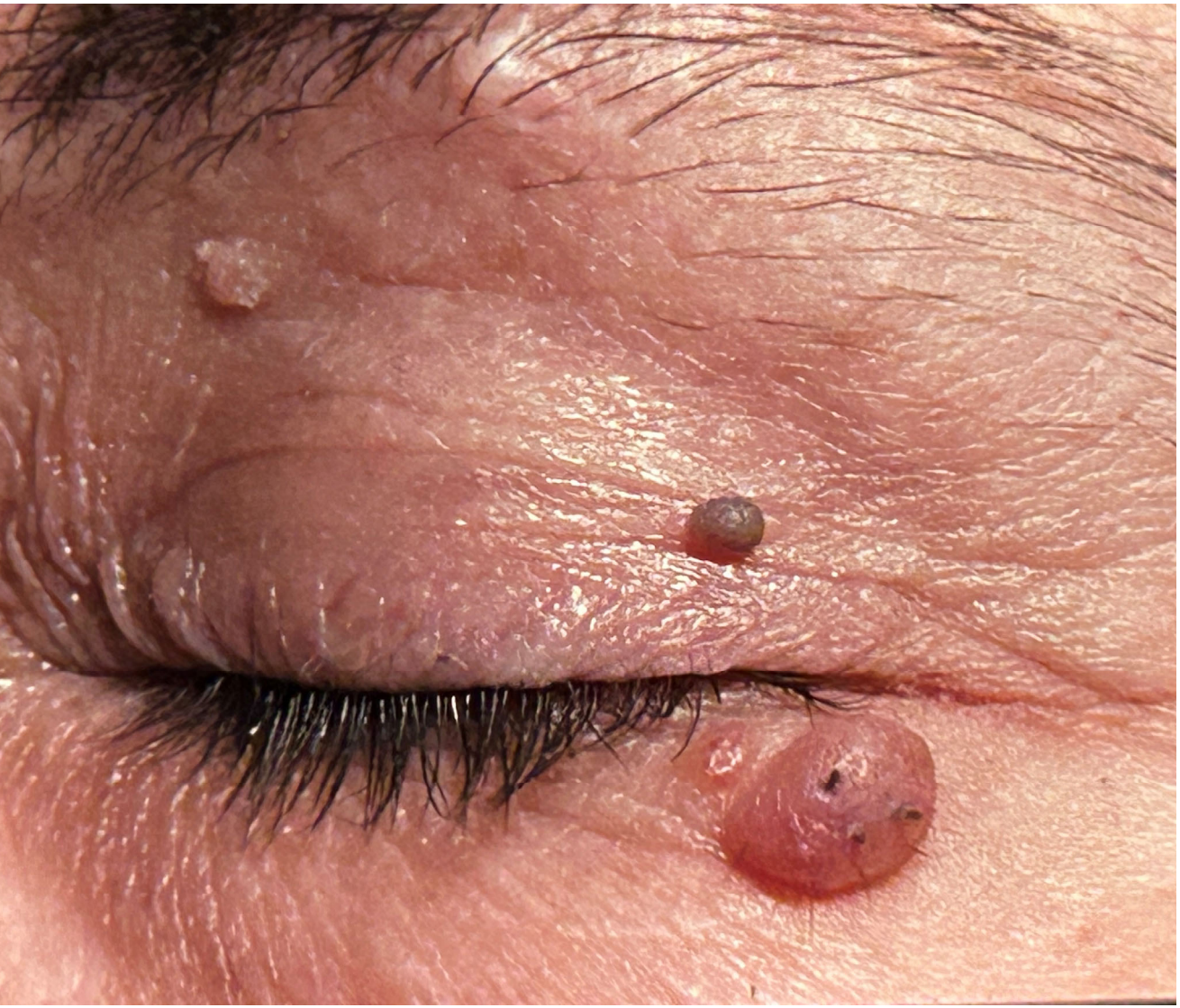
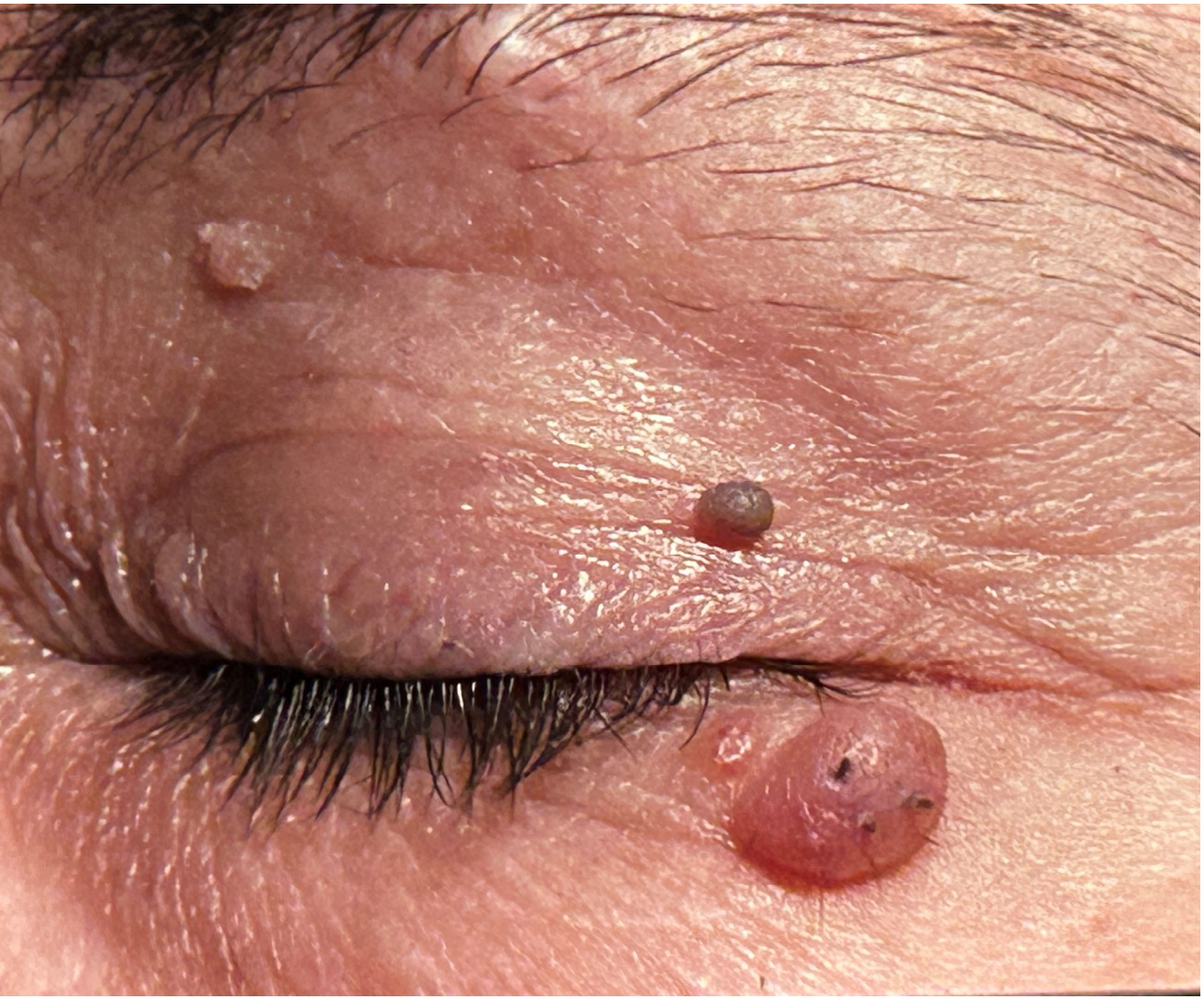


