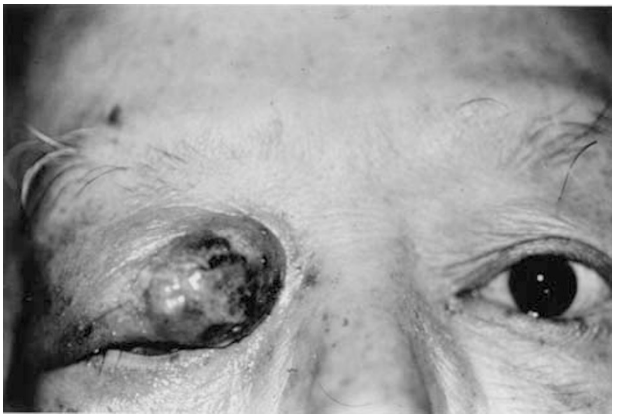

Figure 2 A 3 × 3-cm nodular mass with central hemorrhage and ulceration on the medial aspect of the right upper eyelid. The inflammatory tumor initially mimicked an hordeolum.

patients with documented malignant hematologic disorders for a second malignancy.

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Sir,

Squamous cell carcinoma of the eyelid in a renal transplant patient

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Immunosuppressive therapy following organ transplant surgery is known to significantly increase the incidence of cutaneous squamous cell carcinoma (SCC).[1–5] One Dutch study[6] found the incidence of SCC to be 250 times greater than that of the general population and that the risk increased with the duration of immunosuppression. In their study approximately 7% of transplant patients had developed a SCC after 10 years of treatment, this figure increased to 35% after 20 years.[6] SCC in immunosuppressed patients most commonly affects the sun-exposed areas of the body and tends to be more aggressive that those lesions in immunocompetent individuals.[2–5] We report the case of a renal transplant patient who developed an aggressive SCC on the right upper eyelid.

Case report

A 35-year-old renal transplant patient was referred to our eye department with a large lesion affecting the right upper eyelid (Figure 1). The lesion had developed rapidly over the previous 8 weeks, reaching approximately 25 mm in size. An incisional biopsy prior to referral, reported the lesion to be a squamous

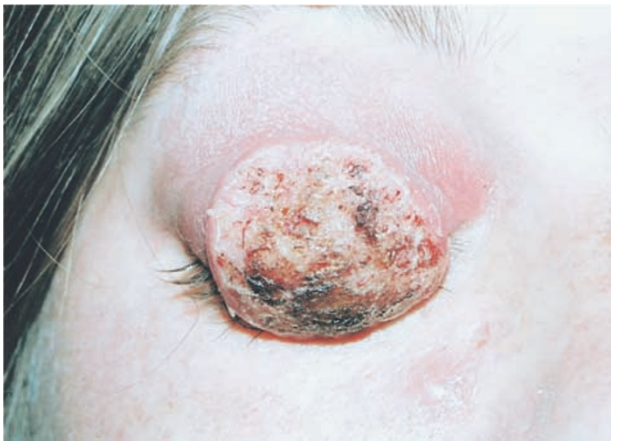

Figure 1 The large squamous cell carcinoma of the right upper eyelid.

cell carcinoma. There were no other lid or skin lesions at presentation and no previous history of skin cancer.

The patient had undergone renal transplant surgery 12 years prior to presentation and was on an immunosuppressive regime of 75 mg of azothiopine and 100 mg of cyclosporin. Other medication consisted of warfarin as prophylaxis against recurrent deep vein thrombosis and pulmonary emboli, which she had suffered from in the past, and also hydralazine and atenolol to control her blood pressure. Prophylactic trimethoprim was taken daily to prevent urinary tract infections.

An urgent excisional biopsy of the lid lesion was performed. Histology confirmed this to be a squamous cell carcinoma with complete clearance. The right upper eyelid was reconstructed using a Cutler–Beard procedure, involving the grafting of free auricular cartilage and a lower eyelid skin, muscle and conjunctiva graft (Figure 2).

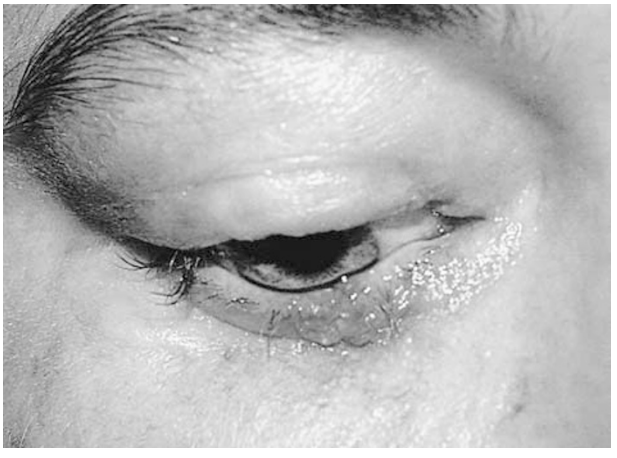

Figure 2 The right upper eyelid following reconstruction.

