diplopia, photophobia, temporary visual impairment, and retinal vein occlusion.[2,3] Although these adverse ocular effects generally disappear within a few days to weeks following discontinuance of therapy, shimmering after-images (palinopsias) and photophobia have been reported to be symptomatic in three cases for 2–7 years.[3]

Maculopathy associated with CC was not reported in previous series. Our case was taking CC by her own for an overextended period and developed irreversible visual impairment with maculopathy. Although CC has a similar molecular structure to tamoxifen,[4] CC-associated retinopathy differs from tamoxifen retinopathy as there are no blocking crystals in FA, but atrophic maculopathy. Our case indicates that CC may induce irreversible retinal damage and visual deterioration if used for an overextended period.

Conflict of interest

The author declares no conflict of interest.

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Sir,
Eyelid nodule in a child: a chalazion or idiopathic facial aseptic granuloma?

Chronic, painless facial nodules in children, which may be misdiagnosed as chalazions if located on eyelids are subject of a new entity called 'idiopathic facial aseptic granuloma' (IFAG). IFAG is a dermatological disorder characterized by solitary eyelid nodules or accompanying facial nodules located on the cheeks with an unknown etiology.[1] The role of trauma and insect bite has been discussed.[2] Nodules include a discharge of pus. Cultures are negative, except in cases of superinfection.

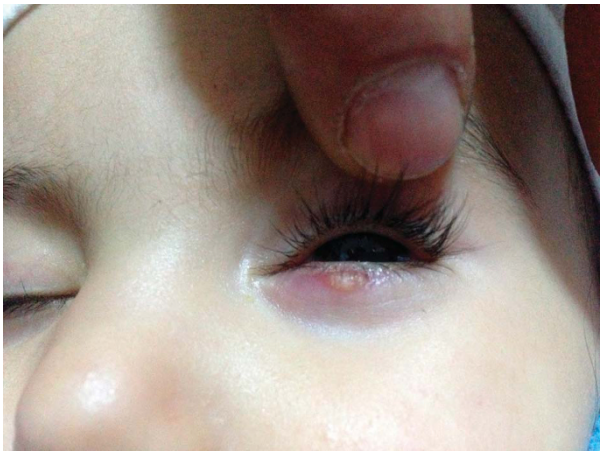

Figure 1 Eyelid nodule of IFAG.

Eyelid nodules resemble nodules of meibomian cysts (chalazions) (see Figure 1). Ultrasonography of IFAG nodules shows a well-demarcated hypoechoic lesion located in dermis only.[3] But chalazions—which are due to meibomian gland inflammation—are located inside eyelid tarsus.[4] IFAG nodules are thought to be related to a granulomatous process surrounding an embryological residue, rather than inflammation of meibomian glands.[1] Chalazions are not accompanied by facial nodules unless they are related to rosacea.[4] IFAG lesions on eyelids are often self limited and heal without any scar,[1] whereas surgical management is necessary in most cases of chalazia, especially for the large ones.

Characteristic appearance of the eyelid nodules and accompanying facial lesions are typical for IFAG. But coexistence of facial and eyelid nodules is also a common feature for ocular rosacea. These two diseases demonstrate major differences despite this overlapping clinical picture. As a major difference, conjunctival hyperemia, blepharoconjonctivitis, or keratitis-like ocular manifestations are typical for rosacea and very rarely seen with IFAG.[1] Oral antibiotic regimens like oral clarithromycin or erythromycin fasten the healing process,[5] unlike ocular rosacea, which always necessitates systemic antibiotic treatments–even surgical interventions in unresponsive cases.

Despite these differences, some authors assume it to be early childhood rosacea,[1] whereas some others regard it as rosacea's granulomatous form.[6]

Ophthalmic and dermatological evaluation in IFAG is important, as these cases are recommended to be followed up for pediatric rosacea development—although the association is not exactly verified. Associated with rosacea or not, we believe that awareness of this new dermatological disorder by the ophthalmologists is the most important point, to avoid unnecessary surgical interventions, because of its good response to oral antibiotics.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
On the safety profile of Ocublue Plus (BBG 0.05%)

Ooi *et al*[1] raised concerns regarding the safety profile of Ocublue Plus brand of Brilliant blue G dye (BBG, Aurolab, Madurai, India) as compared to Brilliant Peel (Geuder, Heidelberg, Germany) on the basis of their experimental study in a rodent model. The authors gave the impression that BBG was approved for use in the European Union (EU) only as Brilliant Peel, at 0.025% concentration. We herewith inform that Ocublue Plus at 0.05% concentration is also approved for use in EU, and is exported to 25 countries globally, including UK (V Kannan, Division Manager—Pharmacy, Aurolab, Madurai, India, personal communication). The authors stated that there was no preclinical/clinical study using Ocublue Plus. We and others have published several surgical studies using Ocublue Plus in peer-reviewed journals;[2–6] all have reported excellent anatomical and visual outcomes. The authors next stated that studies using Brilliant Peel have shown it to be non-toxic. However, three of their five references to support this claim did not use Brilliant Peel; their first reference is our own study with Ocublue Plus!

The authors state in Discussion 'the reduction in mean total neurosensory retinal thickness induced by Ocublue Plus was significantly greater than that of Brilliant Peel when compared with their controls.' There are no data in their Results section to support this statement. They go on to conclude later that 'Ocublue Plus caused thinning to the total neurosensory retina and reduction in the RGC density….' Under Results, however, the total retinal thinning is reported to be similar to Ocublue Plus and Brilliant Peel (8 and $-7\,\mu$m, respectively); the reduction in RGC density with the former was 'equivocal'.

Some limitations such as the excessively long dye contact time (7 days) were discussed by the authors themselves. Their first figure highlights the limitations of statistical analysis using small numbers: the mean of retinal thickness difference is skewed by a single point data in each of the two BBG groups.[1] While experimental studies on dye safety are essential and frequent, a study comparing two commercial brands of the same dye needs to be detailed and meticulous in its methodology, and cautious in its conclusions.

Conflict of interest

The authors declare no conflict of interest.

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