A rare case of extensive sebaceous carcinoma of the left eyelid: A case report with literature review

Chandar Agrawal¹, Arjun Agarwal¹, Cheena Garg²

¹Department of Surgery, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India, ²Department of Pathology, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

INTRODUCTION

Ocular adnexa has numerous sebaceous glands and carcinoma arises from the glands of the eyelid.¹ It occurs most frequently on the eyelids, where it comprises 4.7% of malignant epithelial tumors. It can occur in other body areas of skin with hair even genitalia with 25% involving head-and-neck region.² There is slightly higher incidence among females with female-male ratio of 1.5:1.³ Sebaceous carcinomas can occur sporadically or may be associated with Muir-Torre syndrome (MTS), a subset of the hereditary nonpolyposis colorectal cancer syndrome (HNCCS, Lynch syndrome) characterized by single or multiple sebaceous neoplasms, keratoacanthomas, and internal malignancy.⁴

CASE REPORT

A 65-year-old female presented with progressive ulcer over the left upper eyelid for 6 months with a history of accidental spilling of red chilly in the left eye 6 months back [Figure 1]. After that accident, the patient’s vision slowly got blurred in the left eye with complete vision loss for 4 months. The patient developed symptoms of facial nerve paralysis for the past 2 months and difficulty in chewing for the past 2 months. The

Figure 1: Large ulceroproliferative lesion over the left eye involving the left eyeball and left lower eyelids, extending up to the left cheek and the preauricular region

Sebaceous carcinoma involving eyelid is one of the rare malignancies. Its diagnosis presents a challenge as it masquerades other periorcular lesions. Its prognosis is poor as compared to other malignant eyelid tumors and mortality second highest to malignant melanoma. The present case report is an extensive sebaceous carcinoma involving the left eyelid.

KEY WORDS: Histopathology, ocular adnexa malignancy, sebaceous carcinoma
patient has no other significant medical or surgical history. 10 × 20 cm, ulceroproliferative growth was seen in the left eye region. Eyeball and lower eyelids were not seen separately. Lesion had everted margins and extended up to the left cheek and the preauricular region. Preauricular and post-auricular lymph nodes were enlarged and fixed, largest measuring 3 × 2 cm in the preauricular region.

Incisional biopsy revealed multiple tissue bits with large areas showing neutrophilic debris. Tumor cells were seen in the form of nests and infiltrating trabeculae, cords in fibrovascular stroma. Cells were polygonal with high N: C ratio, marked nuclear pleomorphism, vesicular chromatin, and prominent nucleoli with clear to moderate eosinophilic cytoplasm. Center of sheets showed foamy cells (apocrine differentiation). Fair number of atypical mitosis and apoptotic bodies was seen. Diffuse lymphoplasmacytic infiltrate was also seen in stroma. Final impression of biopsy was suggestive of sebaceous carcinoma [Figure 2].

Contrast-enhanced computed tomography head and neck showed large irregular heterogeneously enhancing mass lesion arising from the left side of face infiltrating subcutaneously and extending up to the frontoparietal region and infiltrating into the orbital cavity-causing erosion of the left orbital wall and superior wall of the orbit, encroaching the left frontal sinus [Figure 1]. The left globe was distorted and displaced anteromedially and a large contrast-enhancing left parotid mass was seen [Figure 3].

Due to extensive disease and poor performance status, the patient was advised palliative chemo-radiotherapy.

**DISCUSSION**

One of the rare malignant tumors of sebaceous gland is sebaceous carcinoma.[⁵] It can occur in any body site, where sebaceous glands are present, but is most commonly found in the head-and-neck region, particularly in the periocular area.[⁶] Sebaceous carcinoma of the eyelid may be mistaken for inflammatory lesions, such as chalazion or blepharoconjunctivitis, resulting in a delayed diagnosis and poorer prognosis.[⁷] Sebaceous carcinomas can occur sporadically or may be associated with MTS, a subset of the HNCCS, Lynch syndrome characterized by single or multiple sebaceous neoplasms, keratoacanthomas, and internal malignancy.[⁴] There is a higher incidence of tumor originating from upper eyelid as compared to lower eyelid.

The ratio varies from 1.3 to 3.0.[¹] Carcinoma develops from Meibomian and Zeis glands and tumor mostly originates from upper eyelid due to greater number of Meibomian glands in the upper eyelid.[¹] The clinical diagnosis of sebaceous carcinoma may be difficult, partly because it is rarely encountered and partly due to its propensity to simulate other eyelid lesions.[⁸] Due to diagnostic difficulties, emphasis is given to biopsy in uncertain and suspicious inflammatory states which fail to respond to appropriate treatment.[⁹] The prognosis of the tumor is multifactorial. However, tumors in excess of 10 mm are associated with a particularly poor outcome. Carcinomas of the gland of Zeis are claimed to have the best prognosis.[¹⁰] Histopathological features such as tumor differentiation, extent of infiltration, and intraepithelial spread have also been linked to prognosis. The treatment of sebaceous carcinoma of the eyelid around wide excision of the lesion with at least 4 mm of tumor-free margins. Frozen section control and Moh's technique are of great value and can be employed in specialized centers having experience ophthalmic pathologists, as these methods may alter the histological appearance of sebaceous carcinoma.[¹¹,¹²] The reported incidence of the recurrence of sebaceous carcinoma is 6–29%. Literature suggests 14–25% of cases with distant metastasis and involves lymphatic spread to lymph nodes and hematogenous spreads to liver, lungs, brain, and bones.¹⁰ In the post-operative period, the patient should be followed more frequently due to the fast growing nature of the tumor and its close anatomical location to the orbit. Follow-up visits include meticulous examination of the operated site along with complete head-and-neck examination to rule out and local or lymphatic metastasis such as preauricular, submandibular, and other neck lymph nodes.
REFERENCES


