LETTERS TO THE EDITOR

Primary sebaceous carcinoma of the lacrimal gland

EDITOR,—Sebaceous carcinoma is a rare primary neoplasm of the lacrimal gland and to the best of our knowledge only five cases have previously been reported.1–3 Sebaceous carcinoma of the orbit more commonly occurs as secondary invasion from the eyelid but may occur as metastatic spread from elsewhere in the body. We report a case of primary sebaceous carcinoma of the lacrimal gland and discuss the histological diagnosis and management of the disease.

CASE REPORT
A 35 year old woman was referred with a 6 month history of a gradually enlarging palpable mass arising in the left superotemporal orbit and causing painless, and progressive diplopia. On examination she had a palpable, hard, fixed, left superotemporal orbital mass, a non-axial proptosis, and hypoglobus. The eyelids were normal. Examination of ocular motility revealed a restriction of left elevation. In addition, she was found to have an enlarged, painless ipsilateral preauricular lymph node. Computed tomograph (CT) and magnetic resonance imaging (MRI) scans showed the mass was arising from the lacrimal gland (Fig 1).

A transseptal biopsy of the mass was performed and histological examination showed tissue infiltrated by carcinoma in which the neoplastic cells were large and contained prominent nucleoli. Many cells were vacuolated and contained lipid as confirmed by fat stains on unprocessed, fixed material. Immunohistochemistry revealed strongly positive staining for epithelial membrane antigen (EMA) but negative staining with antibodies to cytokeratin, indicating the carcinoma to be of sebaceous origin (Fig 2). Metastatic spread from another primary site was excluded by general physical examination, chest x ray, mammography, and isotopic bone scan undertaken by an oncologist.

A left orbital exenteration with left superficial parotidectomy and excision of left cervical lymph node was performed. Histological examination of the excetration specimen showed a 35 × 30 × 18 mm tumour arising in the region of the lacrimal gland, which had been entirely replaced by sebaceous carcinoma, with only a small focus of ducal tissue being present at the margin of the tumour at one point. There was no involvement of the overlying periocular skin, eyelid, or conjunctiva. The preauricular lymph node contained metastatic deposits, although her cervical lymph nodes were free from metastatic disease.

Postoperatively she underwent radiotherapy to the involved area and the orbit was allowed to granulate and re-epithelialise. Nine months after the surgery an isolated soft, mobile node was noted in the neck. This increased in size over 2 months and was found to be recurrent metastatic carcinoma on fine needle aspiration biopsy. Radical dissection of nodes in the neck confirmed involvement of 30–40 nodes and the patient received further radiotherapy. Six months after this, a swelling in the parotid region without lymphadenopathy again showed recurrent tumour. This lesion responded well to radiotherapy alone. Since then she has achieved good cosmesis with an orbital prosthesis and at the time of writing 3 years after original diagnosis she remains well with no signs of residual tumour.

COMMENT
Primary sebaceous carcinoma of the lacrimal gland possibly arising from heterotopic sebaceous tissue is extremely rare and must be differentiated from secondary invasion of the orbit by a primary eyelid tumour or metastatic spread from other areas of the body. The tumour is highly malignant and metastases to the preauricular and deep cervical lymph nodes occur early in the disease. Orbital exenteration is required and in addition parotidectomy and cervical lymphadenectomy combined with postoperative radiotherapy should be considered as part of the management. The prognosis in previously reported patients was poor with local recurrences and metastases leading to death within 1 year. One previous patient survived to 22 months postoperatively.1 At the time of writing our patient is the first to show 3 year survival without evidence of further recurrence.

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Accepted for publication 20 December 2000

Coneal circumscribed choroidal haemangioma associated with infantile hepatic haemangioendotheliomatosis

EDITOR,—Choroidal haemangiomas are vascular hamartomas that occur in two distinct forms, circumscribed and isolated, or diffuse, as seen in the Sturge–Weber syndrome. Likewise, hepatic haemangioendotheliomas are benign hamartomatous tumours composed of anastomosing vascular channels lined with endothelial cells. Infantile haemangioendotheliomas (IHE) of the liver are congenital lesions noted at birth or during the first 6 months of life. Hepatomegaly, congestive heart failure, and haemangiomas of the skin combine to form the classic symptomatic triad. To our knowledge, this is the first report of a congenital circumscribed choroidal haemangioma and the first noted association of a circumscribed choroidal haemangioma with a visceral neoplasm.

CASE REPORT
A 3.75 kg male with an uncomplicated prenatal history was born at full term by normal spontaneous vaginal delivery. At birth, the patient was noted to have a single 1 cm diameter cutaneous haemangioendothelioma of his left upper extremity. There was no family history of ocular diseases or any haemangiomatous syndromes. The patient’s early postnatal course was complicated by hepatic and congestive heart failure. During this time, his cutaneous haemangioendotheliomas had increased in number ranging from 2 mm to 1 cm in diameter involving his right upper extremity, occiput, and chest wall. An ophthalmological examination was requested to exclude the diagnosis of LCHAD (long chain 3-hydroxyacyl coenzyme A dehydrogenase) deficiency, a disorder of mitochondrial fatty acid β-oxidation, which is associated with choroidal haemangiomas. Funduscopic examination revealed papillary motting of his macula and a dull foveal reflex bilaterally. The optic discs and vasculature were within normal limits. A diagnosis of LCHAD deficiency was not supported by further serological testing. Diagnostic imaging revealed multiple hepatic lesions associated with hepatomegaly. Subsequently, at 7 weeks of age, a liver biopsy was performed which confirmed the diagnosis of a benign hepatic haemangioendothelioma of the liver. Owing to progressive hepatic and congestive heart failure the patient underwent a living related liver transplantation at 6 months of age. His postoperative course was otherwise unremarkable with normal growth and development and resolution of his cutaneous haemangioendotheliomas.

