When Is a Chalazion Not a Chalazion?

Sometimes we can observe an eyelid lesion without recognizing it or being certain of the diagnosis. In this issue, Ozer et al. bring to our attention a diagnosis that I was not familiar with but have observed in many children. Idiopathic facial aseptic granuloma is a recently described pediatric dermatological disorder, characterized by chronic and painless soft facial nodules with a red or purplish appearance, usually presenting as a single lesion on the cheek. The facial nodules may present concurrently with unilateral or bilateral eyelid nodules or with only eyelid lesions. The eyelid nodules may resemble external chalazia that extend on to the surface of the skin of the eyelid near the margin. I suspect most ophthalmologists are unaware of this diagnosis and would consider them to be “external chalazia” as I have for years. I believe that on reviewing the images in the article in this issue, most readers would agree with my conclusion.

Chronic subepidermal eyelid nodules resembling skin abscess should alert clinicians for idiopathic facial aseptic granuloma. As the authors state, because idiopathic facial aseptic granuloma responds well to oral antibiotics, particularly clarithromycin, surgical intervention may be avoided in many cases. The time to resolution of this condition was found to be shorter than that for chalazia. Similar to chalazia, the etiology of idiopathic facial aseptic granuloma remains undetermined. Unproven hypotheses include mild trauma and insect bites as potential causes.

There is also histologic evidence that differentiates idiopathic facial aseptic granuloma from chalazia. Idiopathic facial aseptic granulomas are inflammatory granulomas located inside the dermis, with lymphocytes, histiocytes, neutrophils, and giant cells. This is different from the typical lipogranulomas found in chalazia. Furthermore, the nodules of chalazia have a deeper anatomic location within the tarsal plate of the eyelid. Idiopathic facial aseptic granuloma nodules appear as subepidermal skin abscesses. This observational clue can be used for the identification of idiopathic facial aseptic granuloma nodules.

The authors conclude that, as with chalazia, children with idiopathic facial aseptic granuloma have a greater risk of developing rosacea and regular ophthalmologic examination is advised in these cases. We are all aware of the difficulties we face in treating hordeola and chalazia in children. Applying warm compresses is challenging in young patients. Patients with idiopathic facial aseptic granuloma have been successfully treated with systemic antibiotics. We all should include idiopathic facial aseptic granuloma in the differential diagnosis of inflammatory lesions of the eyelids.

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