

# CASE REPORT

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## SQUAMOUS CELL CARCINOMA OF EYELID MASQUERADING AS BASAL CELL CARCINOMA

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### HOW TO CITE THIS ARTICLE:

Nagaraju G, Chinmayee J. T, Natarajan M, Vanitha M. D. "Squamous Cell Carcinoma of Eyelid Masquerading as Basal Cell Carcinoma". Journal of Evidence based Medicine and Healthcare; Volume 2, Issue 16, April 20, 2015; Page: 2456-2459.

**ABSTRACT:** The main malignant tumors affecting the eyelid are Basal cell carcinoma (BCC), Sebaceous gland carcinoma (SGC), Squamous cell carcinoma (SCC), and Malignant melanoma (MM) in that order of frequency in Asia. SGC and BCC forms majority of tumors in India. SCC is rare in Indian population and generally occurs in predisposed individuals like in patients with Xeroderma pigmentosa. BCC may present as pigmented or non-pigmented, nodular or noduloulcerative lesion. Usually SGC and BCC are not confused because of varied clinical appearance and morphology. However non pigmented noduloulcerative BCC can be confused with SCC. We report a case of histopathologically proven squamous cell carcinoma presenting as basal cell carcinoma in a 90 year old patient and its management.

**KEYWORDS:** Squamous cell carcinoma, Eyelid, Basal cell carcinoma.

**INTRODUCTION:** Eyelid malignancies have a varied pathology and include Basal cell carcinoma, Squamous cell carcinoma, Malignant melanoma, Sebaceous gland carcinoma. The western and Asian data have considerable variations in case distribution and presentation.<sup>1</sup> Case series reported from Asian countries have shown a higher prevalence of SGC.<sup>2</sup> The lower lid is the most common site for tumour location for all histological subtypes except SGC.<sup>1</sup> If an eyelid lesion is localized, it can be managed by wide excision and eyelid reconstruction with pathological section control of surgical margins. BCC has good prognosis and SGC poor prognosis.<sup>3</sup>

**CASE REPORT:** A 90 years old female patient presented with a lesion in left lower eyelid which was present since 6 months. It was initially small in size and had gradually increased to its present size. Patient had no history of pain, redness, sudden increase in size of the lesion, discharge from wound, fever, loss of weight, loss of appetite. There was no other significant medical or surgical history.

On clinical examination there was a large, non-tender, irregular, non-pigmented, ulcerative lesion in left lower eyelid near medial canthus measuring 2cm×3cm extending horizontally from dorsal part of nose to middle of lower eyelid and vertically from 3mm above medial canthus to 2cm below medial canthus. Ulcer had a dry irregular surface with rolled out margins and an indurated base. No discharge was seen. Lacrimal syringing was patent. There were no palpable lymph nodes. Systemic workup for metastasis was normal.

Diagnosis of basal cell carcinoma of eyelid was made due its clinical appearance and morphology and site of lesion. Wide excision of tumor with 4mm normal skin margin was done and specimen sent for histopathology examination. Histopathology report - squamous cells with full thickness dysplasia, increased mitotic activity, eosinophilic cytoplasm and hyperchromatic

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nuclei with keratin pearls suggestive of well differentiated Squamous cell carcinoma and all margins except deep resected margin was free of tumor. Margin clearance excision biopsy was again done and it was free of tumor.

The eyelid defect post excision of tumor was large involving lower eyelid and around medial canthus and was extending into cheek. It was reconstructed by combination of mustarde cheek rotation flap and glabellar flap under general anaesthesia. Mustarde cheek flap was taken by making an incision from lateral part of eyelid defect to lateral canthus and then extending by a curved incision in front of ear. Flap was dissected from underlying structures and rotated medially to cover the lower part of defect and sutured. Glabellar flap was taken by making inverted u shaped incision and dissecting the flap. This flap was rotated inferiorly to cover upper part of the defect and sutured. The defect in forehead and cheek was sutured by direct apposition after undermining the skin on either side.

