Answers to the Medical Quiz

CASE 1 a. Naevus
b. Benign

Naevi of the conjunctiva are common and they are classified like those of the skin with minor modification. Most of the conjunctival naevi are compound or subepithelial. Spindle or epithelioid cell nevi and cellular blue nevi are seldom observed on conjunctiva.

They usually appear first during childhood as single, sharply demarcated, flat or slightly elevated lesions most commonly located near the limbus or in the bulbar conjunctival fissure. On slitlamp examination cystic spaces are frequently seen within their substance. Naevi present a growth phase, followed by a maturational arrest and a stationary phase. The amount of pigment within a naevus normally varies. About 1\3 show little or no pigmentation. However the amount of pigment and also the size of the lesion may increase at puberty or occasionally during pregnancy. Most naevi that have been observed to grow are found to be entirely benign on histological examination. Occasionally, a non-pigmented naevus can become inflamed and vascularised so that it may be by mistake confused with an angiomatous tumour.

Histologically a junction naevus may be indistinguishable from primary acquired melanosis with atypia. In adolescents, naevi may attract a vigorous lymphocytic response and cause confusion with other entities such as melanoma. However, malignant diagnosis are rare.

Naevi should be excised either for cosmetic reason or for fear that malignant change could have occurred.

Radiotherapy is not appropriate for naevi.

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CASE 2 a. Cataract
b. Intraocular implant

Traumatic cataract is the most common cause of unilateral cataract in young individuals. This is commonly due to a foreign body injury to the lens or blunt trauma to the eyeball. Overexposure to heat (exfoliation), x-rays and radioactive materials are less frequent causes.

Penetrating injuries with direct involvement of the lens may cause less opacities.

Concussion injuries may lead to the development of a Vossius ring due to an imprinting of iris pigment onto the anterior lens capsule.

The lens becomes white soon after the entry of the foreign body since the interruption of the lens capsule allows aqueous and sometimes vitreous fluids to penetrate into the lens structure.

The patient complains immediately of blurred vision. The eye becomes red, the lens opaque and there may be an intraocular haemorrhage. A soft eye may be present if aqueous or vitreous fluids escapes from the globe.

Complication include infection, uveitis, retinal detachment and glaucoma.

Visual prognosis is variable due to the extent of trauma to the lens and other ocular structures.

Systemic and topical antibiotics and topical corticosteroids should be given over a period of several days to minimise the chance of infection and uveitis. The pupil has to be kept dilated to prevent the formation of posterior synechiae.

With proper evaluation and careful surgical repair of the initial injury, followed by cataract surgery at the ideal time and under ideal conditions, with implantation of a proper lens, a useful functional visual result may be expected. Other viable options with traumatic cataracts include epikeratophakia lenticules, contact lenses and optical glasses in rare occasions.

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