limited exposure of ophthalmic staff to spinal anaesthesia, and that clear and appropriate instructions are given regarding post-operative care and the monitoring of the return of normal power and sensation.

In the case reported, the major risks of pulmonary aspiration and post-operative respiratory insufficiency were avoided by the use of spinal anaesthesia. The combination of local anaesthetic techniques could be extended to any patient undergoing brow suspension with autogenous fascia lata, depending on the preferences of the patient, surgeon and anaesthetist. Certainly for patients with OPMD, it should be considered as an effective and well-tolerated alternative to general anaesthesia, enabling the optimal material for brow suspension to be harvested without exposure to the increased risk of general anaesthesia.

References

1. Molgat YM, Rodrigue D. Correction of blepharoptosis in oculopharyngeal muscular dystrophy: review of 91 cases. Can J Ophthalmol 1993;28:11–4.
2. Crawford JS. Repair of ptosis using frontalis muscle and fascia lata: a 20-year review. Ophthalmic Surgery 1997;8:31–40.
3. Smith CL, Bush GH. Anaesthesia and progressive muscular dystrophy. Br J Anaesthes 1985;57:1113–8.
4. Brais B, *et al.* Short GCG expansions in the PAB2 gene cause oculopharyngeal muscular dystrophy. Nature Genet 1998;19:404.
5. Tome FMS, Fardeau M. Nuclear inclusions in oculopharyngeal muscular dystrophy. Acta Neuropathol (Berl) 1980;49:85–7.
6. O'Higashi T, *et al.* Spinal anaesthesia for patients with progressive muscular dystrophy. Matsui – Jpn J Anaesth 1995;44:723–8.
7. Kang SB, Goodnough DE, Lee YK, *et al.* Comparison of 26- and 27-G needles for spinal anaesthesia for ambulatory surgery patients. Anaesthesiology 1992;76:734.

C. Marsh
R. Manners
Department of Ophthalmology
Southampton General Hospital
Southampton SO16 6YD, UK

M. Platt
Department of Anaesthesia
Southampton General Hospital
Southampton SO16 6YD, UK

C. Marsh ✉
Eye Department
Queen Alexandra Hospital
Cosham
Portsmouth PO6 3LY, UK

e-mail: catmarsh@doctors.org.ul

Sir,

Orbital involvement with angiolymphoid hyperplasia with eosinophilia – a benign condition for the practising ophthalmologist to be aware of

We report the case of a 14-year-old girl presenting with rapidly developing ptosis of the right upper lid and mild proptosis. Excision biopsy revealed angiolymphoid hyperplasia with eosinophilia (ALHE), an uncommon, benign and poorly recognised condition.

Case report

A 14-year-old Caucasian girl presented with a history of right ptosis and numbness of the cheek for 2 weeks. She was otherwise healthy. Examination showed her corrected visual acuity to be 6/6 in both eyes. There was mechanical ptosis of the right upper lid with an indistinct mass having a rubbery consistency. There was a mild proptosis of the right eye. Systemic examination was normal. Blood counts and serum immunoglobulins were normal. A MRI scan of the right orbit showed an extraconal mass in the superolateral orbit merging with the levator palpabrae superioris anteriorly (Fig. 1). Because of the possibility of malignancy a complete excision biopsy was performed by bicoronal approach rather than a transseptal biopsy. This was performed as a combined procedure by the ophthalmologist and maxillofacial surgeon.

Tumour was noted to be extending both anterior and posterior to the orbital septum. The excision of the tumour was complete. Histopathological examination revealed ALHE and there was no evidence of malignancy (Figs. 2, 3). The patient had an uneventful post-operative recovery with a mild residual ptosis. The ptosis was repaired subsequently.

