10 MINUTE CONSULTATION

Chalazion

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This is part of a series of occasional articles on common problems in primary care. The BMJ welcomes contributions from GPs.

A 21 year old girl presents with a painless lump in her right upper lid. She says that this has been present for a few weeks and seems to be enlarging slowly. Her pharmacist suggested an antibiotic ointment, which she has been using for a few days with no benefit.

What you should cover

A chalazion, or meibomian cyst, is a focus of granulomatous inflammation within the eyelid. It arises from retained meibomian secretions. It is benign and often self limiting. It can occur in all age groups and is common in primary care.

• Patients report a slowly enlarging lump with some variability in size on a day to day basis.
• Ask about skin conditions which predispose to meibomian gland dysfunction—acne rosacea and seborrhoeic dermatitis.
• Larger chalazions may be associated with visual symptoms. Ask about blurry vision from induced astigmatism or an awareness of visual field obstruction from mechanical ptosis.
• Ask about pain, as this allows the chalazion to be differentiated from a hordeolum (a small abscess); chalazion is painless.
• Ask if the eyes have been unusually gritty, uncomfortable, or “tired”—these symptoms point to blepharitis, which predisposes to chalazion formation. Patients with severe blepharitis also report sticky eyes, especially on waking.

What you should do

During examination, look and feel:

• Observe the facial skin for midface telangiectasia (rosacea) or an unusually “oily” or “dry” appearance (dermatitis). The patient will usually point to an obvious lump in the eyelid. Note the appearance, which should be smooth. The overlying skin is usually normal but may occasionally be indurated. Ptosis may be obvious. Swelling and redness indicate early or established infection. Observe the lid margins for crusting and a red rimmed appearance (blepharitis). Ulceration and destructive changes of the lid margin are red flag signs indicating possible malignancy and warrant referral.
• Run the tip of your finger along the eyelid margin. The lump is non-tender and can be either firm (longstanding) or soft and slightly fluctuant (early). There may be more than one lump. Tenderness and erythema are signs of infection (hordeolum).

Management consists of dealing with the presenting lump and preventing recurrence:

• Most chalazions will respond to conservative treatment of applying heat and massage at least twice a day (figure⇓). Explain that the lump is caused by an obstructed eyelid gland that contains fatty material; heat softens this material, and massage disperses it. Early treatment may lead to faster resolution. To improve compliance, explain that resolution often takes time and that several weeks of regular hot bathing may be required. Topical antibiotic preparations are of no benefit and should be avoided. Surgical management, involving incision and curettage or intralesional triamcinolone, should be regarded as second line treatment. Infected chalazions (hordeolums), with or without cellulitis, require oral antibiotics.
• Prevention relies on management of blepharitis and its causes. Advise twice daily lid hygiene (heating and cleaning; figure⇓), on a long term basis, to those with obvious blepharitis. Explain that blepharitis is a chronic condition and that flare-ups can be managed with regular lid hygiene. Lid hygiene also reduces the likelihood of a gland becoming obstructed. Consider a course of tetracycline (doxycycline 50-100 mg once daily or lymecycline 408 mg once daily for at least three months) for blepharitis that is severe or associated with rosacea. Erythromycin is a good alternative in children and

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pregnancy. Have a low threshold for referring young children with large chalazions on account of the risk of amblyopia. In elderly people, consider the possibility of sebaceous cell carcinoma if a chalazion fails to settle or recurs.

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**Useful reading**

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**Figure**

**Daily routine for managing blepharitis and chalazion**