
Ocular Adnexal Neoplasm

On encountering an eyelid or orbital mass, apart from common skin lesions, the diagnosis requires systemic evaluation, radiological and eventually histological confirmation. The majority are uncommon conditions for ophthalmologists.¹ The presenting signs in all soft tissue neoplasms and carcinomas are rather similar with lid swelling and proptosis. In this edition Langerhans cell histiocytosis (LCH), granular cell tumor (GCT) and eyelid conjunctival amyloidosis have been reported. In all the diagnosis is based on confirmation of an adnexal mass and by imaging followed by a histopathological report along with systemic investigation.

The timely and meticulous biopsy is the key to their successful management. Apart from lacrimal tumors which require en bloc excision there is a scope to perform minimal access biopsy such as fine needle aspiration (FNA), tru-cut and incisional biopsy. FNA for inaccessible lesions and those which might not need surgical excision seem to be an option. But in circumstances where a surgical excision is to follow in my personal experience a frozen section controlled excision will reduce the unnecessary manipulation of the adnexal tissue and can follow surgical and medical treatment based on the findings at the operating theatre.²

Malignant tumors including metastasis need to be excluded. GCT is a well circumscribed benign mass usually involving extraocular muscles. Full excision is required to prevent recurrences. But it can present as amputation neuroma following orbital trauma and surgery including enucleation. The 3rd type is rare and presents de novo as malignant Schwannoma.^{2,3} LCH or eosinophilic granuloma has typical clinical features. It presents in the first decade of life with signs similar to ruptured dermoid cyst. Radiological feature of bone destruction particularly in supra-temporal orbit can be diagnostic. The lesion has a tendency to heal spontaneously or by immunosuppressant and systemic steroid. A FNA and medical treatment only is justified. But if surgical excision is planned a frozen section followed by excision seems to be superior.^{2,4} Localized amyloidosis can involve eyelid, orbit or both. A non-aggressive meticulous excision following a biopsy or frozen section is superior to radiotherapy and cryotherapy.⁵

Appropriate biopsy with minimal tissue manipulation is the key for perfect management and treatment of ocular adnexal neoplasm.

Keywords: Ocular Adnexal, Neoplasm, Orbit, Biopsy

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References

1. Ni C, Ma X. [Histopathologic classification of 1921 orbital tumors]. *Yan Ke Xue Bao* 1995;11(2):101-4.
2. Shields JA, Shields CL. *Orbital tumors*. Lippincott Williams & Wilkins Philadelphia, 1999.
3. McNab,AA, Daniel EE. Granular cell tumours of the orbit. *Aust N Z J Ophthalmol* 1991;19(1):21-7.
4. Kempster R, Ang GS, Galloway G, Beigi B. Langerhan cell histiocytosis mimicking preseptal cellulitis. *J Pediatr Ophthalmol Strabismus* 2009;46(2):108-11.
5. Leibovitch I, Selva D, Goldberg RA, et al. Periocular and orbital amyloidosis: clinical characteristics, management, and outcome. *Ophthalmology* 2006;113(9):1657-64.