Ocular Dermatology: Papilloma or Problem?

Presented for the Idaho Optometric Physicians

Course Description

- This lecture reviews the basic concepts in Dermatology with emphasis in ocular tissue.
- Differential diagnosis as well as the medical / surgical treatment of common lesions will be discussed in detail.

Learning Objective

- To enhance the primary eye care providers’ ability to differential diagnose and initiate treatment for benign eyelid lesions, eyelid inflammations and eyelid neoplasms.

Course Instructor

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Credentials

- Dr. Talley is a board certified (ABO) Optometric Physician at a large optometric group practice in Memphis, Tennessee.
- He trained Optometric Externs and Residents for 20 years and has given over 1000 presentations in the areas of primary eye care, ocular disease and practice management.

Advocacy

- Dr. Talley has served in every elected position of the Tennessee Board of Optometry (TNBO) and the Tennessee Association of Optometric Physicians (TAOP).
- He has also served in many capacities for the American Optometric Association (AOA) to include the Third Party Center Executive Committee.

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Ocular Dermatology: Papilloma or Problem?

Commercial Disclosure

- The content of this course was prepared independently by Dr. Talley without input from members of the ophthalmic industry.
- Dr. Talley has no direct financial or proprietary interest in any companies, products or services mentioned in this presentation.

Skin: Structure and Function

Skin: Examination

Benign Eyelid Lesions

- Papilloma
- Seborrheic Keratosis
- Cutaneous Horn
- Epidermal Inclusion Cyst
- Molluscum Contagiosum
- Xanthelasma
- Syringoma
- Apocrine Hydrocystoma
- Trichoepithelioma
- Nevi (Nevocellular Nevi)
- Keratoacanthoma
- Hemangioma

Papilloma

Examination
- Lesions are soft; skin colored, tan, or brown; round or oval, pedunculated
- Size ranges from < 1 mm to 10 mm.

Epidemiology / Etiology
- Age: Increase in age
- Gender: F > M
- Etiology: Unknown

History
- Usually asymptomatic; may become crusted or hemorrhagic

Differential Diagnosis
- Pedunculated Seborrheic Keratosis
- Dermal Nevus
- Solitary Neurofibroma
- Molluscum Contagiosum
### Papilloma

**Special Considerations**
- May grow or become more numerous during pregnancy
- More common in obese patients

**Treatment**
- Excision by simply snipping the lesion at the base

**Prognosis**
- Excellent, patients may develop other papillomas with time

### Minor Surgical Procedures

**REMEMBER**

**THE 5 'Ps**
1. PREOP
2. PREP
3. PROCEDURE
4. POSTOP
5. PAPERWORK

### Papilloma Excision: Preop

- A – asymmetry
- B – borders/bleeding
- C – color/care
- D – duration/diameter
- E – evaluate

### Papilloma Excision: Prep

- Set-up tray
- Informed consent
- Wash hands & glove
- Clean surgical site
- Administer anesthetic

### Video Clip

**Anesthetic Alternatives**

**All Primary Eye Care Procedures can be performed utilizing topical anesthetic.**
### Topical Anesthesia

**Proparacaine**
- Good for removal of corneal foreign bodies and sutures
- Corneal and conjunctival scrapings
- Other surgical procedures requiring surface anesthesia

**Xylocaine Solution**
- Excellent for anesthesia of the conjunctiva and surgery of the punctum
- Surgical procedures requiring deeper anesthesia

**Cetacaine Spray**
- Superior for anesthesia of the conjunctiva and surgery involving the nasolacrimal duct
- Surgical procedures requiring deeper anesthesia

**Lidocaine Cream**
- 4% - 40mg lidocaine per g (OTC)
- Uses encapsulated liposomes
- $48.00 per 30g tube
- Use with or without occlusive dressing

**Cetacaine FACTOID**
- Cetacaine Topical Anesthetics are also available in both liquid and gel forms
- Rapid onset within seconds and effective for up to 60 minutes

**ELA – Max**
- Max topically applied 30 minutes before IV sedation is as effective as injected buffered lidocaine in reducing pain

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Topical Anesthesia

• Method of delivering medication to a localized tissue area by applying electrical current to a solution

Iontophoresis

Topical Anesthesia

- Phoresor II
- Fully Programmable
- Dose range: 0-80mA-minute
- Current range: 0-4.0 mA
- Includes twin lead wires, two 9-volt batteries, carrying case and instruction guide

