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## CANCERS OF EYELID: REPORT OF TWO CASES

P. W. Atipo-Tsiba, Ophthalmology Department, University Hospital of Brazzaville, Congo and E. S. Kombo Bayonne, Dermatology unit, Talangai Hospital Brazzaville, Congo

Request for reprints to: Dr P. W. Atipo-Tsiba, Marien Ngouabi University of Brazzaville, Head of Clinic at University Hospital of Brazzaville, Congo, Email: atipo.kani@gmail.com

## CANCERS OF EYELID: REPORT OF TWO CASES

P. W. ATIPO-TSIBA and E. S. KOMBO BAYONNE

### SUMMARY

**There are four main types of eyelid cancer. Basal Cell Carcinoma that by far the most common (85% of cases). This is a tumour of older person, after 50 years. Its occurrence in a child must search for Basal Cell Hamartoma. Squamous Cell Carcinoma represents about 5% of cases. It can occur de novo or more frequently on precancerous lesions. Acquired immunosuppression, xeroderma pigmentosum and albinism predispose to the occurrence of this cancer. The Sebaceous Carcinoma represents a little less than 5% of cases. The third type may arise in the meibomian, Zeis or sebaceous glands. Its diagnosis is often delayed because of its seemingly benign clinical appearance. Malignant Melanoma is a rare tumour of the eyelids, less than 1% of cases. From two observations, one Basal Cell Carcinoma and one Squamous Cell carcinoma in HIV/AIDS context, we did a short review of the literature on eyelid cancer pathology.**

### INTRODUCTION

Clinical aspects of eyelid tumors are varied. Eyelid tumors are benign in their majority. Precancerous forms, led by actinic keratosis, are usually due to prolonged sun exposure (1,2). The risk of progression to cancer is estimated at less than 0.1% per year. There are four main types of eyelid cancer (1-3):

- Basal Cell Carcinoma (BCC): 85% of cases;
- Squamous Cell Carcinoma represents (SCC): about 5% of cases;
- Sebaceous Carcinoma (SC): represents a little less than 5% of cases;
- Malignant Melanoma (MM): is a rare tumor of the eyelids, less than 1% of cases.

We made a short literature review of eyelid cancerous lesions from two observations. A HIV positive woman who was seen for a voluminous SCC; and a man suffering from a BCC.

### CASE REPORT

#### *Case One*

A woman aged 48, HIV positive, was seen for a major left eyelid swelling lasting for almost a  
 – an exorabitation of left eye, the eye was completely redesigned; no more of its structures (conjunctiva, cornea, sclera, and lens) was recognizable. Everything looked like a pulp mass, highly vascularized, the size of an orange, with a necrotic and purulent center

Figure 1



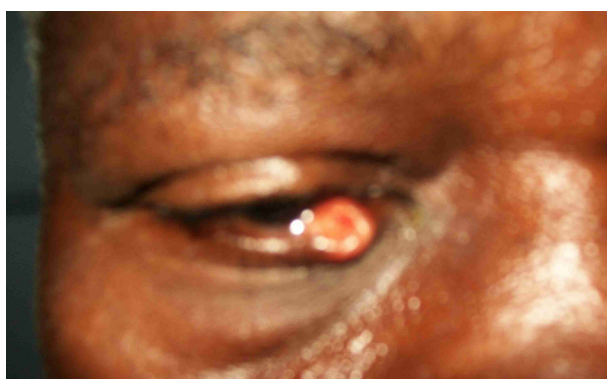
– there were 3 ipsilateral mandibular lymph nodes under the size of a small lemon.  
 – histological examination of a biopsy specimen was allowed to diagnose a SCC  
 – the clinical and paraclinical exams (MRI, abdominal ultrasound) did not show any metastasis.  
 The diagnosis of eyelid SCC, stage T4N1M0 was retained. Given the size of this tumor, radiation therapy before surgery (exenteration) was advocated. The patient died a week after this diagnosis in an acute liver failure context.

#### *Case Two*

A man aged 60 years was seen for a non-traumatic wound of the lower right eyelid evolving for nearly two months. His review noted:

– a wound of the lower right eyelid was located on the “gray line”, at the inner 1/3 of the eyelid. It was the size of a piece of one euro cent with the shape of the crater, the edges were more or less regular, the center was highly vascularized and bleeding easily with a complete fall of eyelashes (Figure 2).

**Figure 2**



– there were no locoregional lymphadenopathy. A complete resection was performed (total resection of the internal quarter the eyelid covering the lacrimal punctum). The extemporaneous histological examination confirmed the healthiness of edges before surgical suture, and cytological nature of the lesion (BCC). The reconstruction of the eyelid was made following the technique of “Tenzel’s semicircular flap”. The postoperative period was favorable; the patient was followed two years.

## LITERATURE REVIEW

The BCC is by far the most common eyelids malignant tumor. The preferred locations are in order of frequency the lower eyelid, the internal canthus, upper lid and the outer canthus. The main risk factor is cumulative sun exposure (1, 2-4). There are many clinical presentations, the most common is the ulcerated nodules pigmented or not followed by the sclerodermiform. A fairly typical clinic element of this cancer is the presence on its surface of beads-shaped lesions (2-4). Treatment is sometimes very large mutilating surgical resection. BCC almost never has metastasis, but its locoregional mutilating power can be very devastating (1, 3).

