Comment

Many cases of suprachoroidal haemorrhage previously described had underlying age-related macular degeneration and disciform scars.[1–3] Although PCV may cause subretinal haemorrhage, the authors are unaware of any previous reports on PCV causing massive and rapid suprachoroidal haemorrhage leading to secondary angle closure glaucoma. This may be because the diagnosis of PCV has increased in recent years with the advent of ICG angiography.

Spontaneous suprachoroidal haemorrhage[1–5] or haemorrhagic retinal detachment,[6] if sufficiently anterior and large, may cause forward displacement of the lens–iris diaphragm, occluding the angles and causing secondary angle closure glaucoma. This may occur in patients with or without systemic anticoagulation or associated bleeding diathesis. It is believed that shearing forces acting on blood vessels as they enter the suprachoroidal space rupture the vessels and cause suprachoroidal haemorrhage.[3] Systemic risk factors such as advanced age, hypertension, and arteriolosclerosis increase fragility of these vessels and hence their susceptibility to mechanical shearing forces, such as a valsalva manoeuvre. Our patient did not have any known predisposing factors for a suprachoroidal bleed — she was not taking anticoagulants, and was not straining or coughing at the time the massive suprachoroidal haemorrhage occurred.

The visual prognosis for patients with angle closure glaucoma secondary to suprachoroidal haemorrhage is guarded despite both surgical and medical therapy.[1–4,7] Our patient, who presented in an advanced stage of visual loss, had a recurrent suprachoroidal bleed but was eventually free of pain and was therefore managed conservatively.

Our report illustrates that PCV may bleed significantly, resulting in suprachoroidal haemorrhage, which can cause secondary angle closure. Management is difficult with poor visual prognosis. Therefore, it is important for clinicians managing patients with PCV to be aware that suprachoroidal haemorrhage is a potentially vision-threatening outcome of this condition.

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CSH Tan, H-T Wong, B-A Lim, OK Hee and TH Lim

Department of Ophthalmology, The Eye Institute at Tan Tock Seng Hospital, National Healthcare Group, Singapore, Singapore

Correspondence: CSH Tan,
Tel: +65 63577726;
Fax: +65 63577718.
E-mail: Colintan_eye@yahoo.com.sg

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Sir,

Intrastromal corneal limbal epithelial implantation cyst

Corneal cysts are uncommon. We report a case of an intrastromal corneal cyst following squint surgery and present a simple surgical technique used to successfully manage it.

Case report

A 10-year-old girl presented with a slowly progressive painless left corneal–limbal mass. Her visual acuity was 6/6 in both eyes. In the left eye, temporally there was a whitish cystic swelling extending from the limbus to the para-central cornea, in the mid-stromal plane. When the patient was standing, the lesion simulated the

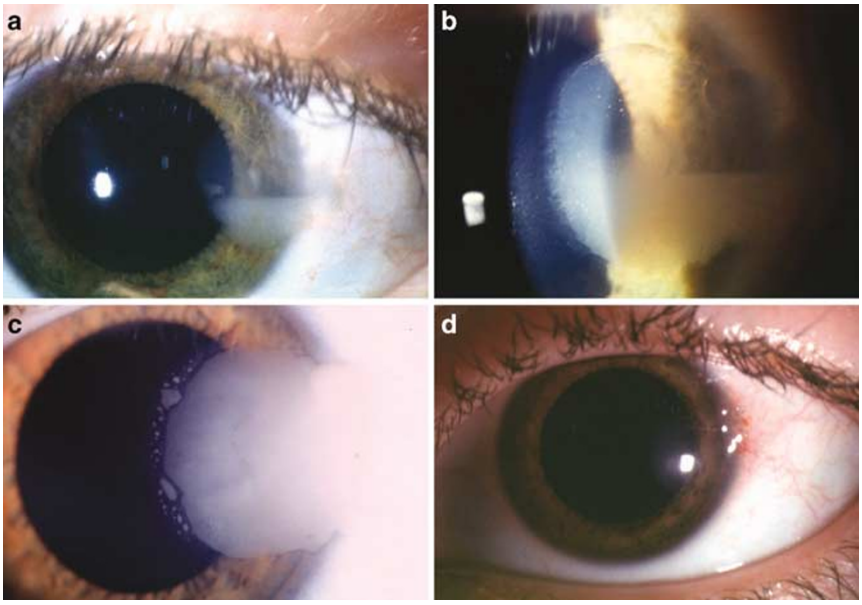

Figure 1 (a) Slit-lamp photograph of the left corneal lesion. The cell debris collecting inferiorly and simulating a hypopyon can be seen. (b) At higher magnification, the cellular nature of the viscous fluid and surrounding stromal haze may be noted. (c) Preoperative slit-lamp photograph showing the growth of the lesion, increasing opacification, and its further encroachment on the pupillary margin. (d) Postoperative slit-lamp photograph showing mild temporal stromal haze but no recurrence of the cyst.

appearance of a hypopyon in the inferior part of the cyst (Figure 1a and b).

She had been seen in the same institute for exotropia treated primarily with bilateral lateral rectus recessions 3 years earlier. Surgical records showed that, during the squint surgery, a 5/0 silk on a cutting needle was used at the limbus as a traction suture.

