A Case Report:

SEBACEOUS GLAND CARCINOMA MASQUERADING AS SEBACEOUS CYST : INTERESTING CASE REPORT

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INTRODUCTION

Sebaceous gland carcinoma (SGC) is a highly malignant and potentially lethal tumor that arises from meibomian glands of the tarsal plate, from glands of Zeis or from sebaceous glands of the caruncle, eye brow or facial skin. SGC arises from sebaceous material secreting glands and are known to be occasionally multicentric. These tumors are reported to behave aggressively with the tendency to metastasize early with higher mortality rates especially if there is a delay in the diagnosis. In many cases correct diagnosis of SGC of the eyelid is delayed because of its ability to masquerade as a variety of other ocular conditions such as chalazion, chronic blepharoconjunctivitis, basal cell carcinoma or other eyelid tumors.

CASE REPORT

A forty year old female presented to us with a swelling of the upper eyelid for the past three months. There was a history of recurrent swelling and excision of the swelling 2 year back once. On ocular examination a left upper eyelid

swelling of 4.0 cm×2.5cm of lid margin was seen. It was soft to firm, non-tender and slightly restricted movement over the underlying tissue found. On general examination no lymphadenopathy or organomegaly was detected. A differential diagnosis of giant chalazion, sebaceous cyst, basal cell carcinoma, sebaceous gland carcinoma, squamous cell carcinoma, was made.

An excisional biopsy confirmed the diagnosis of Meibomian gland carcinoma. Histopathology showed anaplastic tumor cells arranged in irregular, lobular formation with central necrosis giving it a comedo pattern. The tumor cells were polyhedral with central atypical nuclei, vacuolated eosinophilic cytoplasm and abnormal mitosis. The lateral margins of excision were found to be free from tumor invasion. Based on history, clinical and histopathological findings a diagnosis of Meibomian gland carcinoma of upper lid was made. Patient was asked for follow up after 6 months.

DISCUSSION

Meibomian gland carcinoma was described more than a century ago by Fuchs. SGC needs special attention not only because of its masquerading tendency but also because of its much higher prevalence in the Indian subcontinent in contrast to the Western world. Prognosis is still regarded as being poor compared with most other malignant eye lid tumors with a mortality second only to malignant melanomas.

Numerous factors have been reported to influence the prognosis. Tumors in excess of 10 mm are associated with a poor outcome. Tumors of the upper eye lid have been associated with an adverse outcome relative to

those affecting the lower lid. The various other clinico-pathologic features that indicate a worse prognosis are vascular, lymphatic and orbital invasion, poor differentiation, multicentric origin, duration of symptoms greater than 6 months, a highly infiltrative pattern and pagetoid invasion of the overlying epithelia of the eye lids.

The majority of recurrences in SGC appear within the first 4 years of treatment. Patients with SGC must be followed up at short intervals post-operatively as the tumor has a fast growth potential. Adequate follow-up includes meticulous inspection of the local site. Palpation of the pre auricular, submandibular and other neck lymph node chains is mandatory. The approximate guidelines for follow up are 3 monthly interval during the first year, 6 monthly during the second year and then on a yearly basis for life.

In conclusion, it may be said that our case underlines the importance of suspecting a malignant tumor when a cyst occurs, or recurs after removal in patients over the age of 40 years. Early diagnosis and treatment may decrease the long term morbidity and extend the survival rate of such patients.

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