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Sir,
Re 'Isolated eyelid edema in Melkersson–Rosenthal syndrome: a case series'

Rawlings *et al*¹ have reported on a series of five patients with isolated eyelid edema and have made the diagnosis of Melkersson–Rosenthal syndrome on the basis of granulomatous inflammation. Melkersson–Rosenthal syndrome is described as a granulomatous disease with the triad of facial palsy, facial edema, and a fissured tongue, although the complete triad is reported to be seen in only 25% of cases.²

We have recently reported on a series of 15 patients with chronic eyelid edema, and in 9 of these cases (60%) there was an associated diagnosis of acne rosacea.³ Granulomatous inflammation was present in some of these patients, and this has been reported before in the presence of acne rosacea.⁴ Indeed, acne rosacea and Melkersson–Rosenthal syndrome have some overlap in their clinical and pathological features and both are classified as granulomatous dermatopathies. The illustrations of Cases 1 and 2 in the series of Rawlings *et al*¹ show facial features that would be consistent with acne rosacea, with rhinophymatous change and thickened glabellar skin. I suspect these two illustrated patients do indeed have acne rosacea rather than Melkersson–Rosenthal syndrome, and it would be of interest to know whether any of the other three patients in the series also showed features of rosacea.

It is likely that Melkersson–Rosenthal syndrome is over diagnosed when the other features of the syndrome are absent, and many of the reported cases of eyelid edema as the only feature of the syndrome are more likely to have acne rosacea as the underlying cause of their eyelid edema. Such phymatous change in the eyelid was certainly the commonest cause in our series, which to date is the largest published series of chronic eyelid lymphedema.

Conflict of interest

The author declares no conflict of interest.

References

- 1 Rawlings NG, Valenzuela AA, Allen LH, Heathcote JG. Isolated eyelid edema in Melkersson–Rosenthal syndrome: a case series. *Eye* 2012; **26**: 163–166.
- 2 Chen C, Huilgol SC, James C, Selva D. Melkersson–Rosenthal syndrome presenting with upper lid edema and facial palsy. *Can J Ophthalmol* 2002; **37**: 361–363.
- 3 Chalasani R, McNab AA. Chronic lymphedema of the eyelid: case series. *Orbit* 2010; **29**: 222–226.
- 4 Lai TZ, Leibovitch I, James C, Huilgol SC, Selva D. Rosacea lymphoedema of the eyelid. *Acta Ophthalmol Scand* 2004; **82**: 765–767.

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Sir,
Response to Dr McNab

We thank Dr McNab¹ for his comments on our report of isolated eyelid edema in Melkersson–Rosenthal Syndrome (MRS).² He suggests that our cases are better considered examples of acne rosacea, and cites his own study³ and the case report of Lai *et al*⁴ in support of this.

In Dr McNab's case series, histopathological examination of eyelid skin from five patients with a clinical diagnosis of acne rosacea and chronic eyelid edema showed some degree of granulomatous inflammation in three specimens.³ The granulomas were not illustrated but were described as 'poorly formed' (case 4), 'single' (case 11) and 'surrounding dilated lymphatics' (case 15). Lai *et al*⁴ also referred to the presence of 'ill-defined perivascular granulomas' but did not illustrate them. Other studies of chronic eyelid edema in rosacea did not mention dermal granulomas.^{5,6} In none of our cases was rosacea felt to be the primary underlying cause, either clinically or histopathologically.

In our practice, we do not regard poorly defined granulomas as indicative of any specific diagnosis. Granulomatous rosacea is typically characterised by a tuberculoid (necrotising) or sarcoid-like response, possibly to the contents of hair follicles. In our series, the granulomas were neither tuberculoid nor sarcoid-like but were sharply defined, perivascular, and perilymphatic, often with an intralymphatic component. In addition, and illustrated in our paper, discrete granulomas were identified in orbicularis muscle and anterior orbital soft tissue, which does not appear to have been described in rosacea.

Dr McNab may be correct in saying that MRS is over diagnosed in cases of isolated eyelid edema.¹ Nevertheless, the clinico-pathological pattern that we and other authors have ascribed to monosymptomatic MRS appears quite distinct. Until our understanding of the etiology and pathogenesis of oro-facial granulomatosis, of which MRS is one part, increases, we see no justification for regarding these cases as a form of granulomatous rosacea.

Conflict of interest

The authors declare no conflict of interest.