Because disc hemorrhages are usually associated with optic disc hemorrhages in glaucoma, the findings point against a thin cornea as an associated factor for disc hemorrhages in glaucoma.

**Comment.** The findings point against a thin cornea as an associated factor for disc hemorrhages in glaucoma. Because disc hemorrhages are usually associated with optic disc hemorrhage, the results do not support a thin cornea to be a pathogenic risk factor for glaucoma progression.

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**Financial Disclosure:** None reported.

**Funding/Support:** This work was supported by grant 7071003 from the Beijing Natural Science Foundation.


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**Primary Clear Cell Carcinoma of the Conjunctiva**

Clear cell carcinoma is a rare variant of squamous cell carcinoma of the skin characterized by extensive cytoplasmic hydropic change.1,2 These tumors tend to occur in the head and neck of elderly white men. Because the clear appearance of the cytoplasm is due to hydropic change rather than the accumulation of lipid, mucin, or glycoprotein, histochemical stain results are negative. Some of these clear cells have a "bubbled" cytoplasm and have been confused with sebaceous carcinoma.1 To our knowledge, primary clear cell carcinoma on the conjunctiva has not been reported.

**Report of a Case.** A 79-year-old man visited for continuation of care after changing residency. His ocular history was significant for a conjunctival tumor excised from the right eye 12 years earlier. The patient brought his medical records with him. The original pathologic interpretation was Bowen disease. After the tumor was excised, local recurrences developed 1 and 4 years later. Both were removed surgically and diagnosed as carcinoma in situ. The patient had not had an eye examination in several years. On examination, corrected visual acuity was 20/150 OD. A papillomatous conjunctival tumor was at the limbus, extending from the 9-o’clock position to the 3-o’clock position (**Figure 1**). The anterior chamber was normal. Other than cataract, the remainder of the examination was noncontributory. There was no regional adenopathy. The tumor was excised under local anesthesia with a visible normal margin, and abnormal epithelium was removed from the cornea mechanically. The surgical bed

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**Table. Criteria for the Definition of Glaucoma in the Beijing Eye Study**

<table>
<thead>
<tr>
<th>Criteria Type</th>
<th>Criteria</th>
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<tbody>
<tr>
<td>Absolute</td>
<td>Neuroretinal rim notch in the temporal inferior region and/or the temporal superior region, so that the ISNT rule was not fulfilled (in eyes with an optic cup sufficiently large to allow an assessment of the neuroretinal shape)</td>
</tr>
<tr>
<td>Relative</td>
<td>Neuroretinal rim was markedly thinner in the inferior disc region compared with the superior disc region, even if the smallest part of the neuroretinal rim was located in the temporal horizontal disc region</td>
</tr>
</tbody>
</table>

**Comment.** The only criterion for optic disc glaucoma was a glaucomatous appearance of the optic disc.

**Abbreviation:** ISNT, inferior-superior-nasal-temporal.

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Figure. Box plots showing the distribution of central corneal thickness in subjects with and without optic disc hemorrhages in the Beijing Eye Study. Open circles indicate outliers. The box contains 50% of the data; the line in the box represents the median.

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and surrounding conjunctival margin were treated with cryotherapy.

When the tumor recurred 6 months later in the same location, it was excised with a partial sclerectomy; additional cryotherapy was applied. The patient died of heart disease 4 years later but never showed signs of local or regional recurrence.

The slides obtained from the primary tumor showed conjunctival intraepithelial neoplasia with scattered clear cells. The tumor had a papillary pattern of growth. Slides from the next 2 recurrences were not available.

The third recurrence had a papillary pattern of growth and showed full-thickness dysplasia (Figure 2A). In many areas, the cytoplasm of the dysplastic cells was vacuolated (Figure 2B). The clear cells stained negative with mucicarmine, alcian blue at pH 2.5, periodic acid–Schiff, and S-100 protein and positive for epithelial membrane antigen.

The fourth recurrence consisted almost entirely of moderately pleomorphic clear cells (Figure 2C). The cells stained negative with alcian blue at pH 2.5, periodic acid–Schiff, and HMB-45. Results of a frozen section with oil red O performed at the time of surgery were negative.

Comment. The phenomenon of cytoplasmic clearing is found in a variety of tumors arising from the epithelium, most of which demonstrate positive histochemical evidence indicating eccrine, follicular, melanocytic, or sebaceous cell lineage. The diagnosis of primary clear cell carcinoma is made by excluding these specific entities as well as metastatic carcinoma. The relationship of the clear cells to neoplastic conjunctival epithelium in our patient was evident in the first biopsy and became more evident in the third recurrence as the proportion of clear cells increased.

Too few cases of clear cell carcinoma of the skin have been reported to draw firm conclusions about its clinical behavior. Four of the 6 initially described tumors from the skin displayed rapid growth, and 1 patient died of metastatic disease. The tumor in our patient demonstrated a propensity for local recurrence, had few mitotic figures, and during a 16-year period never showed any evidence of regional or distant spread. Until more information on the behavior of primary clear cell carcinoma of skin or mucous membranes is available, it should be regarded as locally aggressive and possibly lethal.

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Giant Intrascleral Cyst Treated With Trichloroacetic Acid

Intrascleral cysts are a rare complication of strabismus surgery. Treatment of these lesions has previously been described to include excision as well as drainage followed by injection of tetracycline hydrochloride. The use of trichloroacetic acid (TCA) has been described in the treatment of many lesions, including conjunctival and corneoscleral cysts. Here we describe the use of TCA in the treatment of a giant intrascleral cyst.

**Report of a Case.** A 23-year-old man was referred with a diagnosis of retinal detachment in his left eye. The patient had gradual decreased vision, discomfort, and enlargement of his left eye during the past 12 months. His ocular history included strabismus surgery on both eyes at age 10 years and on the left eye at age 21 years. He was noted to have strabismic amblyopia of the left eye. On examination, his visual acuity was 20/20 OD and 20/100 OS. External examination of the left eye revealed proptosis and lagophthalmos. Slitlamp examination showed a large bluish scleral bulge superonasally (Figure 1A) and significant surface keratopathy. On fundus examination, areas of dome-shaped retinal and choroidal elevation were noted superiorly and nasally (Figure 1B). An ultrasonographic examination of the left eye demonstrated a large echolucent area 25.4 × 18.9 × 11.9 mm within the sclera, consistent with an intrascleral cyst. The retina and choroid were attached (Figure 2). A computed tomographic scan was obtained, which showed an intrascleral cyst with no com-

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**Financial Disclosure:** None reported.


**Figure 1.** A slitlamp photograph of the left eye demonstrating a bluish-tinged cystic mass superiorly and nasally (A) and a fundus photograph showing elevation of the retina and choroid nasally (B).

**Figure 2.** A transverse B-scan image at the 12-o’clock position revealing a multilobular echolucent lesion of the left eye (A) and a transverse B-scan image at 9-o’clock position confirming the intrascleral location of the lesion, with the retina and choroid attached (B).