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Sir,

Conjunctival granulomatosis in a patient with ulcerative colitis

Inflammatory bowel disease can be associated with a variety of ophthalmic complications. Here we present a case of conjunctival granulomatosis in a patient with ulcerative colitis (UC).

Case report

A 32-year-old male presented with bilateral conjunctival granulomata. He had no past ophthalmic history and was in good health. The granulomata were restricted to the palpebral conjunctiva and fornices (Figure 1). They were excised but recurred within 3 months. Over the next ten years, he had multiple excisions of recurrent granulomata from the upper and lower palpebral conjunctiva of both eyes.

Histological examination consistently reported a severely inflamed granulation tissue with a mixed acute and chronic inflammatory cell infiltrate. Topical steroids reduced the rate of recurrence of the granulomata. Systemic investigations including allergy testing revealed no systemic associations.

At the age of 42, he presented with a 6-week history of bloody diarrhoea and weight loss. UC was diagnosed on colonoscopy and biopsies that showed crypt architectural distortion, patchy cryptitis and increased inflammatory cells in the lamina propria. Granulomata were not seen in the biopsy specimen. The colitis settled with a course of intravenous and oral steroids and his bowel disease has remained in remission since. During this period his conjunctival disease remained inactive. Fourteen months later he developed a new granuloma in the lateral canthal conjunctiva of the left eye (Figure 2). He was restarted on topical prednisolone and the lesion was excised.

Comment

Inflammatory bowel disease includes UC and Crohn's disease and is characterised by chronic inflammation of the intestines. Both UC and Crohn's have been associated with ophthalmic complications, the most common of which are uveitis, episcleritis, scleritis and keratitis.[1–3] Conjunctival granulomata can form in response to a foreign body, allergen, infectious organism or as part of a systemic disease process, which include sarcoidosis, Wegener's granulomatosis and Churg-Strauss.

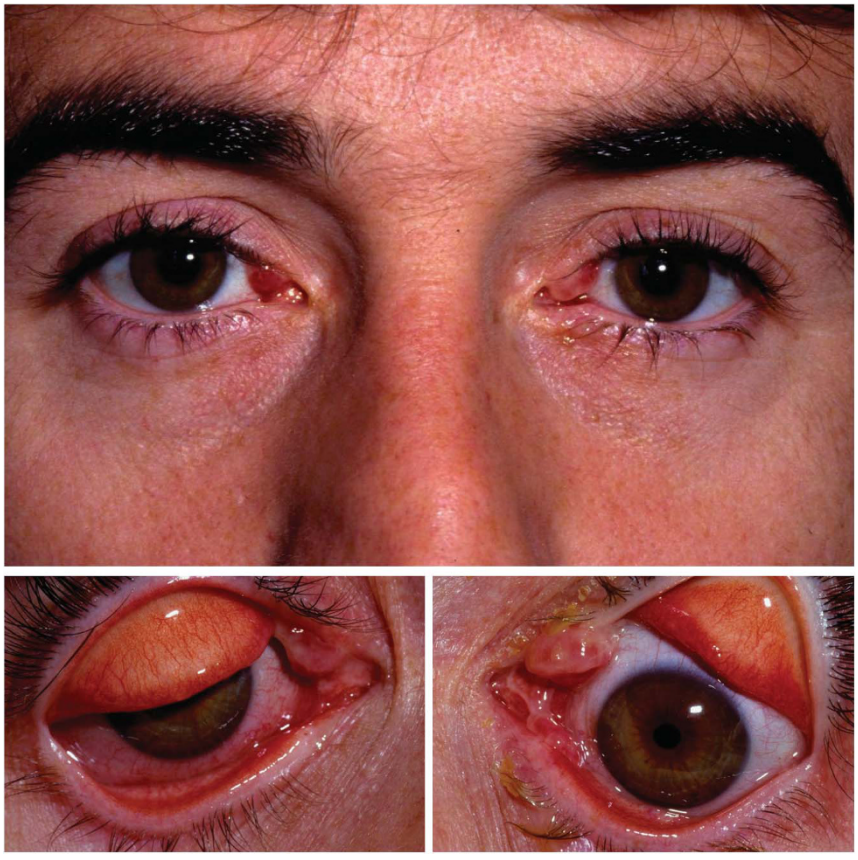

Figure 1 Bilateral conjunctival granulomata.

Figure 2 A recurrent conjunctival granuloma in the left lateral canthus.

There are only two reports of conjunctival granulomatosis in IBD, both in patients with Crohn's disease and not UC.[4,5] In one case the lesions were similar in appearance to this case but in the other bilateral conjunctival circumlimbal nodules are described, neither had a prolonged course. In our case, the ophthalmic findings started 10 years before any bowel symptoms and it is possible that they are unrelated. However, extensive investigations failed to identify any other cause and it is worth noting that during treatment for his UC the eyes were quiescent. It is also interesting to note that although granulomata are classically found in Crohn's disease, they occasionally occur in UC.[6] This would suggest that it is plausible that the conjunctival granulomata seen in this case are due to the same underlying disease process that caused the UC. Our case is the first in the literature to describe conjunctival granulomatosis in a patient with UC.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Reactivation of Darier's disease following Azathioprine treatment for thyroid eye disease

Azathioprine is an immunosuppressive agent commonly used for treating active thyroid eye disease (TED). Documented side effects include gastrointestinal intolerance, bone marrow suppression, and hepatic toxicity.[1] We describe an unusual side effect of Azathioprine treatment.

Case report

A 51-year-old woman was referred for management of active TED. Past medical history included inactive Darier's disease. Her thyroid function tests were controlled and she stopped smoking following our advice. The active TED was controlled with oral Prednisolone 40 mg. Azathioprine was gradually introduced in the treatment as a steroid-sparing agent with gradual tapering of Prednisolone after ensuring normal thiopurine methyltransferase levels (106 mU/l, normal; 68-150 mU/l).

At Azathioprine 150mg daily, the patient reported sudden reactivation of a florid, brown papulomatomatous rash on her forehead and chest consistent with reactivation of her Darier's disease (Figures 1a and b). Azathioprine was discontinued and she was treated with oral acitretin (retinoid) by dermatologists with complete recovery (Figures 1c and d).

Comment

Darier's disease or keratosis follicularis is a dermatological condition affecting seborrheic areas of the skin. Patients present with yellow–brown papules, which have a greasy and warty texture. It is an autosomal dominantly inherited disorder that has been associated with mutations in the gene *ATP2A2*.[2]

To our knowledge this is the first reported case of reactivation of Darier's disease, following the use of Azathioprine treatment. Anolik and Rudolph[3] describe a case of a transplant patient being treated with azathioprine and prednisolone who developed a papular rash consistent with Darier's disease; however, the cause was thought to be secondary to scabietic infestation. In our case scabietic infestation was not identified.