Figure 3 (a–c) Anterior segment fluorescein angiography shows early fluorescein leakage onto the anterior lens capsule, increasing in the late phase.

of NVI (Figures 3a–c). Ultrasonography showed a closed funnel retinal detachment, and therefore no intervention was planned.

Comment

Anterior ocular neovascularization may develop in eyes with chronic anterior segment ischemia, due to peripheral retinal detachment or proliferative vitreo-retinopathy.^{1,2} Deprivation of choroidal blood supply stimulates retinal pericytes, endothelial cells, and retinal pigment epithelium to produce VEGF, which follows its concentration gradient from vitreous to anterior segment causing NVI.³

NVC in our case differs from neovascular membranes, sometimes appreciated in chronic anterior uveitis, which harbor larger caliber vessels growing across the pupillary border in a random manner. In contrast, our case had a regular circumferential arrangement of vessels. In the absence of a fibro-proliferative scaffold for vessel growth behind the iris on UBM, NVC appears to be a primary event. Another possibility could be the abnormal proliferation of vessels on the ciliary body with subsequent extension through ciliary zonules onto the lens capsule. The lens capsule secretes anti-endothelial cell inhibitory factors inhibiting NVC even in the presence of concurrent iris neovascularization.⁴ Any injury allows the lens capsule to respond to lens specific growth factors to permit proliferation of new vessels.⁵ A traumatic microcapsular breach could also have precipitated NVC in our case.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Comarrata MR, Chang S, Sparrow J. Iris neovascularization in proliferative vitreoretinopathy. *Ophthalmology* 1992; **99**: 898–905.
- 2 Barile GR, Chang S, Horowitz JD, Reppucci VS, Schiff WM, Wong DT. Neovascular complications associated with rubeosis iridis and peripheral retinal detachment after retinal detachment surgery. *Am J Ophthalmol* 1998; **126**: 379–389.
- 3 Aiello LP, Avery RL, Arrigg PG, Keyt BA, Jampel HD, Shah ST *et al*. Vascular endothelial growth factor in ocular fluid of patients with diabetic retinopathy and other retinal disorders. *N Engl J Med* 1994; **331**: 1480–1487.
- 4 Williams GA, Eisenstein R, Schumacher B, Hsiao KC, Grant D. Inhibitor of vascular endothelial cell growth in the lens. *Am J Ophthalmol* 1984; **97**: 366–371.
- 5 Rutland CS, Mitchell CA, Nasir M, Konerding MA, Drexler HCA. Microphthalmia, persistent hyperplastic hyaloid vasculature and lens anomalies following overexpression of VEGF-A188 from the α A-crystallin promoter. *Mol Vis* 2007; **13**: 47–56.

S Gupta, V Gogia, A Ramya and R Sihota

Dr Rajendra Prasad Centre for Ophthalmic Sciences,
All India Institute of Medical Sciences, New Delhi, India
E-mail: varungogia@gmail.com

Eye (2014) **28**, 358–359; doi:10.1038/eye.2013.298;
published online 10 January 2014

Sir, Incidental folliculotropic mycosis fungoides in a blepharoplasty specimen performed for dermatochalasis

Blepharoplasty is a common cosmetic procedure carried out throughout the world. The skin that is removed during the procedure is usually discarded. We present a case of a routine blepharoplasty performed for bilateral dermatochalasis, in which a high suspicion of index on the part of the surgeon, resulted in the detection of serious histopathological changes in the redundant eyelid skin that would otherwise have been discarded.

Case report

A 68-year-old woman was referred to the oculoplastic surgeons with dermatochalasis with vision obstruction. In clinic the visual acuities were 6/9 OD and 6/9 OS aided and the lids showed bilateral upper lid dermatochalasis worse on the right, with a mechanical

ptosis (Figure 1a). The facial and lid skin was generally red and thickened. Thinning of both eyebrows was noted. The patient underwent bilateral blepharoplasties and in view of the clinical observations above, the right upper eyelid specimen (that would have otherwise been discarded) was sent for histopathological diagnosis.

The haematoxylin and eosin sections revealed a striking folliculotropic, lymphocytic infiltrate. (Figure 1b). The lymphocytes were rather irregular and

cerebriform in shape at higher power (Figure 1c). No follicular mucin was identified. Immunohistochemistry showed that the atypical lymphocytes expressed CD3 (Figure 1d), indicating a T-cell phenotype and CD4 with some loss of CD7.

CD30 or CD56 was not expressed. DNA extracted from the paraffin tissue showed the presence of a T-cell clone (Figure 1e). The morphological, immunohistochemical and molecular features were those of folliculotropic mycosis fungoides (MF) (WHO classification).