Time course of ophthalmological examination at 7 months of age the patient was able to fix and follow objects bilaterally without evidence of amblyopia. Funduscopic examination, however, revealed bilateral macular pigment epithelial granularity and motting, greater in his left eye. Re-examination at 10 months of age demonstrated persistent macular pigmentary changes in the left eye with elevation of the macula. Examination under anaesthesia was subsequently performed at 11 months of age which revealed normal anterior segment and clear crystalline lenses bilaterally. Funduscopic examination revealed normal discs, vessels, and retinal periphery in both eyes. The right macula was normal without pigmentary abnormalities but the left macula revealed a raised choroidal lesion with an orange coloration and reactive pigmentary changes without retinal detachment or subretinal fluid. On A and B-scan ultrasonography the maximum height of the lesion was 2.1 mm and the reflectivity of the lesion was high. The clinical and ultrasonographic appearance was most consistent with the diagnosis of a circumscribed choroidal haemangioma. Given the patient’s normal visual acuity and absence of subretinal fluid, observation was recommended in lieu of laser or radiation therapy. Follow up examination at 15 months of age revealed normal visual acuities without progression of the lesion.

COMMENT
The pathogenesis of haemangiomas remains largely unknown. Histologically, the hepatic and cutaneous haemangioendotheliomas are composed of vascular channels lined by endothelial cells as well as cells suggestive of pericytes. Similar vascular characteristics are shared by circumscribed choroidal haemangiomas which consist of a mixture of small (capillary) or large (cavernous) vascular channels lined by flat endothelial cells separated by connective tissue. It has been proposed that persistent arteriovenous shunts, which normally occur in great numbers during the embryogenesis of the choroidal vasculature and then regulate, may play a part in the development of choroidal haemangiomas. Whether a similar model may apply in the development of hepatic and cutaneous haemangioendotheliomas remains speculative.

Infantile hepatic and cutaneous haemangioendotheliomas show a high incidence of spontaneous regression and therapeutic measures are recommended only when associated conditions lead to morbidity. Although our patient’s hepatic lesion was initially required surgical intervention the natural history of these lesions combined with the patient’s normal vision and lack of associated vision threatening complications justified observation. Should the choroidal lesion eventually give rise to subretinal fluid, macular detachment, and/or decreased visual acuity the patient may benefit from photocoagulation or radiation therapy. Thus, albeit rare and usually diagnosed in an asymptomatic infant, choroidal haemangiomas may present in a congenital fashion and may also be associated with visceral abnormalities of vasculogenesis.

Echographic localisation of corticosteroid after retrobulbar injection

EDITOR,—Long acting pericocular corticosteroids are commonly used to treat cystoid macular oedema (CMO) resulting from ocular inflammation or cataract surgery that does not respond to topical therapy. Drug localisation to the macular area is considered important for optimal therapeutic effect. In post-cataract CMO refractory to topical therapy, corticosteroids delivered by retrobulbar and posterior sub-Tenon’s injections are equally effective. Whether the desired site of injection has been previously been shown to localise to the macular area. Retrobulbar anaesthetic injections have been shown to localise in the intracranial space, but not precisely to the macular area. We performed ultrasonography after retrobulbar steroid injection to confirm drug localisation in the macular area.

CASE REPORT
Six patients with chronic CMO secondary to sarcoid, idiopathic uveitis, or cataract surgery (Irvine-Gass syndrome) were included in the study. The main inclusion criteria were presence of a visually significant form of CMO that had either failed topical anti-inflammatory treatment, or was deemed clinically severe enough to warrant systemic or pericocular injections of corticosteroids prima- rily, and willingness to sign informed consent. The main exclusion criteria was refusal to consent to the procedure.

Each eye was injected with 1–2 ml of 40 mg/ml triamcinolone acetonide mixed with 0.5 ml of 2% lignocaine (2%) without adrenaline (epinephrine) using a sharp 1½ inch 25 gauge needle. The needle was inserted at the inferotemporal aspect of the lower lid aiming in the direction of the orbital apex. The patient was asked to look straight ahead while the globe was balloted towards the superior orbit with the index finger of the non-injecting hand. Once the needle was positioned in the muscle cone near the posterior pole, the solution was slowly injected.

B-mode ultrasound was performed within 30 minutes of the retrobulbar injection. After topical proparacaine (proparacaine) was given, a methylcellulose coupling agent was placed on the ultrasound transducer face. The face of this was directly applied to the ocular surface. Standard longitudinal, vertical transverse, and axial planes were imaged (Figs 1 and 2).

