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Sir,

Keratoacanthoma of the lower eyelid

Keratoacanthoma is a benign epithelial neoplasm first described by Sir Jonathan Hutchinson[1] in 1889 as a crateriform ulcer of the face. Although there are many variants of the disease, it usually presents as a solitary rapidly growing lesion and is associated with sun-exposed skin. Its aetiology is diverse, ranging from ultraviolet exposure, viral infection by human papilloma virus, immunosuppression, and genetic susceptibility.[2]

Case report

An 84-year-old lady presented to the clinic complaining of a small painless pea-sized nodule of the left lower eyelid near the medial canthus, which began a week earlier. Her history revealed that she spends most of her time outdoors, gardening, and walking. Examination revealed a firm, nontender, ulcerated nodule of 1 cm in diameter. She also had a skin lesion on her forehead suggestive of basal cell carcinoma. A provisional diagnosis of basal cell carcinoma was made. She was scheduled for biopsy a month later but returned to the clinic in under 2 weeks during which the tumour on the left lower eyelid had dramatically increased in size and was now a fungating bleeding mass. An excision biopsy was performed the following day. The lesion was noted to be friable and was surprisingly easily peeled away from its crater-like base in its entirety (Figure 1). Biopsy of the forehead lesion confirmed basal cell carcinoma. Histology of the lower lid lesion revealed a keratoacanthoma-like squamous cell carcinoma. The lesion was completely excised and the patient has made an excellent recovery with no evidence of recurrence to date (Figure 2).

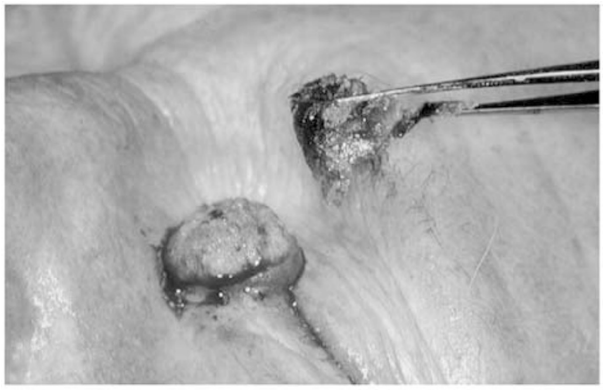

Figure 1 Left lower lid lesion. 'Eschar' from top of lesion came away easily. Note crater-like base.

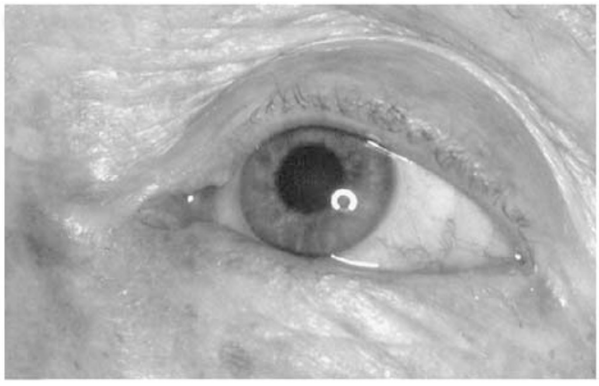

Figure 2 Fully excised lesion. Note skin surrounding the lesion looks healthy. A 0.5 mm margin was excised and confirmed healthy skin on histological examination.

Comment

Typical histology of a keratoacanthoma is an overall symmetrical lesion with a central keratotic crater surrounded by layers of well-differentiated epithelial cells that may have cytological atypia forming a distinct lip around the lesion. Difficulty in histological diagnosis occurs when the lesion is not completely excised, when it is tangentially cut or in the presence of cytologic atypia of the epithelial lip; confusing keratoacanthoma with well-differentiated squamous cell carcinoma.[2] To date, there is no reliable histological criteria to distinguish squamous cell carcinoma from keratoacanthomas[3] in the absence of special immunohistochemical staining for *bcl-2*[4] and proliferating cell nuclear antigen.[5]

Clinically, at least 25% of the keratoacanthomas undergo malignant transformation, particularly in photoexposed areas and in elderly patients. This transformation may occur in a single focus, hence it is essential that the entire lesion is completely excised and serial histological blocks are studied in detail to rule out a small focus of malignant change which may metastasise.[6] The remainder of keratoacanthomas may either remain a benign lesion or may spontaneously undergo resolution, the mechanism of which is suggested to be immunologically mediated.[7] Owing its ability to undergo malignant change and in the absence of predictive prognostic factors, all keratoacanthomas should be completely excised[6,8] and atypical cases should be treated as squamous cell carcinoma.[3]

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Sir,

Retinal detachment surgery outside specialist centres

I read with interest the correspondence by Dr Dinakaran and others concerning the papers in the July 2002 edition of Eye by Sullivan and Snead.

It seems quite clear that vitreoretinal surgeons in tertiary referral units achieve higher rates of primary success following detachment surgery. I agree that the trend over modern times has been for district general ophthalmologists to no longer operate on retinal detachments and for these to be referred to tertiary referral units. No doubt the anatomical success rate is higher in these units, however, I would not wish to restrict the definition of success to anatomical success.

Until we have an audit demonstrating that the visual outcome in terms of visual acuity is also better in tertiary centres, the concern always remains that detachments referred with the 'macula-on' may become 'macula-off' upon arrival in a metropolitan centre. While this may lead to a higher primary rate of success, I do not think we will have done the patient necessarily a service. Certainly I would prefer a 75% chance of a primary repair of superior bullous detachment while the macular was still on to a 90% success rate with a macula-off detachment. I think this area is rarely discussed and I certainly know anecdotally of cases where the vision has deteriorated over the time taken to arrive from a referring unit to a tertiary unit, particularly when the journey involved is prolonged and makes posturing impossible.

With the decline of detachment surgery in district general ophthalmology units, I suspect that there is an ever-decreasing pool of ophthalmologists willing or able to take on this work and if they rarely get to operate on retinal detachments, then they are unlikely to maintain the level of skill required to achieve a reasonable success rate with macula-on detachments. In the meantime, I think that district general hospital consultants who feel confident to operate on macula-on superior detachment-threatening fixation are quite justified in their actions and may well be acting in the best interests of their patients. I see no reason that this could not be incorporated into informed consent explaining that while the success rate is a little lower, there are potential advantages in terms of preserving vision.

I think that guidelines should not be interpreted as inflexible rules, and that while as a general rule it is reasonable to refer to a subspecialist, consultants should feel that they will be supported if deviating from these rules in the patient's interest.

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