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.

The authors take the right eye for analysis, ignoring the left eye without any test of correlation between them to validate the use of just one eye as the subject.

In the definition of 'seasonal allergic conjunctivitis' (SAC), the authors enumerate the symptoms and cite conjunctival follicle as associated with SAC, which is not true. Papillae are the main biomicroscopic, histological, and anatomical finding associated with SAC.

- Reference 3 is incorrect. The correct version is *Ocul Immunol Inflamm* 1994; **2**(Suppl 1): S17–S34.
- In the Results section, Table 1 displays demographic data (number of patients, gender, and age). For methodological reasons, these data pertain to the Materials and methods section, because they are not result of any analysis, only the source/material.
- The conclusion that the configuration of the corneal surface leads to allergic conjunctivitis is inaccurately interpreted by the authors. What the literature shows is that with the allergic process (commonly in vernal keratoconjunctivitis), a complex process involving biochemical (enzymes and enzymatic inhibitors) and cellular (apoptosis) disturbances, which leads to stromal thinning, increase in the corneal curvature and consequently myopic astigmatism.[2–4] Moreover, in susceptible individuals, long-term allergic disease with a chronic traumatic factor on the corneal epithelium could be related to keratoconus, because, as Kim *et al*[5] pointed out that persistent and chronic corneal trauma on the corneal epithelium (in this particular situation, itching or chronic trauma provoked by giant papillae), induces a 'silent' and chronic inflammatory process, leading to progressive loss of stromal mass and consequently to less biomechanical resistance, and thus to anterior corneal steepening, decreasing the optical competence of the anterior corneal surface.

Scientific data support the affirmation that chronic allergic conjunctivitis may be a risk factor for myopic refractive error. In contrast, no consistent data have shown the opposite.

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Sir,

Response to Dantas *et al*

We appreciate the comments expressed by Professor Paulo (EC) Dantas[1] PEC regarding our paper about 'Relationship between Refraction and Allergic Conjunctivitis' published in the October 2007 issue (Mimura *et al*, 2007).

Table 1 Comparison of ocular biometry and refraction between patients with and without seasonal allergic conjunctivitis

	Non-contact lens wearers		t-*test*	*Contact lens wearers*		t-*test*
	Patients with SAC	*Patients without SAC*		*Patients with SAC*	*Patients without SAC*	
Number of patients	224	659		73	59	
Male/Female	68/156	284/375		22/51	16/43	
Age (years)	47.5 ± 20.2	51.4 ± 22.4	0.0077	31.3 ± 10.9	30.1 ± 12.0	NS
Spherical equivalent (D)	−3.01 ± 3.83	−1.36 ± 3.08	<0.0001	−5.47 ± 2.79	−5.31 ± 2.79	NS
Sphere (D)	−2.64 ± 3.63	−1.05 ± 2.88	<0.0001	−5.02 ± 2.62	−4.91 ± 2.75	NS
Cylinder (D)	0.91 ± 0.90	0.89 ± 0.81	NS	0.93 ± 0.78	0.85 ± 0.65	NS
Corneal radius (mm)	7.68 ± 0.31	7.69 ± 0.30	NS	7.78 ± 0.37	7.85 ± 0.43	NS
Maximum corneal refractive power (D)	44.55 ± 1.80	44.45 ± 1.76	NS	44.20 ± 2.12	43.75 ± 2.37	NS
Minimum corneal refractive power (D)	43.44 ± 1.89	43.41 ± 1.83	NS	42.83 ± 1.96	42.55 ± 2.14	NS

D = diopters; NS = not significant; SAC = seasonal allergic conjunctivitis.
Values are expressed as mean ± SD.