Benign and Malignant Skin Lesions

The Good, the Bad, and the Ugly

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Content

• Common benign lesions and features
• Features of malignant lesions
• Management of lesions
• Case examples
Objectives

- Be able to recognise common benign lesions
- Recognise malignant features in a lesion
- Recognise the differences between types of malignant lesions
- Understand the ways in which peri-ocular skin lesions are managed
Normal Eyelid Anatomy

Anterior Lamella

Posterior Lamella
History Taking

• History of rapid growth
• Bleeding - especially when area rubbed
• Personal history of skin malignancy
• Personal history of systemic malignancy
Common Benign Lesions

• Naevus
• Papilloma
• Seborrhiec keratosis
• Xanthelasma
• Hidrocytoma
Actinic Keratosis

- Pre-cancerous change confined to the epidermis
- Histologically has malignant features
- Flat scaly plaques
- Often widespread across the field
- Treatment - observation, cryo, topical
Clinical Signs of Malignancy

- Tissue destruction
- Loss of normal lid margin
- Loss of lashes
- Ulceration
- Irregular borders
- Scirrhous retraction
Malignant Eyelid Lesions

- Basal Cell Carcinoma (BCC)
- Squamous Cell Carcinoma (SCC)
- Melanoma
- Sebaceous Cell Carcinoma
- Others
BCC Features

- Slow growing, nodular lesion with telangiectasia
- Most commonly lower lid > MC > LC > UL
- Rolled edges, often developing central ulceration
- Can be cystic or pigmented
- Close evaluation will show destruction
SCC Features

- Thickened erythematous plaques - skin breaks down easily to abrasion
- Obvious destruction/ madarosis
- Hyperkeratosis or cutaneous horn
- May develop from pre-existing AK
- Beware of signs of peri-neural invasion
Melanoma Features

• Relatively rare (<1% of eyelid tumours)

• Often darkly pigmented nodule with irregular borders, but can be a melanotic

• Pigmentation can vary across the lesion

• May show signs of inflammation or ulceration

• ABCDE
Assessment of Systemic Disease

- Some tumours have a tendency to spread
- Merkel cell > Melanoma > sebaceous > squamous
- MR for local spread - e.g. perineural
- Examination of draining nodes (MRI, SN biopsy)
- Solid organ imaging e.g. Liver USS
Margin Control

• Before undertaking a complex reconstruction we need to know cancer excision is complete
  • Direct visualisation
  • Frozen section
  • Mohs excision
  • Rapid paraffin
Reconstruction

• Often planned in advance, but must be flexible…

• Once clearance confirmed (or believed definite)

• Both eyelid layers need to be restored

• AND, one of the reconstructed layers has its own blood supply
eyelid surgery

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Featuring ...

- Floppy eyelid syndrome
- Upper Blepharoplasty
- Lower lid rejuvenation
- Scar-less ectropion surgery
Floppy Eyelid Syndrome (FES)

- First described in 1981
- 11 male patients
- 34-56 years
- All obese
Why is FES important to diagnose?

- Sight threatening associations
- Life threatening associations
- Many have remained undiagnosed for months or years
FES - Symptoms

- Conjunctival injection
- Chronic discharge
- Watering
- Pain ex trichiasis
- ‘Blood on the pillow’
FES – Signs

- Canthal tendon laxity
- Elastic/lax tarsal plate
- Easy eyelid eversion
- Papillary conjunctivitis
- Mucoid discharge
- Lash ptosis
FES - Pathology

- Alteration in tarsal elastic fibres
- Accumulation of collagen
- Tarsal plate inflammation
Floppy Eyelid Syndrome

- Increasing prevalence ..
- .. or recognition
- Rare .. however ....
Clinic Wednesday 5/3/2014

- 8am – man with watery eyes
- 10.20am – man with intermittent red irritable left eye
- 3.50pm – man with irritation of the right eye and lashes obstruction vision

- All had F.E.S.
Sight threatening

- Keratoconus
- Lash ptosis – corneal abrasion
- Chronic anterior segment inflammation
- Central serous retinopathy
- Retinal vein occlusion
Life threatening

- Obesity

- Obstructive sleep apnoea
  - Pauses in breathing
  - Collapse of soft tissues of the throat
  - Physical obstruction - snoring
  - Hypoxia
Obstructive Sleep Apnoea

