M. Hingorani, FRCOphth
D. Mooney, MRCOphth
A. Singh, FRCS

Department of Ophthalmology
North Middlesex Hospital
Sterling Way
London N18 1QX
UK

References

1. Kranenberg EW. Crater-like holes in the optic disc and central serous retinopathy. Arch Ophthalmol 1960;64:912–24.
2. Brown GC, Ausberger JJ. Congenital pits of the optic nerve head and retinochoroidal colobomas. Can J Ophthalmol 1980; 15:144–6.
3. Ferry AP. Macular detachment associated with congenital pit of the optic nerve head. Arch Ophthalmol 1963;70:346–57.
4. Brown GC, Shields JA, Goldberg RE. Congenital pits of the optic nerve head. II. Clinical studies in humans. Ophthalmology 1980;87:51–65.
5. Theodossiadis G. Evolution of congenital pit of the optic disk with macular detachment in photocoagulated and non-photocoagulated eyes. Am J Ophthalmol 1977;84:620–31.
6. Gass JDM. Serous detachment of the macula secondary to congenital pit of the optic nervehead. Am J Ophthalmol 1969; 67:821–41.
7. Petersen HP. Pit or crater-like holes in the optic disc. Acta Ophthalmol (Copenh) 1958;36:435–43.
8. Neame H. Congenital hole at the optic disc: report of ten cases with especial reference to visual field defects. Trans Ophthalmol Soc UK 1947;57:109–32.
9. Rosen E. Crater-like holes in the optic disc. Br J Ophthalmol 1948;32:465–78.

Sir,

Primary Orbital Lymphoma Presenting as Epiphora

We present a case of epiphora caused by compression of the nasolacrimal sac by a primary orbital lymphoma. This is both a rare cause of a common presenting symptom and an unusual presentation of such a tumour. The history, management and histology are described and their implications discussed.

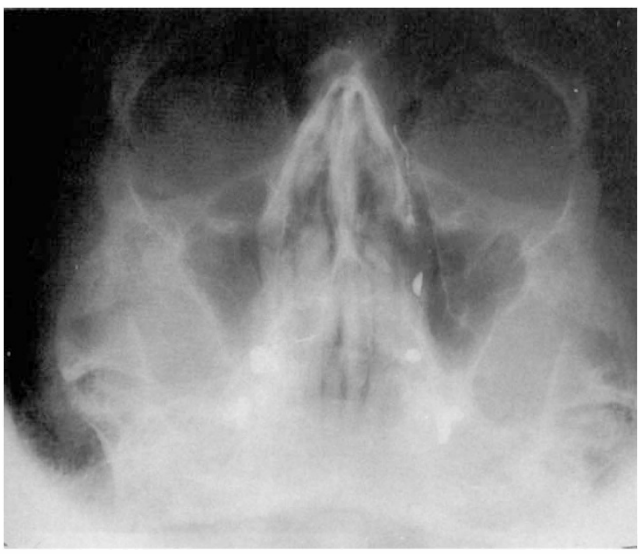

Fig. 1. *Dacryocystogram showing a patent and medially compressed left nasolacrimal sac.*

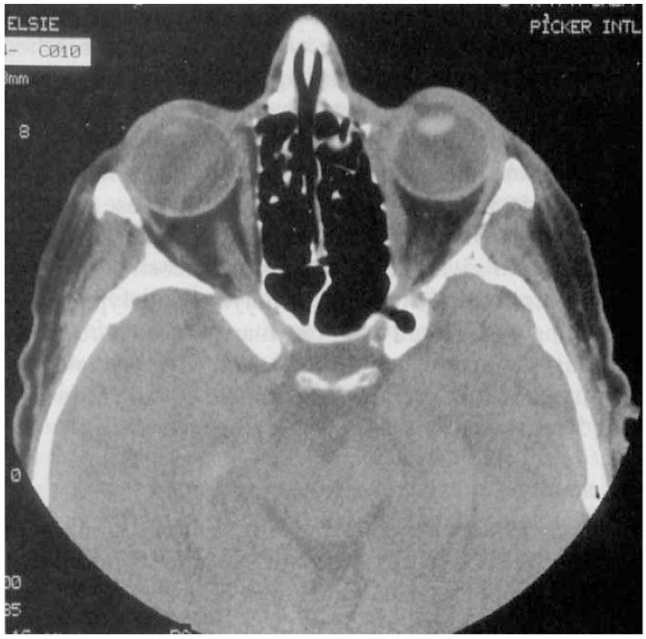

Fig. 2. *CT scan showing a left-sided orbital tumour extending over the orbital rim.*

