rare nonspecific atypical cells. He is currently being followed closely by medical oncology, otolaryngology, our ophthalmic plastic surgery clinic, and the familial oncology clinic. The latter clinic ruled out Muir-Torre syndrome and hereditary nonpolyposis colorectal cancer syndrome. Sixteen months after his initial presentation to our institution, he remains recurrence-free.

Sebaceous cell carcinomas can be locally invasive and can metastasize to lymph nodes and distant organs. There are a few reports in the literature of eyelid sebaceous cell carcinomas producing lymph node metastases after the original tumour was excised.[3–5] Where reported, the time span between excision and metastasis detection ranged from 17 months to 7 years.[3,4] In Shields et al.'s[3] article, it is unclear whether their one case of caruncular sebaceous cell carcinoma had a metastasis. Therefore, to our knowledge, this is the first reported case of a caruncular sebaceous cell carcinoma presenting with lymph node metastasis after surgical excision of the original lesion. Moreover, there were only six months between the initial excision of the caruncular mass and the appearance of the lymph node metastasis, which is a significantly shorter period than what is reported in the literature. This can be partially explained by the fact that sebaceous cell carcinomas are known to masquerade as more benign lesions, thus evading timely diagnosis and excision.

Sebaceous cell carcinoma is primarily a disease of older adults. Shields et al.[3] reported a median age at presentation of 72 years. When sebaceous cell carcinoma occurs in much younger patients, there is typically a history of irradiation for a childhood malignancy, especially retinoblastoma.[6] However, our patient has no such history, making his case even more unique.

Given that sebaceous cell carcinoma can invade the surrounding conjunctiva and even cornea via pagetoid spread, some authors recommend map biopsies of the surrounding conjunctiva even if obvious invasion is not visible.[3] We offered this to our patient at the last visit and are waiting to hear back from him about whether he is interested in pursuing this option.

Because there is a 5-year mortality rate of 50% to 67% for patients with lymph node metastases,[7] this patient will be followed closely into the foreseeable future.

Amaka Eneh, James Farmer, Vladimir Kratky
Queen's University, Kingston, Ont.

Correspondence to:
Amaka Eneh, MD: 7aae1@queensu.ca

References

1. Valenzuela-Flores G, Mozas-Dávila D, Rodríguez-Reyes AA, Gómez-Leal A. Sebaceous gland carcinoma of the eyelids. *Cir Cir*. 2004;72:47-53.
2. Mak ST, Wong AC, Io IY, Tse RK. Malignant eyelid tumours in Hong Kong 1997-2009. *Jpn J Ophthalmol*. 2011;55:681-5.
3. Shields JA, Demirci H, Marr BP, Eagle RC, Shields CL. Sebaceous carcinoma of the eyelids: personal experience with 60 cases. *Ophthalmology*. 2004;111:2151-7.
4. Warnecke KK, Sieg P. Sebaceous carcinoma of the eyelids—case reports and review of the literature. *Klinische Monatsblatter fur Augenheilkunde*. 2006;223:771-4.
5. Ho VH, Ross MI, Prieto VG, Khaleeq A, Kim S, Esmaeli B. Sentinel lymph node biopsy for sebaceous cell carcinoma and melanoma of the ocular adnexa. *Arch Otolaryngol Head Neck Surg*. 2007;133:820-6.
6. Howrey RP, Lipham WJ, Schultz WH, et al. Sebaceous gland carcinoma: a subtle second malignancy following radiation therapy in patients with bilateral retinoblastoma. *Cancer*. 1998;83:767-71.
7. Rao NA, McLean IW, Zimmerman LE. Sebaceous carcinoma of the eyelid and caruncle: correlation of clinicopathologic features with prognosis. In: Jakobiec FA, editor. *Ocular and Adnexal Tumors*. Birmingham, Ala; Aesculapius; 1978;461-76.

Can J Ophthalmol 2014;49:e118–e119

http://dx.doi.org/10.1016/j.jcjo.2014.06.011

Transient homonymous hemianopia caused by cerebral venous sinus thrombosis: Case report

Homonymous hemianopia (HH) is caused by various lesions in the retrochiasmal visual pathways involving the optic tract, lateral geniculate body, optic radiation, and striate cortex.[1] The main causes of such lesions are stroke, head injury, and intracranial tumours.[2] Well-known risk factors of venous thromboembolism in females of reproductive age are obesity (3-fold risk for body mass index [BMI] $>$ 30), varicose veins (1.5-fold risk), coagulation disorders (such as activated protein C resistance or factor V Leiden mutation), immobilization, pregnancy, smoking, medication with corticoids, family disposition, and combined oral contraceptives (COCs).[3] Venous thromboembolism is still a major health problem worldwide, although it is often clinically silent and undiagnosed, especially in younger females. Underlying conditions that may cause cerebral venous sinus thrombosis (CVST) vary, and the etiology is unknown in such cases. There are only a few case series of HH with CVST reported in the literature. Oral anticoagulation for approximately 3 to 6 months is recommended for treatment if it is related to oral contraceptive usage.[4]

Our aim was to describe a rare initial presentation of right HH caused by CVST associated with oral contraceptive use in a 24-year-old female. Her symptoms improved rapidly and the visual field defect was much improved with oral anticoagulation treatment in 1 week. Our case highlights the importance of imaging techniques to resolve unexpected clinical findings.

