CASE REPORT

Multidisciplinary Management of Sebaceous Gland Carcinoma of Upper Eyelid with Regional Lymph Node Metastasis

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Abstract:
Sebaceous gland carcinoma (SGC) of ocular adnexa is a highly malignant, multifocal in origin seen in elderly. SGCs are known to have highly virulent course of progression with more tendency to metastasize locally and systemically resulting in poor outcome.
We managed a case of SGC in 55 years old with multimodality treatment consisting of surgical excision, chemotherapy for tumor bulk reduction and radiotherapy. This offered her long disease free survival.
Aggressive behavior of SGC for early metastasis is associated with high mortality. Hence high index of suspicion for diagnosing SGC in ophthalmic practice is the key for better survival of the patient.
Key words: sebaceous gland carcinoma, eyelid, chemotherapy, radiotherapy, metastasis.

Introduction:

Sebaceous gland carcinoma (SGC) of ocular adnexa is a highly malignant but relatively rare condition. It is multifocal in origin seen in elder population with female predisposition with reported incidence less than 1% of all skin malignancies. [1] It accounts for 1-5.5% of all eyelid malignancies with more predilections for upper eyelid. [2] Predisposing factors reported are advanced age, female gender, Asian race, prior irradiation to head and neck, genetic predisposition to Muir-Torre syndrome or familial retinoblastoma. [1]
SGC may originate from the meibomian glands in the tarsus, zeis glands at the eyelid margin or sebaceous glands at caruncle or eyebrows. [3] SGCs are known to have highly virulent course of progression with more tendency to metastasize locally and systemically resulting in poor outcome. Usually the condition is diagnosed in late stage because it mimics various benign ocular conditions like chalazion, chronic blepharoconjuctivitis, papilloma,

keratocanthoma, dermoid cyst and benign or sessile keratosis. [4]
Herein, we describe clinical course and management of a patient with SGC of upper eyelid with metastasis and recurrence.

Case Report:

A 60 year old hypertensive woman was referred to our centre for nonhealing ulcer on right eyelid and swelling on right cheek. She gave history of excision of nodular lesion on right eyelid 6 month back at her local place. Otherwise, her personal and family history was unremarkable. But 3 months after excision of nodule, she had ulcerative lesion at the site of excision and swelling over parotid area on right side. On examination, ulcer was of 0.7 x 0.8 cm in dimension with everted edges, firm and bleeding on touching. Lymph node was palpable over parotid region. First fine needle aspiration cytology of lymph node was performed which revealed secondary deposits of poorly differentiated adenocarcinoma. So patient underwent right upper eyelid excision with lower eyelid flap reconstruction and right sided total parotidectomy. Histologically case was diagnosed as poorly differentiated sebaceous adenocarcinoma of right upper eyelid.

After healing of the wounds, 6 cycles of systemic chemotherapy (Taxol, cisplatin and 5 Fluorouracil) were administered followed by radiotherapy. Patient tolerated these therapies without any adverse events. She was on regular follow up initially every three months for 1 year, then semiannually. But after six years of disease free survival state, our patient again presented with regional submandibular and preauricular lymph node metastasis on the same side. PET scan revealed secondaries in regional lymph nodes. Again she received radiotherapy followed by chemotherapy (Carboplatin, Docitaxel and Gefitinib).

Discussion:

Present case is reported to describe clinical profile and management of a patient presented with malignant eyelid tumor. Many times SGC is mistaken as chalazion, the most common ophthalmic condition in practice. Same might have occurred in our case when she underwent excision of nodule for the first time and her diagnosis was delayed. But with multimodality approach, she had disease free survival of six years. It has been reported that about 18.6% cases of SGC have been diagnosed by general physician and 50% by ophthalmologists in practice. [5]

Present case report emphasizes thorough diagnostic work up for painless growth on eyelid with suspicion of SGC. Continuous surveillance is necessary for early detection of the secondary and recurrence of the lesion throughout the management. SGC has high tendency to metastasize locally and systemically. Husain A et al studied retrospectively clinical records of 4 patients with metastatic eyelid SGC and observed that metastasis can occur late as 5 years after treatment. In our case we discovered metastasis 6 years after completion of the treatment. [6] Our patient has time length of 84 months from initial lesion to metastasis.

Murthy R and colleagues reported role of neoadjuvant chemotherapy with radiotherapy with eyelid sparing orbital exenteration. [7] Several case reports suggested multimodality management of SGC to prevent metastasis. [8,9] Shields JA et al described their experience of 60 cases with SGC of eyelid and concluded that only 32% cases diagnosed during initial evaluation and 50% on histopathological examination. With the aid of modern therapeutic approach, procedure of exenteration can be avoided. [10]

Conclusion: Aggressive behavior of SGC for early metastasis is associated with high mortality. Hence high index of suspicion for diagnosing SGC in ophthalmic practice is the key for better survival of the patient.

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