(*Refer to page 158*)

Answer: Basal cell carcinoma of the left eyelid

Krompecher first identified the histological feature of basal cells carcinoma (BCC) as an epidermal malignancy originating from the basal layers of keratinocytes in 1900. [1] It is the most common type of eyelid cancer with more than 60% affecting the lower eyelid. [2] The two most recognised subtypes of eyelid BCCs are the infiltrative (morpheaform and micronodular) or the nodular/nodular-ulcerative BCC, with more than 80% being the nodular-ulcerative type. [2]

BCC has classically been described having waxy or pearly appearance on a rolled border with telangiectasia. [2, 3] 'Rodent ulcer' was a term first coined in 1827 to describe an ulcerated lesion. [1] Majority of time this is a clinical diagnosis which can be made confidently, as in the lady. However in certain situations when diagnosis is doubtful or the need to decide on the safe margin to clear for prognostication purpose, a direct biopsy would be required. [1-3]

Genetic predisposition and early age exposure to UV radiation especially of the head and neck area have been established as the most significant contributing aetiology factors. [1-3] Increasing age, fair complexion, arsenic exposure, prior radiation and immunosuppression are also risk factors for BCC. [2] Although it rarely metastasises or kills, it is a malignant skin lesion attributable to its disfiguring local invasion with destruction of surrounding tissue. [1-3] In this case, the lesion may eventually cause local periocular invasion with potential catastrophic consequences on both the cosmetic or function. Important alternative diagnosis to consider includes keratoacanthoma or in the case of pigmented lesion, the melanoma subtypes. [2]

The management of eyelid BCC is governed by the balance between successful eradication of tumours and preservation of an optimal amount of normal tissue (hence function). [1-3] This is done with the common aim to achieve what is acceptable cosmetic outcome for the patient. For practical purpose, patients are stratified into low risk, high risk and those with likelihood of recurrence. The low risk tumours can usually be resected via techniques such as cyrotherapy, curettage, radiotherapy or photodynamic therapy, although not allowing for histological confirmation of clearance margin. On the hand, excision can also be staged for further wider margin excision with predetermined margin edged following frozen section control. In area where there is expertise available, Mohs chemosurgery still offers the best control with the lowest recurrence rate. Meanwhile, when there might be advanced invasion, destruction with orbital exentration may be indicated.

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