IOMED

Topical Anesthesia

- Numby Stuff
- Electrodes teamed with lidocaine 2% HCL and 1:100,000 epinephrine soln
- Clinically effective dermal anesthesia up to 10 mm depth

IOMED

Papilloma Excision: Proc

- Anesthetic test
- Reassure patient
- Excise lesion flush
- Control bleeding

Papilloma Excision: Proc

- Close wound using direct pressure if lesion < 2 mm
- Close wound using high temp cautery unit if > 2 mm

Papilloma Excision: Postop

- Apply antibiotic / steroid combination ointment in office and write Rx BID to surgical site
- Schedule 1 wk PO
Papilloma Excision: Paper

- Complete medical record documentation
- Complete pathology report and arrange for pick-up

Papilloma Profile

- Conjunctival papillomas are flesh colored and friable
- Conjunctival papillomas can be associated with a viral origin

Seborrheic Keratosis

**Examination**
- Starts as flat, light tan lesion; as they age becomes "warty"
- Lesions vary in size from 1 mm to 6 cm

**Epidemiology / Etiology**
- Age: Rare < 30 years
- Gender: M > F
- Etiology: Unknown
  - History
  - Usually asymptomatic; most common on the face and upper body

**Differential Diagnosis**
- Pedunculated Seborrheic Keratosis
- Dermal Nevus
- Solitary Neurofibroma
- Molluscum Contagiosum

**Seborrheic Keratosis**

- Treatment
  - Light electrocautery / cryotherapy permits the lesion to be curried off

- Prognosis
  - Excellent with rare recurrence, often develop other lesions with time

Seborrheic Keratosis

**Special Considerations**
- Most common on the lower lids
- Pathophysiology demonstrates epidermal lesion with proliferation of keratinocytes and melanocytes

**Papilloma Problems**

- What kind of lesion is this?
  - Benign
  - Hyperkeratotic
  - Squamous
Papilloma Problems

When using a cautery unit ... what temperature should you use?
LOW  MED  HIGH

Cautery Concepts

• The use of high temperature (HT) cauterization is quite effective in closing small wound of the skin as well as providing hemostasis

Papilloma Problems

Would the previous papilloma require an infiltrative anesthetic?
YES or NO

Papilloma Problems

Hyperkeratotic Squamous Papillomas are very tough ... so use an injectable, ionic-phoresis or liposome anesthetic

Papilloma Problems

Should you use a scalpel or scissors?
Should you use toothed or untoothed forceps?

Blades, Holders and Scalpels

• Blades - disposable
• Holders - disposable & nondisposable
• Scalpels - disposable and nondisposable
**Fun with Forceps**
- Tissue – single tooth
- Jewelers – no teeth & with long tip
- Cilia – no teeth & short tip

**Papilloma Problems**
- Was this lesion excised flush?
- How could you easily correct this?

**Cutaneous Horn**
**Examination**
- Raised lesion, often like stalk, usually white in color
- The surface is hyperkeratotic

**Cutaneous Horn**
**Epidemiology / Etiology**
- Age: Older adults
- Gender: M = F
- Etiology: Hyperkeratosis associated with underlying lesions
**History**
- Lesion can grow slowly or rapidly

**Cutaneous Horn**
**Differential Diagnosis**
- The base of this lesion may be a seborrheic keratosis, verruca vulgaris, basal cell carcinoma or squamous cell carcinoma

**Cutaneous Curiosity**
- Can tiny skin tags be snipped off without using any anesthetic prep?
- TRUE or FALSE
**Cutaneous Curiosity**

TRUE
Using Vanese scissors you can easily excise small skin tags without using any anesthetic.

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**Epidermal Inclusion Cyst**

**Examination**
- Smooth, round, elevated cyst
- Usually lesions grow slowly

**Epidemiology / Etiology**
- **Age:** Any
- **Gender:** M = F
- **Etiology:** Arises from the infundibulum of the hair follicle

**History**
- May have history of trauma

**Differential Diagnosis**
- Molluscum Contagiosum
- Chalazion
- Syringoma

**Special Considerations**
- These cyst may become secondarily infected and cause a cellulitis

**Treatment**
- Excision; remove entire cyst wall or destroy base with cautery unit

**Prognosis**
- Excellent with rare recurrence,

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**Cyst Evacuation – Sx Summary**

- Make “wrinkle” incision at edge of lesion away from eye with Beaver blade or Vanese scissors
- Clean out with curette

