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LEFT LOWER EYELID MASS EXCISION ALONG WITH LID RECONSTRUCTION: A CASE REPORT

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ABSTRACT

Background: The repair of any eyelid defect depends on size, position and state of the surrounding tissue. It is important to restore the physiologic function of the eyelids with respect to vision, lid closure and mobility and tear drainage. Final result is to reestablish anatomic integrity and to provide best cosmetic appearance. **Aim:** To know the surgical outcome of a skin subcutaneous tissue rotational graft taken from cheek and lateral part of forehead for reconstructing lower eyelid defect following excision of lower lid mass. **Case history:** A 73 yr old male patient came to our OPD with history of left lower eyelid sessile mass since 5 years. He had no history trauma, fever, drug or chemotherapy and no similar history in the past. On examination visual acuity 6/12 in both eyes with pseudophakia. **Result:** Patient was satisfied after surgery with less post operative pain and good cosmetic outcome. **Conclusion:** With partial thickness defects of either anterior or posterior lamella direct closure is done. If it is not possible flap or graft is tried or defect left to granulate and heal by secondary intention.

KEYWORDS: Carcinoma, Cosmetic, Defect, Eyelid, Graft, Mass, Reconstruction, Surgery, Tumor.

INTRODUCTION

The eyelid consist four layers: skin, subcutaneous tissue covering adnexa, striated muscle, tarsal plate and palpebral conjunctiva. Benign and malignant growth comes from each of eyelid layers. Most eyelid tumors are of epidermal or cutaneous origin. Other classification of eyelid tumor divided in to epithelial and melanocytic origin.[1] The most frequent malignant lesion is basal cell carcinoma in Caucasians and sebaceous gland carcinoma in Asians. Our case report explains the malignant lower eyelid growth with no adnexal involvement.

MATERIAL AND METHOD

Case Report: A 73 year old male child came to OPD room with history of Left lower eyelid mass involving more than one third of lower lid thickness since more than five years. The mass was firm, non pedunculated, margins rolled out or cauliflower, ulcerated surface and crusting with pigmentation. The external feature looks like rodent ulcer.

Procedure

After proper history, investigation, lymph node status and systemic evaluation patient was shifted for surgery done under local anesthesia. With full thickness defects, direct closure is tried first but if it is not possible the combination of a flap and graft is usually considered. The approximate 3 to 4 mm mass was excised leaving a healthy area of 3mm around it.[2] C shaped rotational flap from cheek up to pre auricular skin was taken with continuous subcutaneous dissection similar to Mustarde flap. The flap was sutured with (4-0 Mersilk) remaining lower eyelid with typical S shape final appearance. Skin stitches were removed after one week on alternate basis. In every follow up, position of the graft and closure of the eye was observed. Follow up was done after 16 days. There was no graft contraction, ectropion or entropion and epiphora. HPE shows the presence of Basal cell carcinoma (Rodent ulcer).

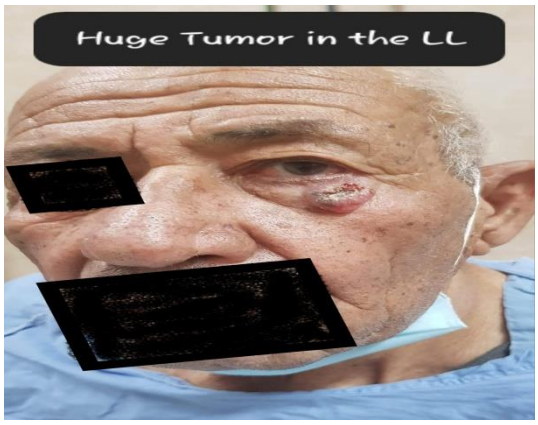
DISCUSSION

The ideal goal of reconstruction is to provide global protection and normal aesthetics. Prerequisites to attain this goal may be like maintaining lubrication while avoiding corneal irritation. Lid rigidity while allowing direct global apposition. Lid stability, orientation with proper medial and lateral canthal support.[3] Opening and closing ability facilitated by adequate muscle power and tone, allowed by subtle skin covering. To attain these goals, reconstruction should ideally replace the delicate, thin, pliable, well vascularised and innervated tissues of the eyelids with kind. Distraction forces like gravity, edema and wound

