Chalazion	Referral Guide: Page 1 of 1	Ophthalmology

Diagnosis/Definition:

Chalazion – A sterile inflammation with nodule formation of the lid tarsus due to Meibomian gland plugging and dysfunction. Each eye lid has an internal connective tissue "skeleton" called the tarsus. It is invested with many sebaceous glands that secrete an important component of the tear film. Chalazia form when the glands fail and the sebaceous material starts to reach into the lid tissue which stimulates an inflammatory reaction. Chalazia can present as indolent slowly enlarging knots or more acutely as a zone of acute inflammation and edema in the eyelid near the lid margin. Uncommonly they can become secondarily infected by bacteria and present as a cellulitis with or without abscess. Chalazia are sometimes referred to as "styes" or "hordeolum". They are most common in children and young adults and recurrences are common. A first-ever presentation in an elderly adult is suspicious for sebaceous cell carcinoma and should be immediately referred.

Initial Diagnosis and Management:

This is a clinical diagnosis. Lesions involving the eyelid margin and tarsal area (up to 10 mm from the lid margin in the upper lids and 3-4 mm in the lower lids) should be initially managed by the frequent use of warm compresses to promote gland dilation and drainage. Topical antibiotics are helpful if the nodule has drained through the skin of the eyelid. Eye drops and ointment generally are not effective when the nodule is subcutaneous and indolent. Parenteral antibiotics are generally not indicated. Patients should be counseled that the resolution of a chalazion is typically slow – weeks to months in some cases, although acute symptoms such as edema, pain, and redness tend to resolve early.

Ongoing Management and Objectives:

The most common perception is that non-resolving nodules should be surgically excised. Ophthalmologists discourage surgical excision since chalazia may present in multiple foci, even on the same eye lid. The eye lid skin is very thin. The scarring from a surgical excision may replace the small residual nodule and leave the patient dissatisfied with treatment. Surgical excision is however considered for large non-resolving nodules that have been present for longer than 4-6 weeks.

Indications for Specialty Care Referral:

Suppurative superinfection, progressive cellulitis, first-time presentation in older adults.

Test(s) to Prepare for Consult:	Test(s) Consultant May Need To Do:
None needed.	Tissue cultures.

Criteria for Return to Primary Care:

Stabilization or resolution of lesion and/or infection.

Revision History: Created **Revised**