



**BASAL CELL CARCINOMA OF THE LOWER EYELID- UNFAMILIAR
PRESENTATION**

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ABSTRACT

Basal cell carcinoma (rodent ulcer), is the most common neoplasm involving the eyelids and is responsible for considerable morbidity owing to its locally invasive nature. Basal cell carcinoma usually spreads to the surrounding skin. Although this is more often than not slow, failure to start appropriate treatment can conduct to a considerable area of skin being put down and thus call for plastic surgical operation. We report case of 40 female who presented with an inflamed lesion on her left lower eyelid, without alteration in size for 2 years duration.

KEYWORDS: Basal cell carcinoma (rodent ulcer).

INTRODUCTION

Basal cell carcinoma (BCC) is the most common malignant neoplasm of the eyelid.^[1,2] Usually the lower eyelid is involved and exposure to sunlight is an important risk factor.^[3,4] Clinically several variants may be seen, nodular, noduloulcerative, cystic and plaque-like (morpheaform). Histologically, they are classified as nodular, adenoid, cystic, keratotic (basisquamous), morphea, Multifocal and pigmented. The nodular and noduloulcerative types are composed of anastomosing nests and cords of proliferating epidermal basilar cells that arise from the basal cell layer of the epidermis. A palisade of nuclei at the limit of the invasive tumor nest may be typical.^[5] The cystic type is similar histologically to the nodular type, with the exception of central necrosis. Cystic basal cell carcinomas frequently appear as a blue eyelid cyst. In the morpheaform type, the tumor tends to get through into the dermis diffusely as branching cords of cells. In adenoid variety glands, like formation is realized, but in that respect is no true secretory activity. In the so called keratotic type there are gratuitous whorls and horn cysts as an outcome of squamous differentiation of basal cells. It may be real difficult to clinically estimate the gross earnings of a morpheaform basal cell carcinoma because of the diffuse infiltration of the skin. A superficial form (Multifocal) and fibroepitheliomatous carcinoma of Pinkus are the other variants of basal cell carcinoma. The other rare variants are the clean cell and mixed type (a noduloulcerative variety with an infiltrative component). Histological examination and sub typing is recommended as some tumors such as the nodular sub type can be potentially invasive and aggressive.^[6] Basal cell carcinoma may masquerade as a number of different clinical benign conditions such as blephritis, Actinic

keratosis, keratoacanthoma, red eye, hurdle, chalazia cutaneous horns and mucoepidermoid carcinoma of the ocular.^[7,8,9,10,11] When tumors lack characteristic epidermal change, histopathological examination may be necessary to confirm the diagnosis. The rate of recurrence of basal cell carcinoma in the periorbital region is higher than in other states. The lacrimal system is often invaded by basal cell carcinoma that arises in the periorbital as well as extensive destruction of the eyeball by basal cell carcinoma has been extended.^[12,13] The risk of recurrence varies according to the adequacy of the surgical margins. Successful management of basal cell carcinomas of the eyelid requires complete resection and the ophthalmic surgeon should design a plan to have the margins of resection checked by a pathologist, either as a frozen section control of margins or by careful scrutiny of the surgical margins of permanent sections or by Moh's micrographic surgery.

CASE SUMMARY

A 40 yr female presented with an inflamed lesion on her left lower eyelid, without alteration in size for 2 years duration. No previous ocular history, eye surgery nor eye trauma was specified. She was a non-smoker with visual acuity of 6/60. Pupils, motility and intra-ocular pressure were normal. The lesion on the eyelid was 8x7 mm in size, with central ulceration and rolled, pearly borders with telangiectatic vessels. (Figure 1) Wide surgical excision of the growth with plastic reconstructive surgical procedure was performed. Microscopic examination demonstrated the tumor cells in dermal nests, cords, islands, with small round cells resembling basal keratinocytes, with peripheral palisading pattern. The tumor cells exhibited little pleomorphism and mitosis was infrequent. (Figures 2,3&4) A final

diagnosis of basal cell carcinoma was made based on the clinical features and histopathological findings. Our

patient is safe after 12 months, followed up periodically.



FIGURE 1: Greyish white firm tissue size 9 x7.5 mm in size, with central ulceration and rolled, pearly borders with telangiectatic vessels.

