Sir,

Dacryoadenitis as a presenting feature of the Churg Strauss syndrome

Churg Strauss syndrome (CSS) was first described in 1951 by Churg and Strauss. Eye involvement, though rare, can present as episcleritis, uveitis, ischaemic optic neuropathy, and nerve palsies. We report a case of CSS presenting with dacryoadenitis.

Case report

A 27-year-old female presented with a 2-week history of a non-fluctuant, mobile, tender left supero-temporal orbital mass. Upper lid eversion revealed a subconjunctival lesion in the same region. Significant medical history included asthma, recent rhinitis, and a 12-month history of a generalized maculopapular rash. Rapid progression was noted over the next week with the development of a partial ptosis and extension of the subconjunctival lesion to the limbus (Figures 1 and 2). A CT scan showed an enlarged lacrimal gland, with no bony erosion (Figure 3). The patient underwent lacrimal gland, conjunctival and skin biopsies.

Histopathology confirmed the presence of granulomatous lesions from both eye sites. Skin biopsy showed similar lesions with extravascular eosinophilic infiltration (Figure 4). Peripheral blood eosinophil levels were raised (2.13×10^9/l). ANCA screen was positive for pANCA but further analysis showed normal PR3 and MPO.

After confirmation of diagnosis, the patient responded dramatically to oral prednisolone 40 mg/day on a tapering regimen (Figure 5).

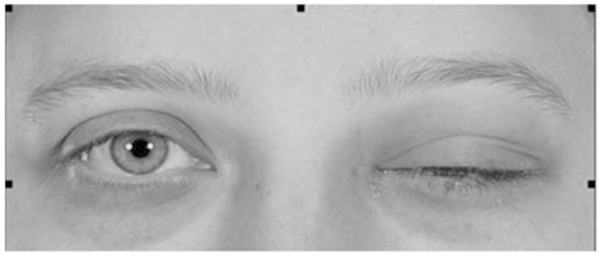

Figure 1 Pretreatment appearance of left supero temporal orbital mass with partial ptosis.

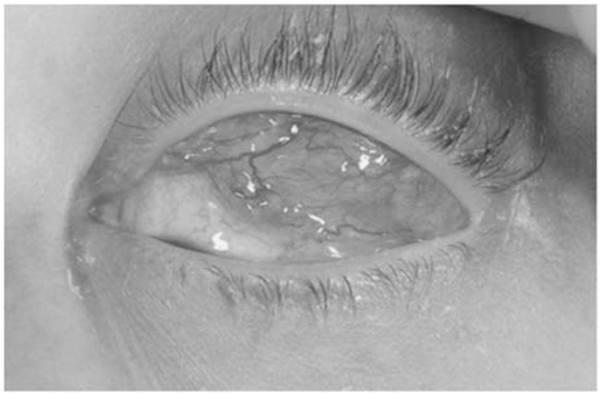

Figure 2 Extensive sub conjunctival lesion.

Comment

Our case showed asthma, eosinophilia, paranasal sinus involvement, and eosinophilic infiltration on histopathology, meeting the diagnostic criteria of the College of Rheumatologists.[1]

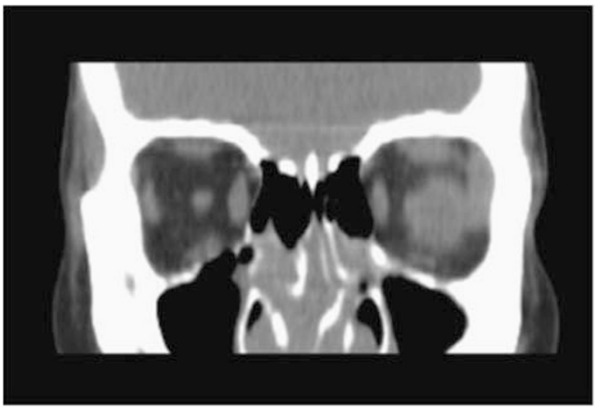

Figure 3 Coronal CT scan showing left lacrimal gland enlargement extending as far as posterior pole of globe. Bilateral sinus opacification also seen.

