thereby increasing intraorbital pressure, which would also explain intraoperative asystole induced by the oculocardial reflex. An operation lasting 5 hours was too long for recovering ischemic retinal tissue. Ophthalmoplegia may have been caused by intramuscular edema and hemorrhage and could, therefore, resolve completely. Besides high intraorbital pressure, low arterial blood pressure and shallow orbits may be additional risk factors. To prevent this disastrous complication, increased intraorbital pressure should be avoided by careful positioning of the patient and precautious preparation of the myocutaneous flap with respect to the patient’s physiognomy. In cases with increased risk, special eye shields may be used to avoid orbital infarction.

Philip Maier, MD
Nicolas Feltgen, MD
Wolf A. Lagrèze, MD

Correspondence: Dr Maier, University Eye Hospital Freiburg, Killianstr 5, 79106 Freiburg, Germany (philip.maier@uniklinik-freiburg.de).

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Solitary Fibrous Tumor of the Conjunctiva

Solitary fibrous tumor (SFT) is a relatively rare tumor that was originally described in the pleura. In recent years, SFTs have been described in many extrapleural sites such as the lung, mediastinum, pericardium, peritoneum, upper respiratory tract, liver, thyroid, nasal and paranasal sinuses, parotid and salivary glands, and spine and other soft tissue.1,2 In 1994, 2 independent articles described the first cases of SFT in the orbit.3,4 Since then, more than 50 orbital SFTs have been described in the medical literature.5 These include SFTs of the lacrimal gland6 and the lacrimal sac.7 Our case is the first reported case, to our knowledge, of SFT of the conjunctiva.

Report of a Case. A 29-year-old woman, a nurse by profession, complained of a lesion in the lower fornix of the right eye that existed for at least a year and that occasionally disturbed her. On examination, her...
Visual acuity was 1.0 (6/6) in each eye. The intraocular pressure was 14 mm Hg in each eye. In the right eye, an elevated, firm, elliptical, mobile, pink mass, about 1 cm in diameter, was found in the lower fornix of the conjunctiva, close to the caruncle (Figure 1). The anterior segments and the fundi in both eyes were normal.

The lesion in the right eye was completely excised under local anesthesia and sent to the ophthalmic pathology laboratory. Macroscopic examination revealed a solid, gray piece of tissue measuring 10 × 10 × 6 mm. Microscopic examination revealed a well-circumscribed mass, partially covered by conjunctival tissue (Figure 2). The mass was composed mostly of spindle cells (Figure 3) that were arranged somewhat differently in various areas but mostly arranged randomly in a “patternless pattern.” In areas, the cells were arranged in a fascicular pattern. In many sites, tumor cells were seen between thick collagen fibers. In areas, confluent collagen fibers displayed “hyalinization” (Figure 4). No multinucleated giant cells, mitotic activity, pleomorphism, or atypia were identified. Tumor cells were stained positively with CD34, O13 (CD99), BCL2, and vimentin (Figures 5–8) and negatively with S100 and α-actin. According to these findings, we made the diagnosis of SFT of the conjunctiva.

Comment. Fibrous tumors of any type are rare in the conjunctiva. Conjunctival tumors such as fibroma, fibrous histiocytoma, nodular fasciitis, giant cell angiofibroma, and elastofibroma oculi have been described in the literature. Solitary fibrous tumor in the ocular region has been reported in the orbit, lacrimal gland, and lacrimal sac but, to our knowledge, never has been described in the conjunctiva.

Solitary fibrous tumors belong to the category of fibroblastic tumors. On cut section, regardless of the site of origin, the lesions are usually well-circumscribed, nodular, firm, gray-white masses, occasionally with myxoid areas, hemorrhage, and necrosis. Regardless of location, the extrapleural tumors are histologically identical to those in the pleura, which are principally composed of spindle cells dispersed among elongated, thin, parallel collagen bands. The arrangement of the cells may vary from area to area in the same tumor. In some zones, they are arranged in short, ill-defined fascicles, whereas in others, they are arranged randomly in what has been described as a patternless pattern. The nuclei are small, and the tumor has little or no mitotic activity and only mild to moderate nuclear atypia. A characteristic feature of the lesion that usually suggests the diagnosis is the relatively striking areas of hyalinization. Artifactual “cracks” may develop between the cells and collagen or between groups of collagen fibers. Myxoid changes may be seen.

The vascular pattern varies from narrow vascular clefts to gaping, branching vascular channels. Areas of the tumor may show fibrous hist-
tiocytomalike storiform pattern, hemangiopericytomalike staghorn and synovial sarcomatous, and neural-like palisading regional architecture. This multiplicity of histologic patterns and an absence of single intralesional architecture characterize SFT.

The light microscopic differential diagnosis of SFT includes giant cell angiofibroma, hemangiopericytoma, fibrous histiocytoma, peripheral nerve sheath tumor, fibromyxoid sarcoma, monophasic synovial sarcoma, and other rare mesenchymal tumors. Immunohistochemical stains are helpful in the differential diagnosis and are supportive of the light microscopic findings. Solitary fibrous tumors are typically positive for CD34, BCL2, CD99, and vimentin and negative for desmin, epithelial markers like cytokeratin, vascular markers like factor VIII–related antigen, neural markers like S100 protein, and muscle-specific actin and smooth-muscle actin. Giant cell angiofibroma may share similar immunostainings, but multinucleated giant cells are not usually seen in SFT. In any case, positive immunomarkers lack sufficient specificity, and the typical light microscopic appearance is important in making the correct diagnosis of SFT.

Solitary fibrous tumors are usually benign, but malignant SFTs have been described. These malignant tumors show more cellularity, more than 4 mitoses per high-power field, cellular pleomorphism, or giant cells. Incomplete resection of benign SFT results in a higher recurrence rate and carries potential for malignant transformation. Malignant SFT may metastasize and cause death. To our knowledge, there was only 1 reported case of malignant SFT of the orbit.

Solitary fibrous tumors are believed to be more common in the orbit than previously suspected, and it should be included in the differential diagnosis of benign orbital tumors. However, SFT of the conjunctiva has never been described previously in the literature, to our knowledge, and the only related conjunctival tumor that has been reported is giant cell angiofibroma. From now on, SFT should be included in the differential diagnosis of stromal tumors of the conjunctiva.

Correspondence: Dr Pe’er, Department of Ophthalmology, Hadassah University Hospital, PO Box 12000, 91120 Jerusalem, Israel (peer@md.huji.ac.il).

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**Correction**

Omissions in End Matter. In the Clinical Sciences article titled “Longitudinal Postnatal Weight and Insulin-like Growth Factor I Measurements in the Prediction of Retinopathy of Prematurity” by Löfqvist et al, published in the December 2006 issue of the ARCHIVES (2006; 124:1711-1718), the “Funding/Support” and “Acknowledgment” sections were omitted from the end matter. They should have appeared as follows.

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