that, even with identical genetic deletions at the Xp22.3 locus, the phenotypes may vary. Patients 1 and 2 were similar in that both of them had microphthalmia, sclerocornea, and skin deformities. They also exhibited hypoplasias and a mild cardiac abnormality in the form of the Xp22.3 microdeletion syndrome. The Xp22.3 microdeletion syndrome (microphthalmia, dermal aplasia, and sclerocornea): an X-linked phenotype distinct from Goltz syndrome. Am J Med Genet. 1993; 47:710-713.


A "Negative" Temporal Artery Biopsy, Positive for Arteritis

Ophthalmologists often participate in the diagnosis and treatment of patients with giant cell arteritis (GCA), typically when the diagnosis is heralded by a central retinal artery occlusion or ischemic optic neuropathy. However, even in the absence of eye symptoms or signs, ophthalmologists may be asked to examine the patient and perform a biopsy of the temporal artery. The microscopic findings in the patient described herein bear on the technique of temporal artery biopsy.
poral artery biopsy, the physician must always consider a diagnosis of a systemic vasculitis other than GCA, as the patient may experience a fulminant and downhill course if appropriate therapy is not instituted.

From personal experience with a patient whose diagnosis of GCA was established from angiitis in small vessels adjacent to a normal temporal artery, one of us (S.L.) routinely includes the perivascular tissue in temporal artery biopsy specimens. Had this tissue been stripped from the specimen in our patient, the biopsy would have been interpreted as negative. Temporal artery biopsy specimens from other patients with Wegener granulomatosis have also shown only small-vessel involvement.1-3

When a temporal artery biopsy is performed, the surgeon should refrain from removing the periarticular tissues except to the extent necessary to ensure accurate identification and secure ligation of the vessel. Nor should the pathologist strip the artery before embedding.

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Euryblepharon is a congenital eyelid anomaly characterized by horizontal enlargement of the palpebral fissure. The eyelid is shortened vertically compared with the horizontal dimension, with associated lateral canthal malpositioning and lateral ectropion.1,2 It may be an isolated finding or associated with ocular anomalies such as lateral displacement of the proximal lacrimal drainage system, a double row of meibomian gland orifices,2 telecanthus, and strabismus.3 In severe cases, it may result in lagophthalmos and exposure keratopathy2 and may require surgical treatment. We report the results of 2 patients with hereditary disorders and euryblepharon treated successfully with midface lift and lateral canthal repositioning surgery. The surgical technique is described.

Report of Cases. Case 1. A 17-year-old girl with Noonan syndrome (Online Mendelian Inheritance in Man 163950) and bilateral lower eyelid euryblepharon since birth was seen with eye irritation and nocturnal lagophthalmos. The parents were also concerned about the aesthetic appearance of their child. Examination revealed upper eyelid ptosis, bilateral inferolateral displacement of the lateral canthus, lateral ectropion (Figure 1), and lagophthalmos with mild punctuate keratitis.

She was treated with bilateral midface lift via a swinging eyelid...