International Journal of Science and Research (IJSR)
ISSN (Online): 2319-7064
Index Copernicus Value (2015): 78.96 | Impact Factor (2015): 6.391

Atypical Chalazion – An Unusual Presentation

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Abstract: ***Chalazion is one of the commonest benign tumours of the eyelid. A typical chalazion is a lipogranulomatous inflammation of an impacted tarsal meibomiangland[2]. Because of its characteristic presentation, of more importance are other lesions like sebaceous gland CA masquerading as chalazion. However, atypical chalazion are uncharacteristic in their presentation with extratarsallocation[1]. Herein, we are presenting one such case of an atypical chalazion.***

Keywords: chalazion, lid swelling, atypica presentation

1. Introduction

Chalazion is one of the commonest eyelid tumour solitary or multiple in nature. Recurrentchalazion are always suspicious of malignant transformation. The commonest aetiological factors being poor lid hygiene, blepharitis, DM, less common being Acne rosacaea and viral infections.

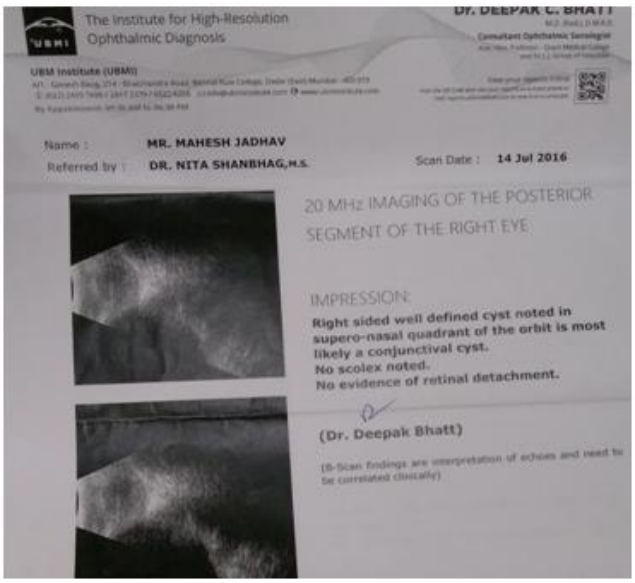
Differential diagnosis of lid swelling

Benign	Malignant
Preseptal cellulitis	Sebaceous glandadenocarcinoma
Tuberculosis	Sq. cell Ca, eyelid
Orbital Cellulitis	Sq. cell Ca, conjunctival
Dacryo adenitis	Basal cell Ca, eyelid
psoriasis	Orbital tumour
Herpes simplex	papilloma of eyelid
Herpes Zoster	Lacrimal gland tumour
Hordeolum	Meibomian cell Ca
Xanthelasma	Microcystic Adnexal Ca
Molluscumcontagiosum	
Contact lens complication	
Spider bite	

A typical chalazion is an uncommon form due to its characteristic feature and external location.

Hence diagnosing one is of extreme significance to rule out other lesions. Chalazion can recur and should be evaluated for Tb or malignancy in case of adults and in case of children. Hyper IgE syndrome (Job syndrome) should be ruled out.

Pre Operative Photo



2. Case Report

A 28 year old male presented with a palpable nodule in the right upper lid near the medial canthi, which was initially of pea size which gradually increased to 2mm by 2 mm in size near the medial canthus. Due to the extra tarsal location, it was suspected to be a lipoma , a USG B scan was done to rule out other causes. There was no past history of any refractive error, no H/o tuberculosis, viral infections or skin infections. Detailed ocular examination

including visual acuity, slit lamp biomicroscopy and fundoscopy was carried out. The visual acuity of both eyes on Snellen's chart was 6/6. Anterior segment examination was carried out with slit lamp biomicroscopy and was within normal limits thus excluding some aetiological factors i.e. blepharitis. Fundoscopy examination was within normal limits. Routine haemogram and HIV testing was done which were normal.

Management

The patient was first subject to conservative therapy with hot fomentation and systemic and topical antibiotics for a week.
As there was no improvement with this therapy, the patient was taken up for lipoma excision but on table on everting the lid a white nodule was seen resembling a chalazion and hencechalazion Incision and drainage was carried out. The wound was closed with chloramphenicol ointment and eye pad applied.

Patient was started on post-op oral and topical antibiotics for 5 days. The post-op course was uneventful and there was no recurrence.

First post operative day photo

1 week post operative day

3. Discussion

Chalazion is the most common inflammatory lesions of the eyelid. In Greek chalazion means a small lump or pimple. It can be further categorized into superficial or deep depending on glands which are blocked. Inflammation of Meibomian gland leads to deep chalazia, whereas inflammation of Zeis sebaceous gland leads to superficial chalazia.[6]

A chalazion normally presents as a firm nodular mass extending from the tarsus either anteriorly towards the skin or posteriorly towards the conjunctiva.

No racial predilection is thought to exist with male female ratio of 1:1 [5], Adults are more commonly affected than children mainly related to the hormonal changes in sebum with 30-50 years being the increased risk age group.

More commonly seen in hypermetropes probably due to increased eye rubbing done to get relief from fatigue. Various therapies have been proved to be effective against chalazion. Conservative therapy have consisting of hot fomentation with or without topical antibiotic having a cure rate of 25-80%. [7]

Triamcinolone actenoide (0.1-0.2ml diluted with lignocaine to concentration of 5 mg/ml) has proved to be affective. Intralesional 5-FU a well known anti-fibrotic agent is also found to be effective without local side effects of steroid injection.
Surgical management of chalazion consisting of I and C remains the mainstay of treatment in unresponsive cases.

4. Conclusion

- Based on aetiological factors chalazion can cause a variety of symptoms such as: [3, 4, 5]
- Blurring of vision due to induced astigmatism
- Cosmetic deformity
- Mechanical ptosis leading to amblyopia in children.
- Secondary infection leading to internal hordeolum.
- Preseptal and orbital cellulitis.
- Dermal depigmentation due to steroid therapy.
- Hence counselling the patient regarding lid hygiene, correction of refractive errors if any and control of blood sugar levels is of extreme importance.
- Recurrent chalazion should be evaluated for malignant transformation and treated at earliest.

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