Figure 1 (a) Clinical appearance of the eyelids. Note bilateral dermatochalasis, thinned eyebrows, reddish, rugged skin on forehead and slight thickening of the right upper eyelid compared to the left. (b) Haematoxylin and eosin stained section of the right upper lid blepharoplasty specimen showing a folliculotropic infiltrate. (c) Higher power of the follicular infiltrate showing abnormal lymphocytes with irregular/cerebriform nuclei. (d) CD3 (pan-T-cell antigen) expressed on the folliculotropic lymphocytes, as detected by immunohistochemistry (brown = positive reaction). (e) 186 base pair T-cell clone detected by PCR (tallest peak is the dominant T-cell clone).

Dermatological review subsequently discovered reddish patches on her anterior chest, with biopsy showing an identical histological diagnosis.

Comment

To the best of our knowledge, this is the first report of folliculotropic MF to affect the peri-ocular skin. Ophthalmic manifestations of mycosis fungoides have shown that late plaque or tumour phase MF affected the eyelids in a significant number of patients.¹ MF can present clinically with lower eyelash and eyebrow loss² as in our case. The significance of folliculotropic MF is that it carries a worse prognosis compared to conventional plaque stage MF and therefore important to distinguish histologically.³ From a practical perspective, oculoplastic surgeons carry out a large number of cosmetic blepharoplasty procedures. Sending every blepharoplasty specimen for routine histological analysis would not constitute wise use of the histopathology service. However, this case serves to illustrate the point that any eyelid skin that is deemed to be even faintly abnormal during examination or during the surgical procedure should be sent for histopathological examination to exclude serious pathology, of the kind identified in this case.

The study was performed in accordance with the declaration of Helsinki. The patient consented to an identifiable photograph of the eyes to be used for publication. The signed consent is in the medical notes.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Stenson S, Ramsay DL. Ocular findings in mycosis fungoides. *Arch Ophthalmol* 1981; **99**(2): 272–277.
- 2 Gül U, Soyly S, Aslan E, Yazar Z, Demiriz M. Uncommon presentation of mycosis fungoides: eyelid margin involvement. *J Dermatol* 2008; **35**(9): 581–584.
- 3 van Doorn R, Scheffer E, Willemze R. Follicular mycosis fungoides, a distinct disease entity with or without associated follicular mucinosis: a clinicopathologic and follow up study of 51 patients. *Arch Dermatol* 2002; **138**(2): 191–198.

HS Mudhar¹, N Tiffin², Z Currie³ and S Salvi³

¹National Specialist Ophthalmic Pathology Service (NSOPS), Department of Histopathology, Royal Hallamshire Hospital, Sheffield, UK

²Department of Histopathology, Royal Hallamshire Hospital, Sheffield, UK

³Department of Ophthalmology, A-Floor, Royal Hallamshire Hospital, Sheffield, UK
E-mail: hardeep.mudhar@sth.nhs.uk

Eye (2014) **28**, 359–361; doi:10.1038/eye.2013.297;
published online 10 January 2014

Sir, Local safety of repeated intravitreal Ozurdex

The article entitled ‘Twelve-month experience with Ozurdex for the treatment of macular edema associated with retinal vein occlusion’¹ highlights the significant cataract progression in eyes receiving more than one Ozurdex implant. We retrospectively reviewed the charts of all patients with macular edema secondary to retinal vein occlusion (RVO) refractory to current therapies and treated with Ozurdex from April 2010 until March 2012.

The mean age of patients with branch RVO ($n = 33$) was 72.4. In eyes receiving a second Ozurdex implant, four out of the five phakic eyes showed progression of cataract requiring surgery. We registered one case of anterior chamber migration resulting in a bullous keratopathy.² The mean age of patients with CRVO ($n = 23$) was 68.3. In eye receiving a second Ozurdex implant, four out of the six phakic eyes showed progression of cataract requiring surgery.

Real-life studies are necessary in order to better define the safety and efficacy of new therapeutic approaches. Although the GENEVA study³ reported an incidence of 29.8% of cataract progression in eyes receiving a second Ozurdex intravitreal implant, Mayer *et al*¹ found a significant higher proportion of these eyes in their study after a third implant (50.0%), and we also evidenced a higher progression of lens opacity in patients with macular edema secondary to RVO refractory to conventional therapies receiving a second implant (75.0% in branch RVO and 66.7% in central RVO). These data should be taken into account when an individualized strategy is planned for patients with RVO.

Conflict of interest

The authors declare no conflict of interest.

Acknowledgements

All the authors conceived and designed the work that led to the submission, acquired data, playing an important role in interpreting the results, drafted the manuscript and approved the final version.

References

- 1 Mayer WJ, Wolf A, Kernt M, Kook D, Kampik A, Ulbig M *et al*. Twelve-month experience with Ozurdex for the treatment of macular edema associated with retinal vein occlusion. *Eye* 2013; **27**(7): 816–822.
- 2 Pardo-López D, Francés-Muñoz E, Gallego-Pinazo R, Díaz-Llopis M. Anterior chamber migration of dexametasone intravitreal implant (Ozurdex®). *Graefes Arch Clin Exp Ophthalmol* 2012; **250**(11): 1703–1704.