which may supply a constant source of cells to proliferate and migrate into the cleavage plane.

Presentation is usually with an obvious lesion noted by the patient or by a parent. The cysts are usually circular or oval and may be loculated.[3] As in our case, a level comprising necrotic epithelial cells in the cyst cavity may be present resembling a hypopyon.[3] The cysts are cavities filled with necrotic debris and lined by stratified epithelium.[3,4,8,9] Microscopy of aspirated cyst contents shows degenerate cell debris and epithelial cells.[4,5]

With regard to treatment options, it has been felt that corneal cysts not affecting vision should be managed conservatively and surgical intervention should only be undertaken in progressive cases.[3] Simple drainage procedures or aspiration have not been shown to have long-lasting benefit and recurrence is common.[3,5] Cytodestruction with chemical cautery using 1% iodine followed by irrigation with cocaine and with 10% acetic acid[3,6] has been described as has the use of electrocautery[3] and cryotherapy.[4] This can be combined with suturing of the cyst cavity[3,6] or excision of the anterior cyst wall.[3,5] In advanced cases, a lamellar corneal graft[5,9]or penetrating keratoplasty may be required.[8]

The technique we employed was simple to perform and no toxic chemicals were required. Following drainage of the cyst, the positioning of closely lined sutures to close a small wound ensured adequate fibrosis and kept the cyst walls closely opposed preventing recurrence.

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Eye (2007) **21,** 133–135. doi:10.1038/sj.eye.6702456; published online 26 May 2006

Sir,

Eyelid lymphoma in a patient with multiple lipomatosis

Lipomas are common benign soft-tissue tumours of adipose tissue.[1] Lymphomas are tumours of proliferating lymphocytes and in the adnexal region are commonly non-Hodgkin's B-cell lymphomas.[2] We report a patient with multiple lipomas and a suspicious eyelid mass.

Case report

A 58-year-old male was referred to the oculoplastic clinic for assessment regarding left upper lid mass. The mass had been present for 2 years and slowly increasing in size. The patient has a history of multiple lipomas elsewhere on the body and was referred with a provisional diagnosis of left upper lid lipoma (Figure 1). On examination, a firm mass in the medial half of left upper lid with no lymph node enlargement was noted. The visual acuity was 6/9 in both eyes. Biopsy revealed the mass to be confined to the eyelid. Histopathology showed connective tissue infiltrated by small–medium lymphocytes in a follicular pattern (Figure 2). Immunohistochemistry confirmed diagnosis of follicular lymphoma. The patient was referred to haematology team for staging and further treatment.

Comment

Ocular adnexal lymphomas represent 6–8% of all orbital tumours.[2] Non-Hodgkin's B-cell type constitutes in excess of 95% of adnexal lymphomas with the remaining being T-cell lymphomas, Burkitt's lymphoma, or rarely Hodgkin's lymphoma. Follicular lymphoma is one of the most common variants in adnexal lymphomas after extranodal marginal zone B-cell subtype.[3] These lymphomas exhibit a nodular pattern of growth, and on immunohistochemistry neoplastic follicle centre cells are positive for CD10, Bcl-2, and Bcl-6 antigens.[4] Follicular lymphomas are often slow growing tumours and indolent in comparison to other lymphoma variants such

