section. Although rare, Rosai-Dorfman disease can be confused with nodular scleritis and should be considered in patients with epibulbar masses and uveitis.

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Granulomatous Choroiditis in Wegener Granulomatosis

Wegener granulomatosis (WG) is characterized classically as the triad of necrotizing granulomatous lesions of the upper and lower respiratory tract, focal segmental glomerulonephritis, and necrotizing vasculitis of small arteries and veins. Ophthalmological disease is the manifesting feature of WG in 8% to 16% of patients but develops in an estimated 50% to 60% of patients. Orbital disease is the most common ophthalmological manifestation of WG, uveal involvement is uncommon, and granulomatous sclerouveitis is rare. Only 1 histological description of isolated choroidal involvement by WG exists, to my knowledge. The patient described by Cutler and Blatt

Comment. Choroidal involvement in WG may manifest clinically as uveitis, choroidal folds, retinal epithelial pigmentary changes, choroidal arterial occlusion, or choriocapillaritis. Only 1 histological description of isolated choroidal involvement by WG exists, to my knowledge. The patient described by Cutler and Blatt

Figure 1. The posterior choroid of both eyes had many foci of granulomatous inflammation. A confluent area of granulomatous inflammation is to the left in the photomicrograph, while 2 smaller granulomas (asterisks) are to the right (hematoxylin-eosin). Scale bar indicates 100 μm.

5. Levy-Clarke G, Ding X, Gangaputra S, et al. Recalcitrant granulomatous sclerouveitis reported in WG, which contains a mixture of fibrinous necrosis and hyperplasia of the retinal pigment epithelium; and degeneration of the overlying sensory retina.

In my patient, both eyes had many foci of granulomatous inflammation in the posterior choroid, rare minute foci of fibrinous necrosis in the choroid just beneath the choriocapillaris, and areas where the choriocapillaris was infiltrated by inflammatory cells. The inflammatory infiltrate in my patient resembled the granulomatous sclerouveitis reported in WG, which contains a mixture of T and B lymphocytes, macrophages, and enhanced expression of adhesion molecules and ligands.

I postulate that the difference in the histological appearance of the choroid in my patient's eyes and that reported by Cutler and Blatt is due to the shorter duration of the WG in my patient and its stage of activity at the time of death. However, I cannot exclude the possibility that the difference reflects underlying variation in choroidal manifestation of WG.

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