operative techniques has resulted in less aggressive treatment with preservation of the eye.

Our case demonstrates some unusual features of orbital teratoma. The presence of globe displacement was not very obvious with the eye closed. In the presence of tumour mass in the orbital apex, ocular movements were still full, whereas visual function did not appear to be severely reduced. Following complete excision of the tumour, vision had not changed clinically. A high index of suspicion in the presence of a cystic lesion in the neonate, even in the absence of obvious proptosis, particularly in the presence of calcifications, may lead to the diagnosis of orbital teratoma. Surgery by a route allowing complete excision should be planned as soon as possible.

**Fig 1A**

**Fig 1B**

**Figure 2** Computed tomography scans of the orbits after corticosteroid treatment but before antimycotics. Axial views, increase in subcutaneous mass (arrow) compared with that shown in Figure 1A.

**COMMENT**

Coccidioidomycosis is a pathogenic, endemic fungal disease caused by the organism *Coccidioides immitis*. The ocular manifestations of coccidioidomycosis are many and can involve different extraocular or intraocular tissues. However, to our knowledge, lachrymal gland invasion by the organism has not been reported previously. Our patient presented with a painful proptosis suggestive of bacterial orbital cellulitis, for which he was treated with intravenous antibiotics. The tentative diagnosis of dacyrocystitis was based on the moderate improvement with intravenous antibiotics and the CT scan findings which were consistent with an inflammation of the lacrimal gland. The usual incidences of lacrimal gland masses are benign mixed tumour (12%), dacrocyce (6%), malignant epithelial tumours (4%), inflammatory pseudotumour (idiopathic orbital inflammation) (50%), sarcoid (13%), lymphoid masses (15%), and acute dacrocyeadenitis (1%).

Dracula infections that involve the lacrimal gland initially produce only non-specific inflammatory changes on CT scan, such as thickening of the scleral-uvular rim, enhancement of the lacrimal gland, or thickening of an extraocular muscle, changes that often disappear on follow-up. Delayed enhancement of orbital inflammation in the lacrimal gland region. An abscess can be clearly delineated by CT scan only when necrotic tissue is present within encapsulated fibrous tissue. Since a CT scan may not reveal an abscess during the initial presentation, orbital ultrasound has been recommended when an abscess is suspected. In a review of 15 cases with orbital abscess, ultrasound consistently revealed well-defined lesions of low internal reflectivity with high reflective borders. Balchunas et al examined 32 patients with lacrimal gland/fossa masses who had CT scans and/or standardised A-mode echography (SAE), and concluded that the initial examination of a lacrimal gland/fossa mass should begin with SAE since its specificity exceeds that of CT scans in this region. However, many orbital surgeons prefer to rely on CT scanning.

The current treatment of choice for ocular coccidioidomycosis is intravenous amphotericin B, which has been proved to be effective in the treatment of extrapulmonary dissemination of *Coccidioides immitis*. Drainage is indicated if the abscess is large or if it is
unresponsive to antifungal treatment. Our patient responded well to maintenance fluconazole therapy, and there is no evidence of recurrence 1 year after the initial presentation.

In conclusion, this case illustrates the danger of treating a patient with a presumed diagnosis of idiopathic orbital inflammation with a trial of corticosteroids. Such an approach masks the true nature of the fungal abscess, delays incisional biopsy for histopathological diagnosis, and increases the risk of progressive dissemination. Although corticosteroids remain the mainstay of treatment for idiopathic orbital inflammation a poor response, recurrence, or abscess formation require a re-evaluation. Coccidioidomycosis, especially in endemic areas, should be considered in the differential diagnosis of any lacrimal gland fossa mass that does not resolve with intravenous antibiotics.

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A case of primary orbital melanoma treated by local excision

EDITOR—Melanotic tumours of the orbit as a rule are secondary, arising chiefly from the uveal tract and adjacent areas such as conjunctiva, eyelids, nasal sinuses, and intracranial meninges. 1 Primary orbital melanoma is much less common than these secondary tumours and accounts for less than 1% of primary orbital neoplasms. 2 We describe a case of an uncommon slowly progressing well circumscribed primary orbital melanoma. This was treated by primary resection with no evidence of recurrence or metastasis on follow up.

A CASE REPORT

A 79-year-old man was admitted to the Ophthalmology Clinic of the University of Cummhuriyet Medical School, Sivas with a 9 year history of progressive tumour of the left eye, which had been increasing in size for about 2 years. He had subjective symptoms such as pain, bleeding, and an unbearable smell for about 1 month. He had not sought medical help in this 9 year period. When he was first seen at our clinic, the left upper eyelid was grossly distended by a large bluish tumour mass extending approximately 5 cm anterior to the orbital rim (Fig 1). On palpation, a semi-soft mass could be felt through the lids, evidently filling the orbit. There was a fragile and bleeding ulcer and necrosis on the anteronasal surface of the tumour. The eyeball was obscured from view, but when the mass was elevated with retractor a vascularised cloudy cornea was seen. He had no light perception in his left eye. The visual acuity of his right eye was 20/30 and there was no significant abnormality except nuclear sclerosis of the lens.

An orbital computed tomographic scan demonstrated a well demarcated non-homogeneous, large mass located anterosuperiorly in the left orbit. The eyeball itself was normal. There was no calcification or bony erosion (Fig 2).

The surgical approach was via incision through the upper eyelid margin. Overlying conjunctiva was intact and it was seen to be easily separable from the tumour. A dark blue pseudocapsulated mass was easily freed from the globe and other orbital tissues by

Figure 1 (A) Patient at presentation showing a large mass filling the left orbit. The eyeball was obscured from view. (B) Upper eyelid was grossly distended by the tumour extending approximately 5 cm anterior to the orbital rim.

Figure 2 Computed tomography of the orbits show circumscribed mass located anterosuperiorly in the left orbit.

Figure 3 Microscopically it is nodular in configuration, and consists of spindle-shaped cells, some containing melanin. There is no junctional activity in the overlying epithelium. Haematoxylin and eosin, ×25.