Cicatricial ectropion due to herpes zoster ophthalmicus

Sir,
We present the clinical features and management of an unusual case of cicatricial ectropion of the upper lid secondary to herpes zoster ophthalmicus (HZO) in an immunodeficient patient.

Case History

An 83-year-old lady suffering from chronic lymphocytic leukaemia (CLL) was referred with a history of left herpes zoster ophthalmicus (HZO). The episode, which had been treated with systemic antivirals, had occurred 4 months prior to the referral. There was no intraocular involvement. On presentation to us, the vision was 6/24 on right and 1/60 on the left side. She had an uncomfortable red left eye. On examination [Figures 1 a, b, c, d], there was scarring on the left forehead extending down to the upper lid. The scar tissue had contracted resulting in upper lid eversion and retraction. She had poor lid closure and significant lagophthalmos. The exposed tarsal conjunctiva was keratinised and she had developed exposure keratopathy with a circumferential pannus, a hazy lustreless cornea and a central epithelial defect. Rest of the ocular examination was unremarkable.

In view of her age and general condition, she was offered a conservative tarsorrhaphy but she preferred reconstructive surgery. Under local anesthesia, a left upper lid wedge (18 by 12 mm) was resected to remove the cicatrix. The temporal upper lid was refashioned with a modified lateral tarsal strip. A full thickness skin graft from the left upper arm was excised, thinned and sized to reform the anterior lamella. Histopathology of the excised tissue revealed squamous metaplasia and a chronic active inflammatory infiltrate indicating post-inflammatory scarring.

Post-operatively the graft took well [Figure 2]. Full lid function was restored and the corneal epitheliopathy resolved.
Satisfactory cosmetic improvement was achieved. She was discharged after being instructed to vertically massage the lid with petroleum jelly.

Cicatricial ectropion of the upper lid is not seen as frequently as that of the lower lid. When present, it is usually due to cicatrization of the anterior lamella (skin and orbicularis) secondary to lacerations, burns, infections and skin disease. In this case, there was probably a marked inflammatory reaction and as the soft lid tissue cannot withstand the forces of vertical lid traction due to scarring, contracture occurred resulting in ectropion.

Immunodeficiency increases the risk of developing zoster and amplifies the associated morbidity. The other main risk factor is increasing age. In immune-competent patients, duration of the rash until disappearance of crusts is 2-3 weeks. However, immunodeficient patients may have an atypical, chronic course lasting for months with repeated vesicular eruptions, inflammation and hemorrhages.

A satisfactory local therapy for HZO with proven antiviral efficacy does not exist. Oral antiviral medications such as acyclovir, valacyclovir and famciclovir remain the mainstay of therapy and are most effective in preventing ocular involvement when begun within 72 hours after the onset of the rash. However, we suggest that in high-risk patients with severe cutaneous involvement the elasticity of the lid skin should be improved by consistent vertical lid massage and by increasing the relative humidity of the environment. This may have avoided the extensive cicatrisation that occurred in our patient.

This case illustrates that immunodeficient patients with HZO can have severe scarring leading to cicatrical upper lid ectropion. Although cicatrical ectropion secondary to necrotising zoster infection has been reported, this is the first case of upper lid cicatrical ectropion developing in a non-necrotising form of the disease but in the presence of immunodeficiency. Therefore, it is important that immunodeficient patients are appropriately managed to prevent this complication. Even though the upper lid was extensively scarred, excision of the cicatrix and reconstruction with a skin graft relieved the tractional forces resulting in a return to normal lid function. To prevent corneal complications and avoid metaplasia and keratinization of the conjunctiva, reconstructive surgery may thus be contemplated in these patients.

**References**


**Spontaneous ovarian hyperstimulation syndrome presenting with acute abdomen**

Sir,

The ovarian hyperstimulation syndrome (OHSS) is a serious complication of ovulation induction therapies used in infertile patients. Enlargement of the ovaries, ascites, pleural