Editorial

Dr. Syeed Mehbub Ul Kadir

Sebaceous Gland Carcinoma: Terrifying scenario in Bangladesh

Malignant eyelid tumors are uncommon among eyelid lesions. Basal cell carcinoma is the common malignant eyelid tumor reported in the literature. Eyelid malignancies can be diagnosed clinically, but histopathologic and immunohistochemical analysis are essential for confirmation of the diagnosis. In the United States of America, basal cell carcinoma accounts for 90-95% of eyelid cancers, and sebaceous gland carcinoma accounts for 1.5-5%. However, in China, basal cell carcinoma accounts for 50% of eyelid malignancies. In Korea, sebaceous gland carcinoma accounted for 42.2%, basal cell carcinoma for 36.6%, and squamous cell carcinoma for 10.5%. In India, basal cell carcinoma accounts for 44.5% and sebaceous gland carcinoma for 37%. In Bangladesh, Sebaceous gland carcinoma is the most common, at 42%; basal cell carcinoma, 38%; and squamous cell carcinoma, 18% in a study of 348 cases. Reported case series from Asian countries have shown a generally higher prevalence of sebaceous gland carcinoma and a lower rate of basal cell carcinoma. Sebaceous gland carcinoma (SGC) is a lethal malignant tumor of the eyelid that arises from meibomian glands of the tarsal plate, glands of Zeis, or from the sebaceous gland of the caruncle, eyebrow, and facial skin. Sebaceous gland carcinoma usually affects individuals in their 5th decade or older adults, with a preponderance for females. The exact cause is still unknown, but the associated risk factors include betel leaf and nut chewing, smoking, race, prior irradiation, systemic associations such as Muir-Torre syndrome, prolonged sun exposure, prolonged use of diuretics and immunosuppressant agents, chronic exposure to carcinogenic chemicals, etc. The sebaceous carcinoma most commonly occurs in the upper eyelid, and the basal cell carcinoma commonly occurs in the lower eyelid. It often masquerades as a recurrent chalazion, stye, or chronic blepharitis, and the correct diagnosis may be delayed until the tumor has spread to the orbit and metastasized. Typically, SGC has a superficial, yellowish appearance due to its lipid content. It can present a focal nodular mass, a multicentric tumor, or a diffuse lesion with pagetoid spread. Poor prognostic factors in SGC include invasion of vascular-lymphatic or orbital tissues, diffuse involvement of both eyelids, multicentric origin, tumor diameter > 10 mm, and symptoms for> 6 months. The goal of management is tumor control to reduce morbidity and mortality. We prefer standard surgery with frozen-section control of tumor margins, allowing tissue conservation and potentially lowering recurrence rates (2%) in our view. Moh's micrographic technique has been used in some cases, but it is not performed in Bangladesh. Conjunctival map biopsies may help to eradicate the pagetoid spread. Sentinel lymph node biopsy is usually done in case of recurrent lesions and for extensive eyelid, orbital, or lymph node involvement.

Figure 1: Clinical pattern of the Sebaceous Gland Carcinoma (SGC)

The exact eyelid reconstruction depends on the extent of acquired coloboma after tumor excision. A newer technique, "Triangular musculocutaneous flap," is a good option for reconstruction of the upper eyelid compared to Tenzel or reverse Tenzel semicircular flap. Adjuvant radiotherapy may be considered in cases with perineural invasion or positive excisional margins, and primary radiation therapy can be reserved for non-operative cases. In conclusion, Sebaceous gland carcinoma of the eyelid is more common in Asian countries, whereas basal cell carcinoma is the most common in Western countries. The reason for the difference in the frequency of eyelid malignancies between Western and Asian countries is quite unknown. The researchers should identify the exact causes of the differences.

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Dr. Syeed Mehbub Ul Kadir
Associate Professor,
Head, Oculoplasty Green Unit
National Institute of Ophthalmology & Hospital

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