

Fig. 2. Histopathological appearance of the lesion.

with chalazion, epidermoid cyst, dacryocystitis and tumours.^{1,6} Ocular leishmaniasis of the lower lid may heal spontaneously.

The treatment of ocular leishmaniasis includes prevention of secondary infections, intralesional or systemic antimony compounds (meglumine antimoniate) and allopurinol.^{1,3-9} Systemic interferon has been shown to be effective in the treatment of cutaneous leishmaniasis.¹⁰ We used allopurinol in the treatment of our case since antimony compounds can lead to serious side-effects such as fatal cardiac arrhythmias, hepatotoxicity and nephropathy, in addition to gastrointestinal upset such as nausea and vomiting. Additionally, it is difficult to supply antimony compounds in Turkey.

In conclusion, ocular leishmaniasis should be considered in the differential diagnosis of ulcerations, abscesses and nodules of the eyelids and ulcerated lesions of the conjunctiva, especially in endemic areas. Cicatrising sequelae of ocular leishmaniasis can be prevented by early diagnosis and treatment.

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Sir,

Endoscopic transnasal removal of orbital foreign body

Facial trauma involving breakable objects may result in concealed orbital foreign bodies. These may be missed unless specifically sought, and excluded with careful clinical examination and imaging techniques. We report an unusual case of an orbital foreign body with no apparent entry wound. The object was subsequently discovered to have entered the orbit via a nostril. To our knowledge, endoscopic transethmoidal removal of a posterior orbital foreign body via the nares has not previously been reported.

Case report

A 40-year-old man was admitted following an assault with a blunt object. He had a full-thickness left upper lip laceration and a right-sided 4 mm proptosis with associated periorbital bruising. On examination, unaided visual acuity was 6/9 in the affected right eye, 6/6 in the left. There was limitation in right abduction and depression. No trauma to the anterior segment or relative afferent pupillary defect was detected. Colour vision and fundoscopy was normal. There was no facial anaesthesia or surgical emphysema, nor any evidence of cerebrospinal fluid rhinorrhoea. Facial radiographs revealed a large, deeply placed radio-opaque foreign body within the right orbit (Fig. 1). Examination under general anaesthesia was undertaken and the lip wound repaired. Periorbital and lid examination did not demonstrate any breach in the skin or conjunctiva as a possible route of entry.

To accurately locate the foreign body and plan orbital surgery a CT scan was performed. This revealed a 41 mm object lying superior to the right lateral rectus and optic nerve, with the medial end of the object transfixing the medial rectus and lying partly within the ethmoidal sinus. The scans showed no evidence of orbital roof fracture. Examination by an otolaryngologist confirmed mid-nasal septal lacerations, trauma to the middle

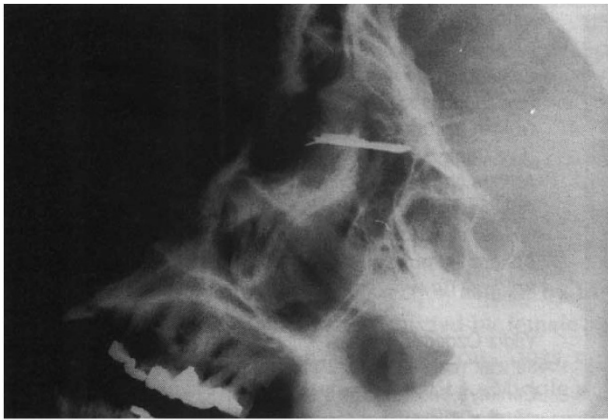


Fig. 1. Lateral plain radiograph.

turbinate and blood clot within the middle meatus, highlighting the hitherto unsuspected entry route of the foreign body.

Under general anaesthesia a 4 mm straight endoscope was passed to the middle meatus. On clearing traumatised soft tissues and clots, the tip of the foreign body was visualised and easily removed with gentle traction under endoscopic visualisation. No significant bleeding occurred during or after the procedure. Vision was 6/6 in both eyes 1 h after surgery. This level of acuity was maintained at 4 months follow-up with minimal limitation of abduction and diplopia on extreme laevoversion.

Comments

Reports of projectiles arrested within the paranasal sinuses are not uncommon and their endoscopic removal has been described. No previous description of a transethmoidal, transnasal route has been reported. It should be stated that whilst the outcome in this case was favourable, the risks associated with this technique compared with the more conventional orbital approach are unknown.

With sufficient force an almost limitless variety of foreign bodies may enter the orbit. Reports in the literature frequently emphasise the fact that skin or conjunctival breaches associated with foreign bodies may



Fig. 2. Foreign body with scale.

be comparatively small, and a high index of suspicion is urged.¹⁻³ Furthermore, organic foreign material may not be apparent on the plain radiograph,² in which case ultrasound or MRI examination of the orbits should be performed. In this case radiography was performed in the accident and emergency department to exclude orbital fracture because of the limitation of extraocular motility and this unexpectedly identified the radio-opaque foreign body.

Foreign bodies within the posterior orbit can cause visual loss either immediately, through trauma to the globe, optic nerve or the ocular circulation, or after a variable interval through delayed toxic or infective complications.⁴ Damage to the extraocular muscles and significant retro-orbital haemorrhage can also occur and, despite this, even sizeable foreign bodies may not compromise vision. This case highlights the need for circumspection when dealing with accidental or criminal trauma cases, especially since the mechanism of injury is often unclear from the patient's account. The lack of any visible trauma to the skin immediately surrounding the external nares in this case initially misled the clinicians concerning the true route of entry of the foreign body resulting from a thrusting motion across the face, through the lip, nares and ethmoidal sinuses to the posterior orbit. The foreign body (Fig. 2) was later identified as the missing portion of a golf club recovered by the police.

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