

One Eyelid, A Thousand Faces

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Abstract

Introduction: Cutaneous leishmaniasis (CL) is characterized by significant clinical polymorphism. Its occurrence in the eyelid remains rare and can be misleading.

Case Report: We report the case of a 49-year-old male patient receiving corticosteroid therapy and immunosuppressants for an autoimmune bullous dermatosis. He presented with recurrent bilateral eyelid swellings initially labeled as multiple chalazions. Given the failure of conventional treatments and the appearance of multiple indurated nodules along the free margin, an excisional biopsy was performed. Histological and parasitological examination revealed *Leishmania* bodies, confirming eyelid CL.

Conclusion: In the presence of any atypical or refractory chalazion, particularly in endemic areas or in an immunocompromised patient, the diagnosis of cutaneous leishmaniasis should be considered to avoid therapeutic missteps.

Keywords: Chalazion, Cutaneous leishmaniasis, Eyelid, Immunocompromised, Morocco.

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I. Introduction

Endemic in several regions of the world, including the Mediterranean region, cutaneous leishmaniasis is a parasitic disease characterized by a wide range of clinical presentations. Despite this diversity of presentations, isolated eyelid involvement remains a rare clinical occurrence (less than 2–5% of cutaneous cases). This may be due to the presence of eyelashes and rapid blinking movements, which prevent sandfly bites at this site—the parasite's vector. This condition is often misleading, mimicking common benign conditions such as chalazia, thereby delaying diagnosis and treatment. This mimicry leads to diagnostic delays and inadequate management. We report here the observation of a form of eyelid leishmaniasis mimicking recurrent chalazia in an immunocompromised patient.

II. Clinical Observation

We report the case of a 49-year-old patient, being treated for autoimmune bullous dermatoses with corticosteroids and immunosuppressants, who had been presenting with recurrent eyelid swellings for several months, initially mistaken for multiple chalazia. Various standard medical treatments (antibiotic and corticosteroid eye drops, ophthalmic ointments, eyelid hygiene) as well as local incisions had been attempted. The course of the disease under these standard therapies was consistently marked by recurrent and aggressive relapses.

The clinical ophthalmological examination in our department revealed multiple indurated, painless nodules located along the free edge of the upper and lower eyelids. The remainder of the ophthalmological examination was unremarkable.

Given the atypical nature of the presentation—characterized by the multiple nodules, their recurrent and indurated nature, and the patient's immunosuppressed state—a surgical biopsy of one of the nodules was scheduled for diagnostic purposes. Histopathological examination and parasitological analysis of the tissue samples revealed the presence of *Leishmania* bodies (amastigotes) within a granulomatous infiltrate, with pale blue cytoplasm and bright red nuclei on Giemsa staining. This finding allowed for a revised diagnosis and confirmed the diagnosis of cutaneous eyelid leishmaniasis. The patient was then referred for appropriate systemic management.



Figure 1: Slit-lamp findings in cutaneous eyelid leishmaniasis mimicking multiple chalazia.
Note the indurated nodular infiltrate and the granulomatous appearance of the free edge of the upper eyelid, with no obvious signs of acute inflammation.

III. Discussion

Ocular leishmaniasis remains a clinical entity largely unknown to practitioners due to its rarity. Its polymorphism can mislead the ophthalmologist or dermatologist by mimicking other eyelid conditions such as basal cell carcinoma, chronic stye, cutaneous tuberculosis, sarcoidosis, or even a simple chalazion.

In this case, two factors have significantly complicated the situation:

1. Immunosuppression: Treatment with corticosteroids and immunosuppressants has likely altered the local immune response, leading to a multifocal presentation (involvement of both the upper and lower eyelids) and frequent relapses.
2. Chronicity: Repeated incisions and local corticosteroid treatments mask the natural course of the parasitic infection, perpetuating a vicious cycle of misdiagnosis.

In endemic areas, such as Morocco, heightened vigilance is required for any chronic eyelid lesion. The clinician must avoid the easy diagnosis of a chalazion when the lesion recurs abnormally or resists properly administered treatments. The diagnostic gold standard relies on biopsy and the detection of the parasite via PCR or histopathological examination. Making an early diagnosis is crucial to avoid invasive and repeated surgical interventions that prove unnecessary and potentially damaging to the eyelid's structure.

IV. Conclusion

Although rare, cutaneous eyelid leishmaniasis should not be overlooked; it should be considered in the differential diagnosis of recurrent or atypically presenting chalazia. This clinical consideration should be routine for patients living in endemic areas or returning from travel, especially if there is an underlying immunosuppressive condition. A simple biopsy can guide the diagnosis, allow for targeted treatment, and spare the patient from unnecessary repeated surgeries.

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