Electron microscopic studies of these tumours have shown luminal cells to have vacuoles and lipid granules and microvilli that project into the lumen of the tubules.[6] We have presented a case of tubular apocrine adenoma, a rare tumour with a predilection for the scalp region, on the eyelid margin, which recurred following initial excision. To our knowledge, this tumour has not previously been reported in the eyelid skin.

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Sir,

Extranasal nasal glioma

A 1-week-old girl was referred for an opinion on a possible dacryocoele (Figure 1) by her paediatrician. The lesion was fluctuant but not mobile and approximately 2 cm in diameter. Because of the paracentral location, a dermoid cyst was considered the most likely diagnosis. MRI scanning excluded intracranial extension of the lesion (Figure 2).

2 months before the planned surgery, the oculoplastic team was consulted. It was felt that because of the midline location, a small encephalocoele should be considered. Thin slice CT sagittal scans were performed, which excluded any small bony defects (Figure 3). The scans were examined by a paediatric neuroradiologist who felt that a dermoid cyst was the most likely cause.

Excision biopsy was performed. The lesion appeared to be firmer than a typical dermoid cyst and was removed *en masse* without rupture. There was attachment via a thin stalk to a small depression on the anterior surface of the frontal process of the maxilla. There was no leakage of CSF from the cut end of the attachment when severed.

Histological analysis suggested extranasal nasal glioma (Figure 4). The child remains well with no evidence of local recurrence.

Discussion

Congenital midline nasal masses (CMNMs) are rare, presenting in 2–5 per 100,000 live births.[1] The differential

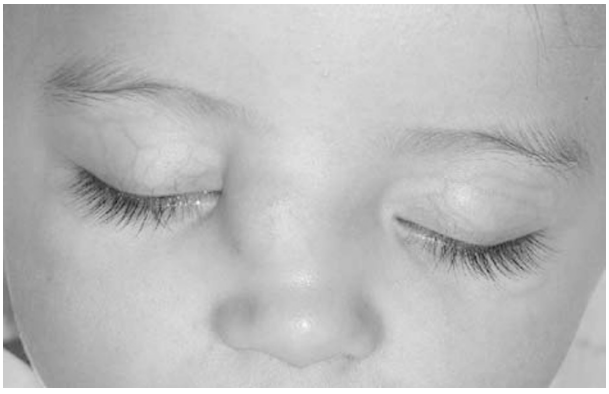

Figure 1 Photograph of the congenital midline nasal mass.

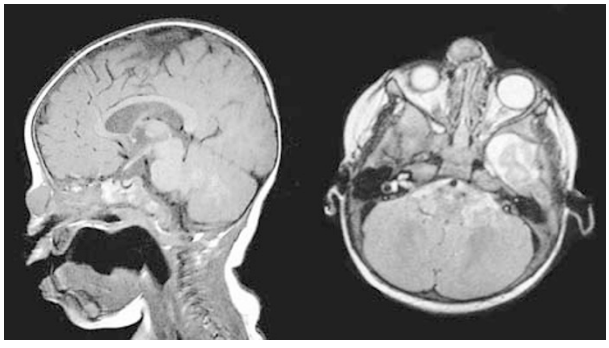

Figure 2 Sagittal MRI T1 weighting (left) and axial MRI T2 weighting (right) scans: the brain is normal. The lesion shows an isointense signal on T1 and a slight hyperintense signal on T2 weighting.

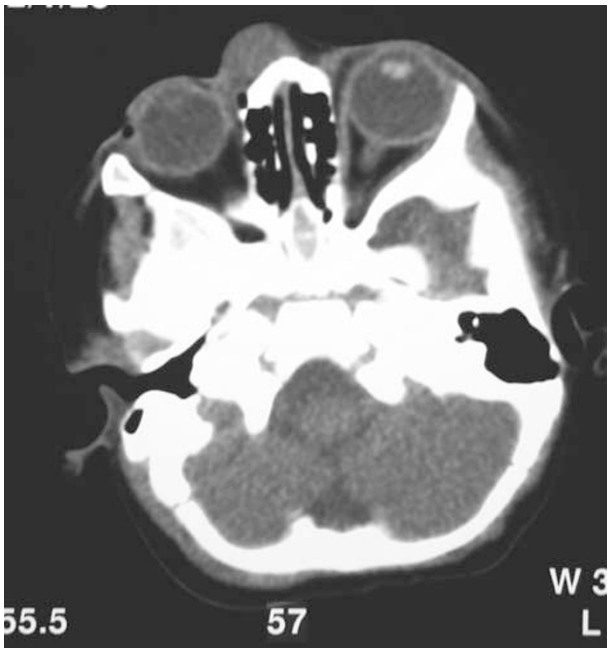

Figure 3 Axial CT scan. There is no bony defect to suggest an encephalocoele.

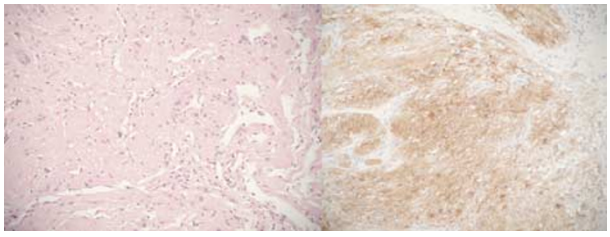

Figure 4 (Left) The lesion is composed of bands, whorls, and sheets of eosinophilic cells, typical of mature glial tissue. The nuclei are small with bland chromatin. There are no mitoses and there is no necrosis or invasion ($\times 100$ H&E). (Right) The eosinophilic cells are strongly positive with glial fibrillary acidic protein, confirming glial tissue ($\times 100$).

diagnosis includes dermoid/epidermoid cysts, encephalocoeles, and nasal gliomas. Nasal gliomas are thought to be collections of heterotopic tissue of neurogenic origin, which have lost their intracranial connection and may represent variants of encephalocoeles,[2] with approximately 20% retaining intracranial connectivity.[3] Intranasal involvement is associated with breathing and feeding difficulties. Nasal gliomas are benign lesions and complete excision, often requiring ENT and neurosurgical support, is the treatment of choice since recurrence is rare. The presence of a fibrous stalk is associated with CSF leaks and defects in the bony cranium.[4] Although rare, the ophthalmologist needs to be aware that CMNMs require high-resolution neuroimaging, prior to surgical intervention, to exclude bony defects and to delineate the lesion looking for both intracranial extension and connection,[5–7] since misdiagnosis may cause catastrophic CSF leaks.[8]

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