collision, sustained by the driver while the passenger, without an airbag, had no injuries. While there is ample literature to show that the use of airbags decreases driver fatalities,1 there are no data showing the optimum threshold impact for their deployment. Optimum threshold deployment pressure should be studied in order to maximise the benefits of fatigue reduction and minimise the risks of airbag induced morbidity.

Also, in light of recent literature concerning airbag associated injuries, it would seem reasonable that airbag impact sensors should be checked regularly.

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Unilateral Malassezia furfur blepharitis after perforating keratoplasty

EDITOR,—Malassezia furfur (Pityrosporum genus), a yeast considered part of the normal skin microflora, is also known to cause pityriasis versicolor, folliculitis, and seborrhoeic dermatitis. We report two cases of unilateral blepharitis where Malassezia was retrieved from eyelid scrapings. These occurred after an uncomplicated perforating keratoplasty for keratoconus in two young (central European) patients, and resolved rapidly after local antifungal therapy.

CASE REPORTS

Case 1

A woman aged 22 underwent perforating keratoplasty. The postoperative period was uneventful. Prednisolone acetate eye drops were applied postoperatively five times daily, and later at reduced frequency, without other therapy. At follow-up 6 months later, she exhibited a slightly pigmented scaling lesion of the upper eyelid on the side of surgery, without itching or discharge. The eyelid margin was unaffected, the skin was not inflamed or ulcerated (Fig 1). There was no evidence of conjunctival infection, and the transplanted cornea was clear. No skin lesions were seen elsewhere.

Fungal infection was suspected and an im

potassium hydroxide preparation of an eyelid scraping disclosed a spherical yeast (Fig 2) characteristic of M furfur. No culture was performed. Local antifungal ointment ( clotrimazole) was prescribed. She missed the follow up visit, but 3 weeks later reported that she was asymptomatic. When seen 6 months later the condition had resolved.

Figure 1 Pigmented scaling lesion of upper eyelid (case 1).

Case 2

A 19-year-old man presented at follow up with a brownish scaling lesion of the upper eyelid on the side of surgery, 1 month after the operation. Postoperative treatment was identical to case 1. The eyelid margin was seborrhoeic with slightly mucopurulent discharge (Fig 3). The corneal transplant was clear, but there was mild conjunctival injection, photophobia, and tearing. The latter were probably related to the surgery, not to the eyelid lesion. A dermatologist prescribed an antibiotic-fluocinolone ointment. However, 9 months later the condition was unchanged.

This case was strikingly similar to case 1; the same organism was found. Local antifungal treatment was followed by complete resolution within 2 weeks.

Comment

Blepharitis is a common ophthalmic disease, involving various infection agents.1–4 M furfur, a dimorphic lipophilic yeast, is part of the normal cutaneous microflora. It has been linked to seborrhoeic blepharitis, but without convincing proof.4 The dimorphic forms have long been considered different organisms.5 While the mycelial form is associated with pityriasis versicolor, the yeast form causes seborrhoeic dermatitis. In pityriasis versicolor the skin becomes scaly and skin pigmentation is altered, while seborrhoeic dermatitis gives excessive scaling and chronic inflammation.

Clinically, case 1 better fits the pityriasis versicolor category; however, the organism was a round yeast and mycelial elements were not seen. Case 2 exhibited features of pityriasis versicolor and seborrhoeic blepharitis simultaneously, with microscopic picture similar to case 1.

Information about factors predisposing to diseases caused by M furfur is limited. Being an opportunistic pathogen, a defect in the host defence mechanism is presumed. The strikingly similar clinical presentation and history of our patients may have a common pathogenesis. Neither patient had evidence of atopic disease, which might link keratoconus to fungal susceptibility. The lesion being unilateral, without other skin lesions, argues for a local disorder. Possibly prolonged corticosteroid use had modulated local lymphocyte transformation depressing cellular immune response. Other factors, however, cannot be excluded—for example, both patients reported that they had not washed the post-ocular region since the operation. Possibly the patients' age could be significant; we have never seen this condition in older patients after perforating keratoplasty.

It is important to consider the possibility of fungal infection in longstanding blepharitis. Eyelid scrapings are easy to perform and are valuable in establishing therapeutic guidelines.

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