

Sir,

A Migrating Scleral Explant Presenting as a Chalazion

This is a report of an unusual case of a migrating explant which was initially mistaken for a chalazion. Most explants migrate anteriorly into the transparent bulbar conjunctiva making their identification simple. We are unaware of any previous report in the literature of an explant migrating into the eyelid.

Case Report

A 67-year-old woman was referred by her general practitioner because of a progressively enlarging swelling in her left upper eyelid over a period of 2 months. On examination, the mass, situated in the medial side of the left upper eyelid, resembled a chalazion (Fig. 1). However, it was mobile and also appeared to move within the eyelid when the eye moved from side to side. Eversion of the eyelid revealed hyperaemia of the tarsal conjunctiva and a protruding mass on the inner lid surface at the upper margin of the tarsal plate (Fig. 2).

The patient's past ophthalmic history consisted of a superior retinal detachment 2 years earlier. At surgery, a radial silicone sponge measuring 1.5 cm was sutured to the sclera, between the superior and medial rectus, 9 mm from the limbus. She was discharged from the clinic 1 year after the operation. Because of the synchronised movement of the mass with the eye, a protruding explant was suspected. She was admitted as a day case for exploration of the swelling. When the tarsal conjunctiva was incised at the upper margin of the tarsal plate, a silicone sponge 5 mm in diameter and 15 mm in length extruded easily (Fig. 3).

Comments

The use of an explant to appose the detached retina and seal the break was first reported by Jess in 1937¹ and has become an established part of retinal detachment procedures. Some of these explants may need removal post-operatively. The reported

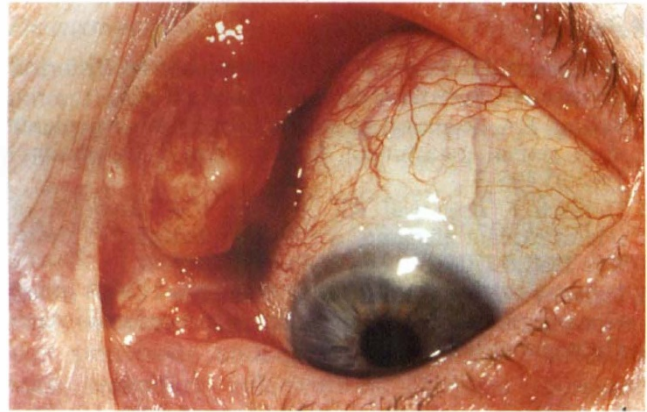


Fig. 2. The protruding mass revealed by eversion of the eyelid.

rate of explant removal ranges from 1.2% to 24%.² The most common reasons for removal are extrusion and infection or a combination of both.³ Extruding explants can cause irritation, conjunctivitis and interfere with ocular motility.⁴

Most scleral explants in common use are of the non-absorbable type and are either solid silicone rubber or silicone sponge. The latter has the advantage of creating a higher buckle than the former but the disadvantage of a thinner capsule growing under it and therefore exposure occurs more easily.¹

We believe this is the first reported case of migration into the tarsal conjunctiva of a silicone sponge explant. Anterior migration of an explant is not uncommon but it invariably comes to lie underneath the bulbar conjunctiva.

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Fig. 1. The patient at presentation.

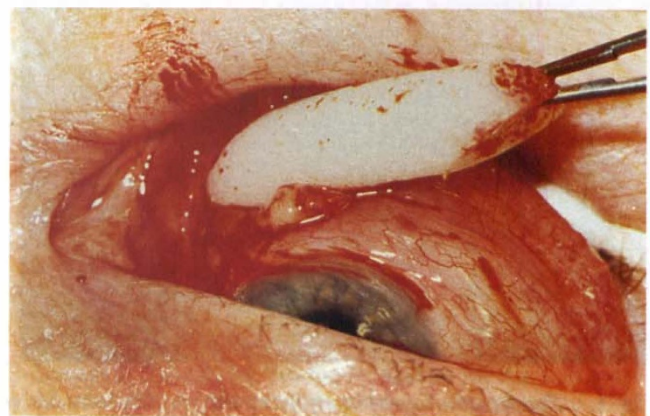


Fig. 3. The silicone sponge being removed at operation.

References

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Sir,

Choroidal Calcification in Primary Hyperparathyroidism

Metastatic calcification in the eye is often seen in the cornea and the interpalpebral conjunctiva. In hypercalcaemic subjects calcium has also been

described in the sclera.¹ Rarely has calcium been detected in the uvea.¹ There have been few previous case reports of patient with clinically evident choroidal calcification following hypercalcaemia due to primary hyperparathyroidism.^{2,3} We present the clinical and investigative findings of a patient who had been treated for primary hyperparathyroidism and who was found some years later to have choroidal calcification.

