then the possibility of aberrant lacrimal gland with fistula needs to be considered among other rare causes. The use of probing can demonstrate the presence of a fistula, which usually fills with dye on retrograde injection. The mass of the aberrant gland may be too small to show up on a radioisotope uptake study, as happened in our case. Surgical excision of the offending aberrant gland and fistula is the treatment of choice.

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Sir,

Desmoplastic trichilemmoma of the upper eyelid

This rare benign neoplasm of the hair follicle usually presents on the face, scalp or chest of middle-aged patients. It can mimic various skin carcinomas, verrucas or cutaneous horns both clinically and histologically. We describe a case of desmoplastic trichilemmoma occurring in the upper eyelid of a middle-aged woman. This site of occurrence has not previously been reported.

Case report

A 51-year-old Caucasian woman presented with a 12 month history of a slowly enlarging painless left upper lid lump. Examination revealed a 5 mm warty lesion attached to the left upper eyelid margin with evidence of crusting over the surface. The lump was completely excised under local anaesthetic and the specimen sent for histopathological diagnosis.

The tissue report was as follows: Histological examination showed a thickened skin with an attached underlying well-circumscribed, nodular fairly symmetrical lesion (Fig. 1). The tumour showed a characteristic biphasic appearance. At the periphery, there were irregular lobules of squamous cells with peripheral palisading and focally displaying periodic acid-Schiff (PAS)-positive glycogen-containing cells representing proliferation of the outer root sheath.

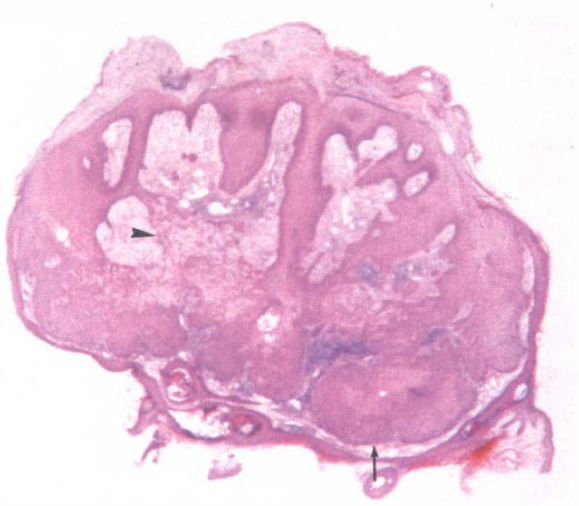

Fig. 1. *Skin with a nodular lesion displaying a biphasic appearance of peripheral sheets of squamous cells (arrow) and cords of smaller epithelial cells in the centre. Arrowhead indicates desmoplastic areas. (H&E; ×10.)*

Towards the centre, the squamous cells merged with narrow cords of smaller epithelial cells displaying a pseudocarcinomatous growth pattern. There was prominent stromal sclerosis (Fig. 2). A basement membrane was seen around the cell masses of both phases, staining positively for PAS and collagen type IV by immunohistochemistry. Mitoses were not seen in any portion of the tumour and there was no significant cytological atypia.

Comment

Desmoplastic trichilemmoma is a rare benign adnexal skin tumour related to the outer sheath of the pilosebaceous hair follicle (trichilemmoma), occurring with a frequency of about 0.003% of all skin tumours.[1] It predominantly affects women, and is almost always situated on the face. It presents typically as a slow-growing, asymptomatic, solitary, hard, annular lesion, 5–10 mm in size, with a raised border and depressed centre. As a consequence of the variety of its appearances this tumour can easily be misdiagnosed as a basal cell carcinoma (nodular or morphoeic forms), squamous cell carcinoma, invasive carcinoma, follicular keratosis or cutaneous horn.[2]

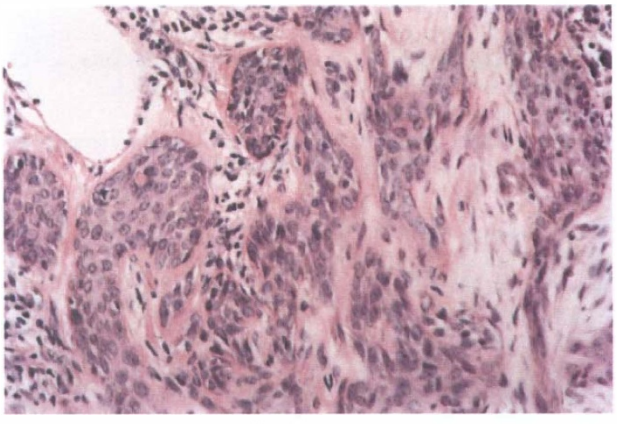

Fig. 2. *Deeper central component of smaller epithelial cells in a dense eosinophilic hypocellular stroma. (H&E; ×400.)*