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**Tools of the Trade**

- What’s a Beaver Blade?
- What’s a Curette?
- ...A Microsurgical Blade
- ...An Microsurgical Scooper
Epidermal Inclusion Cyst

- A smaller cyst of the left lower lid
- May be confused with stye
- No pain to touch

7/3/16

Molluscum Contagiosum

- Pearly white or skin colored with a central keratin plug providing umbilication
- Single or multiple, 1 mm to 2 mm papules

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Molluscum Contagiosum

- Examination
- Look for a central keratin plug
- Etiology: Viral lesions spread by contact

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Molluscum Contagiosum

- Epidemiology / Etiology
- Age: Children / young
- Gender: M > F
- Etiology: Viral lesions spread by contact

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Xanthelasma

- Soft, yellow orange plaques located medially on the upper and / or lower eyelids

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Special Considerations

- If located at eyelid margin, may cause follicular conjunctivitis
- May cause disfiguring lesions in immunocompromised patients
- Good skin to skin contact

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Epidermal Inclusion Cyst

- Score the top of the cyst using a 25 gauge needle or Vanese scissors
- Place two applicators at opposite sides of the base of the lesion and squeeze

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Molluscum Contagiosum

- Examination
- Treat core with electrodesiccation or direct excision of lesion

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Molluscum Contagiosum

- Differential Diagnosis
- Age: Children / young
- Etiology: Viral lesions spread by contact

7/3/16

Cyst Evacuation – Sx Summary

- Treated cyst of the lid
- No pain to touch

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Xanthelasma

- Soft, yellow orange plaques located medially on the upper and / or lower eyelids

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Molluscum Contagiosum

- Examination
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Molluscum Contagiosum

- Epidemiology / Etiology
- Age: Children / young
- Gender: M > F
- Etiology: Viral lesions spread by contact

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7/3/16

Xanthelasma

- Soft, yellow orange plaques located medially on the upper and / or lower eyelids

7/3/16
Xanthelasma

Epidemiology / Etiology
• Age: Over 50 years
• Gender: Either
• Etiology: Unknown

History
• Lesions are noted for months to years with slow enlargement

Differential Diagnosis
• Epidermal Inclusion Cyst
• Syringoma

Syringoma

Epidemiology / Etiology
• Age: Puberty
• Gender: Women
• Etiology: Adenoma of the intraepidermal eccrine duct

History
• Insidious onset

Differential Diagnosis
• Epidermal Inclusion Cyst
• Trichoepithelioma
• Basal Cell Carcinoma

Xanthelasma Excision Summary

• Make “wrinkle” incision at center of lesion with Beaver blade or Vanesse scissors... then excise
• Align wound edges to assure good apposition
• Close w/ vertical cautery

Syringoma

Examination
• Skin colored / yellowish, multiple, 1 mm to 2 mm
• Common on lower eyelids

Treatment
• Excision, electrodesiccation, laser or trichloroacetic acid

Prognosis
• Good, but additional deposits may reoccur

Special Considerations
• In younger patients consider a familial lipoprotein disorder (ie. elevated LDL)

Prognosis
• A large number on face are difficult to remove, may reoccur
**Apocrine Hydrocystoma**

**Examination**
- Cystic lesion near/at lid margin which are translucent
- May be multiple lesions

**Epidemiology / Etiology**
- **Age:** Adults
- **Gender:** Equal
- **Etiology:** Cyst formation from gland of Moll

**History**
- May slowly enlarge

**Differential Diagnosis**
- Cystic Basal Cell Carcinoma
- Eccrine Hydrocystoma

**Special Considerations**
- The lesion is an adenoma of the secretory cells of Moll and not a retention cyst

**Treatment**
- Marsupialization of the cyst for superficial lesions
- Complete excision for deeper lesions

**Prognosis**
- Excellent with rare recurrence

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**Trichoepithelioma**

**Examination**
- Small pink or skin colored papules that can increase in size

**Epidemiology / Etiology**
- **Age:** Puberty
- **Gender:** M > F
- **Etiology:** Benign appendage tumor with hair differentiation

**History**
- Lesions of eyelid and forehead

**Differential Diagnosis**
- Epidermal Inclusion Cyst
- Basal Cell Carcinoma
- Syringoma

**Special Considerations**
- May be confused with a Basal Cell Carcinoma, especially if it appears as a solitary tumor

**Treatment**
- Excision with pathological evaluation

**Prognosis**
- Excellent
Nevi (Nevocellular Nevi)

**Examination**
- Junctional Nevi are round or oval, flat or slightly raised, less than 1 cm, tan or brown in color with smooth boarders