retraction may lead to complications, such as eyelid malposition and corneal exposure. Most of the lower lid defects which are > 50% are closed by anterior lamella reconstruction using primary closure or lid bridging, full thickness skin graft, O- S plasty, rhombic flap, musculocutaneous advancement flap.[4] Posterior lamellar reconstruction is done by replacing lost conjunctiva with buccal mucosa, hard palate mucosa, turbinate mucosa and tarsoconjunctival free graft.[5][6] Tarsus reconstruction can be done with auricular or nasal septal cartilage or mucous membrane graft.[7] However we have filled the left lower eyelid defect using rotational flap with 6-0 mersilk sutures. Post operative good cosmesis was achieved.

CONCLUSION

This is a simpler method of lower eyelid reconstruction for tumor involving lateral third of lower eyelid with skin, subcutaneous tissue or tarsal plate involvement. No role of skin grafting was considered.



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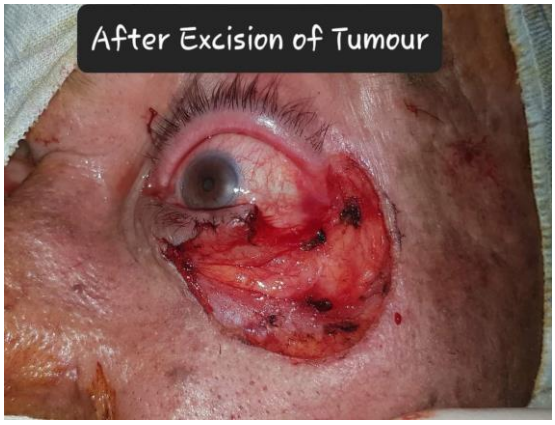

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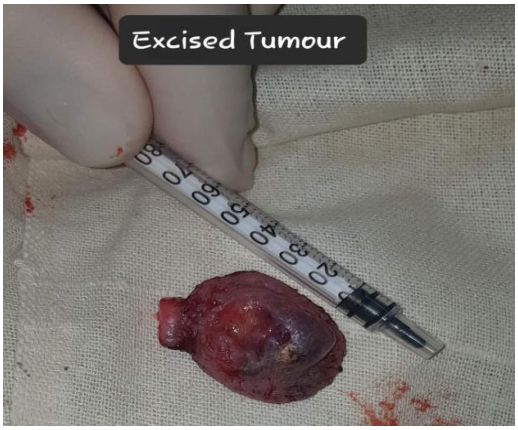

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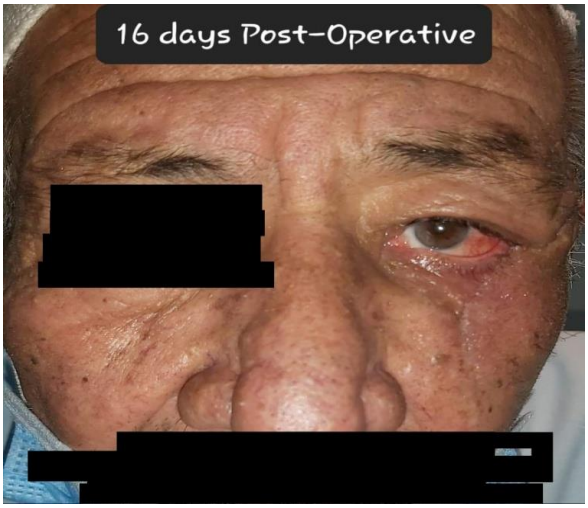

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