ROLE OF INTRALESIONAL CORTICOSTEROID THERAPY IN EYELID HAEMANGIOMA

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PRESENTATION OF CASE
A 2-month-old female child presented in P.M.C.H Eye O.P.D with an oclusive lesion involving the right upper eyelid, which resulted in ptosis within early weeks of normal delivery as told by mother. The lesion increased in size over the past one and a half month without any systemic feature.

Ocular Examination
On Examination of eye and adnexa, it was suggestive of a superficial cutaneous lesion (Strawberry naevi) bright red on the right upper eyelid. There was difficulty in opening of right eyelid fully and left eye showed fixing following. On measurement of lids the right palpebral fissure was 2 mm, while left palpebral fissure was 10 mm. The orbital ultrasonography revealed no intraorbital extension.

DIFFERENTIAL DIAGNOSES
- Nevus flammeus (port-wine stain) of Sturge-Weber syndrome.
- Lymphangioma or other vascular malformation.
- Metastatic neuroblastoma.
- Kasabach-Merritt syndrome.

Course
The examination and history of patient consistent with a capillary haemangioma of right upper eyelid resulting in partial occlusion of involved eye. Orbital ultrasonography demonstrated no intraorbital extension of lesion.

CLINICAL DIAGNOSIS
The diagnosis of infantile haemangioma is done by history and physical examination in majority of cases. Imaging ultrasound with Doppler, magnetic resonance imaging and cytology or histopathology are also used in rare cases for confirmatory diagnosis. The depth of involvement can also be ascertained by ultrasonography. The blood flow into the lesion can be demonstrated by CT scan. MRI scan can also be helpful.

PATHOLOGICAL DISCUSSION
Capillary haemangioma are classified as hamartomas or abnormal proliferation of normal tissue in normal location.

Histopathologic Picture of Capillary Haemangioma showing Lobules of Capillaries separated by Fibrous Tissue

Treatment
Both long and short term acting intralesional injectable steroids are useful in these type of cases; 1 mL of short-acting triamcinolone (40 mg/mL) is mixed with 1 mL of long-acting betamethasone (4 mg/mL) in tuberculin syringe and injected in the lesion. With a single use of intralesional injection, most of the haemangiomas reduced. In this case we had given repeated injection at an interval of six weeks. After the six months of two intralesional injections of corticosteroid, there was excellent regression in tumour size. Propranolol, a non-selective beta-blocker that can be used systemically for orbital capillary haemangioma with high efficacy.

Surgical treatment is rarely indicated, but can be considered in those with visual symptoms, not responding to pharmacologic modalities of management.

DISCUSSION OF MANAGEMENT
Spontaneous involution is the rule. Observation is also necessary. In the natural course of time there is 40% complete involution by the age of 4 yrs., whereas 80% complete involution by the age of 8 yrs. If there is occulsion amblyopia or significant astigmatism, treatment must be started earlier for the best result. The intralesional steroid treatment carries a risk of soft tissue atrophy, hypopigmentation, glaucoma and possible systemic absorption.
CONCLUSION
This case highlights the importance of intralesional corticosteroid therapy in the management of regressing eyelid haemangioma as an initial modality.

REFERENCES