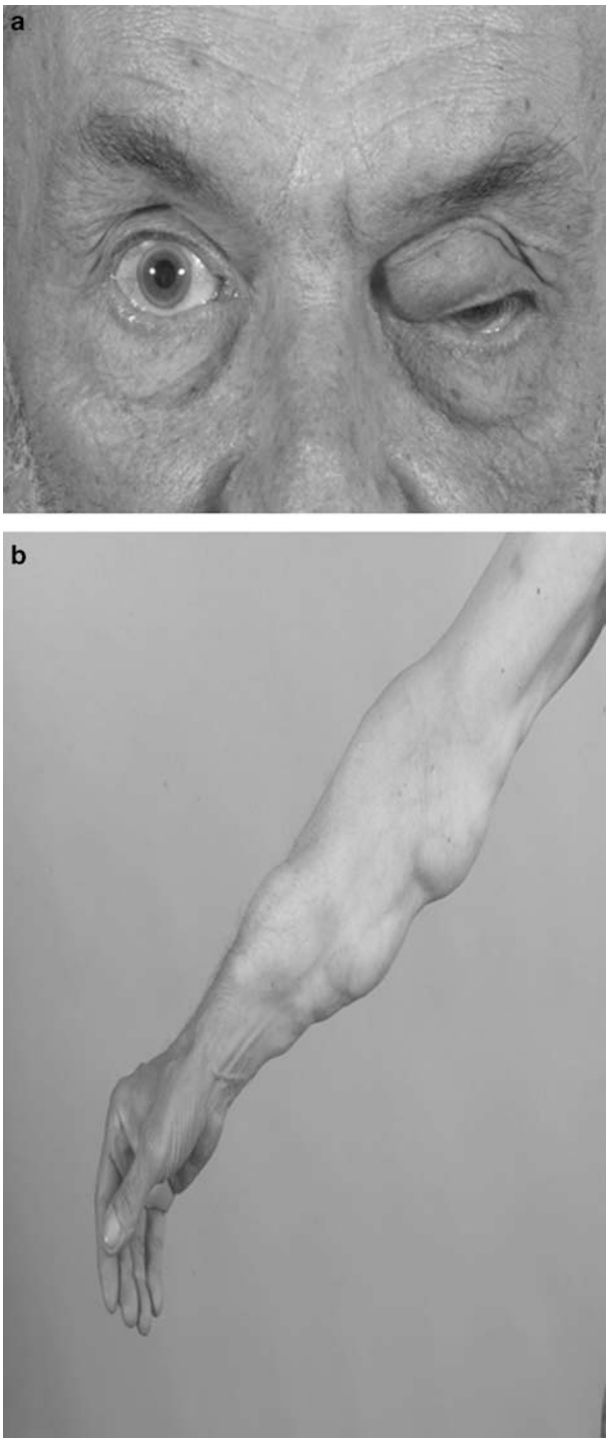

Figure 1 Clinical photographs. (a) Left upperlid mass; and (b) right arm multiple lipomas.

as mantle cell and diffuse large B-cell lymphomas.[2] However, Nicoló *et al*[5] describe a case of follicular lymphoma with an aggressive course resulting in multiple recurrences despite chemotherapy and radiotherapy.

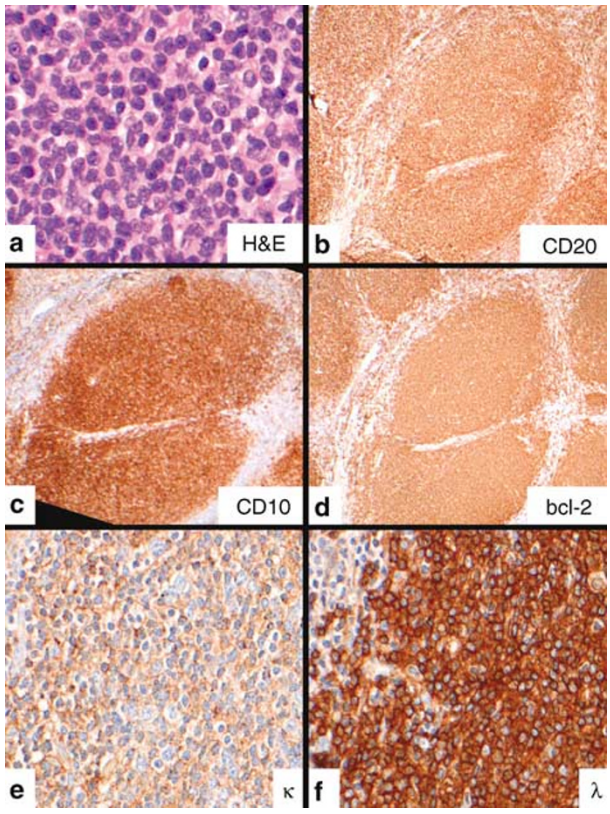

Figure 2 Histopatholgy slides. (a) Follicle centre cells—centrocytes and centroblasts (H&E); (b) lymphoid follicle and interfollicular cells—B-cell marker (CD20); (c) lymphoid follicle—follicle centre cell marker (CD10); (d) neoplastic lymphoid follicle (bcl-2); (e) kappa light-chain negative; and (f) lambda light-chain positive.