Hartzell was the first to publish (in 1904) a convincing photomicrograph of the condition known as desmoplastic trichilemmoma. This is a symmetrical, circumscribed lesion confined to the dermis. It classically consists of basaloid cells in columns and cords with the formation of infundibulo-cystic structures, and sometimes displays a biphasic appearance of squamous cells and basaloid cells in a sclerotic stroma. The latter mimics invasive carcinoma.[3] In fact, the main importance of desmoplastic trichilemmoma is its pathological appearance, which can mimic trichilemmal carcinoma, squamous carcinoma and morphoeic basal cell carcinoma. There is hence a major implication for treatment in the case of a pathological misdiagnosis. The present case was well-circumscribed and symmetrical with the typical biphasic appearance, had a basement membrane and lacked mitoses or any significant cytological atypia.

The histiogenesis of desmoplastic trichilemmoma is controversial but is thought to be the same as for the classical trichilemmoma. It is histomorphologically similar to lesions such as verrucae vulgaris and inverted follicular keratosis. This has influenced some to believe that the desmoplastic reaction represents an involuting verruca showing trichilemmomal differentiation.[4] Unfortunately there is no molecular or cytopathogenic evidence to support a human papilloma virus aetiology. Perhaps the stromal changes in desmoplastic trichilemmoma simply reflect the host response to superficial ulceration. As far as we are aware, this is the first report of desmoplastic trichilemmoma affecting the eyelid. The extent of its pseudocarcinomatous changes and general architecture may cause diagnostic confusion at both the macro- and microscopic levels. Tumour recurrence following excision has never been reported.[1] This has important implications for the patient since simple excision of this lesion effects cure. Recognition of this benign neoplasm as such will prevent misdiagnosis and unnecessary aggressive treatment.

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Sir,

An unusual chorioretinal dystrophy?

Chorioretinal atrophy is observed as a consequence of congenital, hereditary or acquired disorders which may be infective, inflammatory or degenerative in nature. Geographic location and patterns of atrophy are used to classify each type.[1] We report a case of chorioretinal atrophy with a striking symmetrical appearance not previously described.

Case report

A 68-year-old woman was incidentally noted by her optician to have bilateral chorioretinal scarring which was thought to represent inactive chorioretinitis. She had no significant past medical history other than hypertension, which was well controlled on atenolol 100 mg daily.

On examination, the unaided visual acuities were 6/6 bilaterally and her visual fields, tested by Goldmann perimetry, were full. No abnormality was noted in the anterior segments; vitreous syneresis was present but was unaccompanied by signs of an active uveitis. The striking abnormality was the presence of bilateral, symmetrical, discrete areas of chorioretinal atrophy (Fig. 1). These lay along the vascular arcades near the origin of the vortex veins. *Toxoplasma* serology was negative.

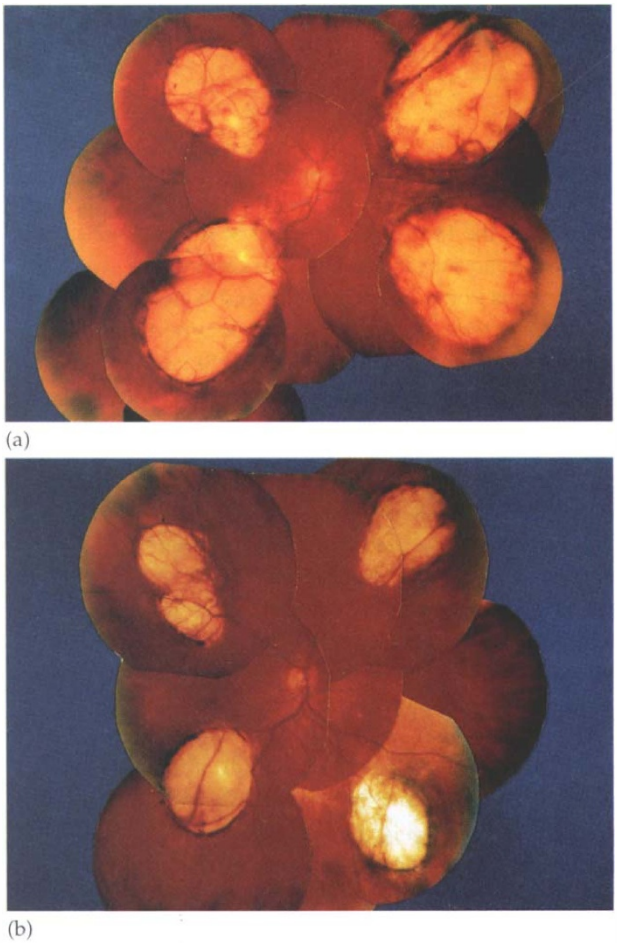

Fig. 1. *Symmetrical chorioretinal atrophy of the right (a) and left (b) fundi.*