In 15 of 16 (94%) eyes the steroid was localised to the macular area defined as the portion of the posterior pole bounded by the optic nerve, major temporal arcades, and 3 mm temporal to the fovea. In eyes where the bolus localised to the macular area, the mean distance between the most anterior aspect of...
Early wound dehiscence with use of hydroxyapatite orbital implant covered with calf pericardium

Eibot,—Enucleation techniques continue to evolve. While sclera covered hydroxyapatite orbital implants have been quite effective, two major limitations have led us to study other covering materials. One, while there has been no documented human immunodeficiency virus transmission, several patients have expressed concerns about the use of allogeneic sclera because of that issue. Two, in some settings obtaining cadaver donor tissue in a timely manner can be vexing.

Processed calf pericardium has been used in a number of clinical settings as diverse as vascular grafts and neurological surgical patches. Animal ophthalmic data with these materials have shown little untoward effect. While theoretic concerns about prion disease can be raised no evidence of this problem has been reported from over 90,000 human implantations. While this material is a xenograft that is stored in glutaraldehyde, we are unaware of significant ophthalmic reactions on the basis of either parameter.

I performed a phase I-II trial with commercially available calf pericardium in 14 patients who underwent enucleations for large intraocular tumours. I compared the results with 126 previous enucleations in similar patients by the same author with placement of allogeneic scleral wrapped HA implants. When two of these 14 cases developed early, apparently non-infective suture line breakdown (compared with none previously) I stopped the use of this approach.

CASE REPORT

In a phase I-II trial 14 eyes of 14 patients, with large intraocular tumours that were not amenable to eye salvage techniques, underwent enucleation. Three patients had large, unilateral retinoblastomas and 11 had uveal melanomas. In the latter group, eight had primary enucleations and three had their eye removed at relatively long intervals after either brachytherapy or proton radiation. The mean age was 49 years old with a range of 1.3–81 years.

Enucleations were performed in a standard manner, as described elsewhere, using double armed 5–0 polyglycolic and polylactic acids (Vicryl) sutures to imbricate each of the recti muscles. An 18–22 mm HA implant was soaked in a combination of antibiotic-bupivacaine (Marcaine) solution for 5 minutes then covered with a preshaped Occlusguard calf pericardium (Bio-vascular, Inc, St Paul, MN, USA). The open end of the preformed, bag-shaped material was placed posteriorly and was partially closed with interrupted 4–0 polyglycolic and polylactic acid (Vicryl) sutures. A scalpeld was used to create four windows, each approximately 3 × 5 mm located at the equator. After haemostasis was achieved the recti muscles were each attached to the anterior edge of their respective 3 × 5 mm window. Tenon’s layer was then closed with a running 4–0 poliglycolic and polylactic acids (Vicryl) circle suture, and overlying interpreted 4–0 poliglycolic and polylactic acids (Vicryl) sutures. The conjunctiva was closed with a running 6–0 plain gut. The retrospective control group was operated on in an identical manner except alcohol preserved allogeneic sclera was used instead of calf pericardium.

Patients who received calf pericardium covered implants have been followed for 7–20 months following surgery. None of the patients has been drilled for placement of an integrated implant. In two adults we noted breakdown and retraction of the anterior suture line within 1 month of surgery. In neither of the two cases in which breakdown of the suture line in the first month postoperatively was there ocular radiation, pre-existing conditions, or untoward events noted at surgery. In both cases cultures were negative. In the first case, since I had never had this complication in the first month after an enucleation, I assumed that the suture material had broken and took the patient back to the operating room to close the defect. A culture was negative, and I easily resutured the conjunctival edges, but it again broke down 1 week later. In that patient and the second case that presented with a slightly larger defect 2 weeks after enucleation, we removed the anterior face of the calf pericardium that covered the HA implant, and the overlying conjunctival defect was closed with a dermal graft. The first patient has done well. The second case had recurrent breakdown anteriorly so that we removed the implant. No pathogenic organisms were seen.

In the historic control group (126 cases), who had scleral covered HA implants, I had no cases with this type of complication in the first 6 months after surgery.

COMMENT

A large variation in the incidence of postenucleation complications have been reported. Using the technique outlined above, I have not had an early (<6 months) wound dehiscence or anterior surface breakdown. It is uncertain why we have developed this complication in 14% of cases operated on with bovine pericardium. It is likely that either these patients had a reaction to the xenograft or to the preservative material (although the pericardium is carefully washed saline solution, bupivacaine (Marcaine) and antibiotics before insertion). In some clinical investigations a higher incidence of early complications with scleral covered hydroxyapatite implants has been reported; these series report wound dehiscence between 5–30%. While that higher incidence has been noted by others, it has not been my experience with a surgical technique that has been basically unchanged for several years.

The mechanism responsible for this early wound dehiscence is uncertain. In an animal study that compared bovine pericardium with homologous sclera there was significantly greater inflammation with the former material; all rabbits that received bovine pericardium wrapped implants had diffuse inflammation in the outer 20% of the material. It is unlikely that our patients had a subclinical infection (cultures were negative and histological studies showed no organisms) although we cannot completely rule out that possibility.

While there are a number of theoretical advantages with the use of calf pericardium instead of allogeneic sclera, the 14% incidence

Financial support: Heed Fellowship (MT).