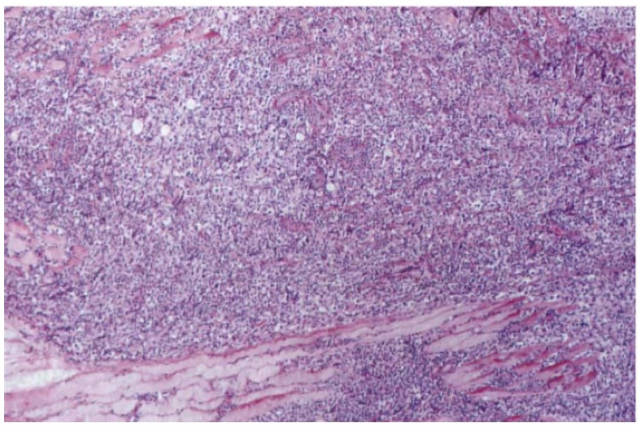

Fig. 3. *Histology shows a mass of lymphoid cells infiltrating between muscle fibres from the orbital tissue. (Haematoxylin & eosin, × 160).*

Case Report

A 68-year-old woman presented with a 6 month history of epiphora from the left eye and a 6 week history of a mass at the medial canthus. Examination confirmed the presence of a firm, non-compressible swelling extending over the medial orbital rim, which exhibited no reflux. The patient was otherwise asymptomatic and had no other medical problems.

A dacryocystogram was performed which demonstrated a patent but medially compressed nasolacrimal sac (Fig. 1), and a CT scan showed that this was due to compression by an expanding orbital tumour (Fig. 2). This lesion was then biopsied under a general anaesthetic by dividing the overlying skin and fibres of orbicularis to reveal its surface from which samples were taken.

Macroscopically the two biopsied tissue fragments, the larger 5 mm in diameter, consisted of muscle and connective tissue with a white infiltrate. Microscopically both

were diffusely infiltrated by a dense mass of large and small lymphoid cells, some with angulated or notched nuclei, and larger cells with large nuclei and occasional nucleoli (Fig. 3). Immunocytochemical studies confirmed the B-lymphocytic lineage of these cells, showing lambda immunoglobulin light chain restriction, and a small T-cell and dendritic reticulum cell component. These features confirmed that the tumour was a high-grade malignant non-Hodgkin's lymphoma, most closely resembling a diffuse centroblastic lymphoma of polymorphic type.

Staging by CT scan and bone marrow biopsy revealed that this was an isolated orbital lesion. It was treated by localised radiotherapy, and the patient is still alive and well 5 years later with no evidence of recurrence.

Discussion

Epiphora is a common presenting complaint in older patients. Most often this is attributable to the syndrome of primary acquired nasolacrimal duct obstruction.[1] Secondary acquired nasolacrimal duct obstruction may result from a wide variety of infectious, inflammatory, neoplastic, traumatic or mechanical causes.[2]

Nasolacrimal duct obstruction has been reported as a complication of orbital secondaries in known diffuse malignant lymphoma.[3,4] It is also well recognised in malignant tumours of the lacrimal sac,[5] including primary lacrimal sac lymphomas,[3,6] where epiphora has been the presenting symptom.[7] The case described is of a primary orbital lymphoma which had expanded over the orbital rim to compress the nasolacrimal sac. The latter was not infiltrated by tumour and remained patent.

