Best Practice Guideline

Chalazion

I Diagnosis and Screening:

Chalazia (plural of chalazion), which are the most common inflammatory lesions of the eyelid, are slowly enlarging eyelid nodules, formed by inflammation and obstruction of sebaceous gland.

The diagnosis of chalazion is usually clinical and often does not require further workup. The patient's history may include any or all of the following risk factors: poor lid hygiene, seborrheic dermatitis, rosacea, chronic blepharitis, high blood lipid concentrations, leishmaniasis, tuberculosis, immunodeficiency, viral infection, carcinoma, stress, trachoma, eyelid trauma/surgery. Moreover, the external examination of the eye may include the following signs:

Painless bump or lump in the upper eyelid or, less frequently, in the lower eyelid.

Tearing and mild irritation may result as the obstructed glands are needed for healthy tears.

Decreased vision, if the chalazion is large enough to press against the eyeball.

II Treatment and Prevention:

Treatment:

The good news is that many chalazia require minimal medical treatment and more than 50% of chalazia resolve with conservative treatment alone. This may include the following:

Warm compresses: Warm compresses (e.g., a wet facecloth, as hot as can be tolerated) can be used to melt the lipid secretions, thereby encouraging resolution of the ductal blockage and facilitating the drainage of sebum. Compresses should be gently applied over the closed eyelids for 15 minutes 2-4 times per day.

Lid Hygiene: Dilute Baby shampoo or commercial lid wipes can be used over the eyelashes twice daily to remove debris blocking the tear ducts openings.

Dilute shampoo can also be used to treat seborrhea over the eyebrows to minimize possible ductal blockage from skin particles.

Antibiotics: Ophthalmic antibiotic ointments, such as erythromycin or gentamycin, may be used 2-3 times daily to the affected eye when a secondary infection is suspected. Moreover, oral antibiotics, like Augmentin or Clindamycin, may be used in cases of suspected cellulitis.

Close monitoring of the patient's clinical condition by the patient's primary care physician is advised in the acute phase.

Prevention:

Patients at risk for chalazia should receive instructions regarding the importance of adequate lid hygiene and general health measures (eg, rest, stress management, proper diet) to maintain good skin function. Moreover a dermatologic evaluation is recommended for patients who have a history of acne rosacea.

III Surveillance and Indication for Consultation

Routine follow-up after 1 month should reveal resolution of the chalazion, with no swelling, redness or persistent lump. If the chalazion does not resolve, if a recurrence develops, or if additional symptoms arise, follow-up care with an ophthalmologist for a comprehensive eye examination (possibly including dilation) is advised.

In select refractory cases, the ophthalmologist may schedule an incision, drainage and curettage of the chalazion at a later date. In addition, studies have shown that intralesional injection of triamcinolone to be an equally effective alternative to incision and curettage.

References:

Lederman C, Miller M. Hordeola and chalazia. Pediatr Rev. 1999 Aug. 20(8):283-4.

Hosal BM, Zilelioglu G. Ocular complication of intralesional corticosteroid injection of a chalazion. Eur J Ophthalmol. 2003 Nov-Dec. 13(9-10):798-9.