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BASAL CELL CARCINOMA OF THE LOWER EYELID- AN UNUSUAL PRESENTATION

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ABSTRACT
Basal cell carcinoma (rodent ulcer), is the most common tumour affecting 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 generally slow, failure to get appropriate treatment can lead to a considerable area of skin being destroyed and thus requiring plastic surgery. We report case of a 34 female who presented with an inflamed lesion on her left lower lid, without change in size for 2 years duration.

INTRODUCTION

Basal cell carcinoma (BCC) is a type of skin cancer also known as rodent ulcer. BCC is the most common skin cancer, with a lifetime risk of 12% [1]. Twelve to 16% of BCCs occur on the periocular skin[2,3]. It is usually a slowly enlarging tumour and symptoms are rare [4].

It is very common cancer amongst Caucasians but rare among dark skinned peoples. It very rarely spreads to other tissues, unlike melanomas. Basal cell carcinoma usually spreads to the surrounding skin. Although this is generally slow, failure to get appropriate treatment can lead to a considerable area of skin being destroyed and thus requiring plastic surgery [4].

CASE SUMMARY

A 34 female presented with an inflammed lesion on her left lower lid, without change 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 was 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 surgery was performed. Microscopic examination showed the tumor cells in dermal nests, cords and 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) A final diagnosis of basal cell carcinoma was made based on the clinical features and histopathological findings. Our patient is doing well after 12 months of follow up period.

DISCUSSION

Basal cell carcinoma (rodent ulcer), is the most common tumour affecting the eyelids and is responsible for considerable morbidity owing to its locally invasive nature [5]. It arises from the basal layer of the epidermis. It accounts for 85–90% of lid malignancies, two-thirds of which are seen in the lower lid [1,2].

Basal cell carcinoma is the most common malignancy of eyelids (90% of eyelid malignancies). Risk factors include exposure to sunlight and the patient may have a history of other skin cancers. The lower lid is most

commonly involved, followed by the medial canthus and less frequently the upper lid and lateral canthus. Lesions involving the medial canthus are often more deeply invasive [6].

Classically the lesion appears as a slowly enlarging ulceration with raised, pearly borders [7]. There are multiple forms that this malignancy can take including nodular (as is this case), pigmented, and multicentric. The lesion usually develops as a small, firm, painless nodule with a smooth, pearly appearance and may develop telangiectasia (a reddish hue caused by dilated capillaries).

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 [8]. 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 important [9].

Diagnosis is usually dependent on the clinical features and its histolopathological confirmation. Two most common subtypes of basal cell carcinomas are the adenoid and metatypical forms [3]. 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 hair bearing tissue. Tissue processing can cause artifactitious separation of tumor from surrounding stroma.

The usual course of the disease is a gradual enlargement of the lesion with underlying tissue destruction necessitating treatment. Different modalities of treatment are cryotherapy, radiation therapy, chemotherapy, laser ablation and electrodessication, but the most widely accepted choice is surgical excision [10].The overall cure rate for basal cell carcinoma is between 95%-100%

Cases of basal cell carcinoma along with other skin tumors like keratoacanthoma, epithelioma and melanoma have been reported to regress with time, chiefly mediated through an immune response by the CD4+ T lymphocytes release of cytokines [5,6,7]. Partial regression of basal cell carcinomas has been reported in about 50% of skin lesion [11].

Figure 1. Microscopic examination showed the tumor cells in dermal nests, cords and islands, with small round cells resembling basal keratinocytes, with peripheral palisading pattern with little pleomorphism and mitosis was infrequent. H & E x 10X

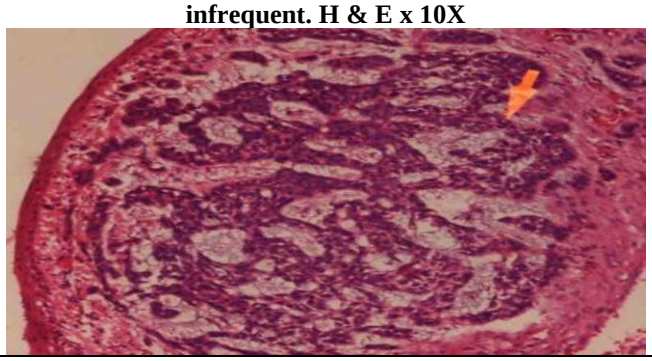


Figure 2. The lesion on the eyelid was 8x7 mm in size, with central ulceration and rolled, pearly borders with telangiectatic vessels

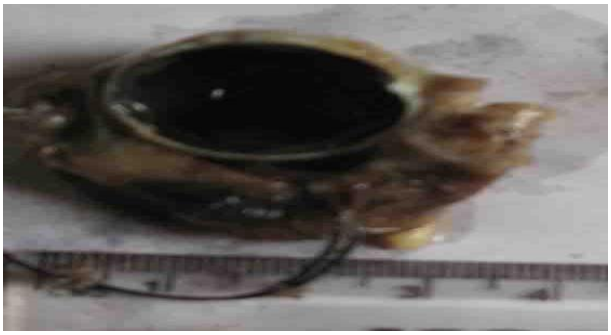
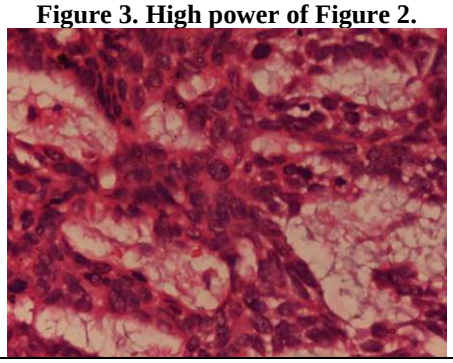


Figure 3. High power of Figure 2.



CONCLUSION

Metastasis is rare with basal cell carcinoma, however these lesions may be deeply invasive and therefore clear surgical margins are extremely important and failure to get appropriate treatment can lead to a considerable area of skin being destroyed and thus requiring plastic surgery.

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