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Accepted for publication 15 December 2000
Wegener’s granulomatosis as a cause of cicatrising conjunctivitis

EDITOR,—Wegener’s granulomatosis is a multisystem disorder characterised by the classic triad of necrotising granulomas in the upper respiratory tract and the lung, a variable degree of systemic small vessel vasculitis, and a focal necrotising glomerulonephritis. A limited form of Wegener’s granulomatosis, with absence of glomerulonephritis, has been described.1

Ophthalmic complications occur in about 30% of patients with biopsy proved disease.2 Among these orbital pseudotumours ulcerations of the sclera and the cornea are observed most frequently and the histopathological findings have been described.3 Involvement of the conjunctiva and eyelids has also been observed,4 but progressive scarring of the conjunctiva and its sequelae has not been unrevealing until early 1987, when he developed necrotising anterior scleritis and a focal necrotising glomerulonephritis. A limited form of Wegener’s granulomatosis, with absence of glomerulonephritis, has been described.1

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CASE REPORT

A 72 year old man was first seen at our department in November 1997 with bilateral conjunctivitis. His medical history had been unrevealing until early 1987, when he developed systemic illness with upper respiratory complaints and renal insufficiency. Wegener’s granulomatosis was diagnosed by biopsy of the nasal mucosa and kidney. In 1993 he developed necrotising anterior scleritis and peripheral corneal melting in the left eye. There was complete remission on systemic immunosuppressive therapy.

Since January 1997 the patient has suffered from recurrent bilateral conjunctivitis. He complained about persistent epiphora in the left eye and irritation in both eyes. He was then on local treatment with fusidic acid gel and prednisolone 1% eye drops for 2 weeks. On examination lid margin disease with obstruction of the meibomian glands and obliteration of the left canaliculi was noted. The left upper lid showed inflammatory thickening with haemorrhagic and mild cicatricial changes of the tarsal conjunctiva (Fig 1A). In the right eye similar changes were noted; they were, however, much less prominent. Bulbar conjunctiva was unremarkable and there were no other signs of active inflammation in the globe. As there was at that time no evidence of systemically active Wegener’s granulomatosis and as cANCA levels were near normal, systemic immunosuppressive treatment was not started again and therapy was restricted to the usual blepharitis regimen (oral tetracycline, lubricating agents, local antibiotics, and steroids).

The patient was referred again in March 1999 after he had suffered several episodes of superficial corneal ulceration in the left eye. On examination the left upper lid was less inflamed than 2 years earlier, but progressive scarring of the tarsus with cicatricial entropion and trichiasis had occurred (Fig 1B). The right upper eyelid showed marked inflammatory thickening, clinically imposing as multiple chalazia. A biopsy from the lateral right upper tarsus disclosed a chronic inflammatory infiltration with lymphocytes, plasma cells, and occasional histiocytes. Numerous eosinophils but no giant cells were noted. Perivascular inflammatory infiltration (Fig 2) and areas of active necrosis were only seen in few areas while disorganisation of the tarsus by fibrous tissue was obvious. Together with the analysis of extracellular tissue and the clinical background, the conjunctival biopsy was regarded as diagnostic.

COMMENT

The current state of knowledge has not recognised Wegener’s granulomatosis as a disorder causing cicatrising conjunctivitis. The diagnosis of granulomatous conjunctivitis in Wegener’s granulomatosis can easily be established in the presence of a history of systemic disease. Conjunctival and eyelid findings, however, may be the presenting symptoms and correct diagnosis is difficult. cANCA levels, a chest x-ray film, and an urinary sediment may be helpful in such situations.

Owing to the small number of cases, the experience in treating conjunctival Wegener’s disease is limited. In the absence of detectable cANCA levels or extracocular disease activity, we did initially not recommend systemic treatment with steroids and/or immunosuppressive agents. Considering the progressive course with severe lid complications this approach has to be reconsidered. Further reports will help in this decision.

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Accepted for publication 15 November 2000

An unusual presentation of diabetic neuropathy

EDITOR,—Diabetic neuropathy can present in numerous forms; as symmetrical sensory polyneuropathy, mononeuropathy, or as an autonomic neuropathy. The earliest functional change in diabetic nerves is delayed conduction velocity, the earliest histological change is segmental demyelination due to damage of Schwann cells. We report an uncommon but important presentation, which can easily be overlooked on clinical examination.

CASE REPORT

A 27 year old woman was referred to Moorfields Eye Hospital complaining of bilateral keratitis and recurrent dryness. Her visual acuity was reduced from 6/6 right to 6/18 left. She had been an insulin dependent diabetic since the age of 11. History of control of her diabetes was good, on a regimen of subcutaneous Monotard and Actrapid. She had no other significant medical history.

