cribrosa in the optic disc center ($P = .73$) or in the periphery of the optic nerve head ($P = .55$), nor was it associated with the thickness of the sclera within the optic nerve meninges ($P = .23$).

Comment. The results suggest that in nonglaucomatous monkey globes, the CCT and the peripheral corneal thickness are not significantly correlated with the thickness of the lamina cribrosa in the center or at the periphery of the optic nerve head. They are also not associated with the thickness of the peripapillary sclera inside the optic nerve meninges or just outside the meninges. Confirming findings from studies on human globes, our study makes one infer that an assumed relationship between the CCT and glaucoma susceptibility may not be explained by corresponding anatomy between corneal thickness and histomorphometry of the optic nerve head.

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Chronic Localized Fibrosing Vasculitis of the Eyelid

Chronic localized fibrosing vasculitis (CLFV) is a rare entity of unknown etiology. To our knowledge, it has never been reported to occur in the eyelid.

Report of a Case. A 42-year-old man had gradually progressive, painless swelling in the lower eyelid for 2 years. There was no history of systemic illness, drug intake, or insect bite. On examination, there was a nontender, firm, nodular mass in the left lower eyelid (Figure 1). The palpable conjunctiva appeared normal. There were no features of orbital involvement. Ocular examination did not reveal any abnormalities in either eye, and best-corrected visual acuities were 20/20 OU. Systemic examination results were normal.

Comment. Although CLFV may be considered a variant of inflammatory pseudotumor of the skin, there are distinct differences. The presence of vasculitis and leukocytoclastic vasculitis of vessel walls in which eosinophils and fewer, scattered neutrophils, eosinophils, and plasma cells were present (Figure 2B). This picture was punctuated by foci of active leukocytoclastic vasculitis, characterized by fibroinoid necrosis of vessel walls in which eosinophils, neutrophils, and nuclear debris were present (Figure 2C). No lymphoid hyperplasia or granulomas were identified. These histological features were consistent with CLFV. The patient was started on topical tacrolimus ointment and is currently being followed up.

Computed tomographic scan of the orbit showed a homogeneous, minimally enhancing, relatively well-defined soft-tissue lesion in the eyelid with no evidence of orbital extension. Paranasal sinuses were normal. Results of a detailed systemic workup performed to rule out autoimmune or infectious systemic disease were within normal limits.

Incisional biopsy of the lesion was performed. Histopathological examination showed features of chronic leukocytoclastic vasculitis with a mild to moderate, diffuse infiltrate consisting predominantly of lymphocytes and fewer, scattered neutrophils, eosinophils, and plasma cells (Figure 2A). The inflamed stroma contained granulation tissue, marked proliferation of small vessels, and an extensive onion-skin pattern of fibrosis of blood vessels (Figure 2B). This picture was punctuated by foci of active leukocytoclastic vasculitis, characterized by fibroinoid necrosis of vessel walls in which eosinophils, neutrophils, and nuclear debris were present (Figure 2C). No lymphoid hyperplasia or granulomas were identified. These histological features were consistent with CLFV. The patient was started on topical tacrolimus ointment and is currently being followed up.

Figure 1. Painless, slowly growing mass in the lower eyelid of a 42-year-old, otherwise healthy man. The differential diagnoses considered were lymphoma, pseudotumor, tuberculosis, sarcoidosis, and Wegener granulomatosis.
may be cured by local excision,\textsuperscript{1} whereas idiopathic pseudotumor of the skin (classified as tumorlike proliferations\textsuperscript{2}) is now considered part of the spectrum of myofibroblastic proliferations\textsuperscript{3} with a potential for recurrence and localized persistent growth.\textsuperscript{4}

Chronic localized fibrosing vasculitis has been considered a variant of granuloma faciale, which usually occurs as 1 or more plaques, papules, or nodules on the face.\textsuperscript{5} Histologically, granuloma faciale has dense inflammation with predominant eosinophils and plasma cells, has dilated blood vessels, and often has extravasated red blood cells and toxic hyaline resembling fibrinoid material in the vessel wall, unlike the picture in our case. Targetoid, angiocentric, concentric fibrosis is also generally not seen in granuloma faciale.

Other pathological differential diagnoses are erythema elevatum diutinum, eosinophilic angiocentric fibrosis,\textsuperscript{6} and angiolymphoid hyperplasia with eosinophilia.\textsuperscript{7} The clinicalopathological criteria that we used to diagnose CLFV in our case were as follows: solitary lesion; negative results on systemic evaluation for vasculitis; chronic inflammatory infiltrate of predominant lymphocytes; foci of acute leukocytoclastic vasculitis with fibrinoid necrosis, neutrophils, eosinophils, and nuclear debris; proliferation of small blood vessels and granulation tissue; concentric fibrosis of blood vessels; and no lymphoid hyperplasia or granulomas.

The clinical differential diagnosis of a nodular lesion in the eyelid as in our case would be lymphoma, pseudotumor, and granulomatous lesions like tuberculosis, syphilis, sarcoidosis, and Wegener granulomatosis. Despite its rarity, CLFV should be considered in the differential diagnosis of an eyelid mass.

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