A CASE REPORT ON: MANAGEMENT AND OUTCOME OF MALIGNANT NEOPLASM OF EYE AND ADNEXA

Gayatri Khond¹, Dipali Ghungrud², Indu Alwadkar³, Manoj Patil⁴, Swapna morey⁵

¹G.N.M. 2nd year, Florence Nightingale Training College of Nursing. Datta Meghe Institute of Medical Science (D.U.) Sawangi (M) Wardha
²Nursing Tutor, Florence Nightingale Training College of Nursing Sawangi (Meghe) Wardha
³Principal, Florence Nightingale Training College of Nursing Sawangi (Meghe) Wardha
⁴Research Consultant, Department of Research and Development, Jawaharlal Nehru Medical College, Datta Meghe Institute of Medical Sciences, Wardha
⁵Clinical Instructor, Department of Medical-Surgical Nursing, Smt. Radhikabai Meghe Memorial College of Nursing, Datta Meghe Institute of Medical Sciences, Sawangi, Wardha, Maharashtra.

Email: gayatrikhond09@gmail.com
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Abstract

Introduction: Although ocular adnexal cancers are relatively uncommon, their distinct spreading behavior and the functional significance of the eye and periorcular tissues necessitate special diagnostic and therapy considerations. Case presentation: In this case, a 50-year-old male admitted to a rural hospital in Wardha. He was admitted with complaints of small growth over the upper eyelid since 1 year hence he visited to a private hospital and took homeopathic treatment but did not get relief. Then it increased in size of swelling hence he visited to rural hospital in Wardha and was investigated. CECT Orbit (10.05.2022) – There is an e/o heterogeneously enhancing soft tissue density lesion with areas of necrosis within it seen in the left periorbital region. The lesion measures 3.6*4.4*3.8 cm. The lesion is causing erosive destruction of the lateral wall of the left orbit and the anterior part of the left zygomatic arch. Anteriorly the fat plane is lost with preseptal and premaxillary soft tissues, medially involving the extra and intracanal compartment, lateral rectus muscle the fat plane with eyeball is lost with its compression, laterally involving the full thickness of adjacent subcutaneous tissue. A similar small lesion is seen in the subcutaneous plane adjacent to the left zygomatic arch. There are enhancing LNs seen in bilateral submental, submandibular, left preauricular region largest of size 18*10 mm with necrosis within in left submandibular region. There is an e/o heterogeneously enhancing lesion seen in the left parotid region with a necrotic area within it. Previous treatment has taken Surgery (06.06.2022) – Left Orbital exenteration with left MRND and left free ALT flap. He had started radiotherapy and completed 30 fractions Patient was admitted under radiation oncology.

Conclusion: Careful visual examination should be a part of cancer patients’ long-term follow-up strategy. Timely treatment and management of disease complications can be prevented.

Keywords: Malignant neoplasm of the eye, adnexa, sebaceous carcinoma of left eyelid.

INTRODUCTION

A wide variety of malignant tumors can affect the eye and its ocular adnexa (EOA). A rising incidence of secondary ocular and adnexal primary malignancies has been identified, which has been made possible by the longer cancer-cured patient survival times and improved diagnostic methods. However, the lack of substantial case series prevented the identification of different epidemiological patterns1.

New primary malignant tumors that are discovered after another primary one are referred to as second primary malignant tumors (SPMTs). Various elements are at play, yet there is no clear pattern. The second primary malignancies are linked to environmental variables, genetic predisposition, and different treatment options. SPMTs are difficult in a variety of ways. In the setting of fatigability related to the main tumor and/or its therapy, symptoms may be disregarded for diagnosis. Planning a subsequent therapeutic course, such as radiotherapy, following an earlier one might have several negative effects on therapy, including the induction of new cancer2.

The eye and its adnexa could potentially receive secondaries from almost any cancer. The breast and lung are the two key places where this region is most frequently affected by metastases. The majority of the time, the hunt for a primary is sparked by
metastatic cancers at the EOA that initially manifest. Breast cancer is an exception, where approximately 90% of secondary tumors are found following original cancer treatment3.