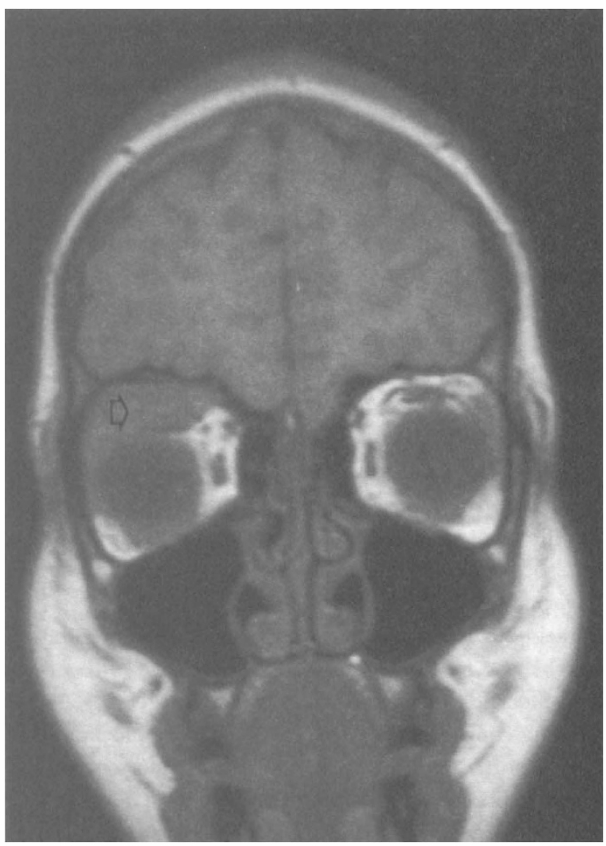


Fig. 1. *MRI scan showing the right orbital mass (arrow).*

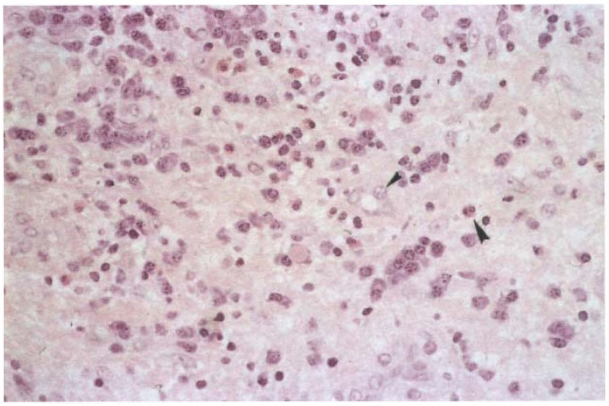


Fig. 2. *ALHE: The capillaries are lined by plump endothelial cells with a marked histiocytoid appearance (small arrowhead). There is a pronounced cellular infiltrate containing many eosinophils (large arrowhead)*

Comment

ALHE is a poorly recognised condition which has masqueraded under various eponyms and descriptive terms such as atypical pyogenic granuloma, eosinophilic granuloma and histiocytoid haemangioma. The original description was given in Japan in 1948.[1] A review of five orbital cases was published in 1983.[2]

The lesions of ALHE can be either single or multiple, and are situated mostly in the head and neck region. They are papular or nodular lesions in the skin and subcutaneous region. A small proportion of patients have associated eosinophilia and lymphadenopathy. These features, in association with an increased vascular component, may be confused with angiosarcoma[3] and thereby unwarranted aggressive procedures may be performed. Most investigators consider ALHE to be a reactive inflammatory process or an immunological condition, possibly a type 1 immunological reaction to an unidentified stimulus or to several causative agents.[4,5] Histologically ALHE shows vascular proliferation characterised by thick-walled blood vessels lined by plump epitheloid endothelial cells, which impart a histiocytoid appearance to the vessels. There is often prominent vacuolation of the endothelial cells. Additionally a lymphocytic infitrate is usually present which, at times, contains germinal centres. There is also a variable, often abundant, infiltration with eosinophils.[2] Histologically, this lesions in confused with a somewhat similar, but distinct entity known as Kimura's disease. Although Kimura's disease also has lymphoid and vascular proliferation with tissue eosinophilia, it lacks the specific 'epithelioid' endothelial cells, the hallmark of ALHE.[6]

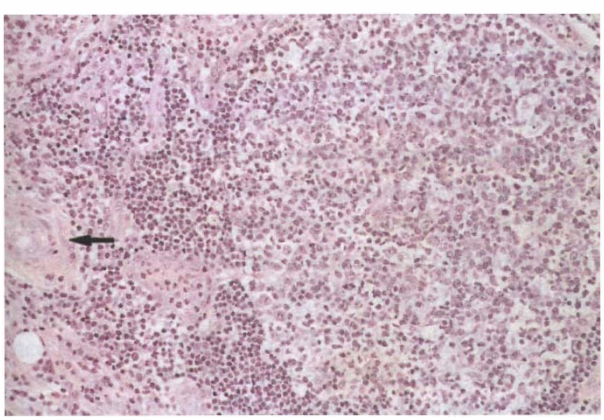


Fig. 3. *Prominent lymphoid follicle containing a germinal centre seen around blood vessels (arrow).*

