The survival rate of cutaneous melanoma is related to the histological type of tumour and the depth of dermal invasion of the original lesion.[10] In this case, the primary cutaneous melanoma was spindle cell type with a depth of 10 mm. The prognosis is poor [11,12] due to disseminated disease and the poor response to chemotherapeutic regimes. However, the behaviour of melanoma is unpredictable and at times quiescent, resulting in long survival after initial diagnosis and even first onset of metastatic disease as demonstrated in this report.

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Sir,

Fluorescein angiography and patchy skin discoloration: a case report

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Fundus fluorescein angiography is an invaluable and commonly used investigation for the management of various chorioretinal disorders. The complications occurring with this procedure are usually mild or rarely serious.[1] We present the unusual case of a patient who developed patchy yellow discoloration of the skin following intravenous administration of fluorescein sodium.

Case report

A 56-year-old male was referred to us with decreased vision in the right eye of 6 months duration. He had low-grade-B-lymphoma of the central nervous system, for which he underwent surgery combined with radiotherapy and chemotherapy 4 years ago. On examination, best-corrected visual acuities were 6/36 in the right eye and 6/5 in the left eye. He was noted to have macular oedema in the right eye and signs of exudative retinopathy in the left eye. A fundus fluorescein angiogram was arranged to investigate his clinical signs. As part of this procedure, a 22-gauge cannula was inserted into the right antecubital vein. A bolus of 5 ml of 10% sodium fluorescein (Martindale, Essex) was injected. No extravasation or leakage of the dye into the surrounding skin was seen. Fifteen minutes after the injection, multiple areas of patchy yellow skin discoloration were noted on the lateral aspect of the right arm and the right side of the anterior chest wall. The pattern of discoloration did not conform to any blood vessel distribution (Figures 1 and 2).

The patient did not develop any other adverse reactions to the fluorescein dye. He was observed for an hour and no further discoloration or allergic reactions were found to develop. The quality of the fluorescein angiography pictures was good. He was discharged home with the advice to seek medical attention should he develop any late reactions. The other patients who received the same batch of fluorescein sodium did not show any similar reactions. The patient was reviewed a week later, and he reported that the discoloration had faded gradually over the following 4 days without the development of any other adverse reactions. No fiuther cutaneous fluorescein staining was seen. A diagnosis of

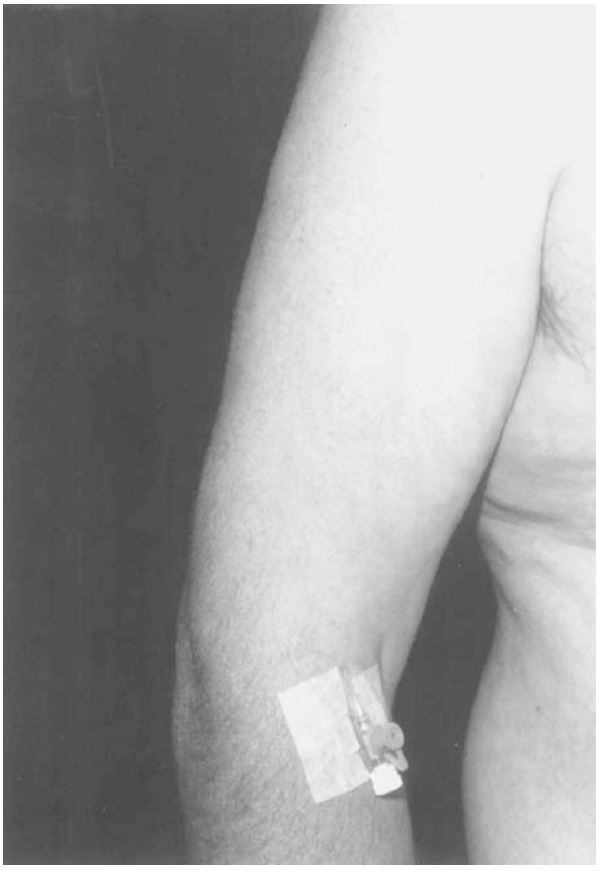

Figure 1 Patient's right arm showing patchy yellow discoloration of the skin.

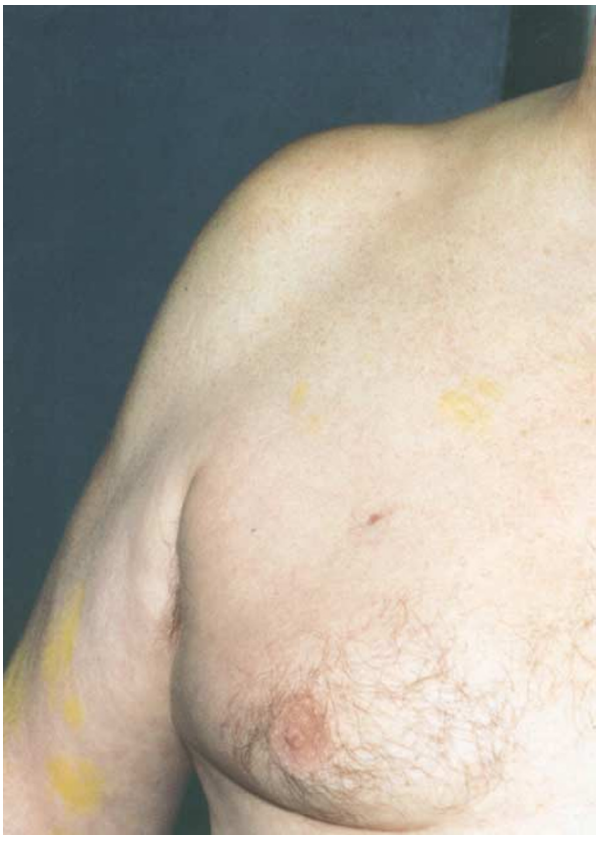

Figure 2 Right side of the patient's chest showing fluorescein staining of the skin on the anterior chest wall.

slow flow retinopathy was made based on the clinical and angiographic findings. The patient was placed on anti-platelet agents and is currently under review.