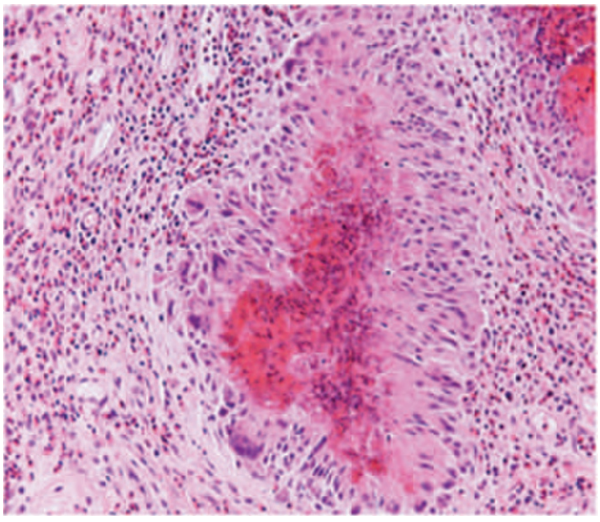

Figure 4 Histopathology of lacrimal gland showing perivascular eosinophilic granulomatous inflammation with giant cells (haematoxylin-eosin stain, magnification X 200).

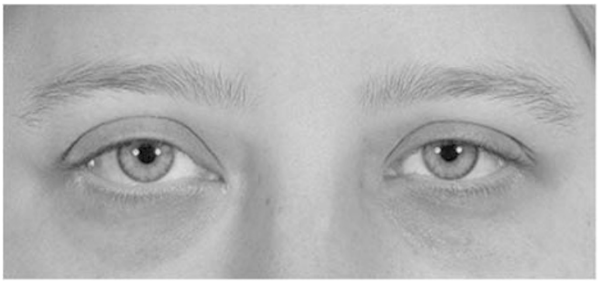

Figure 5 Post-treatment appearance with resolution of ptosis and sub conjunctival lesion.

Dacryoadenitis was diagnosed clinically and on CT imaging. Histopathology confirmed the diagnosis with classical granulomatous inflammation with eosinophilic infiltration. CT imaging, blood tests, and histopathology ruled out lacrimal gland tumour, Wegener's granulomatosis and sarcoidosis.

Takanashi *et al*[2] reported two cases of CSS, one of which presented as chronic dacryoadenitis, the other with vasculitis. It has been proposed that CSS evolves through an allergic phase to eosinophilic tissue infiltration and then a final vasculitic stage.[3] Indeed, various case reports[4,5] have reported ocular involvement from both ends of this disease spectrum.

Although CSS may have varied ophthalmic presentation, asthma, eosinophilia, and multisystem involvement should raise suspicion of this condition. Early diagnosis and treatment could avoid complications and relapses, not uncommon in CSS.

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Sir,

Fine-needle aspiration biopsy in lacrimal gland pleomorphic adenoma

We congratulate Dr Lai and associates on their excellent and timely review on the role of biopsy in lacrimal gland pleomorphic adenoma (LGPA).[1] We would like to further emphasize the distinction between using a fine-needle aspiration biopsy (FNAB) or an incisional biopsy. The first technique includes one or more (usually 25 gauge) transcutaneous or transconjunctival needle passes. For lesions located deep in the orbit, the needle may be guided by computerized tomography. Slides can be immediately assessed for adequacy if the cytopathologist is present at the time of FNAB. The latter technique involves an 'open' surgical approach that will necessarily create a significant break of several millimetres in the thin fibrous pseudocapsule surrounding the LGPA. Potentially, this would increase the risk of local tumour seeding and later recurrence. The obvious benefit of the incisional biopsy is that more material will be available for examination.

We recently reported our findings using FNAB for diverse orbital space-occupying masses and were able to make the correct diagnosis in 81/82 (99%) orbital lesions including all three LGPA in this series.[2] Since then, we have used FNAB for 12 more patients with LGPA and were able to make a correct pre-operative diagnosis in all cases. All these patients with cytologically confirmed LGPA subsequently had en bloc excision and there have been no tumour recurrence during a median follow-up of 67 months (range: 11–135 months).

On the basis of our experience, we strongly encourage FNAB (and not incisional biopsy) as the routine procedure when lacrimal gland pleomorphic adenoma is suspected. At the hands of a well-trained cytopathologist, the material is usually sufficient for a correct diagnosis and the morbidity is minimal. In the unlikely event of an inconclusive finding, a repeat FNAB or an incisional biopsy may be performed.

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Sir,

Relationship between refraction and allergic conjunctivitis

I have read with interest the article 'Relationship between refraction and allergic conjunctivitis' by Mimura *et al*[1]. There are some inconsistencies that need to be addressed.