tween the temporal vascular arcades. Visual acuity was reduced to hand movements OD. The intraocular pressure measurement was within the reference range. In an attempt to reduce subfoveal exudation and to suppress subretinal angiogenesis, the patient received a transconjunctival intravitreal injection of 25 mg of crystalline triamcinolone acetonide in 0.2 mL of Ringer solution in her left eye. The procedure was carried out under topical anesthesia after paracentesis was performed to decrease the volume of the globe. The patient was fully informed about the experimental nature of the therapy. She signed an informed consent form. The ethics committee of the university approved the study, which followed the tenets of the Declaration of Helsinki.

After the injection, the patient’s vision remained stable for 4 months. On indirect ophthalmoscopy as well as Goldmann contact lens ophthalmoscopy, the triamcinolone acetonide crystals were localized in the preretinal vitreous cortex at the 6-o’clock position in the periphery of the fundus. Two months after the injection, intraocular pressure increased to as much as 32 mm Hg, necessitating antiglaucomatous topical treatment with latanoprostone, timolol maleate, and dorzolamide hydrochloride, under which intraocular pressure normalized. Five months after the injection, visual acuity started to decrease. Simultaneously, the triamcinolone acetonide crystals were no longer detectable on indirect ophthalmoscopy and Goldmann contact lens ophthalmoscopy. Eight months after the injection, uncomplicated phacoemulsification was performed with implantation of a foldable posterior chamber lens. Fourteen months after the injection, visual acuity was 0.30 OS with enlargement of the subfoveal neovascular membrane and an increase of the subretinal exudation. In view of the stabilization of visual acuity after the first injection, a second intravitreal injection of 25 mg of triamcinolone acetonide was performed. For 6 months after the second injection, visual acuity remained at 0.30 OS (Snellen charts). Despite maximally tolerable antiglaucomatous topical treatment, intraocular pressure ranged between 20 mm Hg and 30 mm Hg with the eventual development of glaucomatous changes in the appearance of the optic nerve head. Because intraocular pressure remained uncontrolled and triamcinolone acetonide crystals were still detectable in the vitreous cavity on indirect ophthalmoscopy, although 9 months had passed since the last triamcinolone acetonide injection, a standard trabeculectomy was carried out using mitomycin C intraoperatively in a concentration of 0.25 mg/mL. Postoperatively, the anterior chamber was well formed, there was no leakage at the limbal wound edge, and intraocular pressure ranged between 5 mm Hg and 10 mm Hg in the first postoperative weeks. Concentration of triamcinolone in the aqueous humor sample obtained at the start of the trabeculectomy by anterior chamber fluid aspiration was 11.2 µg/L.

Comment. The clinical course of this patient demonstrates that, in contrast to previous reports on an intravitreal presence of triamcinolone for as long as 6 months after the injection, triamcinolone acetonide crystals can be present in the vitreous and soluble triamcinolone can be detected in the aqueous humor for 9 months or longer after intravitreal injection of 25 mg of triamcinolone acetonide. This long intraocular presence of triamcinolone acetonide, especially in patients receiving repeated intravitreal injections of triamcinolone, may not only lead to secondary ocular hypertension but also to steroid-induced secondary open-angle glaucoma necessitating trabeculectomy. This case may also demonstrate that retroocular concentrations of triamcinolone can be achieved for 9 months or longer by a single injection of 25 mg of triamcinolone acetonide. This finding may be interesting for the discussion of when to repeat intravitreal injections and when to use an intracameral slow-release device for corticosteroids.

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The authors have no relevant financial interest in this article.

Bone Located Centrally Within a Dermolipoma

Elsas and Green1 defined a dermolipoma as “a congenital, choristomatous tumor containing dermis-like connective tissue and adipose tissue; it was usually covered by nonkeratinized, or less commonly by keratinized squamous epithelium.” On pathologic study, bone has been found adjacent to excised dermolipomas in several reports.2,4 In an article by Eijpe et al5 on the characteristic appearance of dermolipomas on computed tomography (CT) scan, the authors did not find calcification in any of their 10 reported cases.3 We report the clinical, CT scan, and pathologic findings of a patient with bone located centrally within, rather than adjacent to, a pedunculated dermolipoma.

Report of a Case. At birth, a mass was noted at the left lateral canthal area in an otherwise healthy girl. The mass reportedly remained the same size relative to her eyelid and facial structures as she grew. When she was 6 months old, her pediatrician obtained a CT scan of the orbits. The CT scan showed a cystic area with low density similar to fat at the left lateral canthal angle. Centrally within the cystic area was a high-density structure. The differential diagnosis included both bone within a dermolipoma and bone within a lipoma. The decision was made to observe the patient for at least 6 months until the bone within the cystic area could be more clearly characterized. The CT scan confirmed bone located centrally within a dermolipoma 1 year later.

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density round mass. The orbital bones were normal (Figure 1).

We evaluated the patient when she was 7 months old. At her left lateral canthus was a soft, mobile, 7 × 7-mm, external pedunculated yellow-tinged mass covered by skin. The external mass was contiguous with a 7 × 5-mm, soft, yellowish subconjunctival mass (Figure 2). The eyelids and eyelid tissues were symmetric, with good lateral tendinous support. The orbital rims were normal. No lesions or deformities were present in the preauricular or auricular areas. Her ocular motility was full, and she had no strabismus. There was no globe displacement, and retropulsion was soft. Her corneas and tear films were normal. Her intraocular examination results were normal.

