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## Congenital dacryocystocele: Natural history, differential diagnosis and current management

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Congenital dacryocystocele (CDCC), although an infrequent form of congenital tear ducts obstruction may lead to severe dacryocystitis and periorbital cellulitis if untreated. Bacteremia is also possible. Spontaneous draining of the infected sac may occur and if the problem is not solved recurrent episodes may result in chronic abscesses, fistulization and scarring. Prenatal diagnosis is possible by routine ultrasound with a high rate (76%) of spontaneous resolution at birth and if not resolved then the patient might persist a bluish mass beneath the medial canthus at birth or within the first two weeks after birth. Associated intranasal cysts are frequent. Differential diagnosis with masses within this area is usually not difficult because CDCC characteristically displaces the medial canthus upward. But, fronto-ethmoidal encephaloceles are of concern because they may co-exist with CDCC and the distended lacrimal sac (infected or not) may be adjacent to it. Surgical manipulation in this circumstance may spread infection to the CNS. Our experience at the National Institute of Child Health (Peru) and in the private praxis (Premedic) showed that CDCC gets infected frequently. During the last five years, tear duct probing and marsupialization of the associated intranasal cyst under general anesthesia have shown to be the best treatment for this condition. But it may take time to schedule the patient for a general anesthesia. So, for not infected sacs, we recommend oral antibiotics and lacrimal sac decompression under topical anesthesia as a temporize method to avoid dacryocystitis.

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