ABSTRACT: a 62 yo male presents with a foreign body sensation OU. Tissue biopsy is positive for Ocular Pemphigoid. He is treated with methotrexate and bandage contact lenses and subsequently develops sequela of contact lens overwear.

I. CASE HISTORY

DEMOGRAPHICS 64 year old white male

CC Foreign body sensation OU for multiple months

OHX & MHX Epilation LL 3 years ago
No prior ocular infections
No prior chemical burns
No dryness of the throat
No blistering skin conditions

Meds Artificial tears prn

II. PERTINENT CLINICAL FINDINGS

VISUAL ACUITY OD: 20/20 cc
OS: 20/25 cc

EOMS OU: normal

LIDS & LASHES OU: entropion & trichiasis

CONJUNCTIVA OD: shortened fornix
OS: shortened fornix
inferior lateral symblepharon subepithelial fibrosis

CORNEA OU: clear

GAT IOP OD: 14
OS: 12

C/D OU: 0.60/0.60

POST SEGMENT OU: normal

III. DIFFERENTIAL DIAGNOSIS

LEADING DX Ocular Cicatricial Pemphigoid

OTHER DX Stevens-Johnson syndrome
Scarring from membranous conjunctivitis
Chemical burn
Chronic topical medications
Squamous cell carcinoma
Irradiation

IV. DIAGNOSIS & DISCUSSION

 Conjunctival biopsy confirms the initial suspicion of ocular cicatricial pemphigoid. The patient has no systemic manifestations.

 Mucus membrane pemphigoid is a systemic autoimmune disease that affects the skin and mucus membranes. The average onset is age 65 although it may also affect young adults and children. Females predominate. Oral lesions are the most common sign and occur in 75% of patients or more. When the condition affects the eyes it is known as ocular cicatricial pemphigoid. The hallmark ocular characteristic is a cicatrizing conjunctivitis that may result in inferior symblepharon and fornix foreshortening. Dry eye from a poor tear film, entropion, and trichiasis may follow. Additional ocular sequela include corneal opacification, pannus, keratinization, loss of ocular motility, and ankyloblepharon. Approximately 27% of cases result in blindness.

V. TREATMENT & MANAGEMENT

• Anterior segment photographs obtained.

• Rheumatology starts the patient on 10 mg methotrexate per week—later increased to 15 mg—as well as 1 mg folic acid qd. The patient receives monthly liver function tests.

• Bandage contact lenses are fitted to control the foreign body sensation resulting from entropion, which is successful for some time. The patient is eventually lost to follow up and develops ocular inflammation and meibomian gland dysfunction. He is removed from contact lenses and aggressively treated with topical medication. Lash epilation controls the ocular irritation during the contact lens holiday.

 Possible treatments for pemphigoid depend on disease severity and include artificial tears, autologous serum, topical cyclosporine A, topical steroids, systemic steroids, immunosuppressive agents (eg. methotrexate & cyclophosphamide), dapsone, lid surgery, & mucous membrane grafts. Unfortunately, the condition is chronic and characterized by remissions & flare-ups.
VI. CONCLUSION

Debilitating foreign body sensation resulting from entropion in ocular cicatricial pemphigoid can be controlled by epilation, contact lenses, and surgical means. The efficacy of epilation as a long term solution and its role in exacerbation of flare-ups is questionable. Appropriate use of bandage contact lenses can control irritation caused by lashes when surgery is deferred or not indicated. However, care should be taken to avoid microbial keratitis and other complications of contact lens wear. Furthermore, low grade flare-ups of pemphigoid may be difficult to differentiate from contact lens related problems. Lastly, electroepilation and surgical correction of entropion may promote flare-ups.

VI. BIBLIOGRAPHY