Her parents requested surgical excision of the mass when she was 14 months old. The mass lesion and her ocular examination findings were unchanged. The entire external portion of the mass and the anterior portion of the contiguous subconjunctival mass were excised.

Histopathologic examination of the excised tissue revealed a typical dermolipoma that was lined by squamous epithelium and contained pilosebaceous structures and adipose tissue. In the center of the dermoid, there was a round area of compact bone with hematopoietic bone marrow in the center (Figure 3).

Comment. In a survey of 282 epibulbar tumors in children, Cunha et al8 reported 15 dermolipomas. They did not mention any bone formation in these lesions. They did report one case of an epibulbar osseous choristoma and one case of a choristoma composed of cartilaginous tissue. Fry and Leone7 reported on 45 excised dermolipomas. Three of their cases had osteoma formation, but no further information was given.7 Hered and Hiles8 described an osseous lesion overlying the sclera that was beneath and separate from a dermolipoma. Ferry and Hein9 excised a right outer canthus dermoid, and on microscopic examination, an osseous choristoma was found at the base. The bone was separated from the fat by dense connective tissue.

Daicker and Perren3 described a left superior temporal dermolipoma that after excision on histopathologic study was found to have a small plate of bone. The inferior surface of the bone was concave, and the opposite face was convex.7 The shape of the bone would suggest an epibulbar or episceral osteoma. Marback et al10 described a pedunculated epibulbar mass anterior to the right lateral rectus associated with a right eye retinoblastoma. The CT scan revealed foci of calcification in the seminoma and calcification of the epibulbar lesion. The pathologic examination revealed an intraocular, well-differentiated retinoblastoma without extraocular extension, and a separate epibulbar mass with osseous tissue mixed with fat tissue and dense collagen that they considered an osseous choristoma. Gayre et al11 reported on an epibulbar osseous choristoma associated with fibrovascular connective, adipose, and lacrimal tissues, but no radiologic studies were described. Gonnering et al12 described 2 cases that, clinically, were initially felt to represent dermolipoma. One was excised and shown to have bone adherent to the sclera. Their other case, on CT and echography scans, showed a high-density mass adjacent to, or part of, the sclera.13

The CT scan of our case revealed that the bone was located within the central portion of the dermolipoma, and histopathologic examination confirmed this. This seems to be in contrast with other cases that suggest that the bone was present in an epibulbar or episcleral location at the base of the lidpseudom. Eijpe et al14 found no bone or calcification on CT scans in their 10 cases of dermolipomas. Their microscopic examinations also did not reveal any bone in the specimens.5 Our case’s pathologic examination and CT scan results support each other in demonstrating osseous changes centrally within the lateral canthal pedunculated choristomatous dermolipoma.

The authors have no relevant financial interest in this article.

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6. Cunha RP, Cunha MC, Shields JA. Epibulbar...

Macular Hole Secondary to Fungal Endophthalmitis

Endogenous fungal endophthalmitis is a well-recognized, vision-threatening disorder commonly seen in immunocompromised patients. One of the clinical findings of fungal endophthalmitis is a white, circumscribed region of chorioretinitis, called a focus, which often results in a hypopigmented scar even if antifungal therapy is successful. We report a rare case of endogenous fungal endophthalmitis that led to a macular hole (MH).

Report of a Case. A 53-year-old woman visited our clinic, requesting a second opinion on her treatment for fungal endophthalmitis following intravenous hyperalimentation after thyroid cancer surgery. Her best-corrected visual acuity was 20/20 with -7.0 diopter sphere (DS) OD, and 20/200 with -7.0 DS OS. Slitlamp examination revealed a mild inflammatory response in the vitreous of both eyes. Fundus examination showed a focus involving the macula and surrounding retinal hemorrhages in the left eye (Figure 1). Foci that did not involve the macula were present in the right eye. A Weiss ring was not present in either eye. According to the referral letter, her blood culture was positive for Candida albicans, and intravenous administration of fluconazole (200 mg/d) had already been given for approximately 4 weeks, which seemed to be effective. The patient was therefore advised to continue the treatment at the previous hospital.

Five months after the initial visit, the patient again visited our clinic. She had noticed an increase of metamorphopsia around the central blind area, which began approximately 3 months previously. Her best-corrected visual acuity was 20/20 OD and 20/100 OS. No inflammatory response was observed in either eye. Fundus examination of the left eye showed a circular MH with a vertical diameter of 920 µm, a Weiss ring, and an operculum above the macula. Optical coherence tomography (OCT) showed that the edges of the MH were swollen (Figure 1).

To prevent further visual deterioration, a pars plana vitrectomy with internal limiting membrane removal and 12% perfluoropropane gas tamponade were performed on the left eye. Histopathologic examination of the operculum revealed a neurosensory retinal component and pigment-laden macrophages (Figure 2). After the surgery, a flattening of the MH edge was observed; however, the visual acuity remained unchanged.

Comment. Vitreoretinal complications following fungal endophthalmitis include epiretinal membranes, traction and/or rhegmatogenous retinal detachments, and choroidal neovascularization. However, an MH secondary to fungal endophthalmitis seems to be very rare; only 1 case has been reported, to our knowledge. That patient was a 51-year-old woman who developed an MH adjacent to a focus but not at a preexisting focus as in our patient.

Although the mechanism of MH formation in our patient is unclear, the presence of a Weiss ring at the second visit and the existence of sensory retinal components in the operculum suggest that...