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On examination she was noted to have bilateral corneal erosions. Together with the analysis of extracellular tissue and the clinical background, the conjunctival biopsy was regarded as diagnostic.
Corneal anaesthesia can be physiological or pathological. Corneal sensation decreases with age, and is lower in females, especially premenstrually. Contact lens wear, and infection by herpes zoster and simplex, oedema and surgery will also reduce sensation. Congenital causes of corneal anaesthesia include corneal dystrophy and Riley-Day syndrome, and congenital corneal anaesthesia without an associated syndrome, which is presumed to be due to hypoplasia of the ophthalmic division of the trigeminal nerve. Systemic disease such as diabetes, myotonic dystrophy, scleroderma, and vitamin deficiencies are important causes of corneal anaesthesia, which can often be overlooked. Forty five per cent of diabetic patients had a degree of corneal hypoaesthesia when examined in a study of 130 patients published by Osman et al. There is little or no relation between the age of a diabetic patient and the observed decrease in corneal sensitivity. However, corneal sensitivity thresholds do rise in the first few years of diabetes.

It has been suggested that diabetic peripheral neuropathy was due to occlusive vascular disease and nerve infarctions. More recent evidence suggests that common symmetrical distal polyneuropathy is due to segmental demyelination with associated or secondary axonal degeneration.

Recent studies show that there may be a potential to use topical neurotrophic growth factors in the treatment for neurotrophic corneal ulceration. In a study of 14 eyes Lambiase et al treated neurotrophic corneal ulcers with topical nerve growth factor for 2 weeks. Corneal healing began within 1-14 days and all patients had complete healing of their ulcers after 10 days to 6 weeks.

Corneal anaesthesia may often be overlooked unless it is profound. It can be tested with cotton wisps or an anaesthesiometer. It is important to test the corneal sensation subjectively and objectively and also to test all four quadrants of the cornea.

This case raises three important points:

- Chronically irritable eyes should have their corneal sensation tested. Corneal anaesthesia is easily overlooked by non-ophthalmologists and ophthalmologists alike, and the anaesthetic cornea represents a real risk of profound visual loss from trauma and infection.
- Reduced corneal sensation can be a presenting feature of diabetic neuropathy. This woman had no other symptoms or signs of neuropathy apart from her corneal anaesthesia. If a diabetic develops a red or irritable eye, corneal sensation should be tested.
- There is some promise for the future in that this neurotrophic corneal ulceration may potentially be treated by the use of topical neurotrophic growth factors. The research into this project continues and is currently not in clinical practice.

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- Chronically irritable eyes should have their corneal sensation tested. Corneal anaesthesia is easily overlooked by non-ophthalmologists and ophthalmologists alike, and the anaesthetic cornea represents a real risk of profound visual loss from trauma and infection.
- Reduced corneal sensation can be a presenting feature of diabetic neuropathy. This woman had no other symptoms or signs of neuropathy apart from her corneal anaesthesia. If a diabetic develops a red or irritable eye, corneal sensation should be tested.
- There is some promise for the future in that this neurotrophic corneal ulceration may potentially be treated by the use of topical neurotrophic growth factors. The research into this project continues and is currently not in clinical practice.

COMMENT

Corneal anaesthesia can be physiological or pathological. Corneal sensation decreases with age, and is lower in females, especially premenstrually. Contact lens wear, and infection by herpes zoster and simplex, oedema and surgery will also reduce sensation. Congenital causes of corneal anaesthesia include corneal dystrophy and Riley-Day syndrome, and congenital corneal anaesthesia without an associated syndrome, which is presumed to be due to hypoplasia of the ophthalmic division of the trigeminal nerve. Systemic disease such as diabetes, myotonic dystrophy, scleroderma, and vitamin deficiencies are important causes of corneal anaesthesia, which can often be overlooked. Forty five per cent of diabetic patients had a degree of corneal hypoaesthesia when examined in a study of 130 patients published by Osman et al. There is little or no relation between the age of a diabetic patient and the observed decrease in corneal sensitivity. However, corneal sensitivity thresholds do rise in the first few years of diabetes.

It has been suggested that diabetic peripheral neuropathy was due to occlusive vascular disease and nerve infarctions. More recent evidence suggests that common symmetrical distal polyneuropathy is due to segmental demyelination with associated or secondary axonal degeneration.

Recent studies show that there may be a potential to use topical neurotrophic growth factors in the treatment for neurotrophic corneal ulceration. In a study of 14 eyes Lambiase et al treated neurotrophic corneal ulcers with topical nerve growth factor for 2 weeks. Corneal healing began within 1-14 days and all patients had complete healing of their ulcers after 10 days to 6 weeks.

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- Chronically irritable eyes should have their corneal sensation tested. Corneal anaesthesia is easily overlooked by non-ophthalmologists and ophthalmologists alike, and the anaesthetic cornea represents a real risk of profound visual loss from trauma and infection.
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- There is some promise for the future in that this neurotrophic corneal ulceration may potentially be treated by the use of topical neurotrophic growth factors. The research into this project continues and is currently not in clinical practice.
Adjunctive therapy including cryotherapy, treatment of conjunctival and corneal transplantation, and mitomycin C in the surgical excision, autolimbal transplantation. (D) The lesion has not recurred 20 months after mitomycin C therapy. Arrows indicate the extent of the lesion. Histology of corneal scrapes showed epithelial cell failure with consequent corneal epithelial problems, requiring (auto) stem cell transplantation. Topical cytotoxic agents like 5-fluorouracil and mitomycin C have been used successfully in the treatment of CIN.3 However, inhibition of limbal stem cell division with mitomycin C is thought to notably impair physiological corneal epithelial replacement.4 We report the successful use of prolonged mitomycin C after autolimbal transplantation in the treatment of recurrent CIN.