- Glaucoma
- Non-arteritic AION
- Papilloedema – from raised ICP
- Retinal vein occlusion
- Central serous retinopathy
FES - Treatment

- Lid taping or night shields
- Tear replacements
- Steroid and/or antibiotic medications
- Surgical techniques
- Reversal of OSA
Surgical Treatment

- Lower lid - lateral canthal sling
- Upper lid – medial full-thickness resection
- Ptosis repair
- Lash ptosis correction
8am patient

- 8 Years old male
- Mildly obese
- Bilateral watery eyes
- Mucoid discharge
10.20am patient

- .. Year old male
- Moderately obese
- Recurrent left upper lid inflammation
- Blood and mucous on pillow
3.50pm patient

- 30 year old patient
- Mildly obese
- Irritation from lash inversion
Peri-orbital Rejuvenation

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Auckland, NZ
Patient Satisfaction with Blepharoplasty Surgery

Dr Paul Rosser
Dr Catherine McMurray
Study Outline

- 50 Blepharoplasty patients
- Single surgeon’s private cases 2006
  - All primary procedures
- Telephone survey
  - Standard question format
Postoperative Satisfaction

Percentage distribution of satisfaction levels among women and men.

- **1-"best thing"**
  - Women: 40%
  - Men: 30%

- **2**
  - Women: 30%
  - Men: 50%

- **3**
  - Women: 20%
  - Men: 10%

- **4**
  - Women: 10%
  - Men: 0%

- **5-"worst thing"**
  - Women: 0%
  - Men: 0%
Beware

• Mothers of the Bride
• Unhappy people
• Long Pre-op consultations
• Multiple previous procedures
• ‘Bad Last Surgeon’
Mother of the Bride

• Be clear about aims of treatment
  – A face is not a wedding dress

• Avoid treatment immediately pre wedding
  – 1/12 for fillers or botox
  – 3/12 for blepharoplasty surgery

• Stress Bruising may last >2/52
Long Pre-op Consultations

Beware

• Consultations 50% longer than normal
• Excessive number of questions
• Patients seeking guarantees of results
• Electronic mediaphiles
  – Emailers, Googlers
Multiple Previous Procedures

- Document carefully
- Ask if happy with results
- Correspond re aims of treatment
- Separate consultation from treatment
Bad Previous Surgeon

- Document concerns
- Be careful when discussing likely outcomes
- Be aware you may be the next ‘bad surgeon’

- Never criticise previous surgeon
Unhappy People

- Most unhappy people are unhappy people
- Surgery will not change this
- Aim = unhappy person with improved cosmesis
Blepharoplasty Surgery

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Upper Blepharoplasty

- Functional
- Cosmetic
- Functional and Cosmetic
Aims of Surgery

• Functional Issues

  – Reduced field of vision
  – Feeling of ‘heaviness’
  – Headache, tiredness (frontalis action)
  – Irritation – skin on lashes, cornea
Aims of Surgery

• Cosmetic

  – Natural appearance
  – Reduction of excess tissue
  – Application of make-up
  – Look less like one’s parent
Insurance Criteria

• **Visual Field Effect**
  – Loss of \( \frac{1}{2} \) superior V/F

• **Skin overhanging lid margin**
  – Photographic evidence front and side views
Cosmetic Eyelid Surgery

- Consider
- Eyebrow position
- Upper eyelid issues
Eyebrow

• Brow ptosis contributes to excess skin in the upper lid

• Causes hooded appearance, heaviness and reduced field of vision
Upper Lid Blepharoplasty

- Beware
- Blepharitis
- Dry Eye
- Lacrimal Gland Prolapse
Upper Eyelid

- Consider
- Ptosis
- Skin
- Skin Crease Position
- Fat
Asian Blepharoplasty

- Consider ethnic differences
  - Low skin crease
  - Epicanthic Fold – contour
  - Excess skin – often minimal
  - Fat – variable
Asian Blepharoplasty

- Creation of “Double Eyelid”
- “Pretty Eye”
- Westernisation Procedure
- Skin Crease Reformation
Gender Issues

• Males
  – Flat eyebrows
  – Lower skin creases

• Females
  – Arched eyebrows
  – Variable skin creases – generally higher
Peri-Orbital Rejuvenation

- Tear Trough
- Malar Region
- Brow
- Glabella
- Upper Lid Sulcus
- Upper Lid Position
- Orbit
Malar Region

