Cysticercosis of the eyelid

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DESCRIPTION

A 26-year-old male patient complained of well-defined cystic swelling on the conjunctival aspect of his left lower eyelid for the past 2 months. His medical history was not significant. Visual acuity was 20/20 in each eye with unremarkable anterior and posterior segments, without any extraocular movement restriction. Examination of the left lower lid on its conjunctival aspect revealed a well-defined cystic lesion with soft to firm in consistency and it was completely preseptal (figure 1A). A complete excision biopsy was performed under local anaesthesia. Histopathology showed a multilayered cyst with minimal surrounding fluid around the invaginated scolex (figure 1B, Yellow arrow), four visible eccentric suckers (red arrow) and near central double layered hooklets (green arrow) suggestive of cysticercosis of the eyelid. Non-contrast enhanced CT of the brain and orbit did not reveal any additional foci of infection. The patient was prescribed oral prednisolone 1 mg/kg tapered over 4 weeks along with oral albendazole 15 mg/kg body weight for 4 weeks. At the end of 10 days, there was a healthy wound site (figure 1C) and at the end of 5 months, there was no recurrence/complications.

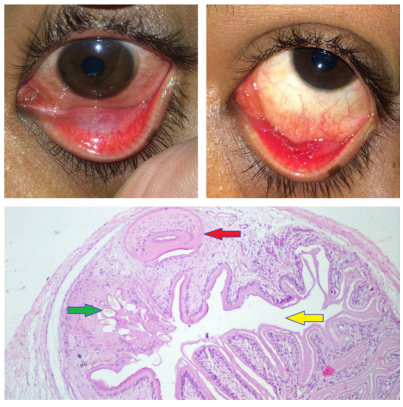

Figure 1 (A) A well-defined cystic lesion along the conjunctival aspect of the left lower eyelid .(B) Histopathology of the cyst showing a well-defined cyst having invaginated scolex (yellow arrow) with four eccentric suckers (red arrow) and a central double row of hooklets (green arrow).(C) At the end of 10 days, the wound is completely healed without much scarring of the conjunctiva.

Human cysticercosis is due to larval infestation by the cestode *Taenia solium*. The ocular involvement can be intraocular involving the vitreous or the subretinal space or as extra-ocular foci mainly involving the muscles.[1] The presentation in these cases can be as recurrent ocular surface inflammation, ptosis or self-limiting extraocular motility restriction. Involvement of the eyelid is rare, but these cases may also present as a subconjunctival mass or as spontaneous extrusion of the cyst. In the current case, the diagnosis of cysticercosis at first was unlikely as it was in an unusual location without any signs of inflammation. We kept a provisional diagnosis of the inclusion cyst before excision. As it was a cosmetic concern for the patient, the excision biopsy was performed with due consent. Postoperative histopathological examination proved vital in this case.

Learning points

- Periorbital involvement of the cysticercosis can have varied presentations. Under these circumstances, the final diagnosis is mainly achieved by a careful clinical examination, orbital imaging and monitored medical/surgical management.
- The differential diagnosis for orbital conditions includes many possibilities and can be a Pandora's box. Any form of tissue excision around the orbit is better subjected to a histopathological examination to ascertain the final pathology.

Contributors AP, MSB, SS and VR: have evaluated the case initially. AP: did excisional biopsy followed appropriate histopathological analysis. After analysing the educational value all authors together wrote the report.

Competing interests None declared.

Patient consent Obtained.

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