The SCC is much rarer than BCC; it can occur de novo or more frequently on precancerous lesions such as actinic keratosis, intra epidermal carcinoma, radio dermatitis, burn scars or chronic inflammatory lesions. The main location is the lower eyelid. Unlike the BCC, SCC presents a real metastatic potential which is proportional to the tumor thickness and the degree of dermis invasion (1, 5). The extension is typically done through lymphatics vessels or by contiguity to the orbit. After a biopsy of the skin for the

diagnosis, complete surgical resection when possible is the best therapeutic approach. Radiotherapy may be an alternative in case of indication against surgery, or due to a large orbital extension or metastasis. Topical or systemic chemotherapy is adjuvant therapy for very advanced lesions and patients suffering from xeroderma pigmentosum. The prognosis is correlated with tumor thickness. Tumors of less than 2 millimeters almost never metastasize; between 2 and 6 mm, the risk is about 4.5%; and 6 mm beyond the risk reaches 15% (especially in cases of muscular or periosteal infiltration) (1, 5, 6).

The MM is now the first fatal skin tumor. However at the eyelid it remains a rare tumor. The prognosis depends on both, the Breslow’s criteria on the maximum thickness of the tumor and histological Clark’s criteria (7, 8). MM may appear de novo as a superficial nodule or evolve from a precancerous lesion (lentigo melanoma) (1, 9). The superficial extension is characterized by a marked tendency to spread of atypical melanocytes in the epidermal thickness or conjunctival epithelium. The wide surgical excision is the mainstay of treatment. The immunotherapy used in very specialized centers appears promising (10).

SC represents a little less than 5% of malignant tumors of the eyelid in the West, but is much more common in China (1, 10, 11). It usually appears goshawks 60 years. This cancer among women is slightly more common, and sits in two thirds of cases at the upper eyelid. It usually begins with a nodule evoking a chalazion, which can eventually ulcerate taking the appearance of a BCC. There is often the notion of recurrent chalazion. This tumor is more aggressive and often with an orbital and locoregional extension. At stage of diagnosis, metastases are present in 15-20% of cases. Pathological examination must be systematic in the presence of a chalazion after 50 years (12). The exenteration is the appropriate treatment in 13% of cases often complemented by radiotherapy.

The eyelid cancer is well known. The aging population and attractiveness of repeated sun exposure make it topical. Its management is changing, especially with the arrival of the sentinel lymph node technique (13). This technique allowed among others decrease of lymph node dissection number and improving some cancers prognosis.

## REFERENCES

1. Lasudry J. Eyelid tumors: clinical and diagnostic aspects. *J Fr Ophtalmol*, 2003;26:70-76.
2. Salomon J, Bieniek A, Baran E, Szepietowski JC. Basal cell carcinoma on the eyelids: own experience. *Dermatol Surg*, 2004;30:257-263.

3. Bogdanov-Berezovsky A, Cohen AD, Glesinger R, Cagnano E, Kriger Y, Rosenberg L. Risk factors for incomplete excision of basal cell carcinomas. *Acta Derm Venerol*, 2004;**84**:44-47.
4. Ducasse A, Pluot M, Gotzamanis A, Brugniart C, Leccia L, Rossi P. Recurrence Factors of basal cell carcinomas of the eyelid and the canthus. *J Fr Ophthalmol*, 2002;**25**:512-516.
5. Rossi R, Puccioni M, Mavilia L, Campolmi P, Mori M, Cappuccini A, Reali EF, Cappugi P. Squamous cell carcinoma of the eyelid treated with photodynamic therapy. *J Chemother*, 2004;**16**:306-309.
6. Sun MT, Andrew NH, O'Donnell B, McNab A, Huilgol SC, Selva D. Periocular Squamous Cell Carcinoma: TNM Staging and Recurrence. *Ophthalmology*. 2015;**122**:1512-1516.
7. Scott JD, McKinley BP, Bishop A, Trocha SD. Treatment and outcomes of melanoma with a Breslow's depth greater than or equal to one millimeter in a regional teaching hospital. *Am Surg*. 2005;**71**:198-201.
8. Metcalf JS. Melanoma: criteria for histological diagnosis and its reporting. *Semin Oncol*. 1996;**23**:688-692.
9. Reddy SC, Darnal HK. Ocular malignant melanoma - a report of two cases. *Nepal J Ophthalmol*. 2014;**6**:113-118.
10. Riker AJ, Jove R, Daud AI. Immunotherapy as part of a multidisciplinary approach to melanoma treatment. *Front Biosci*. 2006;**11**:1-14.
11. Valenzuela-Flores G, Mozas-Davila D, Rodriguez-Reyes AA, Gomez-Leal A. Sebaceous gland carcinoma of the eyelids. *Cir Cir*, 2004;**72**:47-53.
12. Shields JA, Demirci H, Marr BP, Eagle RC Jr, Shields CL. Sebaceous carcinoma of the eyelids: personal experience with 60 cases. *Ophthalmology*, 2004;**111**:2149-2150.
13. Domarus DV, Hinzpeter EN, Naumann GO. The clinical misdiagnosis of chalazion. *Klin Monatsbl Augenheilkd*, 1976;**168**:175-181.
14. Nijhawan N, Ross MI, Diba R, Ahmadi MA, Esmali B. Experience with sentinel lymph node biopsy for eyelid and conjunctival malignancies at a cancer center. *Ophthalm Plast Reconstr Surg*, 2004;**20**:291-295.