- Rx – Cheek Descent

- Injection placed just above periosteum

- Avoid Infraorbital Nerve
Brow

- Rx - Brow Deflation

- Filler placed into brow fat pad region

- Avoid Supraorbital Nerve
Glabella

- Rx – Furrows, scars
- Injection deep to dermis if possible
- Under fill .. and ?use >1 session
- Care to avoid tissue necrosis
Upper Lid Sulcus

- Rx – Loss of Pre-Aponeurotic Fat Pad
- Used in post-enucleation and normal patients
- Injection placed deep to orbicularis muscle
- Adjacent to existing fat pad
- Avoid eye !!
Upper Lid Anatomy
Upper Lid Position

- Rx – Lid Retraction

- Injection posteriorly above tarsal plate

- Titrate to required amount of lowering
Orbit

- Rx – Post Enucleation Socket Syndrome
- Injection into the orbit
- Alternative to surgical volume enhancement
- May destabilise Artificial Eye
- ?Inject orbits of seeing eyes
Lower Lid Rejuvenation

more and more about

Management of the ‘Tear Trough’
Why the Concept Change?

- The ageing face loses tissue bulk
- Tissue removal skeletonises the face
- Hastens the ageing process
Current Concepts

- Remove
- Reposition
- Replace
Replace

*With:*

- Autologous Fat
- Malar Implants
- SOOF Lift
- HA Fillers – Restylane, Perlane
Technique

- Anaesthesia – Emla Cream, Ice
- Pillars of Perlane positioned at upper cheek/lower lid junction
- Deep (sub-orbicularis muscle) injections of threads of Restylane deposited to layer and build up the area
- Tear trough injections placed with a feathering technique
- Needles vs. Cannulae
Anatomy

• If you are going to inject ..
  .. know the anatomy

• Arteries, veins, nerves

• Other structures
Lower Lid Anatomy
Orbital Relations
Why Cannulae?

• Safety
  – Blunt tip
  – Side port

• Reduced bruising

• Stays in correct plane
Ideal Patient

• Young
• Minimal skin atrophy
• Mild-moderate volume loss
• Mild-moderate fat prolapse

• Realistic expectations
Less Ideal Patients*


**Those patients with:**

- Significant skin redundancy
- Very thin skin
- Pre-existing color changes
- Prominent fat pads
- Pre-existing oedema in orbital region
- Patients who have had previous eyelid surgery
Suggestions

• Overload patient with information

• Separate consultation from treatment

• Detail risks on consent form

• Photograph all patients
Lower Lid Rejuvenation

- Role of Surgery
- Role of Non-Surgical Options

- Remove / Reposition / Replace
- ? Refer
Scar-less Ectropion surgery

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Mild – moderate Ectropion

• Combination of:
  
  – Lid Tightening
  
  – Punctal Inversion Surgery
Punctal inversion

- Conjunctival Scarring Procedures
- Medial Spindle
- Inferior Retractor Plication
Eyelid tightening procedures

- Full thickness resection
- Lateral tarsal strip (Anderson)
- External approach canthopexy
- LCT plication via upper blepharoplasty incision (Goldberg)
- Internal Lateral Canthopexy (ILC)
Demographics

- 40 eyelids on 26 patients
- 60% Female : 40% Male
Technique

• Lower Lid Retractor Plication
• Internal Lateral Canthopexy

• All operated under LA
Results

- All attained satisfactory tightening
- Resolution of ectropion
- No significant complications
Post-operative comfort

• Significantly less post-op discomfort

• Compared last 10 cases with 10 Lateral Canthal Sling cases by pressing over the lateral canthus -
  – All LCS patients had definite discomfort at 1/52 and 70% at 1/12
  – No Internal Canthopexy patient had more than mild discomfort
Internal Lateral Canthopexy
– Cosmetic Benefits

– Avoids a skin wound
– Reduces damage to the orbicularis muscle
Internal Lateral Canthopexy
– Functional Benefits

– Tightens upper and lower lids simultaneously
– May improve orbicularis muscle pump function
– (Improved comfort)
Internal lateral canthopexy

- Uses –
  - Lid tightening for suspected Pump Failure
  - Mild cases of Floppy Eyelid Syndrome
  - Lidtightening post Lower Lid Blepharoplasty
  - Mild-Moderate Lower Lid Ectropion