Figure 2 B-scan ultrasound of left eye showing thickened choroid.

Figure 3 Left eye fundus fluorescein angiogram at 30s.

management of retinal detachment. This patient's retinal detachment most closely related to scenario 4 in Ahmad's paper.¹ From the survey, 51–78% of respondents elected for surgical intervention, depending on the presence of a demarcation line. The management of these conditions is clearly controversial. The complication encountered here, although rare, is a cautionary tale and reminds us of the old adage *primum non nocere*.

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We thank the patient for allowing us to publish her case

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Sir,
Refractory discoid lupus erythematosus of the eyelid successfully treated with intra-lesional triamcinolone
A 24-year-old Caucasian woman presented with a 2-month history of a painful, erythematous, scaly lesion on the lateral aspect of the left lower eyelid. There were no cutaneous lesions elsewhere and no other symptoms. She had no significant past medical history and no allergies. Treatment for potentially infective causes including a course of oral flucloxacillin, topical fusidic acid, chloramphenicol, and acyclovir had produced no improvement.

A wedge biopsy of the lesion showed histological abnormalities consistent with a diagnosis of discoid lupus erythematosus (DLE). The erythrocyte sedimentation rate, full blood count, and liver function tests were normal and an autoimmune profile including anti-nuclear, anti-double-stranded DNA, anti-neutrophil cytoplasmic, anti-extractable nuclear, and anti cardiolipin antibodies was negative.

Initial treatment with topical corticosteroid ointment and factor 25 sunscreen produced no improvement. The patient was lost to follow-up for 16 months before she presented again with progression of the original lesion, now associated with significant madarosis and a new smaller lesion at the lateral border of the right lower lid. She was commenced on twice daily oral hydroxychloroquine 200 mg and topical corticosteroid. The topical corticosteroid was discontinued after 3 days owing to local side effects, but there was no clinical response to hydroxychloroquine therapy at 6 weeks.

Progression of the lesions and intolerance of topical corticosteroid led to a 2-week trial of oral prednisolone,

Figure 1 (a) Appearance of the DLE lesions at the lateral aspects of both the left and the right lower lids prior to injection. (b) Appearance of both lids at 12 weeks post injection, demonstrating the response to intra-lesional triamcinolone.

which produced significant improvement, demonstrating a steroid response. However, systemic side effects including a weight gain of 6 kg and gingivitis made this an impractical long-term treatment.

Discontinuation of the oral steroid led to recurrence of the lesions (Figure 1a) and therefore intra-lesional corticosteroid injection was performed. Triamcinolone (4 mg in 0.1 ml) was injected into each lesion under local anaesthesia. At 12 weeks the lesions had completely resolved completely (Figure 1b), without local complication.

The patient remains well and free of any recurrence at 2 years following intra-lesional injections.

Comment

DLE is a chronic autoimmune skin disease that commonly affects sun-exposed skin. It infrequently affects the palpebral skin in isolation. Authors often describe a predilection for the inferior lid, particularly the lateral third.^{1,2}

Isolated DLE of the eyelids can be difficult to diagnose¹ and initial misdiagnosis is common.³ Early diagnosis and treatment is important to avoid permanent scarring and damage to local structures. Conventional treatment for DLE involving the lids includes topical photo-protection and use of topical corticosteroid and the systemic anti-malarial drug hydroxychloroquine. Although these treatments are usually effective, refractory cases have been reported.^{1,4} Use of topical tacrolimus for facial DLE has also been reported to variable effect.⁵ Intra-lesional triamcinolone has been used successfully to treat DLE of the palms and soles.⁶

This case demonstrates the role of intra-lesional triamcinolone as a treatment for refractory DLE of the lids where oral hydroxychloroquine has failed and oral or topical steroid is not tolerated. The intervention is well tolerated and has shown a good response at 2 years.

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