inflammation may be diverse (sarcoid-like reaction to tumour derived components, sarcoidosis, infection, granulomatous lesions of unknown significance or GLUS.³ Sarcoid-like reactions to pulmonary neoplasms were described to occur in regional lymph nodes in the form of non-caseating granulomas.⁴ Granulomas in lymph nodes may be divided into two categories on the basis of the presence or absence of B cells in these lesions (B cell positive: toxoplasmosis, tumour related sarcoid reactions, and GLUS; B cell negative: sarcoidosis, mycobacterial infections).⁵ In our case, a few granulomas showed some admixture with B cells.

To our knowledge, the association of a non-caseating granulomatous inflammation of the eyelid and a squamous cell carcinoma of the lung has not been described before. This case suggests that screening for malignancy might be useful in patients with non-caseating granulomatous inflammation of unknown origin.

T T Q REUSER

Department of Ophthalmology

P WESSELING

Department of Pathology,
University Hospital Nijmegen, the Netherlands

Correspondence to: T T Q Reuser, Department of Ophthalmology, University Hospital Nijmegen, PO Box 9101, 6500 HB Nijmegen, the Netherlands.

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Paraneoplastic retinopathy in association with large cell neuroendocrine bronchial carcinoma

EDITOR,—Cancer associated retinopathy is a rare paraneoplastic manifestation of a variety of tumours, most commonly small cell carcinoma of the lung (SCCL).¹⁻⁴ Characteristically the syndrome presents with reduced vision, photopsia, progressive ring scotomas in the visual field, and nightblindness. Ocular symptoms may precede the diagnosis of malignancy for several months, especially as the ocular signs (attenuation of retinal arteries, mild optic disc atrophy) are easily missed. Pathologically, there is a severe photoreceptor degeneration,³ and it is thought that the disease is mediated by antibodies that cross react between the tumour and photoreceptor antigens.^{1 4} We present a 60-year-old ex-smoker with the typical features of the syndrome whose investigations revealed a large cell neuroendocrine carcinoma.

CASE REPORT

A 60-year-old woman presented with a 1 year history of dimming of vision associated with severe nightblindness. A left cataract had been removed 1 year earlier. There was no relevant family or dietary history and she had taken no potentially retinotoxic drugs. More recently she noticed increasing malaise and weight loss. General examination was normal except for an enlarged right supraclavicular node. Ocular examination showed a vision of 6/24 right, 6/6 left with normal colour vision. Pupils reacted poorly and visual fields (Fig 1) showed gross constriction, the right eye being worse than the left. Fundus examination showed minimal arteriolar constriction and

Fig 1A

Fig 1B

Figure 1 Goldmann visual fields showing marked constriction in the right eye (A) and a dense ring scotoma in the left eye (B).