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Kimura’s disease: no evidence of clonality

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Kimura’s disease: no evidence of clonality

EDITOR—Kimura’s disease is a chronic inflammatory disorder of unknown aetiology. Patients usually present with recurrent painless swellings in the subcutis of the head and neck region, increased serum IgE levels, and peripheral eosinophilia. The disease is described as reactive and data on clonality is absent.

Here we describe a patient with Kimura’s disease involving the orbits. Clonality studies were performed by polymerase chain reaction (PCR) for immunoglobulin heavy chain (IgH) cell receptor gene (TCR-g), and delta (TCR-d) gene rearrangements.

CASE REPORT
A 20 year old man presented with a 2 x 3 cm right eyelid swelling in 1986 with normal visual acuity and absence of diplopia. In 1993, he presented with progressive swelling in the right upper eyelid, which subsided with a short course of prednisolone (50 mg/day x 1 week). He was lost to follow up until May 1997 when he developed recurrent swelling of the right upper eyelid. Excision biopsy of the right upper eyelid mass showed changes consistent with Kimura’s disease. DNA was extracted from lacrimal gland biopsy tissue.

Gene rearrangements for IgH gex, TCR-g, and TCR-d genes were tested by PCR but no clonal gene rearrangement was identified (Fig 1).

In June 1998, he had recurrence of the right upper eyelid mass without any local or systemic symptoms (fever, night sweats, weight loss) and multiple left cervical lymph nodes measuring 1-2 cm in diameter. A complete blood examination showed haemoglobin 14.1 g/dl, platelets 282 x 10^11, and leucocytes 18.4 x 10^9 (differential: eosinophils 5.68 x 10^9, neutrophils 9.2 x 10^9, lymphocytes 1.5 x 10^9, and monocytes 4.0 x 10^9). The IgE level was 1032 IU/ml (normal range: <100 IU/ml). IgA, IgG, and IgM levels were normal. Urea, creatinine, albumin, and transaminase levels were within normal limits. Serology for HIV was negative.

Magnetic resonance imaging (MRI) showed an oval mass in the right lacrimal gland and thickening of the right superior rectus muscle (Fig 2). After only 5 weeks of prednisolone (50 mg/day), there was almost complete resolution of the lacrimal mass and IgE level and eosinophil count went down to 2860 IU/ml.

Figure 1. PCR amplification of TCR-g gene rearrangement showing absence of clonal rearrangement in 6% polysacrylamide gel. Lane: M-PhiX174, HaeIII digest; 1, reagents blank; 2, positive control (B cell lymphoma); 3, water only; 4, patient’s lacrimal gland sample.

COMMENT
Neoplasia is characterised by clonal proliferation of cells and is most often demonstrated in cases of malignant diseases. However, monoclonality has also been demonstrated in some “benign” or “reactive” lymphoproliferative such as angioimmunoblastic lymphoproliferative and Castleman’s disease, both of which are associated with a tendency to aggressive lymphoma.

Kimura’s disease runs an indolent course and has been described as a chronic inflammatory process reactive to some “unknown” stimuli. Our patient had a typical clinical presentation with recurrent lacrimal swelling and lymphoproliferation in the head and neck region. It is an extremely indolent course and, despite the recurring nature of the disease, our patient remained asymptomatic that he was lost to follow up for years. Interleukin-5 has been shown to constitutively express and explains some of the features of the disease such as eosinophilia and elevated IgE level.

TCR-g gene has been shown by PCR amplification to be rearranged not only in clonal B cell disorders, but also in 73% of clonal B cell disorders. The PCR based methods for the IgH gene rearrangement are positive in 55–100% of various types of clonal B cell disorders.

In our patient, the absence of
clonal TCR and IgH gene rearrangements is consistent with the reactive nature of the disease. However, despite the relatively high sensitivity of these PCR based techniques to detect clonality, the finding should be confirmed by testing larger numbers of patients and Southern with appropriate probes if DNA from fresh tissue is available.

In conclusion, our patient illustrates the typically indolent, recurring nature of the disease with lymphadenopathy and swelling confined to the head and neck region. The failure to demonstrate clonality is consistent with the reactive nature of the entity and the lack of report of malignant lymphoma transformation.

