GAVIN PUBLISHERS

Ophthalmology Research & Reports

Pandey AN, et al. Ophthalmol Res Rep: ORRT-123.

DOI: 10.29011/ORRT-123. 100023

Case Report

A Rare Case of Sebaceous Cell Carcinoma of Lower Lid

Achyut Narain Pandey*, Amit Raina, Deepa Hatwal, Sheela Chaudhary

Department of Ophthalmology, Veer Chandra Singh Garhwali Government Institute of Medical Science and Research, Srinagar garhwal, Uttarakhand, India

***Corresponding author:** Achyut Narain Pandey, Veer Chandra Singh Garhwali Government Institute of Medical Science and Research, Srinagar garhwal, Uttarakhand, India. Tel: + 919456792024; E-mail: achyutpandey@gmail.com

Citation: Pandey AN, Raina A, Hatwal D, Chaudhary S (2017) A Rare Case of Sebaceous Cell Carcinoma of Lower Lid. Ophthalmol Res Rep: ORRT-123. DOI: 10.29011/ORRT-123. 100023

Received Date: 17 July, 2017; **Accepted Date:** 31 July, 2017; **Published Date:** 7 August, 2017

Abstract

Sebaceous cell carcinoma arises from the glands within the eyelids, caruncle or eyebrow. They are more commonly found on the upper eyelid and in middle-aged patients. Sebaceous carcinomas are one of the rarest eye cancers and can look like a chalazion (stye). Thus, eye care specialists must suspect this tumor in any patient with persistent conjunctivitis, blepharo conjunctivitis or chronic/recurrent chalazion. Here we report a case of Sebaceous gland carcinoma of lower eyelid, which is very rare.

Introduction

Sebaceous cell carcinoma is suspected due to evidence of eyelash loss and the formation of a yellow-nodule. This tumor can also present as a persistent (months) non-responsive blepharitis or conjunctivitis. In these cases, a high index of suspicion for sebaceous cell carcinoma will lead to biopsy and the diagnosis. Once sebaceous carcinoma is suspected a biopsy is warranted. Before surgery, the pathologist should be advised of this possible diagnosis so the specimen can be processed appropriately Sebaceous carcinomas are one of the rarest eye cancers and can look like a chalazion (stye). Thus, eye care specialists must suspect this tumor in any patient with persistent conjunctivitis, blepharo conjunctivitis or chronic/recurrent chalazion. Any conjunctivitis or chalazion that is not getting better after 3 months of observation should be biopsied [1-4].

Case Report

An elderly female, 84 years old, came to eye OPD for mass in left lower lid since last one year. She gives history of gradual increase in size of mass which is painless. She had no other ocular complaints. On examination, her visual acuity was 6/18 both eyes, with senile immature cataract in both eyes with funds in both eyes been normal. On local examination of left lower lid, a mass of 5×10 mm in size, rectangular, vascular, near to lateral lid margin was noted (Figure 1-2).

Figure 1: Showing mass in left lower lid.

Figure 2: Showing post op picture showing wide resection of the mass.

We suspected it as a pre-malignant growth and examined for any sentinel lymph nodes enlargement. We planned for excional biopsy of the mass with adjacent 2 mm of surrounding area under local anesthesia. We did the complete excision along with adjacent

2mm of heat heir area i.e. wide excision and sent the specimen for biopsy. In biopsy, we had found it as a sebaceous cell carcinoma. Histopathology examination cells occur in irregular lobular masses with distinctive invasiveness. The cytoplasm is pale, foamy, and vacuolated (Figure 3).

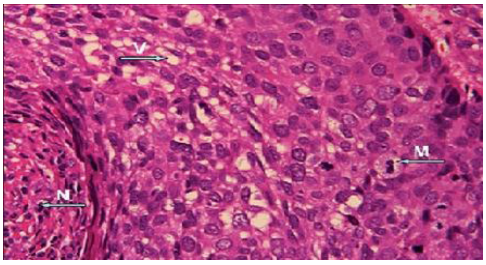

Figure 3: Histopathology slide.

This feature of foamy cytoplasm is seen only in sebaceous carcinoma. The nuclei are hyper chromatic, and the cells stain positive for lipid. We again checked for any secondary's i.e. any lymph node enlargement and we asked the patient for 3 months follow up.

Discussion

Sebaceous carcinoma arises from the glands within the eyelids, caruncle or eyebrow. They are more commonly found on the upper eyelid and in middle-aged patients [1]. Sebaceous Gland Carcinoma (SGC) might be the second most common lid malignancy after Basal Cell Carcinoma (BCC). Sebaceous glands are located in the peri ocular skin, caruncle, and eyebrow skin follicles. The tumor is a very rare, slow growing, and commonly found in elderly population with female predisposition [2]. It is rare in Caucasians and common in oriental Asiatic. The reported incidence of SGC varies from 0.5 to 5% of all lid carcinomas in USA and 28% in China [3,4]. SGC most commonly arises from the meibomian glands anterior to the gray line, occasionally from the glands of Zeis or Moll, and from sebaceous glands in caruncle [5]. In contrast to Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC), SGC is two to three times more common in upper eyelid due to more number of meibomian glands there [3,6]. Five percent cases may have simultaneous involvement of both eyelids due to intraepithelial spread and/or spontaneous development of multiple primaries.