Comment

Fundus fluorescein angiography has been regarded as a relatively safe procedure, although various adverse reactions have been reported.[2] Frequently occurring side effects are usually mild and include nausea, vomiting, extravasation, and inadvertent arterial injection. Moderate reactions include urticaria, thrombophlebitis, syncope, pyrexia, and local tissue necrosis. Serious adverse reactions including laryngeal oedema, bronchospasm, anaphylaxis, circulatory shock, myocardial infarction, and arrest are rare. Numerous skin reactions following intravenous sodium fluorescein have been reported.[1–5] These include urticarial skin rashes,[1] fluorescein flushing of the forearm because of extravasation of the dye[2] or inadvertent intra-arterial injection of the dye,[3] generalised skin discoloration or pseudojaundice,[4] psoriasiform drug eruption,[5] phototoxic reactions, and skin necrosis with dye extravasation.[2]

We hypothesise that our patient's unusual patchy skin discoloration may be related to his lymphoproliferative disorder or the intensive treatment that he had received in the past for his lymphoma. Theoretically, patients with cutaneous infiltrations of B-cell lymphomas may be predisposed to such unusual patchy staining,[6] but our patient was never known to have cutaneous infiltrations. The radiotherapy, chemotherapy, and the central venous catheter insertions in our patient in the past may have contributed to this cutaneous manifestation, but no such association has been reported before. The pathogenesis remains unclear in our patient.

To the best of our knowledge, no case of such unusual patchy fluorescein staining following an intravenous injection of fluorescein sodium has been described before. The observed reaction may perhaps be classified as extremely rare and as a mild and benign reaction.

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Sir,

Primary squamous cell carcinoma of the lacrimal gland

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Primary malignant neoplasms of the lacrimal gland are uncommon causes of lacrimal gland swelling,[1] and they form only 1–2% of referral to specialist orbital clinics.[2] Primary squamous cell carcinoma of the lacrimal gland is a rare epithelial neoplasm. Only two reports of primary squamous cell carcinoma of the lacrimal gland have been briefly mentioned in the literature.[3,4] We report the clinical, radiological, and pathological features of primary squamous cell carcinoma of the lacrimal gland in an elderly woman.

Case report

An 80-year-old lady was referred to the Ocular Oncology service in June 2000. She had an 8-month history of painless progressive proptosis of the left globe and complained of a 2-month history of vertical diplopia. On examination, visual acuity was 6/6 in the right eye and 6/24 in the left eye, the latter because of corneal punctate epitheliopathy from exposure. There was 3 mm of nonaxial proptosis and inferior dystopia of the left globe with gross limitation of upward gaze. A firm smooth nontender mass was palpable over the lacrimal fossa.

A CT scan showed a left-sided lacrimal gland mass without bony erosion. A metastatic screen including chest X-ray, ultrasound scan of liver and liver function tests were normal. The clinical picture and CT findings were suggestive of a benign lacrimal gland tumour (Figure 1).

An en-bloc surgical excision of the tumour was carried out via a trans-septal approach. Macroscopically, the tumour measured $30 \times 22 \times 20\,mm^3$ with a necrotic interior.

The histopathological examination showed a poorly differentiated squamous cell carcinoma of the lacrimal gland. The tumour arose from a cyst lined by dysplastic squamous epithelium, confirming an origin at this site (Figure 2). It was incompletely excised. Subsequently, the patient received 52 Gy of radiotherapy in 20 fractions over 1 month. During this treatment, she required a lateral tarsorhaphy for corneal exposure from a frozen globe and later developed radiation-induced cellulitis, which was treated with liquid paraffin cream and antibiotics. This settled, and her postoperative recovery was otherwise unremarkable. A follow-up of 20 months showed no recurrence of the tumour and no evidence of a primary tumour at an alternative site.

Comment

The most common epithelial tumours of the lacrimal gland are benign mixed tumours (pleomorphic adenomas), adenoid cystic carcinomas, and adenocarcinomas. Some of the primary malignant

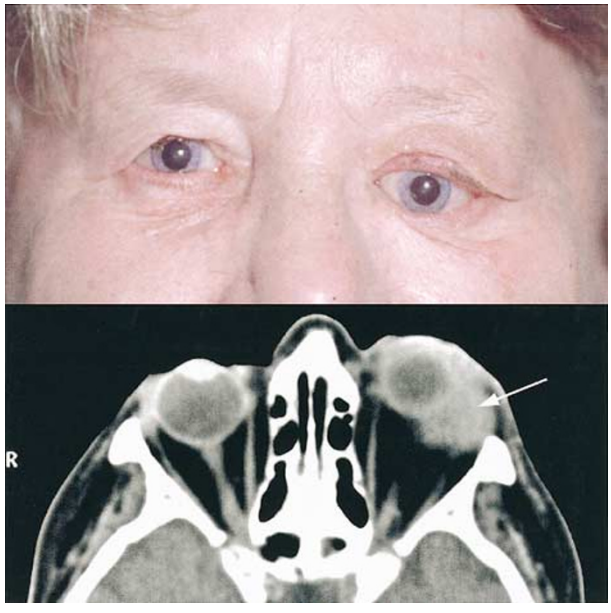

Figure 1 Top: The patient preoperatively shows inferior dystopia of the left globe. Bottom: Axial CT scan of the orbits shows a well-circumscribed lacrimal gland mass (white arrow) in the lacrimal fossa with no bony erosion.