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Idiopathic Haemolacria: A Rare Case Report

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Abstract:

Crying with bloody tear, called haemolacria is a very rare condition in medical practice. There are many conditions such as idiopathic thrombocytopenic purpura, trauma (accidental or induced), factors deficiencies, infections (Epstein Barr virus or bacterial), tumours (malignant melanoma or haemangioma), conjunctival telangiectasia, Rendu-Oslar-Weber disease related to haemolacria. But idiopathic haemolacria may occur in some cases. In our case report, a 17-year-old girl presented with idiopathic bilateral haemolacria and gum bleeding associated with pseudoseizure and psychogenic hyperventilation who was treated and well responded to adequate counselling and Amitriptyline.

Key words: *Haemolacria; Crying with bloody tear; Amitriptyline.*

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Introduction:

Haemolacria, a rare condition which was first reported by Dodanaeus in 1581 where a 16 year aged pubescent girl who discharged her flow as bloody tear throughout the eyes instead of through her uterus.[1] Local, systemic diseases, drugs and idiopathic causes are related to haemolacria. The local causes are related to inflammations, laceration, infections of the conjunctiva, eyelids or nasolacrimal systems and tumors of the lacrimal sac.[2] Some of the systemic diseases such as hereditary hemorrhagic telangiectasia, Henoch-Schonlein Purpura, epistaxis with retrograde flow, vascular malformations, and inherited or acquired bleeding disorders or coagulopathies may cause haemolacria. Some of idiopathic haemolacria have also been reported.[3,4] Here we are reporting a 17-year-old girl presenting with bilateral bloody tear without any definitive causes who responded well to adequate counselling and amitriptyline.

Case summary:

A 17-year-old school going girl was admitted in a private hospital of Jashore, Bangladesh on 28th June, 2018 with the complaints of spontaneous bleeding from the both eyes and gum bleeding during crying for last 15 days. Her parents also complained of abnormal twitching movement of whole body and shortness of breathing for same duration. She was reasonably leading a sound health before these events. Pain, itching, yellowish discharge, swelling, dimness of vision and redness of the conjunctiva were not associated with her bloody tear. She noticed only gum bleeding but there were no other bleeding points in her body parts. There was no signs of inflammation and infection in her gum (Figure 1). There were also some jerky movements of her body and shortness of breathing. But we noticed that were not associated with true seizure due to absence of any pathognomonic feature such as tongue biting, autonomic features or post ictal headache, confusion or dementia. Her general, systemic examination including ophthalmoscopy examination revealed normal.

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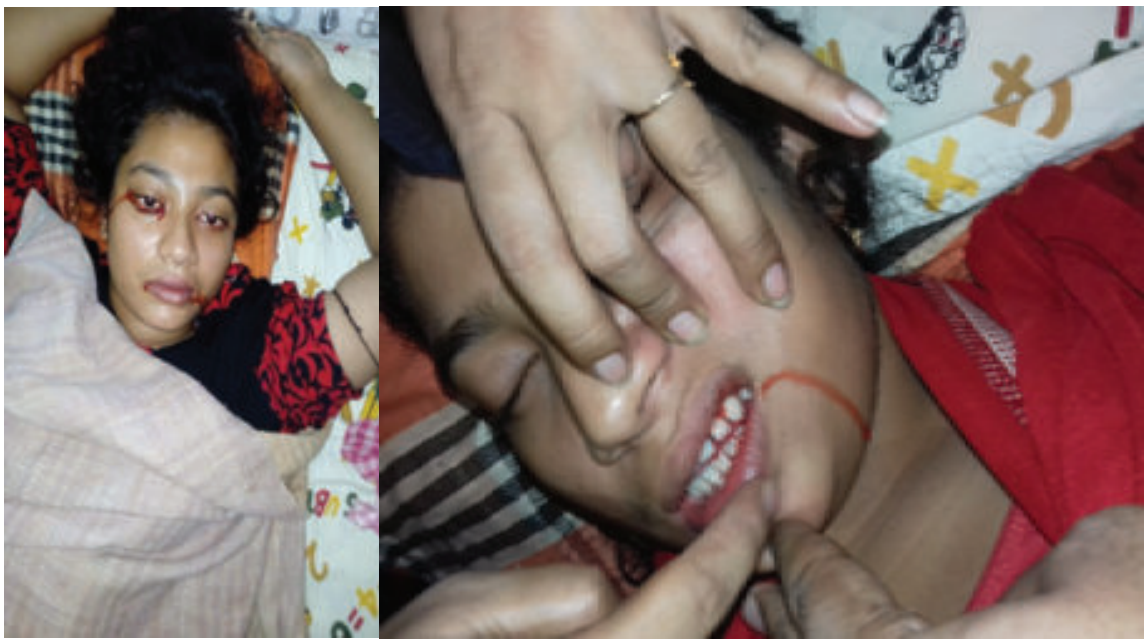