**Compound Nevi**
- Round, elevated, dome-shaped lesion with smooth surface
- Dark brown in color but may become mottled as this lesion evolves into a dermal nevus
do not disappear with age and may become more pedunculated

**Dermal Nevi**
- Round, domed-shaped, elevated nodule, skin colored, tan, or brown with telangiectasias

**Epidemiology / Etiology**
- **Age:** Early Childhood
- **Gender:** Equal
- **Etiology:** Groups of melanocytic cells

**History**
- Asymptomatic pigmented lesions that are stable or involuting

**Differential Diagnosis**
- Seborrheic Keratosis
- Malignant Melanoma
- Dermatofibroma
- Basal Cell Carcinoma

**Special Considerations**
- Any enlarging lesions, those changing color, or becoming irritated in any way after age 20 needs to be biopsied

**Treatment**
- Observation or excisional biopsy with histologic evaluation

**Prognosis**
- Rare chance of malignant transformation

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**Keratoacanthoma**

**Examination**
- Single, dome-shaped nodule with a central keratotic plug
- Firm and is slightly red to light brown in color

**Epidemiology / Etiology**
- **Age:** > 50 years
- **Gender:** M > F / 2 : 1
- **Etiology:** Unknown

**History**
- Rapid onset of growth over a few weeks

**Differential Diagnosis**
- Squamous Cell Carcinoma
- Hyperkeratotic Actinic Keratosis
Keratoacanthoma

Special Considerations
- Differentiation from a Squamous Cell Carcinoma may not be possible both clinically and even sometimes pathologically

Treatment
- Excision with pathological evaluation

Prognosis
- Good, may be significant scarring secondary to size of lesion removed

Hemangioma (Cherry Angioma)

Examination
- Raised, bright red, blood-filled lesions that can occur anywhere on the body
- May be multiple

Treatment
- Excision with pathological evaluation

Prognosis
- Good, may be significant scarring secondary to size of lesion removed

Epidemiology / Etiology
- Age: Adulthood
- Gender: Equal
- Etiology: Unknown

History
- Usually appears spontaneously and may increase in size quickly

Differential Diagnosis
- Pyogenic Granuloma
- Melanoma

Hemangioma (Cherry Angioma)

Special Considerations
- Rarely, these bleed actively, but be prepared for appropriate hemostasis

Treatment
- Excision, usually for cosmetic reasons

Prognosis
- Excellent

Pyogenic Granuloma

• Can look similar to a Hemangioma, but is usually solid and not blood filled

Granuloma Grand Rounds

• 58 YO AA F presents w/ a bump of 3 month duration. No pain, but getting bigger. GEE done by OD partner 1 week prior, completely unremarkable except for refractive error.
Pyogenic Profile in Pictures

Lesion Characteristics:
A → + Asymmetry (lobules)
B → + Borders (smooth) / - Bleeding
C → + Color (flesh) / - Care (previous)
D → + Diameter (10 mm) / + Duration (3 months)
E → + Evaluate (wide base @ conjunctiva)

Pyogenic Progress in Pictures

• Don’t forget to administer proparacaine & Celluvisc

Topical Cetacaine in Action

Pyogenic Progress in Pictures

• Don’t forget to send tissue out to path lab
• Dx: Verucca / Squamous Papilloma w/ an abundant scale crust

Eyelid Inflammation

• Chalazion, Anterior and Retro Tarsal
• Hordeolum, External and Internal
• Floppy Eyelid Syndrome

Chalazion, Anterior / Retro Tarsal

Examination
• A firm mass which is not painful to touch
• May protrude anterior to tarsal plate, posterior to tarsal plate or both

Chalazion

Epidemiology / Etiology
• Age: Any
• Gender: Equal
• Etiology: Obstruction of meibomian glands

History
• May present as an infection

Differential Diagnosis
• Sebaceous Adenocarcinoma
• Squamous Cell Carcinoma
• Basal Cell Carcinoma
Chalazion

Special Considerations
- Chronic, nonresolving or recurring chalazia need to be biopsied to rule out carcinoma

Prognosis
- Good

Treatment
- Warm compresses with massage, Intralesional Steroid Injections or Surgical Incision and Curettage