CASE REPORT
A 37 year old white woman presented in February 1995 with a 6 month history of a fleshy white lesion in the corner of her right eye. In the past she had experienced intermittent episodes of bilateral sore, red eyes. Her visual acuities were 6/18 with pinhole in the right eye and 6/5 in the left eye. Ocular examination revealed a whitish elevated lesion on the right limbal conjunctiva from 7 to 11 o’clock extending almost to the central cornea (Fig 1A).

The patient underwent excision biopsy of the lesion. Intraoperatively the exposed bed of the lesion was treated with absolute alcohol and the conjunctival edge with two cycles of cryotherapy. Postoperatively, a bandage contact lens was inserted and she was treated with topical preservative-free antibiotics and steroids. One month later the corneal and conjunctival epithelium had healed completely and vision improved to 6/12. Histology confirmed the lesion to be conjunctival and corneal intraepithelial neoplasia (Fig 1B).

Two months postoperatively, she developed a recurrence in the form of two central, abnormal areas of corneal epithelium. These were treated by scraping and application of absolute alcohol to the bed of the lesion. Histology identified these lesions to be severely dysplastic corneal epithelial cells. Subsequently she developed right limbal stem cell failure resulting in recurrent episodes of filamentary and punctate keratitis and a reduction of visual acuity to 6/18. Histology of corneal scrapes showed epithelial cells and goblet cells. In February 1998 she underwent a right autologous limbal transplant and vision improved to 6/9.

Two months later she had a recurrence of CIN involving one third of the cornea (Fig 1C). This was treated with four cycles of 0.04% mitomycin C applied four times a day, for 10 days at a time. The tumour regressed completely in 3 months. Twenty months later she remains asymptomatic with a clear cornea (Fig 1D).

COMMENT
Mitomycin C is a cytotoxic alkylating agent which inhibits DNA synthesis and is, therefore, most effective against rapidly dividing cells. While it has been used to treat recurrent CIN, there has been concern about the effects of mitomycin C on the limbal stem cells and the integrity of the corneal epithelium.5 In our patient the grafted limbal stem cells and corneal epithelium remained healthy in spite of the significant dose of mitomycin C required to treat her recurrent CIN.

To the best of our knowledge this is the first reported case of topical mitomycin C used successfully against CIN after autolimbal transplant, despite the prolonged duration of application (40 days).

The authors would like to thank Miss April Powell-Richards and Professor J Lowe for their help with the illustrations.

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Accepted for publication 24 January 2001


Bilateral granulomatous uveitis in association with common variable immunodeficiency

EDITOR,—We report a case of bilateral granulomatous uveitis, which prompted extensive diagnostic review in a 20 year old woman with a long history of recurrent infection and idiopathic thrombocytopenia. Investigations allowed the definitive diagnosis of common variable immunodeficiency with granulomas (granulomatous antibody deficiency syndrome). To our knowledge this is the first reported case of granulomatous uveitis in
association with granulomatous antibody deficiency (GAD). We discuss the features of GAD, and how it may be distinguished from sarcoidosis.

CASE REPORT
A 20 year old woman presented with sudden onset blurred vision. Examination revealed a bilateral granulomatous uveitis with posterior subcapsular cataracts and anterior chamber cells. Two weeks later she developed bilateral optic disc swelling with multifocal areas of choroidal pallor in her left eye (Fig 1). There was no viremia or evidence of retinal vascular changes. Her uveitis settled on topical steroids and she maintained vision of 6/6 in the right eye and 6/9 in the left. The working diagnosis was sarcoidosis.

However, serum angiotensin converting enzyme (ACE) was not elevated and magnetic resonance imaging (MRI) showed no evidence of neurosarcoid. Plain chest films and high resolution computed tomography of the thorax revealed bilateral hilar and paratracheal lymphadenopathy, with air space shadowing and ill defined nodular opacities in both lower zones. Bronchial biopsies, obtained at fiberoptic bronchoscopy, showed inflammation of the bronchial epithelium consistent with bronchial pneumonia. No granulomata were seen.

As a child she had suffered from recurrent chest infections, with severe neutropenia and thrombocytopenia. By 6 years of age she had developed splenomegaly and widespread lymph node enlargement. Kveim and Mantoux tests were both negative. Investigations for lymphoma over several years were negative. At 13 she underwent splenectomy for idiopathic thrombocytopenia. No definitive diagnosis was established for her in childhood.

She suffered an episode of parotitis and then, at 18, infectious discitis of the lumbar spine requiring intravenous antibiotics. This precipitated a drug induced hepatitis with thrombocytopenia. By 6 years of age she had developed splenomegaly and widespread lymph node enlargement. Kveim and Mantoux tests were both negative. Investigations for lymphoma over several years were negative. At 13 she underwent splenectomy for idiopathic thrombocytopenia. No definitive diagnosis was established for her in childhood.