Various treatment modalities for ALHE have been described. Local surgical excision appears to be the most effective treatment[2,3,7] although recurrences can occur if excision is incomplete. Where surgery is not possible radiation therapy has been used with some success.[8] Corticosteroids, whether administered systemically, intralesionally or topically, have been ineffective in most cases.[8–10] A few patients have been treated by chemotherapy and electrodesiccation, but these treatments were generally ineffective.[9,11]

Our patient was a 14-year-old girl with rapidly progressing ptosis and proptosis without eosinophilia or lymphadenopathy. The differential diagnosis included orbital lymphoma, haemangioma, epithelioid haemangioendothelioma and pseudotumour. Epithelioid haemangioendothelioma is a tumour of vascular origin with intermediate grade between well-differentiated haemangioma and malignant angiosarcoma. Orbital involvement with these tumours has been described.[12] Thus orbital ALHE can mimic a malignant condition clinically. In our patient there was no bony destruction of the orbital walls and there was no recurrence at 12 months follow-up. The residual mild ptosis was repaired with excellent cosmetic result. Also the scar in the coronal plane is cosmetically acceptable.

The ophthalmologist may occasionally see this entity in clinical practice and it is important to be aware of this condition in atypical orbital disease. When considering excisional biopsy we feel that, in our case, a bicoronal rather than transseptal approach provided a better possibility for complete excision and good cosmesis, particularly in view of the possibility of a malignant neoplasm at the time of surgery.

References

1. Kimura T, Yoshima S, Ishikowa T. Unusual granulation combined with hyperplastic change of lymphoid tissue. Trans Soc Pathol Jpn 1948;37:179.
2. Hidayet AA, Cameron JD, Font RL, Zimmerman LE. Angiolymphoid hyperplasia with eosinophilia of the orbit and ocular adnexia. Am J Ophthalmol 1983;96:176.
3. Barnes L, Koss W, Nieland MC. Angiolymphoid hyperplasia with eosinophilia: a disease that may be confused with malignancy. Head Neck Surg 1980;2:425.
4. Jones EW, Bleehen SS. Inflammatory angiomatous nodules with abnormal blood vessels occurring about the ears and scalp. Br J Dermatol 1969;81:804.
5. Buchanan R, Sworn MJ, Mousley JM. Angiolymphoid hyperplasia with eosinophilia involving the skeletal muscle. Histopathology 1980;4:197.
6. Helander SD, Peters MS, Kuo TT, Su WP. Kimura's disease and angiolymphoid hyperplasia with eosinophilia: new observations from immunohistochemical studies of lymphocyte markers, endothelial antigens and granulocyte proteins. J Cutan Pathol 1995;22:319–26.

7. Gardener JH, Amonette RA, Chesney TM. Angiolymphoid hyperplasia with eosinophilia. J Dermatol Surg Oncol 1981;7:414.
8. Rao RN, Spurlock BO, Witherington R. Angiolymphoid hyperplasia with eosinophilia: report of a case with penile lesions. Cancer 1981;47:944.
9. Baler GR. Angiolymphoid hyperplasia with eosinophilia: a report of two cases. J Dermatol Surg Oncol 1981;7:229.
10. Daniels DG, Schrot R, Fliegelman MT, Owen LG. Ultrastructural study of a case of angiolymphoid hyperplasia with eosinophilia. Arch Dermatol 1974;109:870.
11. Mehregan AH, Shapiro L. Angiolymphoid hyperplasia with eosinophilia. Arch Dermatol 1971;103:50.
12. Lyon DB, Tang TT, Kidder TM. Epithelioid hemangioendothelioma of the orbital bones. Ophthalmology 1992;99:1773–8.

