Bilateral congenital infantile hemangioma of upper eyelids

Sir,
We read the photo essay titled, “Bilateral congenital infantile hemangioma of upper eyelids” with interest and would like to report a similar case in one of my patients having a unilateral presentation and managed differently.

As we all know that beta blockers do have the risk of exacerbating reactive airway disease, bradycardia, systemic hypotension, and hypoglycemia in the infant population. Masking of hypoglycemic symptoms is valid in patients who are premature or not feeding well. Few suggest monitoring of vital signs and glucose levels while titrating propranolol up to the final treatment dose. Hence, constant monitoring by a pediatrician is needed when using propranolol because of the fatal side effects.

Zarem and Edgerton first reported the use of systemic corticosteroid in the successful treatment of large capillary hemangioma of seven infants in 1967.

A 3-day-old male baby presented to our outpatient department with a swelling of his left eye obscuring the total eyeball [Fig 1]. The swelling was arising from the left upper lid and large enough to occlude the whole globe including the visual axis. The swelling was bright red in color with bleeding from the surface of swelling; globe is hard, nontender, and nonreducible with the inability to open the lids.

The baby was prescribed oral prednisone 1 mg/kg in a single dose along with ointment chloramphenicol with hydrocortisone to apply twice locally under the supervision of a pediatrician and responded well within a week. The swelling diminished in size with the clearing of visual axis. Although corneal opacity was observed over the superior cornea of size 3 mm x 2 mm with central clear visual axis may be due to the pressure of hemangioma superiorly. The drug was tapered in next 2 weeks and stopped. There is no rebound after withdrawal of drug [Fig 2]. Hence, oral prednisolone is a safer alternative in infants with poor feeding.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest
There are no conflicts of interest.

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Sir,

With great interest, we read the article entitled, “A rare case of eyelid sarcoidosis presenting as an orbital mass” by Gaspar et al. [1]

We have a few observations over which we request their comments.

The title of the article presents this case as an eyelid mass due to sarcoidosis whereas, in fact, the text describes it as an orbital mass seen through eyelid. The coronal contrast-enhanced computed tomography (CECT) demonstrates inferior extraconal orbital mass lesion. A sagittal section image would have been useful to evaluate extension of mass toward the lower eyelid. The intraoperative description also mentions the mass to be arising from orbital floor and not arising from lid tissues.

Sarcoidosis presenting as orbital mass is not uncommon. Orbital mass as presenting feature of sarcoidosis is found in up to 7% of patients. Orbital sarcoidosis commonly presents as palpable mass or as pseudotumor with inferior orbit being a common location of orbital sarcoidosis. [2,3]

Most sarcoid lesions are found in extraconal anterior orbital space, which makes the lesion easily palpable or visualized early through the lid. [3]

Eyelid involvement is described in 12–17% cases of orbital sarcoidosis. [2,3]

We would like to know about the presence of any uveitis as the article fails to mention so. Uveitis is the most common finding of ocular sarcoidosis and has been demonstrated in 3–15% patients with orbital sarcoidosis. [2‑4]

Consistency of lesion or any change in lesion size with Valsalva has not been mentioned as the authors considered primary differential being orbital varix. CECT classically demonstrates hyperintense enhancement in case of varix with increase in size with post‑Valsalva maneuver. In case thrombosed varix is suspected, magnetic resonance imaging with contrast and magnetic resonance angiography is a better imaging modality to differentiate vascular and nonvascular pathologies.

We would like to know whether systemic steroid treatment was initiated modality after histological diagnosis of sarcoidosis. We agree with their advice of close follow‑up since patients with orbital lesions as a presenting feature of sarcoidosis may develop systemic sarcoidosis or may have further progression of existing systemic lesions. [5]

Postsurgery clinical picture and radiological (CECT) images would have been helpful.

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