CASE REPORT

Sebaceous Carcinoma of Upper Eyelid

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ABSTRACT

A middle aged lady was surgically treated repeatedly elsewhere for growth on right upper lid before presentation to this department. On examination she was found to have nodulo-ulcerative non-tender growth, about 40 x 20 mm in size involving the lateral three-fourth of the lid. There was associated mild conjunctivitis and palpable pre-auricular lymph node. Lid growth was excised followed by lid reconstruction. Pre-auricular lymph node was also removed. Histopathology report of the tissue revealed it to be the palpebral sebaceous carcinoma, while lymph node showed reactive hyperplasia.

Key words: *Eyelid reconstruction. Masquerading lesion. Sebaceous carcinoma. Pre-auricular lymph node. Palpebral mass.*

INTRODUCTION

Sebaceous gland carcinoma is considered as the third most common eyelid malignancy after basal and squamous cell carcinomas. It is potentially a lethal tumour and constitute 4.7% of all malignant epithelial eyelid lesions. It occurs during the 5th to 9th decade of life with male to female ratio of 1:2.[1]

Sebaceous cells are predominantly present in meibomian glands of the tarsal plate, sebaceous glands of ocular adnexa (gland of Zeis), sebaceous glands embedded in caruncle, brow and associated hair follicles of lid skin.[2] Hence, for obvious reasons, sebaceous carcinoma is more common in upper lid. Clinically it is notorious for deceptive presentation. It may present as chalazion, blepharitis, or conjunctivitis depending upon initial involvement of particular tissue. These are called the 'masquerading lesions'. Differential diagnoses include basal cell carcinoma, squamous cell carcinoma, leukoplakia, ocular pemphigoid and carcinoma *in-situ*. Any unilateral external ocular inflammation of long standing, refractory to medical treatment specially, in elderly patient should arouse suspicion.[3]

The treatment is essentially surgical. Full-thickness eyelid biopsy, followed by complete excision and direct closure is suggested. Nodular sebaceous carcinoma should be removed with 5 mm of clinically normal tissue. Exenteration is to be done if bulbar conjunctiva is involved and reconstruction not possible. Cryotherapy and radiotherapy has some role in inoperable cases or those who refuse surgery. Poor prognostic factors include duration more than 6 months, vascular and lymphatic infiltration, orbital extension, poor tumour differentiation, multicentric origin, intraepithelial carcinomatous changes, and upper eyelid involvement. Improved prognostic factors include early diagnosis and wide and complete excision. Recurrence occurs in 9-36% while metastases occur in lymph nodes (17-28%), lungs, liver, skull and brain. Ten years actuarial tumour death rate is 28%.[4]

This case of nodulo-ulcerative carcinoma of upper lid sebaceous gland is hereby presented for awareness.

CASE REPORT

A 50-year-old female villager, presented in the eye department in October 2008 with complaint of growth on right upper lid of 03 years duration (Figure 1). She had multiple surgeries elsewhere for the same before coming to this set up. Strongly positive factor in her history was that she was a smoker for the last 30 years and used to smoke daily 20 to 40 cigarettes. Her vital signs were stable and systemic examination was within normal limits.

On ophthalmic examination, her vision in right was 6/6 unaided when upper lid was raised manually to clear the pupillary area. Right upper lid was having nodulo-ulcerative, non-tender growth of about 40 x 20 mm in lateral 3/4th of the lid clinically localized to pre-septal area. Orbital margins were palpable normally. There was no diplopia, proptosis, displacement of eye ball or limitation of extra-ocular movements. Right pre-auricular lymph node was also palpable. Left eye was having 6/6 vision being normal in all respects. All the investigations including X-rays of chest and lumbo-sacral spine, mammography, and USG abdomen were within normal limits.

Based on these findings, she was provisionally diagnosed as a case of 'sebaceous gland carcinoma'. Other possibilities were also kept in mind.

Whole tumour was resected and pre-auricular lymph node was removed under local anaesthesia on 11.11.2008

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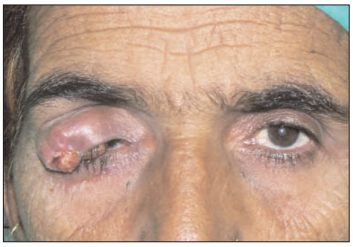

Figure 1: Showing growth of right upper lid.

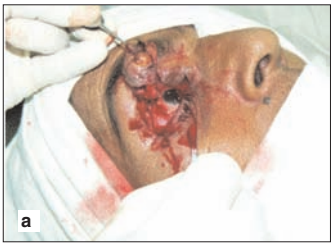

Figure 2A: Showing excision of lid growth.

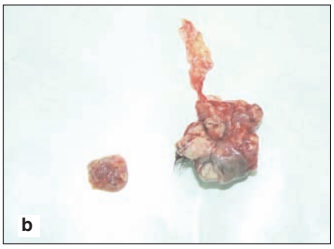

Figure 2B: Tumour and the lymph node.