PATIENT INFORMATION

Patient-Specific Information:

A 50-year-old male admitted to a rural hospital in Wardha. He was admitted with complaints of small growth over the upper eyelid since 1 year hence he visited a private hospital and took homeopathic treatment but did not get relief.

Then he increased in size of swelling hence he visited a rural hospital in Wardha and was investigated. CECT Orbit (10.05.2022) – There is an e/o heterogeneously enhancing soft tissue density lesion with areas of necrosis within it seen in the left periorbital region. The lesion measures 3.6*4.4*3.8 cm. The lesion is causing erosive destruction of the lateral wall of the left orbit and the anterior part of the left zygomatic arch. Anteriorly the fat plane is lost with preseptal and premaxillary soft tissues, medially involving the extra and intracanal compartment, lateral rectus muscle the fat plane with eyeball is lost with its compression, laterally involving the full thickness of adjacent subcutaneous tissue. A similar small lesion is seen in the subcutaneous plane adjacent to the left zygomatic arch. There are enhancing LNs seen in bilateral submental, submandibular, left preauricular region largest of size 18*10 mm with necrosis within in left submandibular region. There is an e/o heterogeneously enhancing lesion seen in the left parotid region with a necrotic area within it. HRCT Thorax (31.05.2022) – Fibrotic bands seen in bilateral lower lobes.

Surgery is done – Left Orbital exenteration with left MRND and left free ALT flap.

HPR (13.06.2022) – Resected specimen – 8*6*4 cm. Tumour – 3.6*3.4*2.2 cm. All margins are negative for infiltration. Section from tumor mass shows Sebaceous Carcinoma (Moderately differentiated). The tumor is 3 cm away from the superior margin, 2.5 cm away from the inferior margin, 2.2 cm away from the lateral margin, 1 cm away from the medial margin, and 0.3 cm away from the base. Perineural and vascular invasion is positive.

Section from the orbital apex and optic nerve, superior bone margin, inferior bone margin, the tail of parotid is positive of malignancy, Depth of parotid is positive for infiltration, LN- Level IA is negative for infiltration, Level IB:1/3 - one LN is positive for infiltration, Left level IIA: 2/2 nodes identified largest measuring 1.2*1 cm, Level III: 0/0, Level IV: 0/2. Submandibular gland – 1/1.Total LN-04/09 in past no any Co-morbidities found. During local examination Wound healed, No palpable neck nodes were found. The patient was diagnosed with sebaceous carcinoma of the left eyelid, pT4N2bM0, stage IV. And was planned for Adjuvant radiotherapy to the Left face and neck to a dose of 60 Gy in 30 fractions using IMRT technique with concurrent chemotherapy with Cisplatin as advised. He had started radiotherapy and completed 30 fractions Patient was admitted under radiation oncology. The patient tolerated treatment well, RT Reactions, Skin - Grade II, Mucositis - Grade II, and Dysphagia - Grade I.

The patient was on oral medication - Tab. Tramadol 50 mg BD, Tab. Chymoral forte BD, Tab. Zerodol sp BD, Fucibet cream for LA, Mucopain Ointment LA, Syrup. 7 LA 5 min before each meal, Ensure protein powder 2 Scoops BD. A medical oncologist call was done 5th cycle of chemotherapy with Cisplatin given.

Clinical finding:

General Appearance

Body built - Thin

General condition: Unsatisfactory

State of consciousness: The patient was fully aware of time, place, and person.

Pallor: Present
Vital Signs

Blood pressure: 110/70 mm of hg

Temperature: 98°F

Pulse: 70 beats per minute

Respiration: 18 breaths per minute

SpO2: 97%

CVS: S1S2+

P/A: Soft non-tender

DIAGNOSTIC EVALUATION:

The patient was conscious and aware of the place and time at the time of the physical examination. The patient's blood pressure readings were 104/70 mmHg, HR-72 beats/minute, and 97 percent Spo2 at room temperature. Treatment for the current complaints included strictly two-hourly TPR/BP charting and Spo2 monitoring. The patient underwent a regular investigation, with the following findings: 10.6% hemoglobin, 4.26 red blood cells, 8900 white blood cells, 18.6% HCT, 22.9% MCHC, 65 MCV, and 17.5 MCH. 1.51 total platelets.