She suffered an episode of parotitis and then, at 18, infectious discitis of the lumbar spine requiring intravenous antibiotics. This precipitated a drug induced hepatitis with thrombocytopenia, which became infected, resulting in a chronic, low grade peritonitis. Epstein-Barr virus, cytomegalovirus, and parvovirus serology was normal. Histological review showed that the spleen had little white pulp and few germinal centres (Fig 2), while lymph nodes showed multiple, small, non-caseating granulomata and few germinal centres (Fig 2). Immunological investigation showed all immunoglobulin levels were reduced, with IgG 0.1 g/l (normal 5.4–16.1 g/l), IgA <0.1 g/l (normal 0.8–2.8 g/l), and IgM 1.0 g/l (normal 0.5–1.9 g/l). Lymphocyte subclasses and bone marrow biopsy were normal.

The diagnosis of common variable immunodeficiency syndrome (CVIS) with granulomas was made. Her exacerbations of idiopathic thrombocytopenia responded to immunoglobulin therapy.

COMMENT
CVIS is a primary immunodeficiency characterised by decreased or absent levels of immunoglobulins. Patients suffer from recurrent bacterial infections and respiratory failure is the principal cause of death. Autoimmune disease is seen in approximately 10% of cases, especially thrombocytopenia, haemolytic anaemia, and rheumatoid arthritis; 25% have splenomegaly and approximately one third have non-caseating granulomata in sites such as the liver, lungs, spleen, and lymph nodes. This variant is called granulomatous antibody deficiency (GAD). A sarcoid-like syndrome may be seen in 7.5% of patients.

To our knowledge this is the first reported case of bilateral granulomatous uveitis in association with GAD. As in sarcoidosis, serum ACE may be elevated if the granuloma burden is high and a Kveim test may be positive. The diagnosis of GAD hinges on the presence of hypogammaglobulinaemia, while in sarcoidosis immunoglobulin levels are normal or raised.

Granulomatous uveitis is often an indicator of systemic disease. When there is a history of recurrent infection or of autoimmune disease, immunoglobulin levels should be measured to exclude the possibility of a treatable immunodeficiency.

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Accepted for publication 13 December 2000

References

A postoperative complication far worse than endophthalmitis: the coexistence of orbital cellulitis

EDITOR.—The coexistence of endophthalmitis and orbital cellulitis in one individual is often a result of endogenous complications, such as metastatic septicaemia or infiltration from a neighbouring orbital infection. However, the coexistence of both these diseases as complications following intraocular or extraocular surgery is very rarely recognised and has only been reported previously in two patients who underwent radial keratotomy and penetrating keratoplasty. We report a patient who underwent uncomplicated phacoemulsification surgery under sub-Tenon anaesthesia and presented with an acute endophthalmitis and orbital cellulitis, leading to phthisis bulbi despite a good response to prompt treatment.

Figure 1 Composite fundal photograph showing optic disc swelling and multifocal areas of choroidal pallor, representing granulomata.

Figure 2 (Left) Lymph node showing multiple, small, non-caseating granulomas (haematoxylin and eosin, ×125). (Right) Spleen showing little white pulp and few germinal centres (haematoxylin and eosin, ×125).
CASE REPORT

A 77 year old woman with high myopia and left aphakia underwent uncomplicated phacoemulsification surgery of the right eye, and was noted to have coexisting orbital cellulitis.

Figure 1 Patient presented with acute endophthalmitis following uncomplicated phacoemulisation surgery of the right eye, and was noted to have coexisting orbital cellulitis.

Comment

The cause of postoperative endophthalmitis is often a result of inoculation of pathogens directly into the ocular cavity during surgery or indirectly into periocular tissues with subsequent access gained via an open wound. However, the precise mechanism leading to orbital cellulitis from endophthalmitis alone, early recognition and the initiation of aggressive treatment are vital.

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Accepted for publication 31 January 2001


NOTICES

National prevention of blindness programmes and Vision 2020

The latest issue of Community Eye Health (36) discusses national prevention of blindness programmes. For further information please contact Community Eye Health, International Centre for Eye Health, Institute of Ophthalmology, 11–43 Bath Street, London EC1V 9EL. (Tel: (+44) 020 7608 6909/6910/6923; fax: (+44) 020 7250 3207; email: info@second-sight.org.uk or by contacting Dr Lucy Mathen (email address lucymathen@yahoo.com).

Second Sight

Second Sight, a UK based charity whose aims are to eliminate the backlog of cataract blind in India by the year 2020 and to establish strong links between Indian and British ophthalmologists, will be sending volunteer surgeons to India early in 2001. Details can be found at the charity website at www.second-sight.org.uk or by contacting Dr Lucy Mathen (email address lucymathen@yahoo.com).

14th Annual Meeting of German Ophthalmic Surgeons

The 14th Annual Meeting of German Ophthalmic Surgeons will be held in the Münchner Hofgarten, Nuremberg, Germany on 17–20 May 2001. Further details: MCN Medizinische Congress-organisation Nuremberg AG, Zerbstehofstrasse 29, 90418 Nuremberg, Germany (tel: ++49-911-3931621; fax: ++49-911-3931620; email: doerflinger@mcn-nuernberg.de).

European Association for the Study of Diabetic Eye Complications (EASEDEC)

The next meeting of the European Association for the Study of Diabetic Eye Complications (EASEDEC) will be held in Paris, France on 19–20 May 2001. Further details: Colloquium, 12 Rue de la Croix Faubin, 75 557 Paris Cedex 11, France (tel: +33-1-44 64 15 15; fax: +33-1-44 64 15 10; email: s.mundler@colloquium.fr).