**DISCUSSION:** The clinical presentation of eyelid tumors varies and histological examination is required for accurate diagnosis. Eyelid skin cancers occur most commonly on the lower lid but may also occur on the upper lid, medial or lateral canthal area, eyebrow, or adjacent eyelid skin. They appear as painless elevated nodules with or without some ulceration in the center of the growth.<sup>4</sup>

Clinically BCC may appear as nodular, noduloulcerative or morphea form. Black or brown pigmentation may be seen. Noduloulcerative lesion will usually have rolled out margins. Morpheaform will present as flat indurated plaque.<sup>5</sup> SGC has varied clinical presentation. Most commonly seen in upper lid. It can mimic blepharoconjunctivitis, or have wide local and distant metastasis. It is also characterized by intraepithelial pagetoid spread.<sup>6</sup>

SCC is an invasive tumor showing keratinocytic differentiation. Extrinsic risk factors for development of SCC are ultraviolet light/actinic damage and exposure to arsenic, hydrocarbons, radiation, or immunosuppressive drugs and Intrinsic risk factors are albinism, pre-existing chronic skin lesions and genetic skin disorders such as xeroderma pigmentosum and epidermodysplasia verruciformis.<sup>7</sup>

SCC has wide variation in clinical appearance and hence difficulty in differentiating SCC from BCC. In one study 15 cases out of 51 SCC patients were diagnosed preoperatively as BCC and it highlighted the difficulties in clinical diagnosis of SCC.<sup>7</sup> Wide excision of tumor with histopathological examination and margin clearance should be done for all cases.<sup>3</sup>

Choice of eyelid reconstruction depends on amount of defect caused by excision of tumor. Reconstruction of wide (more than two thirds) deep defects of the lower lid is difficult especially in the cases when the defect exceeds the lids limits, extending either to the cheek or over inner canthal area.<sup>6</sup>

One of the most versatile flaps for these situations used is Mustarde cheek rotation flap. It was described for the first time by Mustarde in 1971, it is a rotation flap used to reconstruct the defects involving wide full-thickness part of the lower lid.<sup>8</sup> Glabellar flap can also be used for defects in the medial canthus.<sup>9</sup> Our case of a 90 year old patient with squamous cell carcinoma presenting as a basal cell carcinoma highlights the varied clinical appearance of SCC and

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importance of histopathological examination in all cases for diagnosis and options of combination of reconstruction methods for closure of large eyelid defects.

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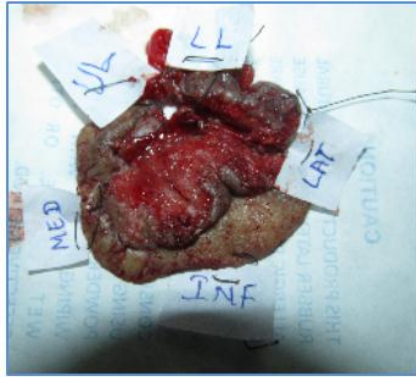


**Fig. 1: Clinical photorgaph**

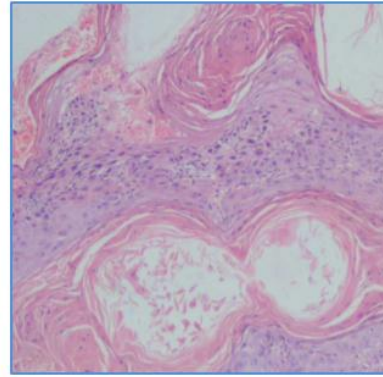


**Fig. 2: Excision of Tumor**

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**Fig. 3: Labelled excised tumor**



**Fig. 4: Histopathology - SCC**



**Fig. 5: Post-operative photograph**

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Date of Submission: 02/04/2015.  
Date of Peer Review: 03/04/2015.  
Date of Acceptance: 08/04/2015.  
Date of Publishing: 20/04/2015.