THERAPEUTIC MANAGEMENT:

The present case took medical treatment with 5h cycle of chemotherapy with Cisplatin.

NURSING MANAGEMENT:

Provided intravenous fluid to maintain electrolyte balance. Monitoring vital signs every 2 hours. Maintain intake and output chart.

DISCUSSION:

In this case, a 50-year-old male was admitted to a rural hospital in Wardha. He was admitted with complaints of small growth over the upper eyelid since 1 year hence he visited a private hospital and took homeopathic treatment but did not get relief2.

Then he increased in size of swelling hence he visited the rural hospital in Wardha and was investigated. CECT Orbit (10.05.2022) – There is an e/o heterogeneously enhancing soft tissue density lesion with areas of necrosis within it seen in the left periorbital region. The lesion measures 3.6*4.4*3.8 cm. The lesion is causing erosive destruction of the lateral wall of the left orbit and the anterior part of the left zygomatic arch. Anteriorly the fat plane is lost with preseptal and premaxillary soft tissues, medially involving the extra and intraconal compartment, lateral rectus muscle the fat plane with eyeball is lost with its compression, laterally involving the full thickness of adjacent subcutaneous tissue. A similar small lesion is seen in the subcutaneous plane adjacent to the left zygomatic arch. There are enhancing LNs seen in bilateral submental, submandibular, left preauricular region largest of size 18*10 mm with necrosis within in left submandibular region. There is an e/o heterogeneously enhancing lesion seen in the left parotid region with a necrotic area within it. Previous treatment has taken Surgery (06.06.2022) – Left Orbital exenteration with left MRND and left free ALT flap. He had started radiotherapy and completed 30 fractions Patient was admitted under radiation oncology3-18.

Simple eye symptoms like dryness, allergies, or a change in refractive error could be hiding hidden cancer. Additionally, these lesions may be the initial indication of metastasis [14, 15]. Second-primary tumors are incorrectly referred to as secondary
malignancies [16]. Metastatic tumors or relapsing tumors with ocular or adnexal origin are both referred to as secondary tumors. The likelihood of a subsequent primary malignancy in the eye or its adnexa after the occurrence of a prior primary malignancy elsewhere in the body is the main topic of our research19-25.

More cancer survivors as a result of advancements in early identification and treatment regimens, which has increased the number of persons getting new cancers. In contrast to the incidence of first EOA malignancies in the general population, we discovered that the overall risk of obtaining a second primary EOA malignancy increased dramatically after a cancer diagnosis. This is in line with other research that has shown how common second malignancies are in cancer survivors. Planning the follow-up and screening measures after the initial cancer diagnosis requires an understanding of the pattern of second malignancies26-30.

CONCLUSION:

In summary, we suggest that second ocular primary malignancies and those of its adnexa are driven by a distinct underlying mechanism than the first primaries. Additionally, any innocent presentation should prompt screening for metastases or SPMT if there is a primary tumor. Therefore, it is advised that patients who have had cancer treated undergo a complete ophthalmic examination, paying close attention to the eyelid, conjunctiva, and eyeball in particular.

If a patient of white race developed their first primary tumor after becoming 20 years old, this is of utmost concern. Additionally, any prior history of NHL, EOA cancer, melanoma, or oropharyngeal cancer should be thoroughly examined for any possibility of SPMT in the EOA region.

ETHICAL APPROVAL

Not applicable

PATIENT INFORM CONSENT

While preparing a case report for publication patient's informed consent has been taken.

CONFLICT OF INTEREST

The Author declares that there are no conflicts of interest.

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Not applicable

REFERENCES
