Quizzical optical coherence tomography

We often question our diagnoses, but how often does your diagnosis question you? A patient was referred for surgical management of an epiretinal membrane. During the encounter, she asked *many* intelligent questions. Amazingly, the optical coherence tomography of her macula seemed to reflect her quizzical nature and was found to have a question (mark) of its own! (Fig. 1)

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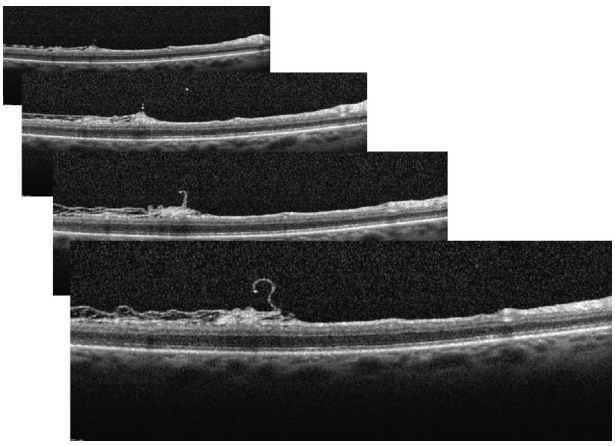

Fig. 1—A quizzical OCT. Macular OCT demonstrating visually significant epiretinal membrane that has taken the configuration of a question mark. OCT, optical coherence tomography.

Sebaceous adenomas in the absence of Muir–Torre syndrome

Sebaceous adenomas (SA) are rare tumours that have commonly been regarded as pathognomonic of the rare autosomal dominant cancer predisposition syndrome, Muir–Torre syndrome.[1] We present 2 cases of isolated eyelid SA and examine their clinical features and investigations for association with Muir–Torre syndrome.

Two unrelated male patients, 51 and 57 years old, respectively, presented with very slowly enlarging upper eyelid lesions that had been present for over a year. Neither patient had a personal or family history of cancer. On examination, both lesions were 4–5 mm in maximum diameter and were well-circumscribed, yellow, exophytic, and verrucous papules with surface telangiectasis (Fig. 1). Excision biopsy followed by histological examination found both lesions to be SA. Immunohistochemistry work-up showed normal expression of DNA mismatch repair (MMR) proteins, including MSH2, MSH6, MLH1, and PMS2. Neither patient has had recurrence or evidence of tumours elsewhere at 6-month follow-up.

SA is a benign and slow-growing skin tumour. It usually bears the appearance of a well-circumscribed exophytic yellow papule that is often mistaken as basal cell carcinoma.[2]

Identification of SA is crucial because of its association with Muir–Torre syndrome. In Muir–Torre syndrome, germline mutations in MMR genes result in regions of DNA microsatellite instability and subsequent increased risk of developing internal malignancies, commonly colorectal and genitourinary carcinomas.[3] After histopathological diagnosis of SA, immunohistochemistry of MMR protein expression should be conducted. If these identify abnormal (negative staining) protein expression or the patient has a personal or family history of cancer, a systemic or oncological work-up for Muir–Torre syndrome is indicated.[4,5] To date, the most commonly

