Chalazion

the royal victorian eye and ear hospital

Disclaimer: This Clinical Practice Guideline ('CPG') was written for use in The Royal Victorian Eye and Ear Hospital Emergency Department. It should be used under the guidance of an Ophthalmology or ENT registrar. If clinical advice is required, please contact the Eye and Ear Admitting Officer for assistance: EYE: +61 3 9929 8033; ENT: +61 3 9929 8032. Links to internal Eye and Ear documents cannot be accessed from the website CPG.

See also: Blepharitis, Preseptal cellulitis

Description:

An area of focal inflammation within the eyelid due to obstruction of a meibomian gland.

Red Flags:

- Consider sebaceous cell carcinoma in older patients with recurrent/non-resolving lesion
- Beware associated preseptal cellulitis requiring systemic antibiotics

How to Assess:

History:

- Symptoms: eyelid lump, swelling and tenderness
- History of blepharitis, rosacea or seborrheic dermatitis
- May be past history of chalazia

Examination:

- Vision may be affected due to induced refractive change/astigmatism from lid lesion (uncommon)
- Eyelid swelling, focal tenderness. There may be associated preseptal cellulitis
- Well-defined nodule in eyelid (evert lid to rule out other causes). Early in presentation, a nodule may not be apparent
- Associated blepharitis, rosacea or seborrheic dermatitis

Differential diagnosis:

- Preseptal cellulitis from other causes
- Sebaceous cell carcinoma
- Herpetic disease involving the lid
- Dacrocystitis (if lesion is located infero-medially)

Acute Management:

- Advise patient on frequent warm compresses and lid hygiene for blepharitis
    - Many chalazia will resolve with this management
- If discharging anteriorly, consider chloramphenicol 1% eye ointment to lesion TDS for 5-7 days
- No oral antibiotics required unless concerned about preseptal cellulitis
- Rarely, consider early incision/drainage if large chalazion, vision affected, patient in extreme discomfort
- Incision & Drainage (I&D) should not be done in ED with rare exception
- Patient presenting with non-resolving chalazion despite treatment for 2 months may be booked and consented from Emergency Department directly to Day Surgery Treatment Room (DSTR) for I&D.

Follow up:

- Review by General Practitioner (GP) in 4-8 weeks
- If non-resolving chalazion despite treatment for 2 months, GP to refer to RVEEH Outpatients
    - Note: chronic/recurring chalazia non-responsive to warm compresses is a Triage Category 2 appointment (2-6 weeks) as per Primary Care Referral Guidelines
- Advise patient to return if signs of preseptal cellulitis or if condition worsens

Discharge instructions:

- Warm compresses (3 minutes) QID, reheating clean flannel/facewasher/cotton make-up pad as it cools
- Gentle, frequent lid massage: rolling fingers over lids toward lid margins to express meibomian secretions
- Blepharitis lid hygiene: may be needed long term
- Advise patient **NOT** to attempt to open or drain lesion themselves as can result in scarring and infection

Additional notes:

- Give patient copy of Chalazion and Blepharitis patient information sheets

Evidence Table

Author(s)	Title	Source	Level of Evidence (I – VII)
Lippincott, Williams and Wilkins	Wills Eye Manual 6th edition, 2012		VII
	Oxford Handbook of Ophthalmology, Oxford University Press, 2006		VII

The Hierarchy of Evidence

The Hierarchy of evidence is based on summaries from the National Health and Medical Research Council (2009), the Oxford Centre for Evidence-based Medicine Levels of Evidence (2011) and Melynk and Fineout-Overholt (2011).

I) Evidence obtained from a systematic review of all relevant randomised control trials.

II) Evidence obtained from at least one well designed randomised control trial.

III) Evidence obtained from well-designed controlled trials without randomisation.

IV) Evidence obtained from well-designed cohort studies, case control studies, interrupted time series with a control group, historically controlled studies, interrupted time series without a control group or with case series.

V) Evidence obtained from systematic reviews of descriptive and qualitative studies.

VI) Evidence obtained from single descriptive and qualitative studies.

VII) Expert opinion from clinician, authorities and/or reports of expert committees or based on physiology.

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