apart from side-effects of pain and photophobia,[2,3,7] been associated with late, sight-threatening complications; even at concentrations (0.02–0.04%) previously reported as safe.[7,8] Conjunctival autografting is associated with complications (graft retraction, graft cysts, haematoma, dellen) which tend to be less severe and rarely sight-threatening.[6]

Corneo-scleral dellen[6] and corneal perforation[7] are described complications of pterygium excision with adjunctive treatment, but to our knowledge scleral dellen has not been a previously reported complication of the bare sclera technique. In our case, because there was good compliance with post-operative medication, no return to adverse working conditions and no severe tear film deficiency, we relate this complication to a dellen effect created by the heaping up of granulation tissue at the margin of the bare sclera (Fig. 1). There was no evidence to suggest that this was an episode of scleritis of either autoimmune or surgical origin – a diagnosis further refuted by the resolution of the lesion with a conjunctival flap.

To our knowledge this represents the first reported case of scleral dellen as a complication of non-adjunctive, bare sclera excision of primary pterygium; this is therefore a procedure not without serious complication. This adds further support to the use of conjunctival autografting as a first-line treatment for primary pterygium.

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Sir,

An effective therapeutic modality for the management of hyperaemic conjunctival margins following the Hughes' procedure

A common cosmetic problem following the Hughes' procedure is the presence of an exuberant and hyperaemic conjunctivalised lid margin (22% in our recent series). Frequently this feature is seen for the first few months following division of the Hughes' flap[1] but with time the conjunctiva usually retracts, and the mucocutaneous junction at the lid margin settles down forming a normal appearance. The question remains how to manage the patient with a persistently unacceptable cosmetic result.

Case report

A 50-year-old man underwent excision of the middle half of the right lower lid using Mohs' micrographic technique for a recurrent basal cell carcinoma. The defect was repaired with a tarsoconjunctival pedicle flap to re-form the posterior lamella and an advancement flap of skin to re-form the anterior lamella. The tarsoconjunctival flap was divided at 21 days leaving the conjunctiva flush with the skin edge. The conjunctiva was not sutured to the skin. Nine months following the procedure the lid was cosmetically unsatisfactory with exuberant and hyperaemic conjunctiva extending too far anteriorly over the lid margin (Fig. 1).

Following the instillation of topical amethocaine drops 1% and injection of 0.5 ml lignocaine 2% to the lid margin a protective contact lens was inserted and argon green laser photocoagulation was applied to the hyperaemic conjunctiva. A spot size of between 200 and 500 μm was used with the power being titrated between 600 and 1000 mW and exposure time varying between 0.1 and 0.5 ms. The aim was to coagulate, producing a blanching effect rather than carbonating the conjunctival surface. The treatment was well tolerated.

Two months later the lower lid was more cosmetically acceptable (Fig. 2) and the patient was pleased with the result.

Fig. 1. *The cosmetically unsatisfactory lid with exuberant and hyperaemic conjunctiva extending too far anteriorly over the lid margin.*

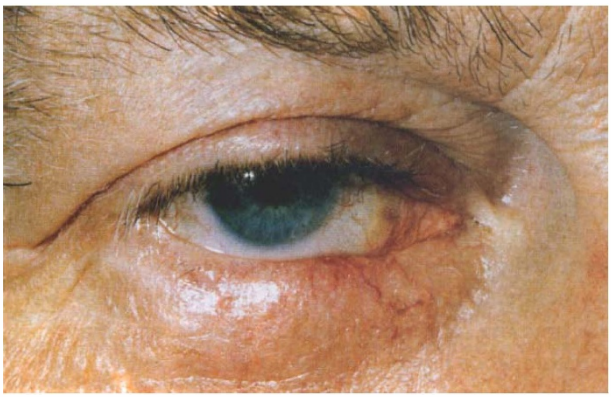

Fig. 2. *The lid 2 months after argon laser treatment, showing the more cosmetically acceptable appearance.*

Comment

We have found that the cosmesis of the lid margin is improved if the conjunctiva is not sutured to the skin at the initial surgery, thereby allowing the superior edge to retract behind the lid margin following division of the flap. Rogers[2] suggests that the skin should be divided 4 mm higher than the normal lid margin so that as the skin retracts the conjunctiva remains behind and unexposed. There is no doubt that with time many of these cases settle down; however, if there is a persistently hyperaemic conjunctival margin argon laser is effective. We do not have histological evidence but propose that the cosmetic improvement is produced by the destruction of the hyperaemic vessels, metaplastic change in the conjunctiva and the destruction of the goblet cells.

This treatment is also effective in the management of conjunctivalised lid margins following cryotherapy for trichiasis. Treatments can be reapplied with further therapeutic effect.

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Sir,

Conjunctivitis – sometimes more than meets the eye!

Children with red eyes are frequently encountered in general practice, eye clinics, and accident and emergency departments. We describe the case of a child with Kawasaki disease who presented with conjunctivitis.

Case report

A 3½-year-old girl was referred to the eye clinic by her general practitioner with conjunctivitis not responding to 4 days of topical treatment with fusidic acid. Her mother gave a history of an unwell child, who had 5 days previously developed fever followed by bilateral red eyes and a sore throat. She had also noted the appearance of a rash on both upper and lower limbs on the morning of the hospital visit.

On examination the child was alert, but ill looking with a temperature of 38.8 °C. There was bilateral diffuse conjunctival hyperaemia without any discharge. Ocular examination was otherwise unremarkable. Systemic examination revealed lymphadenopathy involving the right preauricular, upper deep cervical and both submandibular groups. She had dry cracked lips, two petechiae on her palate, a few mouth ulcers and pharyngeal hyperaemia. A macular skin rash involving upper limbs, lower limbs and upper chest was also noted. Her pulse was 120/min, and regular. Heart sounds were normal and on auscultation an ejection flow murmur was heard in the aortic area.

On the basis of the patient's systemic findings a clinical diagnosis of Kawasaki disease was made and she was referred to the Paediatric Department. Both electrocardiography and echocardiography were normal, as was the full blood count. The erythrocyte sedimentation rate was 32 mm/h and the blood cultures were negative. Conjunctival swabs for adenovirus, *Chlamydia* and bacteria were also negative. The child was treated with intravenous gammaglobulin 2 g/kg and aspirin 30 mg/kg per day. Within 24 h of beginning treatment the temperature had returned to normal and all systemic signs and symptoms were rapidly resolving. A day later mild desquamation of the feet was noted, but the child was otherwise well. After 3 days the patient was discharged on aspirin for follow-up as an outpatient with serial echocardiograms. To date she remains well without any cardiac sequelae.

Discussion

Kawasaki disease, or mucocutaneous lymph node syndrome, is a generalised vasculitis of unknown aetiology. Its frequency is increasing worldwide[1] and it is now the commonest cause of acquired heart disease in children in developed countries. It typically affects children aged less than 5 years, the incidence in Britain being 3.4 per 100 000.[2]

A high index of suspicion is necessary for its diagnosis, as it mimics many common childhood infections. There is no single diagnostic test and diagnosis is based on the clinical findings (Table 1).[3] Conjunctival injection is first noted shortly after the onset of the pyrexia and is typically bilateral, painless and non-exudative. Cardiac involvement with its potential for long-term morbidity and mortality is the most important manifestation. Coronary arteritis leading to formation of aneurysm occurs in 20–30% of untreated patients.[4] Thrombosis within an aneurysm, myocardial ischaemia,