Chalazion, Anterior Tarsal

- Always use the most direct approach to treat a chalazion
- This patient should have a transcutaneous intralesional injection or surgical incision with curettage

Chronic Chalazion

Injectable Steroids

- Kenalog 40 is the drug of choice for treating chalazia
- Remember the “rule of Six”

Periocular Injections

Infiltrative Intralesional Technique
- Apply topical anesthetic
- Insert chalazion clamp
- Use 27 gauge, ½ inch needle
- Insert needle directly into center of lesion

Acute Vs. Chronic Chalazia

Acute Chalazion

Periocular Injections

Infiltrative Intralesional Technique
- Inject contents of syringe & remove needle
- Remove chalazion clamp
- Apply gentle pressure through closed eyelids
- Discard waste

Periocular Injections

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Ocular Dermatology: Papilloma or Problem?

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Ocular Dermatology: Papilloma or Problem?

Chalazion I & C – Apply Clamp

• Apply Clamp
  • Tighten the circular knob firmly
  • Evert the eyelid and allow the clamp to rest away from the cornea

Chalazion – Incision / Curettage

Chalazion I & C – Clamp Eversion

• Using 4% Xylocaine on the lid margins prior to clamp application significantly reduces patient discomfort
• Don’t forget to tighten the clamp

Chalazion – Incision / Curettage

Chalazion I & C – Anesthetic Test

• Lesion should be centered in the chalazion clamp
• If any pain when lesion is pinched with tissue forceps... administer more anesthetic

Chalazion – Incision / Curettage

Chalazion – Incision / Curettage

• Don’t Forget When administering additional anesthetic using an infiltrative injection technique... position injection at edge of lesion
Chalazion – Incision / Curettage

Incision and Open
- Make a 2-3mm vertical incision through the lesion with a #11 blade
- Remain parallel to the meibomian glands and 2 to 3mm away from lid margin

VIDEO CLIP
- Vertical incision through the palpebral conjunctiva, staying away from the lid margin

Chalazion – Incision / Curettage

Incision and Open
- To promote drainage a small elliptical piece of the flap can be removed using Vanese scissors and tissue forceps

Chalazion – Incision / Curettage

Curettage and Close
- Insert the curette and vigorously remove the granulomatous material
- Cauterize the wound to control bleeding before removing the clamp

Chalazion I & C – Clean Up

Curettage Vigorously
Granulomatous Material

VIDEO CLIPS
- Cystic Wall Excision
- Hemostasis w/ Cautery

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Chalazion I & C – Post Op

Immediate Post Op  24 Hour Post Op

Chalazion – Incision / Curettage

Did You Know?
Some chalazia will require a transcutaneous approach for adequate curettage

Chalazion: Transcut Approach

• Apply mechanical Chalazion Clamp and make wrinkle incision w/ beaver Blade
• Clean out w/ curette & cotton tip applicators
• Control bleeding w/ cautery and close

VIDEO CLIP QUIZ?

Wound Cauterization … Is the technique demonstrated correct?

YES or NO!

Wound Closure: Steri Strips

• Steri Strips can be used for small to medium wound closure of the skin
• Excellent for excision of a chalazion using a transcutaneous approach

Wound Closure: Tissue Glue

Laceration Dermabond

Immediate Postop 10 Day Postop
Wound Closure: Tissue Glue

- Apply using three thin layers using a light brushing stroke while holding wound together
- Flexible bond in 45 – 60 seconds and full strength in 2½ minutes

Suture Equipment & Materials

- Typically use 5.0 Plain Gut – dissolves in 7-10 d
- 6.0 Polypropylene for near lid margin
- May use cautery, steri-strips or tissue glue

Wound Closure: Suturing

VIDEO CLIP QUIZ?

Wound Closure … Is the technique demonstrated correct?

YES or NO!