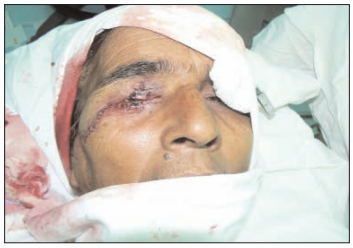

Figure 3: Showing lid reconstruction with Tenzel sliding flap operation.

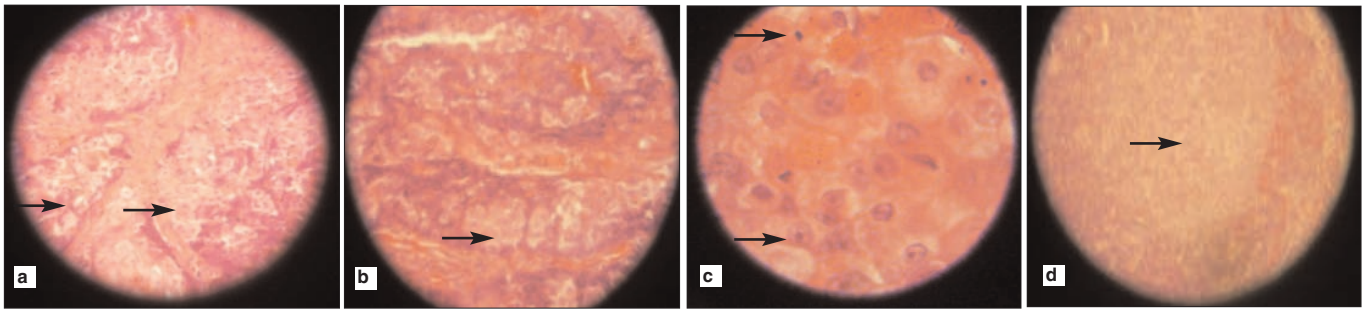

Figure 4: Histopathology of the specimen showing: (**a**).Lobuated structure in low power; (**b**).Sebaceous differentiation in medium power; (**c**). Mitotic figures, nuclear pleomorphims and nucleoli in high power; (**d**). Normal looking lymph node with normal lymphoid follicle.

(Figure 2). Reconstruction with Tenzel sliding flap was done (Figure 3). Tissues were sent for histopathology. Report received 10 days after operation confirmed the diagnosis of 'sebaceous gland carcinoma', in which deep resection margin was free of tumour while it was extending to the line of resection on one side. Lymph node showed only reactive hyperplasia and no tumour cells were found (Figure 4). Since the histo-pathololgy showed tumour extension on one side, the remaining part of the upper lid was also excised and reconstructed with Cutler-Beard procedure in January 2009 (Figure 5). Tissue was again sent for histo-pathololgy, which showed it to be tumour free. She was seen in July 2009 for follow-up and was still under medical care. There was no recurrence and patient was satisfied.

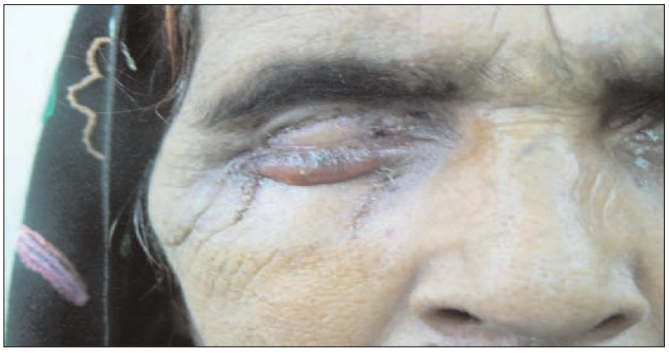

Figure 5: Showing Cutler-Beard procedure after complete upper lid excision.

DISCUSSION

This patient had few interesting features. These included; remote village background, heavy cigarette smoking for more than 30 years, lid lesion of more than 3 years' duration, multiple surgeries elsewhere presumably for recurrent chalazia, and pre-auricular lymph adenopathy due to reactive hyperplasia but without actual tumour cellular impermeation. Though clinically complete but histopathologically incomplete, tumour resection in the first attempt lead to re-do surgery and ultimately achieving histopathologically complete tumour resection.

Wide surgical excision was recommemnded by Reese,[5] and the same recommendation was adopted for this case. The prognosis of the sebaceous carcinoma depended on the differentiation of the tumour tissue.[6] It is hoped that this case will have good prognosis due to sebaceous differentiation. Glassman had updated a review of 120 cases of extraocular sebaceous carcinoma on website.[7] Some national literature has been available on this subject. Khan reviewed 26 cases of exenteration, out of which 2 cases were of sebaceous carcinoma, the description of which was not given as such.[8] Khan presented one case in the local national ophthalmological conference in mid 80's and published it in local unindexed journal.[9]

Since sebaceous cell carcinoma of the eyelid may mimic other benign lesions; delay in diagnosis seems to be a usual factor. This must be strongly suspected in patients with recurrent chalazion especially above 50 years of age. Once the diagnosis is confirmed, its treatment is essentially surgical with total excision.

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