

# Section 1

Lids and lacrimal

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Basal cell carcinoma (BCC) is a proliferation of the basal cells of the dermis in human skin. There are four recognised types of BCC: nodular, cystic, granular and sclerosing. Nodular BCC is the most common finding and easily recognised with a little experience.

Basal cell carcinomas rarely metastasise but do retain the capacity to do so. Twenty-four per cent of all diagnosed BCCs are to be found in the eyelids and BCCs make up 90% of malignant lid lesions (Sowka et al. 2007). Incorrect diagnosis is possible, with confusions being made with sebaceous cysts, squamous cell carcinomas, solar keratosis and chalazion.

## SIGNS AND SYMPTOMS

Typically, all except the sclerosing type have a similar pattern of growth. A discrete spot appears that is not troublesome to the patient. Over a period of 12–18 months the spot slowly grows to 10mm in diameter. A well-defined, rolled, pearlesque edge is evident. Also present is hyperpigmentation of the lesion, often with small blood vessels growing through it close to the skin surface (telangiectasis).

Nodular and cystic lesions bleed easily and the patient often reports that touching a lesion will produce this effect. Patients often present with a lesion with a bloody crust sitting in the crater at the centre of the BCC.

## DIAGNOSIS

Diagnosis is based on careful ophthalmic history taking and inspection of the lesion. The only sure way of confirming diagnosis is by histological analysis. Depending on the site of the lesion a wedge biopsy will be performed, and should include the

centre of the lesion, the edge and a sample of normal skin; this biopsy is sometimes known as a Panttone biopsy. The wedge biopsy confirms the diagnosis but preserves most of the lesion *in situ* and the surrounding skin, for more accurate excision and improved cosmetic outcome.

If the lesion is positioned in such a place, with adequate spare skin, the lesion can be removed in its entirety and the wound sutured. Most BCCs require no further treatment; however, some patients do need adjunctive treatment such as radiotherapy.

All suspicious lid lesions that demonstrate irregular growth, changes in colour or appearance, or purulent or bloody discharge, should be biopsied to rule out cancer (Sowka et al. 2007).

### CAUSES

Basal cell carcinomas arise in hair-bearing skin, particularly in the periorbital region. Incidence is more pronounced in the lower lid, medial canthus, upper lid and lateral canthus (Tasman and Jaeger 2002).

Aggravating contributory factors include age, smoking and outdoor occupations. There is no recognised gender difference in incidence. Skin type is also a significant factor with a skin type that 'always burns' being more vulnerable.

### TREATMENTS

The vast majority of BCCs can be removed in their entirety during a minor surgical list. Some larger BCCs in some lid areas, particularly medially and in young, tight-skinned patients, should be removed using Mohs' procedure, which involves removing minute areas of the lesion, continually sending sections to histopathology for confirmation of malignancy. This procedure continues until 'clear tissue' is returned and ensures that only the minimum amount of tissue is removed, preserving the maximum amount of normal tissue to ensure wound reconstruction and closure.

### LIKELY PROGNOSIS

Prognosis depends upon the duration of the BCC and histopathological data; however, BCCs rarely metastasise (Royal

College of Ophthalmologists: [www.rcophth.ac.uk](http://www.rcophth.ac.uk)). If the patient requires referral to the oncology services, careful liaison should be ensured between the services to promote a holistic and seamless approach to care and management.

#### FOLLOW-UP CARE

Follow-up care depends on the treatment options. All lesions are removed surgically and standard postoperative wound care should be managed. Long-term postoperative advice should include gentle massage and moisturisation of the wound. Patients should be advised that there is a greater chance of developing a second and third lesion after having already developed one. Careful inspection of the face during personal hygiene time should be advised. Support of the patient should be considered at the time of diagnosis and discharge. If not adequately supported, patients could go through unreasonable anxiety with a cancer diagnosis and lifelong observation for a recurrence!

#### PATIENT EDUCATION

Sunblock, especially for the face, should be advised, together with regular inspection of the facial skin for recurrence of a BCC.

Patients must be told that, although a BCC requires prompt treatment, BCCs rarely metastasise and are the most common of skin cancers in the UK. Incidence is approximately 144 per million of the UK population (Wong et al. 2003).

#### REFERENCES

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