The authors believe that this case illustrates a new and unusual presenting symptom in orbital lymphoma. Although rare, it emphasises the recognised need for care when diagnosing and treating nasolacrimal outflow obstruction in the older population lest a serious, and in this case readily treatable cause is missed. In addition to the importance of thorough examination the value of other investigative procedures is well demonstrated, especially in this case dacryocystography which showed the compressed nasolacrimal sac, CT scan which defined the position, shape and size of the mass, and of course an adequate biopsy.

M. P. Edwards
M. A. Parsons
I. G. Rennie

University Department of Ophthalmology and Orthoptics
and Department of Pathology
Royal Hallamshire Hospital
Glossop Road
Sheffield S10 2JF
UK

References

1. Linberg JV, McCormick SA. Primary acquired nasolacrimal duct obstruction. Ophthalmology 1986;93:1055–62.
2. Bartley GB. Acquired lacrimal drainage obstruction: an aetiologic classification system, case reports, and a review of the literature: Ophthalmic Plast Reconstr Surg 1992;8:237–42.
3. Bartley GB. Acquired lacrimal drainage obstruction: an aetiologic classification system, case reports, and a review of the literature: III. Ophthalmic Plast Reconstr Surg 1993;9:11–26.
4. Benger RS. Lacrimal drainage obstruction from lacrimal sac infiltration by lymphocytic neoplasia. Am J Ophthalmol 1986;101:242–5.
5. Flanagan JC, Stokes DP. Lacrimal sac tumours. Ophthalmology 1978;85:1282–7.
6. Karesh JW, Perman KI, Rodrigues MM. Dacryocystitis associated with malignant lymphoma of the lacrimal sac. Ophthalmology 1983;100:669–73.
7. Carlin R, Henderson JW. Malignant lymphoma of the nasolacrimal sac. Am J Ophthalmol 1974;78:511–3.

Sir,

Scleral Explant Mimicking Malignant Melanoma

Scleral explants in retinal detachment surgery may cause a number of problems. These are extrusion,[1–3] infection,[1–8] scleritis and scleral abscess,[3,9] discomfort,[10] diplopia or visual distortion,[3,11] cheesewiring through the extraocular muscles,[12] and recurrent subconjunctival haemorrhages following mechanical movement of the explant.[2]

We report a case of a 72-year-old man with pigmented subconjunctival tumours mimicking an episcleral malignant melanoma. Surgical exploration revealed the tumours to be two 'chocolate' silicone plombs.

Case Report

A 72-year-old man was referred from another centre with suspected conjunctival melanoma. On routine examination for ocular hypertension, he was found to have a pigmented raised subconjunctival nodular tumour, firmly attached to sclera, in the left upper fornix. No pigmented tumour had been noted previously and it was, therefore, uncertain how long it had been there. Although there was mild discomfort, there had been no recent visual disturbance.

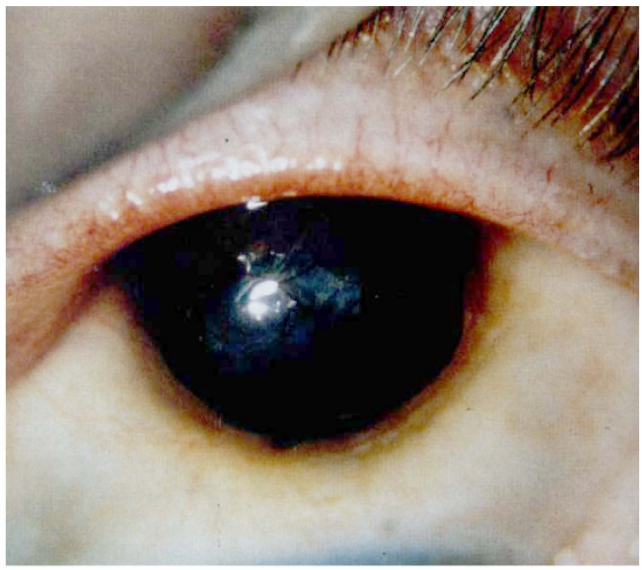

Fig. 1. *Photograph of the pigmented raised subconjunctival nodular mass in the upper fornix of the left eye at presentation.*