

arion lysis, often with the addition of antibiotics and topical steroids. Nevertheless, the prognosis in these patients is often extremely guarded.²

Due to the anti-inflammatory and antiscarring properties of AM, AMT has become an emerging strategy to treat ocular surface involvement of SJS/TEN in the acute phase.^{4,5}

This case report shows rapid and remarkable improvement in a patient with severe, acute ocular manifestations of SJS. AMT should be considered in the initial treatment for SJS/TEN with severe ocular involvement to prevent the devastating ocular sequelae found in many patients who survive this rare mucocutaneous disease.

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Pagetoid spread of sebaceous cell carcinoma to the cornea

Sebaceous cell carcinoma (SebCC) is a malignancy that most commonly presents in the eyelid.¹ Pagetoid spread to the conjunctiva has been well documented,¹⁻³ but spread to the cornea is less common.⁴ We report a 64-year-old female who was diagnosed with pagetoid spread of SebCC to her right cornea. She initially presented with a 3-year history of red eyes and trichiasis. After multiple epilations, she was referred to the oculoplastics service for electrolysis. On examination, her visual acuity was 20/70 in the right eye and counting fingers in the left eye (the vision was limited due to a central stromal scar and a dense cataract). She was being scheduled for cataract surgery in her right eye. Slit-lamp examination revealed bilateral, asymmetric lid findings of blepharitis and aberrant lashes on the right upper lid (RUL) (Fig. 1). Pertinent negatives included no thickening or ulceration of her lids, no lid masses, absence of an Arlt line or symblepharon, and no history of usage of glaucoma drops or topical antivirals or of trachoma or foreign travel. Even with electrolysis over several months, the



Fig. 1—A 64-year-old female who presented with findings of ocular rosacea, meibomian gland dysfunction, blepharitis, and trichiasis (right eye).

patient developed worsening trichiasis. Given the lack of improvement despite medical management and the irregularity of the RUL margin, a full-thickness RUL biopsy was performed, and it returned positive for SebCC. Map biopsies were then taken in the superior, inferior palpebral, and superior and inferior bulbar conjunctiva (medial, central, and lateral positions). All superior palpebral and conjunctival biopsies were positive for SebCC. Surgical excision of the following was performed: the superior bulbar conjunctiva from 9 to 3 o'clock, the entire superior palpebral conjunctiva, and the RUL with entire tarsus. Multiple margins, including the limbus, were clear. Despite negative limbal margins intraoperatively, because the 12 to 3 o'clock peripheral cornea appeared suspicious (Fig. 2A), mitomycin C 0.04% was applied to that corneal limbal area for 2 minutes intraoperatively and then irrigated with normal saline. In addition, double freeze-thaw cryotherapy was applied to the scleral base. Metastatic investigations were negative. After several weeks, a pseudopterygium appeared from 12 to 5 o'clock. Increasing numbers of white plaques were also observed (Fig. 2B). Incisional biopsy of the pseudopterygium and scrapings of the white plaques using a 64 blade were performed. The pseudopterygium biopsy was negative, but the corneal plaque scrapings were positive for SebCC. Treatment options were discussed, including the option of exenteration. The patient opted for a more conservative approach and underwent a 4-week course of topical mitomycin-C 0.04% 4 times daily, 1 week on, 1 week off.

Pagetoid spread of SebCC to the conjunctival epithelium has been reported with corneal involvement in up to 18% of patients, appearing as superficial punctate keratitis, a corneal ulcer, or superior limbic keratocon-

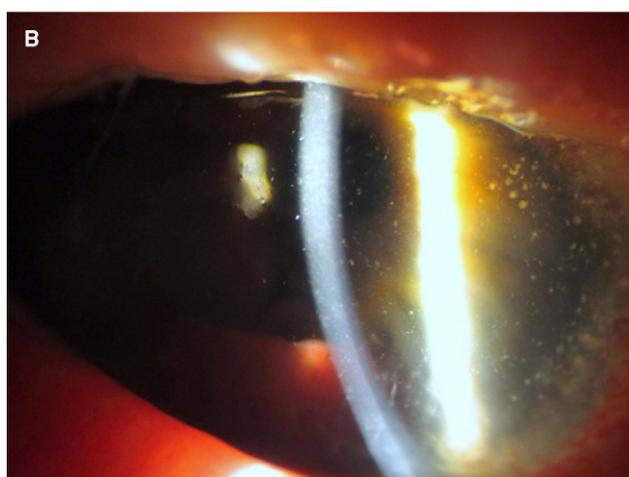


Fig. 2—(A) Pseudopterygium from 12-3 o'clock and few elevated white plaques adherent to the corneal surface, for which corneal scrapings were positive for sebaceous cell carcinoma (2 o'clock midperipheral cornea at the leading edge of the pseudopterygium). (B) Significant spread of elevated corneal plaques from 12 to 6 o'clock while awaiting results of the pseudopterygium biopsy and corneal scrapings.

conjunctivitis.³⁻⁵ To our knowledge, this is the first report of SebCC with pagetoid spread over the cornea that presented as multiple elevated white plaques. Corneal scrapings may be performed in such cases. In any patient with a history of SebCC with corneal involvement, incisional cataract surgery should be avoided because disruption of the Bowman membrane may seed carcinomatous cells into the eye.

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Topical podophyllin as a cause of keratopathy

A 30-year-old man presented to the emergency room with redness, pain, photophobia and blurry vision in the left eye during the previous 2 days. The symptoms had begun a few hours after treatment of his left lower lid papilloma with topical podophyllin. Pinhole acuity in the left eye was 20/40. On slit-lamp examination he had a 2 mm lower lid skin papilloma located 2 mm from the lid margin. There was conjunctival congestion and diffuse superficial punctate keratopathy in the left eye without anterior chamber reaction. Intraocular pressure was 17, and the rest of the eye examination was unremarkable.

Treatment with lubricating drops was started. The next day, OS acuity had decreased to 20/100, and the cornea had become diffusely opaque with stromal edema but no



Fig. 1—Diffuse opacification of the cornea 3 days after topical administration of podophyllin to the eyelid.