woman aged 42 years who presented with a sore eye; the other in a male whose age and presentation were not stated. Pathological examination of biopsies in both showed 'cysts' in which an initial diagnosis of 'concretions' in the former and 'grains' in the second was made. The third was a man aged 94 years who presented with a senile ectropion of the eyelid. Biopsy revealed a cyst and initially a diagnosis of nematode infestation was made.

The appearance of the structures in the current case, along with the lack of any organoid structure resembling known parasitic infestations in association with a cyst of Molli's glands, satisfies the criteria for Liesegang rings.

When considering the differential diagnosis of unusual cystic lesions of the eyelid the oculopathologist needs to be aware of Liesegang rings as a separate entity and not related to parasities.

A PADWELL
Department of Pathology, Glänzer Hospital, Glänzer, New Zealand

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Surgical management of primary localised conjunctival amyloidosis causing ptosis

EDITOR,—Primary localised conjunctival amyloidosis characteristically presents as an enlargement or swelling of the eyelid which is frequently associated with spontaneous haemorrhage.1 The condition usually presents in the third or fourth decade of life. Typically, there are solitary or multiple, firm, rubbery, well vascularised, waxy appearing, painless, fusiform or polyoid subconjunctival elevations. If the tarsal plate and adjacent muscle and subcutaneous layers are infiltrated, the eyelid may be diffusely thickened. Ptosis may result from the weight of the amyloid and infiltration or stretching of the levator palpebrae superioris complex.

The surgical management for this condition has not been well described and indeed surgery is often avoided for fear of severe haemorrhage. We present a case in which a meticulous excision of the amyloid mass using a microdissection needle, combined with an advancement of the levator aponeurosis, provided a good functional and cosmetic result.

CASE REPORT
A 70-year-old white woman was referred for a second opinion on her longstanding bilateral ptosis. In 1982 the patient had developed a gradual swelling of her left upper eyelid which gradually resolved over a 2 week period and was associated with the development of a bruise in the same region. Over the course of the next 3 years the patient suffered recurrent spontaneous haemorrhages into both upper lids with extensive bruising. Both lids became increasingly swollen and a secondary ptosis developed. In 1985 a left posterior approach levator resection was attempted but the procedure was abandoned because of severe haemorrhage. In 1990 a Fasanella-Servat procedure was performed by another surgeon on the left upper lid as the ptosis was obscuring the pupil. This procedure gave a functional improvement for 3 years. Histopathological examination of the excised tarsocconjunctiva showed the presence of amyloid tissue.

On examination the patient had a bilateral ptosis with a palpebral aperture of only 3 mm on the left side and 5 mm on the right. She had a bulky appearance to both upper lids with firm, painless, rubbery swellings palpable in and above the upper tarsal plates. The swelling was more extensive in the left upper lid (Fig 1). There was evidence of subcutaneous haemorrhage in and around the left upper lid. The diffuse thickening of the upper lids made eyelid eversion difficult. Levator function was 8 mm on the left side and 10 mm on the right.

The patient underwent an exploration of the left upper lid via a skin crease incision under general anaesthetic. The surgery was performed using a 'Colorado' microdiathermy needle which permitted excellent dissection of the tissues with minimal bleeding. The amyloid material was exposed and dissected from the underlying tarsus and conjunctiva. The levator aponeurosis was involved in the lower two thirds. This was excised and the remaining healthy levator aponeurosis advanced onto the tarsal plate. The skin incision was closed and a pressure dressing applied for 24 hours.

Histopathological examination and immunohistochemical analysis of the material removed at surgery confirmed that the mass was composed of AL type amyloid tissue which has previously been identified in deposits of primary localised amyloidosis.1,2 Positive staining occurred with antibodies to kappa and lambda light chains.

Postoperatively the patient made an uneventful recovery. The left palpebral aperture measured 7 mm. There was no lagophthalmos. Both the functional and cosmetic results were good. The patient remained unchanged after 12 months’ follow up (Fig 2).

Figure 2 Twelve months postoperatively functional and cosmetic improvement are apparent.

COMMENT
In the ophthalmic literature there has been little discussion of the management options and operative approaches for this condition. Small, localised lesions have previously been treated by a bleb resection, but in advanced cases surgery is often not attempted because of the potential risk of haemorrhage from the fragile blood vessels typically associated with the lesions, and the extent of infiltration rendering resection impractical. Recently, Patrinely and Koch described a method of treating advanced amyloid deposits by preserving the anatomical planes of the eyelid and debulking the amyloid mass with a spooned curette.4 This method appears to be effective in reducing the size of the amyloid mass in advanced cases.

This case report illustrates that resection of large areas of amyloid is technically possible with preservation of normal eyelid tissue, and avoidance of haemorrhagic sequelae. At the same time it is possible to correct a secondary ptosis safely and satisfactorily.

A D HUBBARD
R E BONSHIEK
B LEATHERBARN
Manchester Royal Eye Hospital, Oxford Road, Manchester M13 9WH

Correspondence to: Mr B Leatherbarrow.

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Orbital varix in Grönlund-Strandberg syndrome

EDITOR,—Pseudoxanthoma elasticum (PXE) is an uncommon hereditary disorder of connective tissue, characterised by fragmentation of elastic fibres in various tissues. This abnormality accounts for its most common manifestations, including angiod streaks (breaks in Bruch’s membrane), reticulated skin lesions (plucked chicken appearance in neck and axillae), and vascular abnormalities.1 The association of PXE and angiod streaks is known as Grönlund-Strandberg syndrome.2 Orbital varices are venous malformations characterised by a weakened vessel wall and often by an interrupted elastic lamina. The combination with PXE has never been reported before. We describe a case of Grönlund-Strandberg syndrome, where an orbital varix was the presenting sign.

CASE REPORT
In October 1993 a 22-year-old woman was referred for the evaluation of a painless superior medial mass, arisen since the age of 4