T.S. Balaji Prasad[1]
P.S. Suresh[1]
G. Rodrigues[2]
M. Patel[2]
A.P. Moriarty[1]
[1]Stepping Hill Hospital
Stockport, UK
[2]Withington Hospital
Manchester, UK

Mr P.S. Suresh ✉
Manchester Royal Eye Hospital
Oxford Road
Manchester M13 9WH, UK
Tel: +44 (0)161 276 1234
Fax: +44 (0)161 272 6618

Sir,

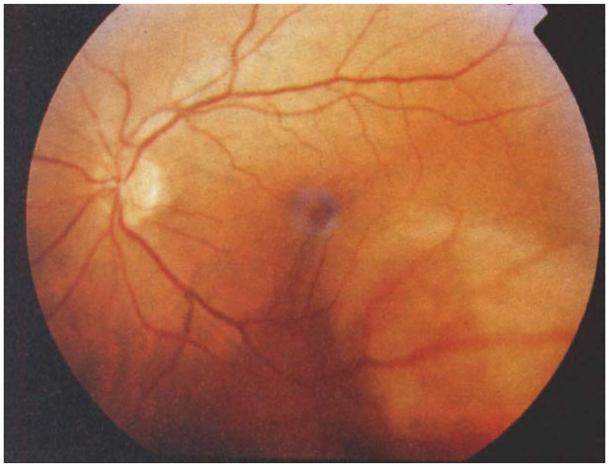
Bilateral multifocal choroidal metastases as the first manifestation of a breast carcinoma

Breast cancer is the most common malignancy among women in Western societies. In the European Union, breast cancer represents 28% of all female cancers. Rates are highest in Northern and Western Europe, with the exception of France, which has a relatively low rate, in common with Greece, Spain and Portugal.[1] The incidence rates of breast carcinoma in the United States, as well as in European countries, are increasing steadily, whereas mortality caused by the disease is fairly constant. The age-adjusted incidence of breast cancer among US women rose by over 30% during the 1980s.[2] Although breast cancer haematogenous metastases favour the skeleton, lung, pleura and liver, virtually any anatomical site may be involved.

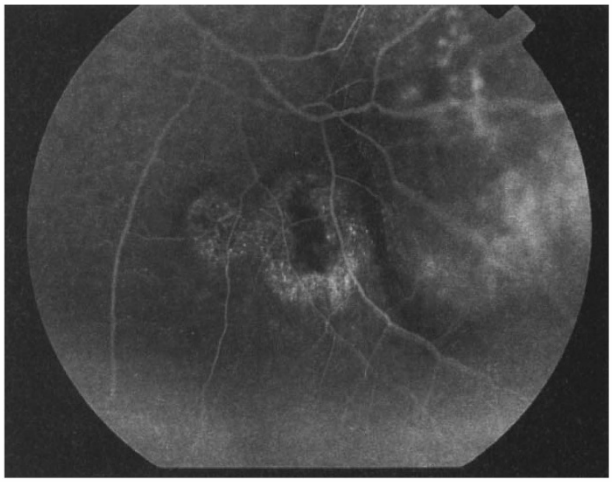
We describe an unusual case of primary breast carcinoma that had not presented earlier. The patient initially presented with visual problems, due to bilateral multifocal choroidal metastases. The clinical presentation, the angiographic and ultrasonographic findings of the uveal lesions implied a metastatic process. Results from a mammogram established the diagnosis.

Case report

A 42-year-old woman presented with a 1 week history of metamorphopsia in the left eye. Neither her ocular nor her medical history were notable. The Snellen visual acuity was 20/20 in each eye. The anterior ocular segments were normal. Fundus examination of the left eye showed a yellowish-orange, round, amelanotic, well-circumscribed mass inferotemporal and adjacent to the macula, that extended below the inferior arcade. An overlying serous retinal detachment extended into the macula causing metamorphopsia (Fig. 1a). Right fundus examination revealed a similar mass, inferonasally to the optic disc, about 1 disc diameter away from it.



(a)



(b)

Fig. 1. *Left eye. (a) Fundus examination shows a yellowish-orange, round, amelanotic, well-circumscribed mass, inferotemporal and adjacent to the macula, that extends below the inferior arcade. An*

Fluorescein angiography of the left eye revealed two additional choroidal lesions, nasal to the larger mass (Fig. 1b). On fluorescein angiography of the right eye there was a highly fluorescent mass located nasal to the optic disc (Fig. 2a) and three flat choroidal lesions, two in the inferotemporal area and one 3 disc diameters temporal to the macula (Fig. 2b). All lesions were rather well circumscribed, round or oval in shape. In the venous phase there was irregular progressive hyperfluorescence at the centre of the lesions and small hyperfluorescent dots at their margins. There was also retinal capillary dilation with late dye leakage.