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Correction of the inadequate lower fornix in the anophthalmic socket

Editor,—A well formed inferior fornix in the anophthalmic socket requires an adequate amount of conjunctival tissue and a deep recess. Obliterating the fornix might occur either secondary to conjunctival shrinkage or as a result of obliteration of the inferior recess and inadequate fixation of the abundant conjunctiva. In the latter condition, the subject of this report, prolapse of the fornical conjunctiva will result in anterior rotation of the inferior edge of the prosthesis and secondary laxity of the lower lid.

This report presents a modification of the technique described previously by Neuhaus and Hawes for the correction of the above condition.1

CASE REPORT

Twenty patients with an inadequate inferior fornix and sufficient amount of conjunctival tissue who presented over a period of 5 years were managed. They all complained of easy prolapse of the lower edge of the prosthesis and sagging of the lower lid.

The procedure was done under local anaesthesia except in the two patients who, in addition, underwent secondary insertion of an orbital implant. A canthotomy and cantholysis were performed. An infracanal conjunctival incision was carried out along the length of the lower lid. Dissection was then performed in the retro-orbicular plane till the orbital rim was reached (Fig 1A). The posterior edge of the conjunctival incision was fixed to the perosteum about 5 mm posterior to the inferior orbital rim with interrupted 5-0 Vicryl sutures. The posterior surface of the lower lid was left to heal by secondary intention (Fig 1B). An adequately sized conformer was inserted. A tarsal strip procedure was performed to tighten the lower lid horizontally. A prosthesis was fitted at about the second post-operative month. The follow up period ranged from 5 months to 3 years. Nineteen patients had a satisfactory result with adequate retention of the prosthesis, and good lower lid level. Inspection of the lower fornix revealed a deep recess with a well epithelialised inner lower lid surface, and no evidence of symblepharon (Fig 2). One patient had loosening of the tarsal strip suture noted at the 1 week postoperative follow up and was later corrected. However, the final lid level remained unsatisfactory.

COMMENT

Adequate retention of the prosthesis in the anophthalmic socket requires a well formed inferior fornix, which in turn requires sufficient conjunctival length and a deep recess.

Obliterating the inferior fornix might occur despite having a good amount of conjunctival tissue.1 This occurs possibly because of dehiscence of lower lid retractors, or development of scar tissue in the inferior recess that ultimately results in prolapse of the fornical conjunctiva and anterior rotation of the lower edge of the prosthesis. The long term effect exerted by the weight and pressure of an improperly accommodated prosthesis will result in secondary laxity of the lower lid.

The traditional solution to the above condition consisted of a lateral canthal tendon tightening and a fornix reformulation using an externalised suturing technique in addition to alloplastic strengthening material.1 Skin erosion and infection necessitated early removal of the externalised sutures and increased the risk of recurrence.

Another method of repair was described by Neuhaus and Hawes for the correction of the inadequate inferior cul de sac. It consisted of a transconjunctival inferior fornix incision used to gain direct exposure of the peristeum of the inferior orbital rim. Direct suture fixation of the edges of the conjunctival incision to the peristeum is then achieved. Externalised sutures and stents were not required. Out of 12 patients reported in the above paper, two developed mild lower lid retraction and two developed mild lower lid entropion. This is because the vertical length of the conjunctival tissue is not always sufficient to allow for fixation of both edges of the incision down to the peristeum. Lower lid retraction or entropion occurs whenever the anterior edge of the incision is forced down and sutured under tension.

The technique described in this report makes the conjunctival incision just at the infratarsal border so as to save the maximum length of conjunctiva for the posterior flap. By the inner lid surface is left to heal by sec-

Figure 1 (A) The bold blue line marks the dissection plane. (B) The posterior conjunctival edge sutured down to the peristeum.

Figure 2 Manual eversion of the lower lid shows a deep fornix with a well epithelialised inner lid surface and no symblepharon.

ondary intention. The tarsal strip procedure performed during the surgery aims to eradicate the lower lid laxity and sag.1

In conclusion, this modified technique allows the use of internal fixation to correct the lower fornix while minimising the risk of lower lid retraction or entropion.

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