Acute Lid Presentations
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Objectives
- Recognize and treat Molluscum Contagiosum infection
- Accurately evaluate and determine etiology of acquired ptosis
- Diagnose and properly refer cases of entropion

Molluscum Contagiosum
The Case

- 42 year old white male presents with referral from PCP for “cyst of left lower lid”
- Bump on lid with red, irritated eye for about 1 week
- Waking up with matter OS in the mornings
- Using Visine to get rid of redness, keeps coming back
- PCP squeezed lesion in attempt to express it, no material expressed

Patient History

- Childhood infection with chicken pox, otherwise unremarkable
- No remarkable family history
- Occupation: Accountant
- No remarkable social history
- Medications: Allegra
- No known medication allergies
- ROS: Denies any other symptoms

Clinical Findings

- Unaided Acuity: OD: 20/20-2 OS: 20/25
- Pupils: PERRL, no APD
- Ocular motility: Full
- Confrontation fields: PPC
- IOP: OD: 14mmHg OS: 13mmHg @ 4:12pm
- Eyelid: OD: normal lid architecture
- OS: umbilicated lesion on nasal lower lid
- Conjunctiva: OD: unremarkable
- OS: follicular response
- Otherwise unremarkable
Assessment and Plan

**Molluscum Contagiosum**
- Refer for lesion excision and possible biopsy for confirmation
- Discussed contagious nature of virus, precautions to prevent spread
- Encouraged patient to return with any changes in size, shape, bleeding
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**Follicular Conjunctivitis**
- Discussed likely related to viral lid lesion
- Instilled 1 drop of Proparacaine OS, 1 drop of 5% betadine OS
- Reviewed contagious nature of virus, precautions to prevent spread
- Gave sample of PFAT's for liberal use for irritation related to virus and betadine use

Lesion Excision

- Returned 16 days later for lesion removal
- Left eye was anesthetized with tetracaine, area around eye anesthetized with lidocaine and epinephrine, area prepped with betadine
- Lesion elevated with .3 forceps, excised with Wescott scissors, pressure applied for hemostasis
- Antibiotic ointment applied, Maxitrol ointment Rx'ed for application TID-QID for one week
- Reviewed signs of infection, patient to return with problems

Biopsy

- Specimen received intact in formalin
- 2mm in greatest dimension
- Final diagnosis: Molluscum contagiosum
“Waxy, umbilicated dome-shaped lesions from pox virus”

Non-inflammatory, can become inflamed
Tend to be normal skin color

Average 2-6mm in diameter, can be over 1cm in size in immune-compromised hosts

Usually single or small cluster of lesions may become disseminated in immune-compromised and atopic individuals
**Diagnosis**

**What can we do?**
- Clinical appearance in most cases is sufficient
- Cannot be cultured
- Core of lesion can be expressed and smeared, will show brick-shaped inclusion bodies

**Differentials**
- Verrucae vulgaris
- Herpes Simplex
- Papilloma
- Basal cell carcinoma
- Keratoacanthoma

**Treatment**
- Self limiting, can monitor (not the best option for most people)
- Cryotherapy
- Excision (consider biopsy)
- Cantharidin
- Tretinoin
- Cimetidine
- Pulsed dye laser
- Imiquimod
- Treat the follicular conjunctivitis if present
- Consider lab testing for immune-compromised status

**Involutional Ptosis**

The Case

- 92 year old white male presents for new onset lid droop OS for the last 2 weeks
- Was driving his car two weeks ago and noticed his eye was closed
- Droop is constant, does not get worse or better depending on time of day
- Denies any weakness/numbness of the limbs, facial weakness/numbness, slurred speech, headache, diplopia, changes to vision
- Denies scalp pain, denies pain while chewing

Patient History

- Ocular history: Pseudophakia, dry AMD
- No remarkable family history
- Occupation: Retired
- No remarkable social history
- Medications: lisinopril, atorvastatin, Preservision
- No known medication allergies
- ROS: Denies any other symptoms

Clinical Findings

- Acuity OD: 20/30 OS: 20/30
- Pupils PERRL, no A/PD
- Ocular alignment: 2 exophoria
- Motility: Full, equal velocity and amplitude
- Lid's: Ptosis, no enhanced ptosis
- MD 2/23 3mm/4mm
- Anterior segment: unremarkable
- Posterior segment: Dry AMD
- Able to smile/ bare teeth symmetrically, able to lift eyebrows symmetrically
Assessment and Plan

