

Delayed Eyelid Masses: When to Suspect Infiltrative Mimickers

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To the Editor: I read with great interest the report by Le and Burgoyne of a 64-year-old woman with painless unilateral lower eyelid fullness that developed three years after malar hyaluronic acid filler injection. The authors correctly identified a delayed filler-related complication, supported by the intraoperative gelatinous material, acellular foreign material on histopathology, the subsequently disclosed history, and improvement after hyaluronidase.¹ I wish to complement their discussion by highlighting four relevant infiltrative mimics.

First, sarcoidosis may involve the eyelids, lacrimal gland, extraocular muscles, and orbital tissues. Eyelid granulomas, dacryoadenitis, uveitis, or proptosis may provide diagnostic clues. A compatible biopsy supports definite ocular sarcoidosis, whereas bilateral hilar adenopathy may support a presumed diagnosis.² In this case, the normal ocular examination and absence of granulomas or an inflammatory infiltrate made sarcoid involvement unlikely.

Second, the diagnostic criteria for IgG4-related ophthalmic disease integrate imaging, histopathology, and serum IgG4 concentration. Imaging may show enlargement of the lacrimal gland, trigeminal nerve, or extraocular muscles, as well as masses involving other ophthalmic tissues. Histopathology typically demonstrates marked lymphocytic and plasmacytic infiltration, sometimes with fibrosis, and abundant IgG4-positive plasma cells; serology alone does not establish a definite diagnosis.³ Isolated lower eyelid involvement, normal ocular motility, and the absence of an inflammatory infiltrate did not favor this diagnosis.

Third, ocular adnexal lymphoma may involve the orbit, conjunctiva, lacrimal apparatus, or eyelid. In the series by Boltezar et al.,⁴ the median age was 68 years, and mucosa-associated lymphoid tissue lymphoma accounted for 71.6% of cases. Ocular adnexal lymphoma may manifest as an eyelid mass, ptosis, or painless proptosis; on imaging, an orbital mass typically is poorly defined and molds to adjacent structures without bony erosion. Diagnosis requires biopsy with histopathologic, immunophenotypic, and molecular studies. The absence of malignancy and the presence of acellular material did not support this diagnosis.

Finally, idiopathic orbital inflammation may cause conjunctival injection, periorbital edema, proptosis, pain, diplopia, or reduced ocular motility. Evaluation integrates clinical findings, magnetic resonance imaging, and blood tests, with biopsy reserved for cases in which the diagnosis remains uncertain.⁵ In this case, chronic painless edema without proptosis or motility impairment, together with the absence of an inflammatory infiltrate, made this possibility less likely.

Together, these comparisons complement the authors' sound assessment. This case reinforces the importance of specifically asking about remote cosmetic procedures and integrating the chronology, anatomic location, imaging when uncertainty persists, and tissue analysis before attributing an eyelid mass to a benign cause.

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In Reply to Emmanuel Vazquez, M.D.: We thank Dr. Vazquez for their comments on our article. We agree with the author's discussion of four relevant infiltrative mimics and the clinical features that should raise suspicion for these conditions. Although this patient's presentation was not consistent with any of these more serious conditions, we agree that clinicians should consider and recognize these entities when evaluating eyelid masses.

Ocular sarcoidosis can involve any ocular structure, and

its heterogeneous clinical presentation can pose a significant diagnostic challenge. The revised International Workshop on Ocular Sarcoidosis (IWOS-2019) and Standardization of Uveitis Nomenclature (SUN) criteria can help guide diagnosis; however, definitive diagnosis relies on biopsy and histopathologic confirmation.¹⁻³ Although granulomatous uveitis remains the predominant manifestation of ocular sarcoidosis, we have encountered a case in which unilateral eyelid mass/swelling was the sole manifestation and was confirmed by open biopsy and histopathologic examination.

IgG4-related ophthalmic disease can present as masses, enlargement, or hypertrophic lesions involving various ophthalmic tissues.⁴ We also have encountered a case presenting with eyelid swelling and a conjunctival mass.

We agree that ocular adnexal lymphoma and idiopathic orbital inflammation may both manifest as eyelid masses and should therefore be included in the differential diagnosis. Another relevant mimic is thyroid orbitopathy, which may present with asymmetric eyelid edema, usually accompanied by mild proptosis, in its early stages.⁵

Overall, we believe Dr. Vazquez's comments complement our discussion and further highlight the importance of maintaining a broad differential diagnosis that includes infiltrative mimics. The widespread use of dermal fillers in the periorbital region can result in long-term complications that often are bilateral and recognizable; however, as illustrated by this case,⁶ patients may not recall prior filler treatments or may not consider them relevant to their current presentation.

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