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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**Financial Disclosure:** None reported.

**Funding/Support:** This work was supported by grant EY-1576 from the National Institutes of Health (Dr Hayreh) and in part by unrestricted grants from Research to Prevent Blindness, Inc, New York, New York.


**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 left 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 palpebral 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.** Chronic localized fibrosing vasculitis, an entity that was first described by Carlson and LeBoit in 1997,1 is characterized by a nonspecific inflammatory reaction with vasculitis of small vessels with a distinctive concentric pattern of fibrosis.

Although CLFV may be considered a variant of inflammatory pseudotumor of the skin,1 there are distinct differences. The presence of vasculitis and leukocytoclastic (nuclear debris) and the absence of dense plasma cell infiltrate in our case clearly distinguished it from cutaneous inflammatory pseudotumor. The distinction between the 2 entities may also have prognostic implications as CLFV (classified as vasculopathic reaction pattern2)
may be cured by local excision, whereas idiopathic pseudotumor of the skin (classified as tumorlike proliferations) is now considered part of the spectrum of myofibroblastic proliferations with a potential for recurrence and localized persistent growth.

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. 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, and angiolymphoid hyperplasia with eosinophilia. The clinicopathological 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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Financial Disclosure: None reported.