

Sebaceous gland carcinoma: a case report

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Introduction

The sebaceous gland carcinoma is a highly malignant slow growing tumor of eyelid arising from meibomian glands located in tarsal plate, gland of zeis, sebaceous glands of caruncle, and periocular skin. It is the third most common malignancy of the eyelid and the incidence is about 1-1.5%¹. Prevalence is more in elderly individuals, usually females with a predilection in the upper lid where meibomian glands are numerous.

The upper eyelid is the site of origin in about two third of all cases, but the carcinoma may exhibit multicentric spread to the other eyelid, conjunctiva or corneal epithelium². This neoplasm may spread through the canaliculus to the lacrimal excretory system and even to nasal cavity³

In many cases correct diagnosis of a sebaceous carcinoma of the eyelid is delayed not only as a result of the rarity of this tumor but also because of its ability to masquerade as a variety of other eye conditions such as chalazion or chronic blepharoconjunctivitis. A high index of suspicion is vital if these tumors are to be adequately treated.

Case Report

A 53 year old male presented to us in January 2016 with chief complains of soft tissue growth on inner side of right upper eyelid (RUL) and difficulty to open the right eye and foreign body sensation since 9 months.

On examination there was bulging of RUL with prominence in middle third.

On everting the lid there was a growth on middle one third of palpebral surface of RUL having irregular borders extending horizontally in middle one third and vertically from lid margin to upper fornix measuring 8x6 mm, fleshy vascularized showing haemorrhages at some places, firm in consistency, lower margin of growth almost parallel to middle one third of upper lid margin, attached with underlying tarsal plate through pedicle(Fig. 1a & 1b)

There was no ulceration, obliteration of eyelid margin, localized loss of eyelashes, any induration or pigmentation seen on local ocular examination. Tano stage 2 nasal pterygium with muddy conjunctiva was present. Cornea slightly hazy and VA 6/12 on Snellens chart. Slit lamp examination of lens revealed grade two nuclear sclerosis. Fundus appeared normal. Examination of left eye was unremarkable.

Submental and preauricular nodes were not palpable and no lymphadenopathy was present on systemic examination.

Routine blood investigations (CBC, BT, CT, FBS, LFT and RFT) were within normal limits.

Patient was provisionally diagnosed as pyogenic granuloma as history of trauma could not be rule out but there was suspicion regarding malignancy and he was posted for excisional biopsy under local anaesthesia. Pedunculated lesion measuring 6x5 mm was excised from tarsal plate with some localized compromise of tarsal plate. 6-0 vicryl sutures applied at margins of tarsal plate and conjunctiva. Specimen sent for HPE.

On first post-op day slight lid edema and lid margin notching at middle was present(Fig. 3). Patient complained of foreign body sensation on eyelid movements.

On HPE lesion was found to be meibomian gland carcinoma (Fig. 2). Patient was posted for excision of growth with reconstructive surgery after two weeks. A full thickness resection of RUL with 3 mm of healthy margins in pentagon shape was performed and lid reconstruction was done with lateral canthotomy for approximation of wound which was done in 3 layers using 6-0 interrupted vicryl sutures. The specimen sent for HPE after marking of sides for evaluation of margins for infiltration by tumor cells. HPE report confirmed that the margins of excised tissue were free of malignant infiltration.

Patient was given tab. Amoxicillin and clavulanic acid 625 mg three times a day and analgesics. Topical antibiotic drops, ointment and lubricants were prescribed post operatively. On seventh post op day suture line was healthy and good lid margin alignment was achieved (Fig. 4).

At one month post op form, function and symmetry of the operated eye was satisfactory. On further follow up patient was asymptomatic on two visits at three month interval and was advised to come for observation at three monthly interval.



Fig. 1a: Growth RUL in middle one third on palpebral surface



Fig. 1b: RUL growth showing pedunculated attachment

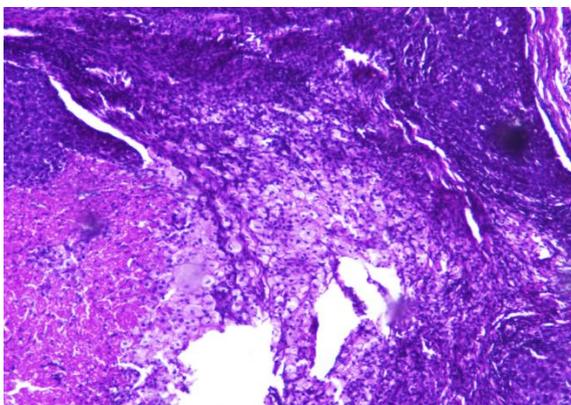


Fig. 2: HPE meibomian gland Carcinoma 40 X H & E



Fig. 3: Post-op after excisional biopsy (day 7)



Fig. 4: Post-op after lid reconstruction (day 30)

Discussion

This case highlights the importance of high index of suspicion for diagnosis of sebaceous gland carcinoma in elderly. There may be minimal signs of malignant eyelid lesion as loss of eyelashes, ulceration, induration, obliteration of lid margin.

Treatment: The treatment of choice for the sebaceous carcinoma is primarily a surgical one^{4,5}. If the tumor is very large or recurrent with demonstrated spread to bulbar conjunctiva, to the other eyelid, or to orbital tissue, a subtotal or complete exenteration may be necessary.^{6,7}

Postoperative patients must be followed up at short intervals as the tumor has a fast growth potential. The approximate guidelines are 3 monthly interval during the first year, 6 monthly during the second year, and then on a yearly basis for life. Sebaceous gland carcinomas of the lid are highly malignant, but with early detection and appropriate management they have excellent long term prognosis. Surgical resection in the form of pentagon provides good cosmesis and complete resolution if performed well.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form patient

has given consent for his images and other clinical information to be reported in the journal. The patient understands that his name and initials will not be published and due efforts will be made to conceal the identity, but anonymity cannot be guaranteed.

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