Conjunctival Keratoacanthoma in an Asian

Keratoacanthoma, a benign epithelial tumor that grows rapidly and shows spontaneous regression, has a characteristic central crater filled with keratin. Keratoacanthomas arise most commonly in sun-exposed skin and only rarely in mucosa.1 The few reported cases of conjunctival keratoacanthoma have occurred mostly in whites.2 Here we describe what we believe to be the second reported Asian case of conjunctival keratoacanthoma.

Report of a Case. On January 3, 2001, a 39-year-old Japanese man noted hyperemia of the right bulbar conjunctiva associated with a foreign-body sensation. One week later he consulted an ophthalmologist because the hyperemic bulbar lesion had become elevated. He was diagnosed as having phlyctenular conjunctivitis and was treated with topical 0.1% dexamethasone and antibiotic eyedrops. This limbal lesion continued to grow and on February 5, 2001, the patient was referred to the Department of Ophthalmology at Kyushu University, Fukuoka, Japan.

His corrected visual acuity was 20/20 OU. Slitlamp examination of the right eye revealed a white, firm, and dome-shaped mass at the nasal limbus. The lesion had a central crater filled with white material. The mass was approximately 4 mm in diameter and was surrounded by hyperemia (Figure 1). A delle was noted on the cornea adjacent to the mass. We curetted the white material plugging the crater; however, 1 week later the crater had refilled with similar material. We then totally excised the tumor.

Results. Findings from histopathologic examination showed a central crater containing a keratotic plug surrounded by acanthotic conjunctival epithelium that included horn pearls (Figure 2). The tumor cells had abundant, glassy, eosinophilic cytoplasm and small nuclei. In the deeper regions, tumor cells showed cellular atypia and infiltrative growth associated with an inflammatory reaction. Based on the overall shape of the lesion, a crater filled with keratin and surrounded by epidermis extending in a lip-like manner over its sides, we diagnosed the mass as a keratoacanthoma. One year after resection no recurrence has been observed.

Comment. Keratoacanthoma ordinarily arises in skin containing hair follicles, and rarely subungually, in the palms, or in buccal or conjunctival mucosa. Keratoacanthoma of the conjunctiva was first reported by Freeman et al3 in 1961. Only 12 cases have been reported in the 40 years since the first account, mainly in whites; one patient was a mulatto,2 and another was black.4 To our knowledge, only 1 Asian case of conjunctival keratoacanthoma has been reported previously in the English-language literature, and this case occurred in a Thai individual.5

Keratoacanthoma is a benign tumor that shows spontaneous regression but often resembles well-differentiated squamous cell carcinoma histopathologically. Like squamous cell carcinoma, keratoacanthoma may show cellular atypia, mitosis, horn pearls, and focally infiltrative growth. In the present case, the initial microscopic section did not show a keratotic plug, and the first diagnosis was squamous cell carcinoma. However, additional sections cut from deeper in the tissue block revealed the central crater. Considering this architecture and the clinical course, the pathologic diagnosis was revised to keratoacanthoma. Specifically, features of rapid growth and a central crater are essential to diagnosis of keratoacanthoma.

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An Unusual Case of Leukocoria: Heterotopic Brain Arising From the Retina

A newborn infant was seen who had leukocoria, total retinal detachment, and a noncalcified mass in the posterior retina. Retinoblastoma was considered a possibility, and enucleation was performed. Pathologic examination findings revealed heterotopic brain tissue arising from the retina to lead us to conclude that posterior segment heterotopic brain tissue is a rare choristomatous lesion that can present as leukocoria.

Report of a Case. An 8-day-old white male was noted to have leukocoria in the right eye on routine examination at his pediatrician’s office. He was referred immediately for ophthalmologic examination. There was no family history of retinoblastoma or childhood eye disease.

On examination, the right eye minimally responded to light. The left eye responded normally to light with a brisk blinking reflex. A right afferent pupillary defect was present. Slitlamp examination of the right eye revealed a thick retrolental white plaque (Figure 1). The horizontal corneal diameter OD was 9.5 mm in comparison with 10 mm OS. The lens in the right eye was subluxated anteriorly and superotemporally. Fundus examination of this eye revealed a funnel-shaped retinal detachment with a fibrous membrane spanning the anterior part of the funnel just posterior to the lens. A large chalky

Figure 1. Slitlamp examination of the right eye shows a dilated pupil, subluxated lens, and leukocoria with a vascularized retrolental membrane.

Figure 2. Computed tomographic scan of the orbits demonstrates a well-demarcated, noncalcified posterior pole mass with posterior staphyloma in the right eye.