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Sir,

Topical and intralesional interferon therapy for recurrent lacrimal papilloma

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Introduction

Papillomas of the lacrimal sac and canaliculus are an uncommon cause of epiphora. Surgical excision with adjunctive cryotherapy is the standard treatment, but results are poor, with multiple recurrences.¹ We present a case of recurrent lacrimal sac papilloma, treated successfully with topical and intralesional interferon alfa-2b.

Case report

A 10-year-old boy was referred with a 2-year history of right epiphora. The left lacrimal outflow system was freely patent, but the right was highly resistant to syringing. A Dacryocystogram (DCG) was requested and he was listed for a Canaliculo-Dacryocystorhinostomy (CDCR) with intubation. A week later, he presented with bloody tears, and epistaxis. Clinical examination and nasoendoscopy were normal. The right nasolacrimal duct was narrow, but patent, with no demonstrable filling defect on the DCG, and the CT scan was normal.

At the time of surgery, multiple papillomata were found within the sac and common canaliculus. Complete excision was performed and the rhinostomy completed. Histology confirmed lacrimal sac papillomas and no evidence of dysplasia. DNA typing confirmed Human Papilloma Virus (HPV) subtype 11. Four months later, he had a recurrence, growing out of the upper canaliculus. This was excised after performing a canaliculotomy, and cryotherapy applied to the base. Histological examination again revealed a lacrimal system papilloma, but with moderate epithelial dysplasia (Figure 1). Two months later there was a second recurrence, which was again excised (Figure 2), but the papilloma reappeared after 3 months.

The patient refused further surgery, and requested alternative therapeutic options. After obtaining informed consent, topical interferon alfa-2b 1 million units/ml four times a day was prescribed. The papilloma dramatically reduced in size within 3 weeks. To augment the effect of topical treatment, a single injection of 3 million-units per 1 ml of interferon alpha-2b was given into the canaliculus. Within one week of the injection, complete clinical resolution was seen (Figure 2). Topical treatment was given for a total duration of 2 months. The only adverse effect seen was a transient, moderate follicular conjunctivitis (Figure 1), during treatment. At 12 months follow-up, the patient remains symptom-free and patent to syringing.

Comment

Many therapeutic options are available for lacrimal papillomas. However, the results have been disappointing.¹ Complete surgical excision with adjunctive cryotherapy is currently the standard treatment. Adjunctive cryotherapy has not been proven to be effective in preventing recurrences, and may lead to stenosis of the lacrimal passages. Interferons are part of the human body's natural defence mechanism against tumours and viruses. Interferons exert their

Figure 1 Epithelial dysplasia in papilloma and follicular conjunctivitis following interferon drops.

Figure 2 Before and after treatment appearance of papilloma.

anti-viral action by preventing the replication of latent virus in the tissues.²

Recombinant Interferon alfa-2b is used for various forms of leukaemia, chronic hepatitis, and in the treatment of laryngeal papillomas caused by HPV.³ Its safety for ocular use has been demonstrated in viral keratitis⁴ and in conjunctival malignancies.^{5,6} Although systemic (intramuscular) therapy has been described for conjunctival papillomas,⁷ topical interferon use for primary or recurrent lacrimal papillomas has not been reported previously.

Topical interferon therapy achieved complete resolution in the case described. A similar beneficial effect on conjunctival papillomas has been reported with another immunomodulatory agent, Cimetidine.⁸ Immunomodulatory agents may help achieve lasting remission in viral papillomas, with maintenance or repeat therapy for recurrences.⁷ Local administration of interferon would avoid systemic side effects. Longer term studies are required to determine the long-term efficacy of interferon treatment.

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Sir,

Acute suprachoroidal haemorrhage with acute angle closure glaucoma as a presenting sign of chronic myelomonocytic leukemia

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Spontaneous suprachoroidal haemorrhage is very rare.^{1–3} We describe a case of acute suprachoroidal haemorrhage presenting as acute angle closure glaucoma. The haemorrhage was eventually found to be secondary to chronic myelomonocytic leukemia (CMML).

Case report

A 79-year-old man presented with a 2 days' history of severe pain and decreased left visual acuity. The pain was relieved by the use of simple analgesics. He had a past history of poor vision in both eyes secondary to age-related macular degeneration, diagnosed 8 years previously. He had hypothyroidism, hypertension and chronic renal failure secondary to prostatism. There was nothing else of note in his history.

On examination, his right visual acuity was 6/60 and his left visual acuity was perception of light (PL). The left conjunctiva was injected, corneal oedema and fine keratic precipitates were present, but there was no hypopyon. His anterior chamber was shallow and the pupil was dilated with moderate cataract. His right intraocular pressure measured 16 mmHg and the left measured 54 mmHg. The right iridocorneal angle was wide open with the ciliary body clearly seen. No view of the left angle was obtained. He had dry age-related macular degeneration in the right eye. An ultrasound B-scan of the left eye indicated a dense vitreous haemorrhage with haemorrhagic choroidal detachment (Figure 1).

The patient was admitted and commenced on intensive topical steroids, apraclonidine and latanoprost and intravenous acetazolamide. His intraocular pressure reduced to 34 mmHg. Oral acetazolamide was started. His anterior chamber remained shallow. A Yag laser peripheral iridectomy