Figure 1: *Bilateral haemolacria with gum bleeding (Taken with permission from the patient)*

Ophthalmologic examination of her both eyes revealed normal conjunctival fornices, puncti, extraocular movements and cycloplegic-refraction. ENT examination including nose and larynx was normal.

Investigations including complete blood count, peripheral blood film, bleeding time, clotting time, prothrombin time, activated partial thromboplastic time, urinalysis, liver and renal function test, thyroid function, CRP, RA test, ANA, Anti DS DNA antibody test were normal. Radiological investigation including x-Ray PNS, CT scan of brain, orbit and paranasal air sinuses were normal. EEG of brain and fundoscopic examinations revealed normal (Table I). Factors VIII and IX could not be assessed due to unavailability in the city.

Table I: *Investigation profile*

Test Name	Results
CBC	WBC: TC:8000, N-57%, L-35%, E-4%, M-04%, ESR-27 mm in 1st hour, Hb-13.30gm/dl, Platelet Count - 210000/Cmm
Blood film	Non Specific Findings
Bleeding time	3 min 30 sec.
Coagulation time	5 min 15 sec.
Prothrombine time	13 sec.
INR	1.2
Activated partial thromboplastin time	29.0 Sec (Control-30.0 Sec)
Urine R/E	Albumin-Nil, Pus cell-0-2/HPF, RBC-Nil
LFT	Bilirubin-0.75mg/dl, SGPT-16.0 U/L, SGOT-20.0 U/L, Alkaline Phosphatase- 220.0 U/L
S. Creatinine	0.89 mg/dl
S. TSH	1.47 N«IU/ML
S.ANA	0.297(0.400)
Anti-Ds DNA	84.21U/ml (0-200U/ml)
X-Ray Chest and PNS	Normal
USG OF Whole Abdomen	Mildly bulky both ovaries
3D Color Fundoscope	Normal
CT Scan of Brain, orbit and air sinuses	Normal

Finally we diagnosed the girl as idiopathic bilateral haemolacria. She was treated with assurance, counselling by the affiliated psychiatrist and Amitriptyline 10 mg at the bed time. She responded well 4 days after initiation of the above mention management. A routine follow up was given after 1 month, 3 months and 6 months of the first event without recurrence of the same condition.

Discussion:

Bleeding from any site of the body is an alarming and frightening to patients, attendants and even to the physicians. Moreover, bleeding tear or haemolacria is a very rare condition in our daily clinical practice. The first step of management of this condition is to rule out the underlying condition. Idiopathic haemolacria is the diagnosis of exclusion. So, meticulous history, physical examination, hematological, biochemical and radiological investigations are required to label as idiopathic haemolacria. Haemolacria may be related to ocular, systemic diseases, drugs but idiopathic in many cases.[2]

Female are more commonly affected than male with a sex ratio of 13:3. Bilateral involvement is usually more than unilateral involvement in a ratio of 2:1. It may persist from 1 day to 5 years. Haemolacria may be associated with headache, epistaxis, haematohidrosis, yellowish eye discharge, twitching of extremities, spitting blood, low-grade fever and menorrhagia. Sometimes psychological stress may be a precipitating factor. Most of the cases may resolve spontaneously within days to months without any recurrence.[1,5,6]

Sometimes haemolacria may be associated with menstrual period in case of female due to default nasolacrimal endometriosis. A 13-year-old girl was reported to have bleeding from left lower punctum simultaneous with cyclical menstrual period.[7]

In this case report haemolacria with gum bleeding occurred bilateral, intermittent, twitching of extremities and spontaneous recovery without any etiology and cyclical menstrual period association.

Conclusion:

Based on this case report, haemolacria should be brought immediate medical concern and extensive clinical evaluation should be made by the internist, hematologist, ophthalmologist, otolaryngologist and psychiatrist to rule out the cause and management purpose.

Conflict of interest: None.

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