CASE REPORT

Meibomian Gland Carcinoma Masquerading as Giant Chalazion

Dr. Nitin V. Trivedi, Dr. Stuti N. Trivedi

Avataran Eye and Oculoplasty Hospital, Ahmedababad

KEY WORDS : Giant Chalazion, Meibomian Gland Carcinoma (MGC)

ABSTRACT

A 50-year-old male presented to us with mass on left eye upper lid for 6 months. It was slowly growing and painless. There was no history of trauma, any mass elsewhere in the body or any previous operative intervention. It was diagnosed as a giant chalazion and operated as usual ; incision drainage and curettage . After 3 months post operative,there was a tumor mass at the same place of the same lid.Clinical diagnosis this time was meibomian gland carcinoma. It was excised as a malignancy and reconstruction was done. Hitoplathologyexamination with H&D stain confirmed the clinical diagnosis.

INTRODUCTION

Chalazion is a chronic granulomatous inflammation occurring commonly and presenting in lids as nodular swelling. It is a smooth hard swelling with normal overlying skin and intact cilia In elderly population. Meibomian gland carcinoma (MGC) or eyelid sebaceous gland carcinoma (SGC) is mistaken as chalazion. MGC is a hard tumor with irregular surface. Overlying lid skin and margin shows vascularization and cilia in that are absent. On incision there is gritty hard feeling and there hardly any granulation and cheesy material which is quite common in chalazion. MCG is a highly malignant tumor with high tendency of spread along the periocular lymphatics. So any misdiagnosis and delay in treatment can be dangerous.]. It is commoner in females.

In over 50% of cases SGC presents as pseudochalazion or chronic Blepharo - conjunctivitis.[4] Meibomian gland carcinoma differs from other eyelid tumors in having a multi-focal origin as sebaceous glands are present along with the length of tarsal plate as well as caruncle. Unlike the radial spread of BCC and SCC, SGC spreads in superficial plane referred to as Pagetoid pattern.[5]

CASE REPORT

A 56-year-old male patient presented with chief complain of painless progressive swelling on the left upper eyelid for 6 months [Fig 1].Systemic examination revealed no significant finding. The uncorrected visual acuity was 6/12 in the affected after lifting up the lid. Pain and tenderness were absent. Prominent cutaneous blood vessels were seen on the regular smooth surface of the mass. Trans-illumination test was positive suggestive of cystic lesion [(Fig 2] Lid margin showed presence of cilia. Complete mechanical ptosis was present due to the large mass. Our diagnosis was a giant chalazion. Standard chalazion surgery was performed from the conjunctival side and gush of fluid (around 5 cc) came out. It was followed by cheesy material which was scooped out from it confirming our diagnosis of a giant chalazion. The swelling totally collapsed and there was no palpable mass

Fig.1 : Lesion on Distant Examination

Fig.2 : Positive Trams-illumination

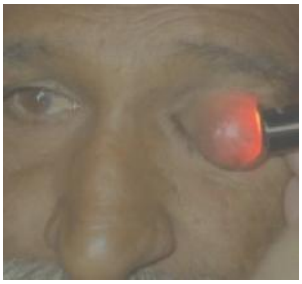


Fig.3 : Recurrent Lesion at the same site

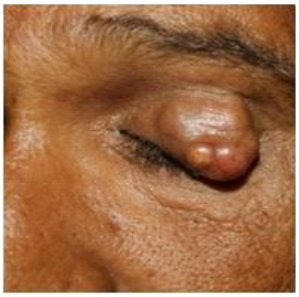
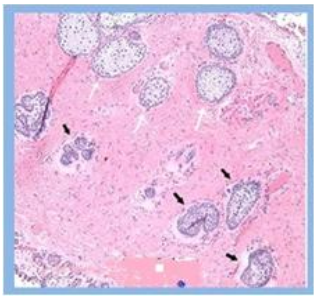


Fig.4 : Histo pathological picture of the lesion



Correspondence Address : **Dr. Nitin V. Trivedi**
49- A, Lad Society, Sandesh Press Road, Opp. Page One Restaurant, Vastrapur, Ahmedabad-380054. • E-mail : trivedinitinv54@gmail.com

left behind. Post-operative treatment consisted of local antibiotics and steroids and systemic anti-inflammatories and antibiotics.

The patient presented to us after 3 months again with a mass on the same location as the previous one. It had an irregular surface and a hard consistency suggesting it to be malignant ([Fig 3,4]. Trans-illumination test was negative. Cilia were absent and surface vessels were present. Pre-auricular lymph nodes were not enlarged and the systemic examination was normal. Keeping in mind the current presentation, excision of the mass with 4mm of clear margins was performed and lid reconstruction was done by Cutler Beard procedure. Mass was sent for histo-pathological examination. It showed the cells in irregular lobular masses with distinctive invasiveness (fig 5). The cytoplasm was pale, foamy and vacuolated .Nuclei were hyperchromic[3-4].

DISCUSSION

Chalazion is a common condition affecting a wide range of population as typical slow growing painless tumor of eyelids. Surface is smooth and regular with presence of normal cilia. Variable amount of ptosis is present depending upon its size. As against the occurance of chalazia in younger age MGC has peak occurrence is in elderly patients (50 to 70 years of age) although, youngest patient recorded was 3.5 years old.[2] Meibomian gland carcinoma is commoner in Asian population than BCC according different studies to different studies.[1-3]

But some meibomian gland carcinomas are notorious enough to masquerade as a benign condition and delays the prompt excision resulting in metastasis.[5] Any unusual or recurrent case of proposed chalazion should be sent for histopathological examination even if the clinical picture suggests a benign etiology. In our case, the initial presentation showed presence of cilia and a regular surface which suggested a benign etiology. Meibomian gland carcinoma has a tendency to metastasize to peri-ocular lymph nodes. As the first and second case scenarios were different, we might assume that it was a giant chalazion in the first place but chances are always there suggestion the former to be a rare presentation of meibomian gland carcinoma.

CONCLUSION

This case study is to present a unique clinical picture of meibomian gland carcinoma which to our knowledge has presenting as a giant cyst has not been mentioned in literature. Cyst formation along with the malignant etiology is thought to be due to obstruction of the serous glands. Initially the tumor mass itself was very small making it rather impossible for us to diagnose it as a malignancy. Though cilia were not affected and had a regular surface, it turned out to be malignant. So we can say tumor extends beyond what is clinically evident Normally this presentation is not suggestive of malignancy and the further histopathology study is not routinely advocated but it is wise to send each and every uncanny appearing “chalazia” for histo-pathological examination to avoid undesirable outcomes like recurrence or malignancy and eventual metastasis.

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