Hordeolum, External / Internal

Examination
- Red, swollen, tender eyelid, often with focal area of infection around a gland
- This patient has a Internal Hordeolum

Hordeolum, External / Internal

Epidemiology / Etiology
- Age: Any
- Gender: Equal
- Etiology: Bacterial infection of Zeiss or Meibomian glands

History
- Sudden onset

Differential Diagnosis
- Preseptal Cellulitis
- Eyelid Abscess
**Hordeolum, External / Internal**

**Special Considerations**
- If patient is febrile, increase the loading dose of the oral antibiotics
- Monitor for the development of a chalazion

**Treatment**
- Warm compresses with topical antibiotic / steroid ointment for external
- Oral antibiotics for internal

**Prognosis**
- Excellent

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**Hordeolum, External**

- May look like an Epidermal Inclusion Cyst, but this lesion is painful to touch

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**Floppy Eyelid Syndrome**

**Examination**
- Eyelids are flaccid
- Chronic papillary conjunctivitis with a keratitis

**Epidemiology / Etiology**
- Age: Adults
- Gender: M > F
- Etiology: Unknown
- History: Chronic nonspecific irritation; mild lid edema may be present

**Differential Diagnosis**
- Other forms of Conjunctivitis
- Hordeolum, Internal

**Special Considerations**
- Significant incidence of obesity and sleep apnea in these patients

**Treatment**
- Patching or shield over the eye for short term
- Horizontal eyelid tightening is usually required

**Prognosis**
- Laxity will recur with time
Eyelid Neoplasms

- Actinic Keratosis
- Lentigo Maligna
- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Sebaceous Cell Adenocarcinoma
- Malignant Melanoma
- Kaposi’s Sarcoma

Actinic Keratosis

Examination
- Rough, slightly elevated, skin-colored or light brown lesions with hyperkeratotic scale

Epidemiology / Etiology
- Age: Over age 40
- Gender: M > F
- Etiology: Sun exposure

History
- Extensive sun exposure in youth; lesions present for months

Differential Diagnosis
- Squamous Cell Carcinoma
- Discoid Lupus

Special Considerations
- It is estimated that one Squamous Cell Carcinoma will develop per 1000 Actinic Keratoses

Treatment
- Excise nodular lesions / pathological evaluation
- Flat lesions with liquid nitrogen or 5% 5-fluorouracil cream

Prognosis
- Guarded

Lentigo Maligna

Examination
- Flat, dark brown or black color, sharply defined edges.
- Often appear as a dark “stain” on the skin

Epidemiology / Etiology
- Age: Median age 65
- Gender: M = F
- Etiology: Sun exposure

History
- Exact onset of lesion is usually unclear

Differential Diagnosis
- Seborrheic Keratosis
- Actinic Keratosis
- Malignant Melanoma
Lentigo Maligna

Special Considerations
- This is a premalignant lesion and should be excised because of the chance of development into a melanoma

Treatment
- Excision with margins sent out for pathological evaluation

Prognosis
- Excellent

Basal Cell Carcinoma

Examination
- Round or oval, firm lesions with depressed center
- The center may be ulcerated

Epidemiology / Etiology
- Age: Over 40 years
- Gender: M > F
- Etiology: Sun exposure

History
- Slowly enlarging lesions in sun-exposed areas. The lesions may bleed

Differential Diagnosis
- Squamous Cell Carcinoma
- Trichoepithelioma

• May present as pigmented lesions, especially in patients with darker skin
• Note the pearly edges on the inferior part of the lesion

• A cystic lesion can be a Basal Cell Carcinoma
• This lesion is larger than most hydrocystomas and has a slightly violaceous hue

• Basal Cell Nevus Syndrome is an autosomal dominant syndrome where the patient develops many Basal Cell Carcinomas all over the face at a very young age

Basal Cell Carcinoma

Basal Cell Carcinoma

Basal Cell Carcinoma

Basal Cell Carcinoma

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**Basal Cell Carcinoma**

**Special Considerations**
- Aggressive treatment of basal cell carcinoma of the medial canthal area is indicated because of risk of orbital extension

**Treatment**
- Complete excision with pathological evaluation
- Reconstruction of the defect is often completed at the same time

**Prognosis**
- Good, when promptly and completely excised

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**Squamous Cell Carcinoma**

**Examination**
- Differentiated lesions are keratinized, firm and hard
- Undifferentiated lesions are fleshy, granulomatous and soft

**Treatment**
- Complete surgical excision with controlled margins and pathological evaluation

**Prognosis**
- Excellent, unless lesion is neglected

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**Squamous Cell Carcinoma**

**Epidemiology / Etiology**
- Age: Over 55 years
- Gender: M > F
- Etiology: Sun exposure

**History**
- Persistent keratotic lesion or plaque that does not resolve after 1 month

**Differential Diagnosis**
- Actinic Keratosis
- Basal Cell Carcinoma
- Keratoacanthoma

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**Squamous Cell Carcinoma**

**Special Considerations**
- Malignant tumor of epithelial keratinocytes
- Incidence: 12 per 100,000 white males; 7 per 100,00 white females; 1 per 100,00 blacks