The history of multiple lipomatosis in our patient suggested that the eyelid lesion might represent a lipoma. The appearance and consistency of the lesion, however, suggested the clinical diagnosis of an adnexal lymphoma, which was confirmed on histopathological examination. The implications of the diagnosis of lymphoma are significant in comparison to a lipoma. It is essential to consider the possibility of dual pathology when the clinical picture does not fit with the 'labelled' diagnosis.

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Eye (2007) **21,** 135–137. doi:10.1038/sj.eye.6702466; published online 16 June 2006

Sir,

Overnight visual improvement after early surgical intervention in Irvine–Gass syndrome

Cystoid macular oedema (CMO) commonly develops following cataract surgery complicated by vitreous loss and vitreous incarceration in cataract wound. Vitrectomy is generally recommended in cases refractory to medical therapy. We report a case where early anterior vitrectomy resulted in dramatic resolution of CMO the following day. This case shows the need for a properly designed study to outline the management of postoperative CMO.

Case report

A 71-year-old female underwent left eye phacoemulsification with intraocular lens implantation (IOL). Posterior capsular tear was noted after IOL implantation, the IOL was stable and intraoperatively no vitreous loss was noted. In the first postoperative week, vitreous strands adherent to inner aspect of the corneal incision site were noted (Figure 1). The best-corrected visual acuity was 6/9, the IOL was stable, and no pupillary distortion and no cystoid macular oedema (CMO) were noted. After 3 weeks, her best-corrected visual acuity was 6/36, with clinically evident CMO, which was also confirmed on optical coherence tomography (Figure 2a). During all this time she was on topical dexamethasone 2 h, topical chloramphenicol q.d.s.

In the same week, she underwent a limbal-based bimanual approach anterior vitrectomy with removal of the vitreous strands adherent to corneal incision site. She received a subconjunctival injection of 0.25 ml of dexamethasone with 0.25 ml of gentamycin after vitrectomy. The very next day on optical coherence tomography (OCT) examination, although the actual posterior hyaloid phase was not seen clearly, it showed no evidence of CMO (Figure 2b) and the best-corrected visual acuity had improved to 6/9. Her visual acuity remains stable 3 months after operation.

Comment

CMO was first described by Irvine after intracapsular cataract extraction, following which Gass studied its fluorescein angiogram features. Ever since, Irvine–Gass syndrome has become synonymous with visually significant CMO after cataract extraction irrespective of

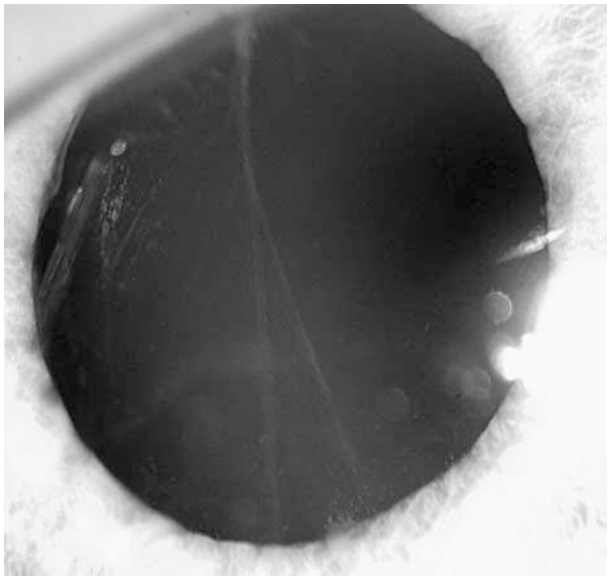

Figure 1 Anterior segment photograph taken during first week after phacoemulsification and IOL implantation showing vitreous strands incarcerated in corneal wound.