Case Report

A 60-year-old woman with a complex medical history was referred to the eye clinic in September 1991. She was diagnosed with infiltrating carcinoma of the breast in January 1991. She had a right mastectomy and axillary clearance in February 1991 and was subsequently placed on tamoxifen 20 mg daily. Visual deterioration on the right prompted referral for examination for uveal metastases.

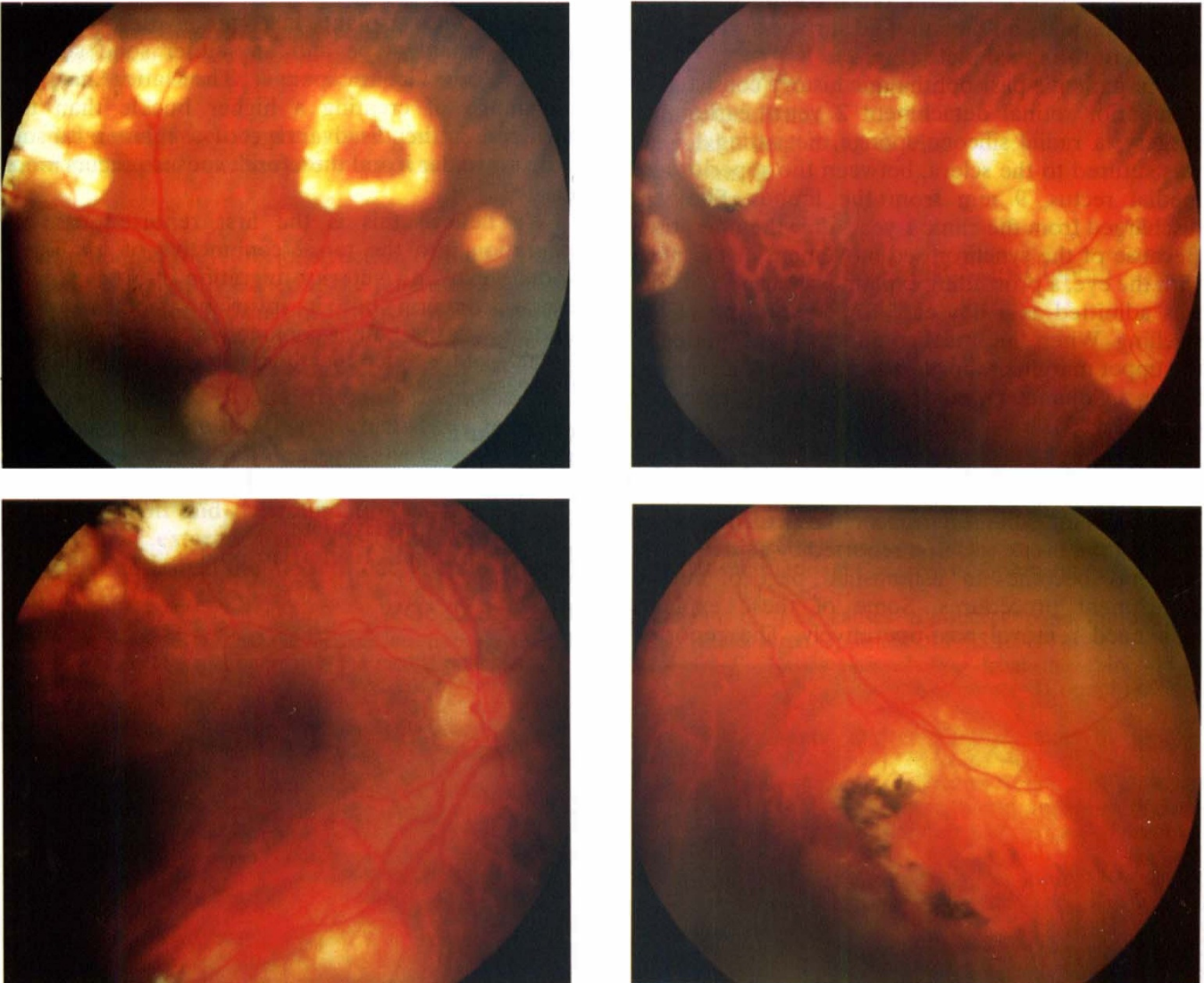


Fig. 1. Fundus photographs showing the creamy-white to yellow-orange lesions representing areas of choroidal calcification: Top left, right superior vessel arcades; bottom left, right temporal vessel arcades; top right, left superior vessel arcades; bottom right, left inferotemporal vessel arcade.