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**Sebaceous Adenocarcinoma**

**Examination**
- Nodular lesion simulating chalazion
- Unilateral chronic blepharitis
- Destructive / ulcerative lesion on the eyelid margin

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**Sebaceous Adenocarcinoma**

- When the eyelid is everted there is an infiltrative lesion of the tarsal conjunctiva
Sebaceous Adenocarcinoma

Epidemiology / Etiology
• Age: > 50 years
• Gender: F > M
• Etiology: Arises from meibomian, Zeiss, and sebaceous glands

History
• Chronic blepharitis or nonresolving chalazion

Differential Diagnosis
• Basal Cell Carcinoma
• Squamous Cell Carcinoma
• Chronic Blepharitis
• Chronic Chalazia

Special Considerations
• This lesion is highly malignant and potentially fatal
• The “great masquerader”
• Can have skip areas

Treatment
• Complete excision with wide controlled margins and pathological evaluation using special lipid stains

Prognosis
• Guarded

Malignant Melanoma

Examination
• Pigmented lesion with irregular pigment deposition, irregular margins
• There may be ulceration and bleeding

Epidemiology / Etiology
• Age: > 3rd decade
• Gender: M = F
• Etiology: Sun exposure

History
• Pigmented lesion with recent growth / change

Differential Diagnosis
• Nevus
• Pigmented Basal Cell Carcinoma

Special Considerations
• Patient may have genetic predisposition
• Early surgical excision significantly increases mortality

Treatment
• Complete excision with aggressive, controlled surgical margins.

Prognosis
• Eight year survival rate is 33% ( > 3.60 mm depth) to 93% (< 0.76 mm depth)

Kaposi’s Sarcoma

Examination
• Elevated dermal lesions that are red or purple
Kaposi’s Sarcoma

Epidemiology / Etiology
- Age: Any
- Gender: M > F
- Etiology: Vascular neoplasm / immune compromise

History
- Rapid growth; HIV positive?

Differential Diagnosis
- Pyogenic Granuloma
- Chalazion
- Hemangioma
- Melanocytic Nevus

Special Considerations
- Vascular neoplasia that can involve multiple systems
- Rare lesion of the eyelid

Treatment
- Excision with pathological evaluation
- Cryotherapy / intralesional chemotherapeutic agents may also be useful

Prognosis
- Guarded

Quiz Alert – What is This?
1. Papilloma
2. Seborrheic Keratosis
3. Apocrine Hydrocystoma
4. Hemangioma

Quiz Alert – What is This?
1. Papilloma
2. Molluscum Contagiosum
3. Syringoma
4. Nevus

Quiz Alert – What is This?
1. Sebaceous Cyst
2. Apocrine Hydrocystoma
3. Xanthelasma
4. Keratoacanthoma

Quiz Alert – What is This?
1. Apocrine Hydrocystoma
2. Molluscum Contagiosum
3. Papilloma
4. Seborrheic Keratosis
Quiz Alert – What is This?

1. Papilloma
2. Squamous Cell Carcinoma
3. Nevocellular Nevi
4. Basal Cell Carcinoma

Quiz Alert – What is This?

1. Keratoacanthoma
2. Actinic Keratosis
3. Lentigo Maligna
4. Chalazion

Quiz Alert – What is This?

1. Syringoma
2. Trichoepithelioma
3. Actinic Keratosis
4. Nevocellular Nevi

Quiz Alert – What is This?

1. Basal Cell Carcinoma
2. Inclusion Cyst
3. Aprocrine Hydrocystoma
4. Hemangioma

Quiz Alert – What is This?

1. Xanthalasma
2. Seborrheic Keratosis
3. Nevocellular Nevi
4. Basal Cell Carcinoma

Quiz Alert – What is This?

1. Malignant Melanoma
2. Kaposi’s Sarcoma
3. Hordeolum, External
4. Actinic Keratosis
Quiz Alert – What is This?

1. Actinic Keratosis
2. Keratoacanthoma
3. Squamous Cell Carcinoma
4. Seborrheic Keratosis

Acknowledgement

- Selected information in this presentation was modified with permission from Penne RB. Oculoplastics: Color Atlas & Synopsis of Clinical Ophthalmology. McGraw-Hill, 2003

Disclaimer

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Talk to the Teacher

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Ocular Dermatology:
Papilloma or Problem?

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