2nd Interdisciplinary Symposium on the Treatment of Autoimmune Disorders 2001

The 2nd Interdisciplinary Symposium on the Treatment of Autoimmune Disorders 2001 will take place on 7–9 June 2001 at the University Hospital, University of Kiel, Kiel, Germany. Further details: Prof Dr Med Michael Sticherling, Department of Dermatology, University of Kiel, Schittenhelmstrasse 7, D-24105 Kiel, Germany (tel: +493 957 1511; email: msticherling@dermatology.uni-kiel.de).

European Intensive Program of Disease and Imaging of the Fundus

The European Intensive Program of Disease and Imaging of the Fundus will be held 2–12 July 2001 at the Clinique Ophthalmologique Universitaire, 40 avenue de Verdun, 94010 Créteil, France. Further details: Béatrice Rousseau (tel: (33 1) 45 17 52 22; fax: (33 1) 45 17 52 60).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series

A course entitled "Obstetrical and Gynecological Ultrasound" will be held in New York City, NY, on 24–26 August 2001. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Sweitzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: ssbessling@aium.org).

14th World Congress of the International Society for Laser Surgery and Medicine

The 14th World Congress of the International Society for Laser Surgery and Medicine is to be held on the 27–30 August 2001 at Sri Ramachandra Medical College and University Hospital, Chennai, India. The American Society of Lasers in Medicine and Surgery has
indicated that it will designate the 14th World Congress of ISLSM as its society’s co-sponsoring meeting. A pre-conference course and separate sessions in ophthalmology will be held as a part of this international meeting. Further details: Dr B Krishna Rau, President, 14th World Congress of the International Society for Laser Surgery and Medicine, Department of Surgery, D2 Ward, Sri Ramachandra Medical College and Research Institute, Porur, Chennai - 600 116, India (tel: 91-44-4765856, 4768027-28, 8527776, 8594804; fax: 91-44-8594578, 4767008; email: krishnar@giasm01.vsnl.net.in and website: www.medindia.net/islsm2001).

**31st Cambridge Ophthalmological Symposium**
The 31st Cambridge Ophthalmological Symposium will be held 3–5 September 2001 at St John’s College Cambridge. The subject is Retinal Detachment. Further details: COS Secretariat, Cambridge Conferences, The Lawn, 33 Church Street, Great Shelford, Cambridge CB2 5EL, UK (tel: 01223 847464; fax: 01223 847465; email: b.ashworth@easynet.co.uk).

**1st Asia Pacific Forum on Quality Improvement in Health Care**
The 1st Asia Pacific Forum on Quality Improvement in Health Care will be held from 19–21 September 2001 in Sydney, Australia. Presented by the BMJ Publishing Group (London, UK) and Institute for Healthcare Improvement (Boston, USA), with the support of the Commonwealth Department of Health and Aged Care (Australia), Safety and Quality Council (Australia), NSW Health (Australia) and Ministry of Health (New Zealand). Further details: quality@bma.org.uk; fax +44 (0) 7383 6869.

**41st St Andrew’s Day Festival Symposium on Therapeutics**
The 41st St Andrew’s Day Festival Symposium on Therapeutics will be held on 6–7 December 2001 at the Royal College of Physicians of Edinburgh. Further details: Ms Eileen Strawn, Symposium Co-ordinator (tel: 0131 225 7324; fax: 0131 220 4393; email: e.strawn@rcpe.ac.uk; website: www.rcpe.ac.uk).

**4th International Conference on the Adjuvant Therapy of Malignant Melanoma**
The 4th International Conference on the adjuvant therapy of malignant melanoma will be held at The Royal College of Physicians, London on 15–16 March 2002. Further details: Conference Secretariat, CCI Ltd, 2 Palmerston Court, Palmerston Way, London SW8 4AJ, UK (tel: + 44 (0) 20 7720 0680; fax: + 44 (0) 20 7720 7177; email: melanoma@confcomm.co.uk; website: www.confcomm.co.uk/Melanoma).

**XXIXth International Congress of Ophthalmology**
The XXIXth International Congress of Ophthalmology will be held on 21–25 April 2002 in Sydney, Australia. Further details: Congress Secretariat, C/- ICMS Australia Pty Ltd, GPO Box 2609, Sydney, NSW 2001, Australia (tel: +61 2 9241 1478; fax: +61 2 9251 3552; email: ophthal@icmsaust.com.au; website: www.ophthalmology.aust.com).

**International Society for Behçet’s Disease**
The International Society for Behçet’s Disease was inaugurated at the 9th International Congress on Behçet’s Disease. Professor Shigeaki Ohno represents the ophthalmology division (Department of Ophthalmology and Visual Sciences, Hokkaido University Graduate School of Medicine, Sapporo, Japan: tel: +81-11-716-1161 (ext 5944); fax +81-11-736-0952; email: sohno@med.hokudai.ac.jp). The 10th International Congress on Behçet’s Disease will be held in Berlin 27–29 June 2002. Further details: Professor Ch Zouboulis (email: zoubbere@zedat.fu-berlin.de).