

**RECURRENT CHALAZION IN THE UPPER EYELID, ANNOYING OR SOMETHING DIFFERENT?**

Periocular lesions are some of the most common complaints encountered in Ophthalmic practice. Whilst some of the diagnoses may be obvious, some are not. There are a few characteristics which are common features of benign lesions such as a long-standing history with no evidence of recent growth, well circumscribed and absence of destruction of normal structures (such as hair follicles growing through the lesion). On the contrary; advancing age, recent rapid growth, recurrences despite initial excision, irregular borders and destruction of normal structures are characteristics of malignant lesions.

A 59 year old lady was referred for a recurrent chalazion despite four episodes of incision and curettage. Its external appearance was of a multi-loculated lesion along the right upper eyelid margin with surface telangiectasia (Figure 1). There was one less row of lashes and the lashes had become sparse in the affected area. Eversion of the eyelid showed destruction of normal eyelid margin architecture and a lesion with sebaceous content subtarsally with an adjacent haematoma. The lesion was surrounded by vascularisation along the tarsal conjunctiva (Figure 2). The above features were highly suggestive of a malignant lesion, such as a sebaceous carcinoma. There was no palpable lymphadenopathy.

A subsequent incisional biopsy confirmed sebaceous cell carcinoma. Simultaneous mapping biopsy ruled out pagetoid spread. Subsequently, the lesion was planned for complete excision with a 4mm margin. During the

excision, the medial 1/3 of whole tarsus with its attaching levator, punctal and upper canicular system were removed. Extensive reconstruction was performed with a combination of flap and graft (upper tarsus, postauricular). Post-operatively, the patient recovered well with reasonably good aesthetic and functional outcome. (Figures 3 and 4). She is under regular follow up for recurrence.



**Figure 2**



**Figure 1**

***“Despite being a rare condition among the Caucasians, the incidence is higher in Asia, with the reported incidence of SGC ranging from 0.5 to 5% of all lid carcinomas in USA and 28% in China”***



Figure 3 (above) & Figure 4 (below)



Sebaceous cell carcinoma is a malignant lesion which mostly affects the upper eyelid, predominantly in females. It arises from the meibomian glands, glands of Zeiss of the eyelashes, caruncle and eyebrow.<sup>1</sup> Despite being a rare condition among the Caucasians, the incidence is higher in Asia, including Malaysia. The reported incidence of SGC varies from 0.5 to 5% of all lid carcinomas in USA and 28% in China.<sup>2,3</sup> It is a great masquerader and can mimic benign lesions such as recurrent chalazion, blepharoconjunctivitis and superior limbic keratoconjunctivitis.<sup>4-6</sup> It therefore presents late and the author has seen cases of exenteration secondary to late presentation. It usually behaves aggressively and progresses quickly and can spread to regional lymph nodes in stage T2b and above. In Stage 3a and above, it can metastasise and lead to death.<sup>7</sup> It is known for its high recurrence rate (33%) and requires long term follow up. Follow-up is also required to monitor additional visceral malignancies as in Muir-Torre Syndrome.

As differentiation of benign and malignant lesions is difficult, it is important to have pre-operative photos prior to any incision. Very often oculoplastic surgeons are referred a malignant lesion post-incisional biopsy. The healing process following incisional biopsy makes determination of lesion margins extremely difficult and over/under further excision frequently occurs without initial photos as a reference. It is advisable that if the lesion is believed to be malignant, it is best to be referred to an oculoplastic surgeon to allow proper planning of the management without an incisional biopsy. As sebaceous cell carcinoma is suspected in this case, a mapping biopsy was also performed during the initial incisional biopsy to avoid another session and allow proper planning. During biopsy, proper handling of tissue is important as crush injury to the specimen often makes the pathological interpretation difficult.



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## References

1. Buitrago, William and Aaron Joseph. Sebaceous carcinoma: the great masquerader. *Dermatologic Therapy*. Vol 21, 2008, 459-466.
2. Ni C, Kou PK. Meibomian gland carcinoma: A clinico-pathological study of 156 cases with long-period follow up of 100 cases. *Jpn J Ophthalmol*. 1979;23:388–401.
3. Khalil MK, Lorenzetti HD. Sebaceous gland carcinoma of the lid. *Can J Ophthalmol*. 1980;15:117–21.
4. Foster CS, Allansmith MR. Chronic unilateral blepharoconjunctivitis caused by sebaceous carcinoma. *Am J Ophthalmol*. 1978;86:218–20.
5. Sweebe EC, Cogan DG. Adenocarcinoma of the meibomian gland; a pseudochalazion entity. *Arch Ophthalmol*. 1959;61:282–90.
6. Condon GP, Brownstein S, Codère F. Sebaceous carcinoma of the eyelid masquerading as superior limbic keratoconjunctivitis. *Arch Ophthalmol*. 1985;103:1525–9.
7. Esmaeli, Bitá et al. American Joint Committee on Cancer T Category for Eyelid Sebaceous Carcinoma Correlates with Nodal Metastasis and Survival. *Ophthalmology* 2012;119:1078-1082.