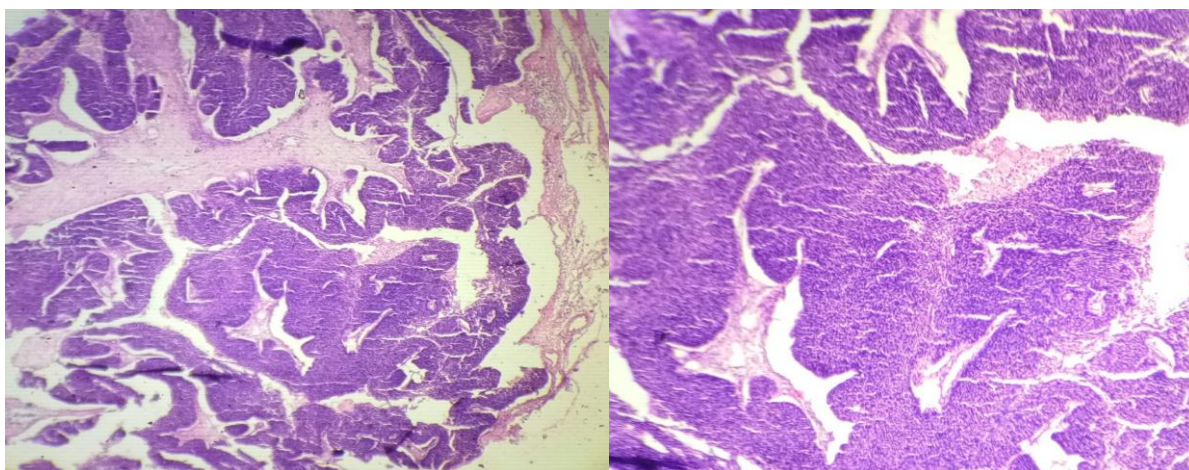


FIGURE 2&3: Section shows stratified squamous epithelium lined tissue, underlying stroma show nest of atypical cells having increased nucleo-cytoplasmic ratio, moderate degree of nuclear pleomorphism, hyperchromatic nuclei, round to spindle shaped nuclei, occasional prominent nucleoli, moderate amount of eosinophilic cytoplasm, few cells having vacuolated cytoplasm. in few cells peripheral palisading also seen. few mitotic figure also seen, stroma is infiltrated by inflammatory cells, blood vessels seen. (10X, 40X, H&E).

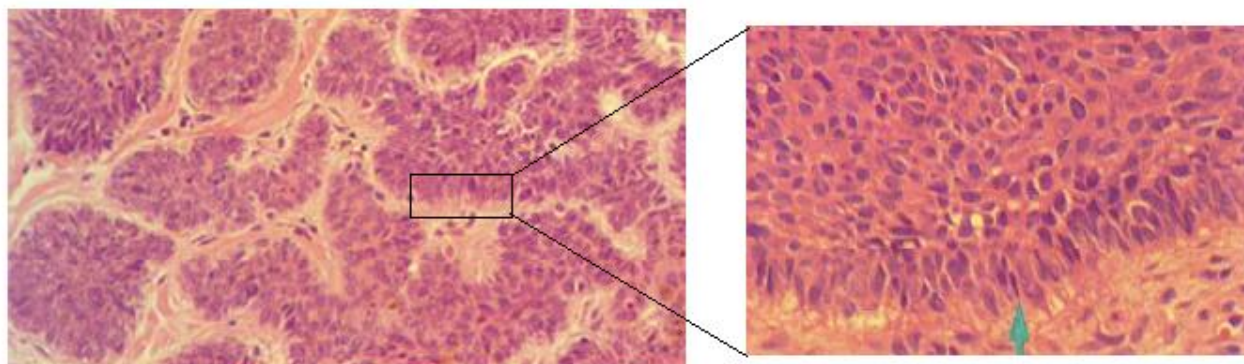


FIGURE 4: Microscopic examination showed the tumor cells in dermal nests, cords, islands, with small round cells resembling basal keratinocytes, with peripheral palisading pattern. (100X, H&E).

DISCUSSION

Periocular basal cell carcinoma is the most common malignancy in humans in our region which more commonly involves the older male population.^[4,13] It has a very likely association with increased exposure to sun,

dry, dusty hot weather and fair complexion.^[15] People with agricultural background seem to be increased risk. Lower lid involvement is the highest, followed by the medial canthal region and the upper lid.^[16] Simple excisional biopsy with a 3-5 mm clinically tumor free

margin, followed by reconstruction and meticulous follow up is a unspoilt and safe method to handle these events.

The biological behavior of basal cell carcinoma (BCC) is usually benign and cure is nearly always achieved by excision, electro desiccation and curettage, cryosurgery, or radiation therapy. Seldom, the clinical course may be aggressive and regional or distant metastases can develop particularly in patients who have received multiple local recurrences, necessitating exentration for local metastases. Once distant metastases develop cure is no longer possible. Early diagnosis is probable to make surgery easier with promising postoperative outcomes.^[13]

Basal cell carcinoma can also originate from the council, which contains sebaceous glands, hair follicles and lacrimal and sweat glands elements, however primary basal cell carcinoma of the council is unusual and only four cases have been reported in the literature.^[8] Another unusual presentation of basal cell carcinoma is that mimicking blepharitis. Other conditions to be studied in the differential diagnosis include pre-malignant lesions such as Actinic keratosis, keratoacanthoma and inflammation and infectious diseases such as red eye, hurdle, colors and cutaneous horns of the eyelid in elderly patients. Among the malignant lesion mucoepidermoid carcinoma of the eye is rare and has a high level of malignancy.^[7,8,9,10,11] It should be distinguished from other tumors such as basal cell carcinoma and squamous cell carcinoma.

Classically the lesion appears as a slowly enlarging ulceration with raised, pearly borders. There are multiple courses that this malignancy can take include nodular (as is this case), pigmented and multicentric. The lesion usually develops as a gentle, firm, painless nodule with a smooth, pearly appearance and may develop telangiectasia (a reddish hue caused by dilated capillaries). On pathology, the tumor cells form cohesive nests of cells with bland appearing nuclei with nuclear palisading of the peripheral cell layer. The malignant cells originate from the basal layer of epidermis and only occur in the hair-bearing tissue. Tissue processing can cause artifactual separation of tumor from surrounding stroma.

Basal cell carcinoma of the eyelid progresses very slowly. Metastasis is rare, but if left untreated, the disease can spread to and destroy surrounding tissue.

CONCLUSION

Diagnosis is usually dependent on the clinical features and its histopathological confirmation. Complete recovery is possible with surgical excision, but basal cell carcinoma can recur. Metastasis is rare with basal cell carcinoma, however, these lesions may be deeply invasive and therefore clear surgical margins are extremely significant.

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