Discussion

In an immunocompetent individual the incidence of squamous cell carcinoma (SCC) in the periocular region accounts for approximately 9% of all malignant eyelid lesions, with the lower eyelid being more frequently affected than the upper lid.[7] Systemic immunosuppression increases the incidence of cutaneous SCC, with lesions tending to occur in large numbers mainly over sun-exposed areas, such as the head and hands.[4,5] Aggressive SCC of the eyelid in an immunosuppressed patient is however an uncommon occurrence, with only three previous reported cases in the literature,[8,9] all of which involved the lower lid.

The growth of SCC in immunosuppressed transplant patients is usually rapid and can be life threatening when there is marked local tissue invasion and regional lymph node metastasis.[2,5] Treatment is often difficult and recurrence common following excision.[3–5]

Immunosuppressive drugs modify the immune response to prevent graft rejection, in doing so however, they predispose patients to cancer, since the host immune system becomes less effective in eliminating oncogenic viruses, and deleting potentially malignant cell lines.[1,8,9] The most common cancers seen in organ transplant patients are the skin cancers, particularly SCC, which occur approximately 250 times more frequently than in the general population.[6] The ratio of SCC to BCC is altered to such an extent, that the incidence of SCCs outnumber BCCs by a ratio of between 2:1[3] to 3.5:1[10] in transplant recipients compared with a ratio of between approximately 1:4[3] to 1:10[11] in immunocompetent individuals, where BCC is the more common.

Ultra-violet (UV) light exposure is thought to play a key role in SCC development, by causing damage to keratinocyte DNA[5] leading to loss of a cell's growth control and results in tumour formation. Damage may be exacerbated by the photo-oxidative effects of azothioprine metabolites, whilst cyclosporin may increase the risk of skin cancer by photo-sensitising the skin.[2,5]

Human papilloma virus (HPV) DNA is found in many premalignant and malignant skin lesions and is thought to play a role in SCC formation. The exact role HPV plays is however unknown.[2]

Recently retinoid drugs, which are commonly used to treat acne and psoriasis,[3] have been used in an attempt to reduce the incidence of SCC in immunosuppressed individuals. They seem to offer some protection against the formation of new lesions, however once the medication is stopped the benefits appear to be lost.[3] These drugs may play a role in the future management of immunosuppressed patients.

Clinicians and patients should be aware that immunosuppression significantly increases risk of skin cancer, and that any suspicious skin lesion should undergo urgent excision biopsy, in an attempt to prevent development and growth of these aggressive lesions. Patients should be advised to take sensible precautions against UV light exposure, such as wearing sun blocking creams and hats, in an attempt to reduce the risks of developing skin carcinoma.

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Sir,

Surgical management of anterior lenticonus in Alport's syndrome

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Alport's syndrome is a rare basement membrane disorder characterized by progressive hereditary nephritis, sensorineural hearing loss and ocular abnormalities. The inheritance is predominantly X-linked (85%), although it can be autosomal recessive (10%) or autosomal dominant (5%).[1] Homozygote males are usually severely affected but females tend to have a mild form, often with only microscopic haematuria and normal renal function.[1] The ocular abnormalities in the X-linked form are characteristically a dot-and-fleck retinopathy, less often anterior lenticonus and rarely a posterior polymorphous corneal dystrophy.[1,2] Additional ocular abnormalities are not uncommon, including cataracts, posterior lenticonus and retinal detachment.[2]

This case report of a female patient has several unusual features. There was no positive family history, renal function was severely affected and prior to developing visual symptoms, the cause of renal failure was unclear. In addition the ocular features included a unilateral dot-and-fleck maculopathy and bilateral anterior lenticonus, known to occur in approximately 85% and 25% of affected males respectively, but both rarely reported in females with the syndrome.[1]

Case report

A 40-year-old lady was referred by her optometrist with bilateral visual failure and a large myopic shift over a 2-week period. Within this period her refractive status had changed from −7.75DS / −1.25DC × 105 right eye, −6.75DS left eye, to −10.00DS / −1.75DC × 115 right eye, −8.25DS / −0.50DC × 30 left eye.

The patient had no significant past ocular history other than wearing spectacles to correct myopia for many years. Her past medical history however, included bilateral hearing loss for which she wore hearing aids and a previous renal transplant (1994) for renal failure secondary to a 'nephritis' of unknown aetiology. She was on long-term immunosuppressive therapy, including oral steroids. There was no family history of ocular or systemic conditions.

On examination the Snellen visual acuity with