It can present with persistent conjunctivitis, blepharo conjunctivitis or chronic/recurrent chalazion. Any conjunctivitis or chalazion that is not getting better after 3 months of observation, should be biopsied. It can have widespread local and fatal distant metastases. Immunohistochemistry, molecular biology, and electron microscopy have greatly improved the diagnosis, management, and prognosis of SGCs overall. Surgery, chemotherapy, and radiotherapy all contribute to the treatment of SGC.

Clinical Features

SGC has a tendency to invade the peri ocular region. Upper eyelid is most commonly involved followed by the lower eyelid and the caruncle [7-9]. It bears no characteristic clinical appearance, but pagetoid infiltration of conjunctival epithelium or skin epidermis is a hallmark of this tumor.

It is one of the most dangerous eyelid tumors due to:

- Inflammatory conditions such as blepharo-conjunctivitis, chalazion or superior limbic kerato conjunctivitis [10] or as other ocular tumors like BCC or SCC, with a result that the correct diagnosis is often delayed until metastasis has occurred.
- The incidence of metastasis is high (41%) [3,5,7].
- Delineation of tumor margins, even with excellent paraffin-embedded sections is difficult due to either intraepithelial pagetoid spread and/or multi centric pattern [5,6,8].

Differential Diagnosis

The list for SGC includes; congenital sebaceous gland hyperplasia or acquired sebaceous gland hyperplasia which is common on face or forehead. Adenoma sebaceum of Pringle is another diagnosis to consider. Sebaceous adenoma is common on the eyebrows and eyelids.

SGC is included in the group of simulating lid lesions (inclusion cyst, papilloma, senile keratosis, kerato acanthoma, benign keratosis, dermoid cyst, and amyloidosis).

Treatment

Treatment modalities include local excision, orbital exenteration, radical neck dissection, radiation, or chemotherapy depending on the stage of the tumor at the time of presentation. Wide excision at an early stage is important. Prior to surgical excision, it is important to examine the patient carefully for evidence of pagetoid spread or multi centric origin by double aversion of the eyelids, and any conjunctival alteration such as telangiectasia, papillary change, or a mass. Surgical treatment may range from a local excision to orbital exenteration Radical surgical excision with frozen section control by either a standard method or Moh's micrographic surgery is the most common and effective method of treatment. Approximately, 30% of SGCs recur after resection [8-10].

Topical mitomycin C has been tried for pagetoid invasion of the conjunctiva by eyelid SGC [9]. Cryotherapy is a useful adjunct to surgery in epibulbar and pagetoid extension of SGC, sparing exenteration. Radiotherapy is usually avoided or may even be contraindicated because of subsequent conjunctival keratinization leading to dry eye, lid atrophy, skin necrosis, lash loss, lid telangi-

ectasia, ectropion, epiphora, keratopathy, cataract [10], Most serious radiation-related complications occur in large tumors of the upper lid.

Conclusion

Sebaceous carcinoma is a rare, highly malignant, and potentially lethal tumor of the skin. Therefore, it is important to obtain a wide excisional biopsy of the primary lesion and proper follow up for secondary's elsewhere in the body.

Compliance with Ethical Standards:

Conflict of Interest: All the authors have no conflict of interest.

Ethical Approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent: Informed consent was obtained from the participant included in the study.

References

1. Buitrago W, Joseph AK (2008) Sebaceous carcinoma: The great masquerader: Emgerging concepts in diagnosis and treatment. Dermatol Ther 21: 459-466.
2. Straatsma BR (1956) Meibomian gland tumors. Arch Ophthalmol 56: 71-93.
3. Ni C, Kou PK (1979) Meibomian gland carcinoma: A clinico-pathological study of 156 cases with long-period follow up of 100 cases. Jpn J Ophthalmol 23: 388-401.
4. Khalil MK, Lorenzetti HD (1980) Sebaceous gland carcinoma of the lid. Can J Ophthalmol 15: 117-121.
5. Boniuk M, Zimmerman LE (1968) Sebaceous carcinoma of the eyelid, eyebrow, caruncle, and orbit. Trans Am Acad Ophthalmol Otolaryngol 72: 619-642.
6. Rao NA, Hidayat AA, Mclean IW, Zimmerman LE (1982) Sebaceous carcinomas of the ocular adnexa: A clinico-pathological study of 104 cases, with five years follow up data. Human Pathol 13: 113-122.
7. Shields JA, Demirci H, Marr BP, Eagle RC, Jr, Shields CL (2004) Sebaceous carcinoma of the eyelids: Personal experience with 60 cases. Ophthalmology 111: 2151-2157.
8. Zurcher M, Hinstchich CR, Garner A, Bunce C, Collin JR (1998) Sebaceous carcinoma of the eyelid: A clinicopathological study. Br J Ophthalmolo 82: 1049-1055.
9. Shields JA, Demirci H, Marr BP, Eagle RC Jr, Shields CL (2005) Sebaceous carcinoma of the ocular region: A review. Surv Ophthalmol 50: 103-122.
10. Foster CS, Allansmith MR (1978) Chronic unilateral blepharo conjunctivitis caused by sebaceous carcinoma. Am J Ophthalmol 86: 218-220.