A diagnosis of an epithelial inclusion cyst secondary to epithelial infiltration of the stroma was made. Over the next 2 years, the lesion grew in size to 5 mm vertically by 5.2 mm horizontally, had become more opaque, and was encroaching on the pupillary margin (Figure 1c). Although vision was unaffected, the lesion became a cosmetic blemish and the patient and her parents requested surgical intervention.

Surgical procedure

A 21-gauge needle was used to puncture the cyst at the limbal margin and 0.1 ml of an opaque viscous fluid was carefully aspirated and sent to pathology for examination. A 15° blade was used to make a small arcuate incision inside the limbus to mid-stromal level. Extensive irrigation of the cyst cavity with balanced salt solution was carried out. The incision was closed with interrupted 10.0 Vicryl sutures to include both anterior and posterior lamellae of the cornea.

Microscopy of the aspirate showed a mixture of degenerate cell debris and epithelial cells together with lymphocytes, occasional polymorphs, and scattered macrophages.

The patient's recovery was uneventful. Minimal stromal haze was noted temporally but visual acuity was maintained (Figure 1d). Six months following surgery, there was no evidence of recurrence of the cyst.

Comment

Corneal cysts were first described by Appia in 1853.[1,2] Reed and Dohlman[3] reviewed a further 30 cases in the literature in 1971. In 2001, Mifflin *et al*[4] reported a further 16 cases. The majority of reported cases have occurred in children[3,4–6] although a corneal cyst has been reported in a man of 70 years.[3]

Corneal–limbal cysts may be congenital or traumatic in origin. Earlier authors suggested that congenital cysts were an extension of the anterior chamber[7] or represented outgrowths of the canal of Schlemm.[6] Both congenital and traumatic cysts are now believed to be a result of the displacement of epithelial cells into the substance of the cornea. Cysts have been reported following routine cataract surgery,[3] lamellar keratoplasty,[8] and squint surgery.[4,9]

A needle (such as that used for a traction suture) passing through the limbus can create a cleavage plane and introduce epithelial cells into the corneal stroma. Unlike an injury of the central corneal, injuries at the limbus may involve a corneal epithelial stem cell source,

which may supply a constant source of cells to proliferate and migrate into the cleavage plane.

Presentation is usually with an obvious lesion noted by the patient or by a parent. The cysts are usually circular or oval and may be loculated.[3] As in our case, a level comprising necrotic epithelial cells in the cyst cavity may be present resembling a hypopyon.[3] The cysts are cavities filled with necrotic debris and lined by stratified epithelium.[3,4,8,9] Microscopy of aspirated cyst contents shows degenerate cell debris and epithelial cells.[4,5]

With regard to treatment options, it has been felt that corneal cysts not affecting vision should be managed conservatively and surgical intervention should only be undertaken in progressive cases.[3] Simple drainage procedures or aspiration have not been shown to have long-lasting benefit and recurrence is common.[3,5] Cytodestruction with chemical cautery using 1% iodine followed by irrigation with cocaine and with 10% acetic acid[3,6] has been described as has the use of electrocautery[3] and cryotherapy.[4] This can be combined with suturing of the cyst cavity[3,6] or excision of the anterior cyst wall.[3,5] In advanced cases, a lamellar corneal graft[5,9]or penetrating keratoplasty may be required.[8]

The technique we employed was simple to perform and no toxic chemicals were required. Following drainage of the cyst, the positioning of closely lined sutures to close a small wound ensured adequate fibrosis and kept the cyst walls closely opposed preventing recurrence.

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PR Bhatt and K Ramaesh

Tennent Institute of Ophthalmology, Gartnavel General Hospital, Great Western Road G12 OYN, Glasgow, UK

Correspondence: PR Bhatt,
Tel: +44 141 211 1039;
Fax: +44 141 211 2054.
E-mail: priyarbhatt@hotmail.com

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Sir,

Eyelid lymphoma in a patient with multiple lipomatosis

Lipomas are common benign soft-tissue tumours of adipose tissue.[1] Lymphomas are tumours of proliferating lymphocytes and in the adnexal region are commonly non-Hodgkin's B-cell lymphomas.[2] We report a patient with multiple lipomas and a suspicious eyelid mass.

Case report

A 58-year-old male was referred to the oculoplastic clinic for assessment regarding left upper lid mass. The mass had been present for 2 years and slowly increasing in size. The patient has a history of multiple lipomas elsewhere on the body and was referred with a provisional diagnosis of left upper lid lipoma (Figure 1). On examination, a firm mass in the medial half of left upper lid with no lymph node enlargement was noted. The visual acuity was 6/9 in both eyes. Biopsy revealed the mass to be confined to the eyelid. Histopathology showed connective tissue infiltrated by small–medium lymphocytes in a follicular pattern (Figure 2). Immunohistochemistry confirmed diagnosis of follicular lymphoma. The patient was referred to haematology team for staging and further treatment.

Comment

Ocular adnexal lymphomas represent 6–8% of all orbital tumours.[2] Non-Hodgkin's B-cell type constitutes in excess of 95% of adnexal lymphomas with the remaining being T-cell lymphomas, Burkitt's lymphoma, or rarely Hodgkin's lymphoma. Follicular lymphoma is one of the most common variants in adnexal lymphomas after extranodal marginal zone B-cell subtype.[3] These lymphomas exhibit a nodular pattern of growth, and on immunohistochemistry neoplastic follicle centre cells are positive for CD10, Bcl-2, and Bcl-6 antigens.[4] Follicular lymphomas are often slow growing tumours and indolent in comparison to other lymphoma variants such