whorled patterns; abnormal mitotic activity (>10 mitotic figures per 50 high power fields and/or the presence of atypical mitoses). MIFS with at least two of these atypical features were noted to recur more frequently than those with only one feature or lacking these features.[4] Despite this, complete initial surgical resection was the only statistically significant clinicopathologic factor for predicting a lower rate of recurrence. Genetically, MIFS has been associated with a marker/ring chromosome 3 with 3p amplicons as well as with a characteristic translocation, t(1;10)(p22: q24) with rearrangements of TGFBR3 and MGEA5 on chromosomes1p22 and 10q24.[7]

Differential diagnosis includes a wide range of conditions including both benign and malignant such as tenosynovitis, giant cell tumor of the tendon sheath, inflammatory myofibroblastic tumor, liposarcoma, epithelioid sarcoma and myxoid malignant fibrous histiocytoma. MIFS is rather difficult to diagnose due to its rather heterogenous histology and all the above mentioned conditions need to be excluded.[9]

Wide resection is generally accepted as the first choice of treatment for myxoinflammatory fibroblastic sarcoma. At present, the efficacy of chemotherapy and radiotherapy remains unclear and the rate of local recurrence is high.[10]

Till date more than 400 cases of MIFS have been reported including a large cohort of 104 cases4 along with descriptions of high-grade, aggressive variants.[5,11] It is usually seen in adults in acral region. There has been a single case report of MIFS in an adult in iris.[12] To the best of our knowledge, ours is the first case of MIFS in a child in eye. Considering its rarity in children and especially in an infant (this seems to be the youngest patient in the literature), close follow-up is essential as biology of these lesions cannot be predicted.

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