The authors named the condition tadpole-shaped pupil and felt that the appearance resulted from a focal spasm of the iris dilator muscle. The aetiology remains unclear, although it is postulated that the cause is of benign neural origin.

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Sir,

Eyelid metastases indicating neuroendocrine carcinoma of unknown origin

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Metastases to the eyelids are rare and mainly related to breast carcinoma. We report here an unusual case of eyelid metastases as the presenting sign of a neuroendocrine carcinoma of unknown origin.

Case report

A healthy 52-year-old man sought medical advice for an erythematous tender nodule, 10 mm in diameter, of the right upper eyelid of recent onset (Figure 1). Physical examination was otherwise unremarkable. The lesion was removed surgically by full thickness resection and reconstruction required cutler beard flap. Histologic examination disclosed solid masses of monomorphous cells poorly differentiated, strongly basophilic, with round nuclei, and low activity in the dermis. Immunohistochemical studies demonstrated that the cells expressed KL1 but not melanA. A diagnosis of primary adnexial adenocarcinoma was made. After 2 months, the patient was admitted to the hospital for

Figure 1 Erythematous nodule of the right upper eyelid.

fatigue; weight loss was 10 kg. Numerous erythematous cutaneous nodules similar to the eyelid lesion were found on the scalp and thorax. A complete blood cell count showed 8.7 g/dl haemoglobin, 9305/mm³ leucocytes with 61% neutrophils, 31% lymphocytes, 1% plasmacytes, 1% myelocytes and 15% erythroblasts, and a platelet count of 37 000/mm³. Serum lactate dehydrogenase activity was 551 IU/l (normal 10–280), aminotransaminase activity was within the normal ranges and alkaline phosphatase activity was 238 IU/l (normal <100). A CT scan of the abdomen and thorax showed multiple nodules in the liver and the lungs, typical of metastases. A biopsy specimen from a nodule of the thorax disclosed the same histologic feature as the eyelid lesion. Immunohistochemical studies showed that most of the tumor cells expressed neuron-specific enolase, synaptophysine and chromogranin A, but did not express leucocyte common antigen, vimentine, protein S-100, and cytokeratine 7 and 20. These features were consistent with a metastases of a neuroendocrine carcinoma. Similar results were obtained from the palpebral lesion. At 2 weeks after admission, the patient died of haemorrhagic shock because of bone marrow involvement, before chemotherapy was begun. Post-mortem examination was refused by the family.

Comment

Metastases to the eyelids are rare, representing less than 1% of malignant eyelid lesions.^{1,2} In 1987, Mansour and Hidayat² reviewed 88 cases from the literature.² The primary site was the breast in 41 patients, the gastrointestinal tract in 12, the respiratory tract in six, the skin in six, and the genitourinary tract in four. The lesions

are observed in generalized malignancy and are rarely the presenting symptom.^{1,2} Metastases to the eyelid present as a painless nodule, a diffuse swelling or an ulcerating lid, and both lower and upper eyelids may be involved.^{1,2} Most of the patients are between 50 and 80 years of the age, and are women because of association with breast carcinoma. Differential diagnosis of the eyelid nodule includes benign lesions such as chalazion, cyst, granuloma, and xanthoma.³ Malignant lesions should also be considered including basal cell carcinoma, squamous cell carcinoma, melanoma, sebaceous cell carcinoma, and primary neuroendocrine of the skin or Merkel cell carcinoma.^{1,2,4} In our patient, the histologic differential diagnosis consisted of poorly differentiated primary eccrine carcinoma, metastatic poorly differentiated carcinoma, poorly metastatic carcinoid tumour, and Merkel cell carcinoma.^{4,5}

Immunohistochemical analyses were useful in this case and Merkel cell carcinoma was unlikely because tumour cells did not express cytokeratine 20.⁶

In conclusion, diagnosis of eyelid metastases requires a high index of suspicion in every patient, even those with no history of cancer, since it may indicate the condition and therefore allows rapid instauration of treatment. A careful histologic examination with immunohistochemical studies is mandated.

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Sir,

Bilateral Ulnar nerve palsies: an unusual complication of posturing after macular hole surgery

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Gas tamponade with face-down posturing has been regarded as a crucial step in the success of macular hole surgery. Most surgeons using long-acting gases recommend face-down posturing for 45–50 min of each hour for 10–15 days. However, posturing is tiring and demanding for patients and is not without its ill effects.

We present the case report of a professional part-time singer who developed bilateral ulnar nerve palsies as a result of face-down posturing after macular hole surgery.

Case report

A 75-year-old man was referred to the eye casualty department by his GP with a 3-month history of distortion of the central field of vision in the left eye. Best corrected visual acuities were 6/12 OD and 6/36 OS. The right eye was amblyopic. Anterior segment examination was normal. Fundus examination revealed a Grade IV macular hole in the left eye with a positive Watzke Allen sign. A vitrectomy with 16% C₃F₈ under general anaesthetic was performed. Despite an uneventful surgery and good compliance with the postoperative posturing regimen, the VA failed to improve beyond 6/36.

He attended a follow-up appointment at the orthopaedic clinic for a routine 12-month assessment after a total hip replacement, which had been performed for osteoarthritis. On examination an incidental finding of bilateral ulnar nerve palsies was discovered. There was obvious wasting and weakness of the interossei, a positive Froment's sign bilaterally, hypoaesthesia along the ulnar border of both hands, and a classical ulnar claw hand deformity worse on the right hand (Figure 1a and b). The patient reported that the onset of the sensory disturbance coincided with his recuperation from ophthalmic surgery. On close questioning, it was found that he was resting his forehead on the dorsal aspects of his wrists with elbows held in approximately 100° flexion.