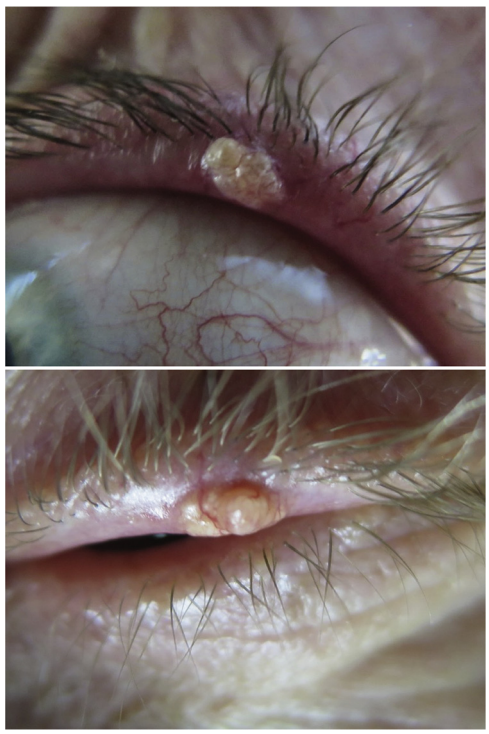

Fig. 1—Two separate cases (top and bottom) of solitary sebaceous adenomas of the left upper eyelid, showing features of a yellow well-circumscribed pedunculated and verrucous papilla with overlying capillaries on the surface.

associated MMR defect with Muir–Torre syndrome is MSH2, followed by MLH1.[4,6] Testing for microsatellite instability by assessing the Bethesda microsatellite markers may also be performed, with the use of polymerase chain reaction, in conjunction with immunohistochemistry.[5]

In the present cases, SA was diagnosed in the absence of any other cancer history as well as MMR protein expression abnormalities. Using a guideline proposed by Jagan et al. for eyelid lesions, further systemic work-up for such cases is not necessary.[4] Nevertheless, it is important to counsel patients as to the small increased risk of internal malignancies even years after the initial diagnosis of SA.[3,7]

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Acute myelogenous leukemia presenting with uveitis, optic disc edema, and granuloma annulare: Case report

Although ocular manifestations of the acute leukemias have been reported commonly, the majority of these reports refer to acute lymphoblastic leukemia rather than Acute myelogenous leukemia (AML).[1] Uveitis is a rare finding with AML. In cases in which uveitis has been reported as a manifestation of AML, it has been identified most commonly as a sign of relapsing or progressing AML rather than as the initial presenting finding of previously undiagnosed AML.[2–6] We report a patient with AML who presented with uveitis, optic disc edema, and an additional suggestive skin finding of granuloma annulare (GA). To our knowledge, this is only the third reported case of AML initially presenting as uveitis and the first reported case in the English language literature of uveitis, GA, and optic disc edema as presenting findings of AML.[7,8]

A 71-year-old male was referred for a 6-month history of painless, blurry vision OD. He was seen at an outside hospital and diagnosed with anterior uveitis OD, for which he was given topical steroids and atropine. The atropine was discontinued after the patient developed urinary retention, but the patient completed a 3-week course of topical corticosteroids with resolution of the uveitis.

The patient then developed a painless, diffuse, erythematous raised annular rash on his back that was biopsied by dermatology and was diagnosed as GA. He was treated with topical therapy, and the lesions improved but did not resolve.

On examination, visual acuity was 20/30 OD and 20/20 OS. Colour vision was normal (14/14 Ishihara plates). The left pupil was reactive normally and round. The right pupil was 5 × 6 mm, poorly reactive, and irregular. There was a right relative afferent pupillary defect by reverse testing. Slit lamp examination OS was normal. In the right eye, there were posterior synechiae at several clock hours, scattered old keratic precipitates along the inferior Arlt triangle, and trace anterior chamber flare, but no active anterior chamber cells (Fig. 1). Extraocular motility and intraocular pressure examinations were normal OU. Automated perimetry (Humphrey 24-2) showed diffuse

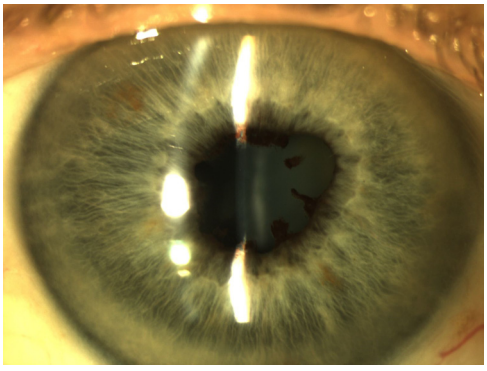

Fig. 1—Slit lamp examination showing posterior synechiae in the right eye.