**Involutional Ptosis**
- Review neurological signs and symptoms and urgent nature of such
- Reviewed signs and symptoms of GCA and urgent nature of such
- Discussed option of surgery for repair
- Return in 2-3 months to check for stability

*Patient cancelled follow-up appointment, stated his eyes were doing well and did not need to be seen*

**Age Related Macular Degeneration**
- Continue AREDS recommendations
- Return for regularly scheduled visits
- Monitor with Macular OCT

Causes of Acquired Ptosis

- **Mechanical**
  - Lid edema
  - Mass
  - Significant dermatochalasis (pseudoptosis)
  - Anterior lid lesion

- **Muscle**
  - Oculopharyngeal Muscular Dystrophy
  - Chronic Progressive External Ophthalmoplegia
  - Kearns-Sayre Syndrome
  - Mystotic Dystrophy
Causes of Acquired Ptosis

Aponeurosis (Involutional)
- Diastasis from its attachment
- Laxity due to stretching

Neuromuscular Junction
- Myasthenia gravis

Causes of Acquired Ptosis

Nerve
- CN III Palsy
- Horner’s Syndrome

The Work-Up
- Careful history (explore possible neurologic symptoms)
- External Exam
  - Raising eyelid(s)
  - Tiling head forward
  - Unilateral vs bilateral
- Margin-Reflex Distance
- Enhanced ptosis?
- Levator Function
- Pupils
  - DHI and Cover Test
  - Basic Neuro exam
Treatment of Involutional Ptosis

- Monitor
- Lid Crutch
- Surgery is indicated for those with visual field or cosmetic concerns
  - Mueller's Muscle Conjunctival Resection
  - Levator Enhancement (still needs Levator function)
  - Frontalis Sling (poor Levator function)

Entropion


The Case

- 75 year old white female presents with irritation OS for the last month
- Excessive tearing, itching, h/o allergic conjunctivitis
- “Feel like something stuck” in lateral canthus
- Uses artificial tears BID, naphazoline BID, minimal relief
- No changes in vision
**Patient History**

- Ocular history: Pseudophakia, allergic conjunctivitis, map-dot-fingerprint dystrophy
- No remarkable health or family history
- Occupation: retired
- No remarkable social history
- Medications: lisinopril, naphazoline eye drops
- ROS: negative

**Clinical Findings**

- Unaided Acuity: OD: 20/30 OS: 20/25+
- Pupils: PERRL, no APD
- Ocular motility: Full
- Confrontation fields: FTFC
- IOP: OD: 12mmHg OS: 12mmHg @ 1:54pm
- Eyelids: OD: normal lid architecture OS: trichiasis, intermittent LL entropion
- Conjunctiva: OD: trace-1+ papillae OS: 1+ papillae
- Cornea: OD: EBMD OS: no staining, EBMD
- Otherwise unremarkable

**Assessment and Plan**

**Entropion of Left Lower Lid**

- Educated patient how hard blinking causes lower lid to roll inward
- Likely cause of irritation due to lashes scraping on lower conjunctiva
- Palliative vs curative options offered
- Epilation of lower lashes
- Referral for surgical intervention
- Pt refused any treatment at this time
- Assured patient symptoms will not resolve without intervention
- Return in 6 months for dilated exam as scheduled

**Allergic Conjunctivitis**

- Zaditor recommended in the past, patient indicated she was unaware of this recommendation
- Recommended Pazeo for use daily OU
- Discussed this will not solve the lid issue, but may help with comfort
Patient Returns

- Two months later, returns with OS still red, irritated, watery, itchy
- Seemed to get better for a short time after last visit, worse in last two weeks
- No changes in vision
- Clinical findings same as previous

Assessment and Plan

- Discussed pathophysiology of entropion
- Refer for surgical consultation
- Pt consented to surgery

Patient Presentation

- Eye irritation, foreign body sensation, redness, watering
- Corneal abrasion, scarring, neovascularization
- May not be immediately obvious looking at the patient
- Look for scarring, symblepharon, ask about previous trauma
Types of Acquired Entropion

Involuntary
- Increased horizontal lid laxity
- Disinsertion of lower lid retractors
- Orbicularis overaction
- Small tarsal plate

Cicatricial
- Previous lid surgery
- Chronic allergy
- Trauma
- Symblepharon
- Infection (Trachoma)

Differential Diagnoses
- Trichiasis
- Distichiasis
- Epiblepharon
Treatment of Involutional Entropion

- Epilation/ laser skin resurfacing
- Tape the lower lid/ liquid bandage
- Botox
- Surgery

Thank you!

Questions?