Case Report

A 24-year-old female was admitted to our Neurology Department with right-sided headache and neck pain for 4 weeks and with sudden onset of blurred vision in her right visual field. On clinical examination, she was alert and healthy. The neurologic examination (including mental, memory, motor, and sensory function, as well as coordination) found normal results. She was referred to our Ophthalmology Department for the visual evaluation. Visual acuities of 0.6 = 20/32 (OD) and 0.8 = 20/25 (OS) were observed. There was no papilledema, and the fundus examination was normal. Anterior segment examination found normal results, and the angles were open. Intraocular pressure was 16 mm Hg OU. The dilated fundus examination found normal results. Visual field to confrontation suggested a right HH. This was confirmed on automatic perimetry showing a complete HH. Automated perimetry was performed using the Humphrey Visual Field Analyzer model 750 (Carl Zeiss Meditec Inc, Dublin, Calif.), and the Swedish Interactive Threshold Algorithm program (30-2 mode, STATPAC for trend analysis) was used to measure the visual field (Fig. 1). Laboratory examinations found all subtotals of the complete blood cell count to be within the reference limits. Her history revealed only COC usage (an antiandrogenic COC containing 0.0035 mg ethinyl estradiol and 2 mg cyproterone acetate per day for 5 months) and no other medications.

The hematologic panel results, including the coagulation profile tests, serum prothrombin time, and prothrombin time/international normalized ratio values, were within the reference limits. On Doppler ultrasonography, no other venous thrombosis in the lower extremities was determined. She was referred to the cardiology department to evaluate the cardiac risk factors. Her electrocardiogram showed no abnormality. Echocardiography found no cardiac abnormality (such as atrial fibrillation, hypertrophic cardiomyopathy, or patent foramen ovale).

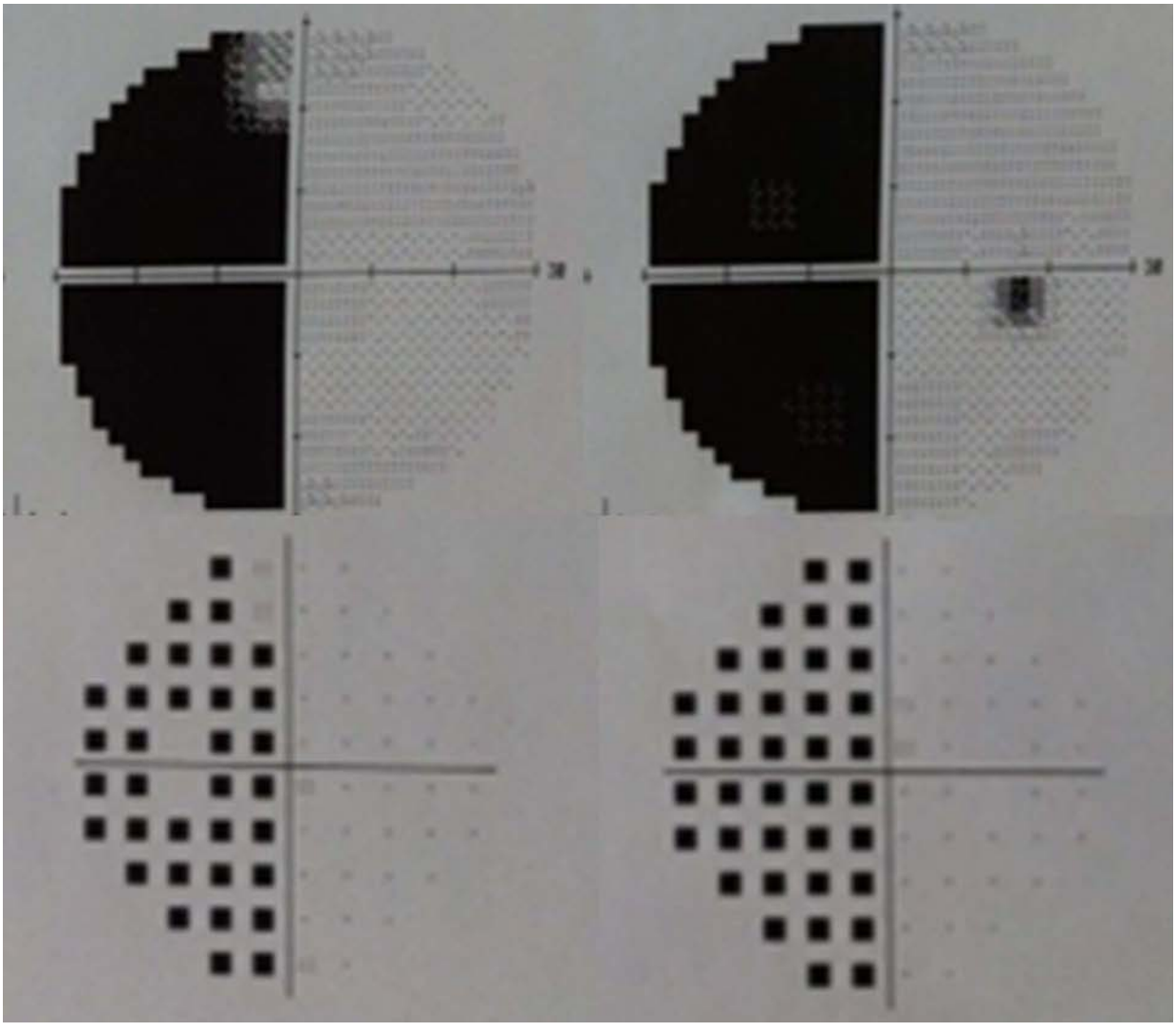

Fig. 1—Automated perimetry found a complete right homonymous hemianopia.