Managing Lid Lesions

Patient Safety
Patient Satisfaction
Practice Reputation

- Kenneth V. Cahill M.D., FACS
- Clinical Professor
- The Ohio State University



Safety

- Statistically, most lid lesions are benign
- Most lid lesions can be identified clinically
- Most lid lesions are best treated in the office
- Photographic documentation
- Send for pathology if any doubt exists

Patient Satisfactions

- Schedule promptly
- Treat promptly
- Favorable outcome

Practice Reputation

- Same factors as patient satisfaction

Squamous Papillomas, “skin tags”

Exophytic

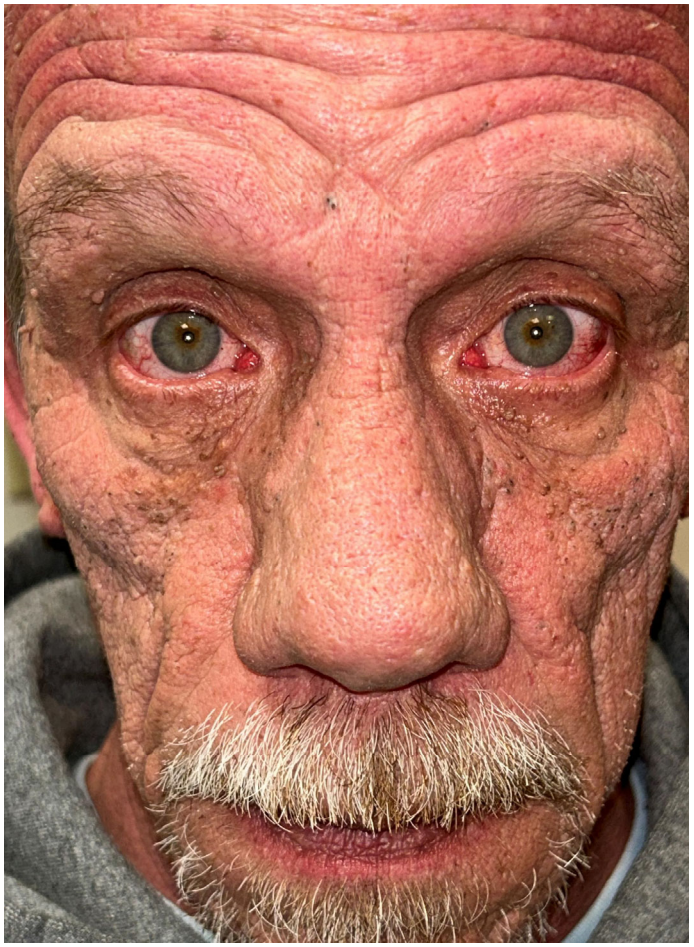
Often have a narrow base

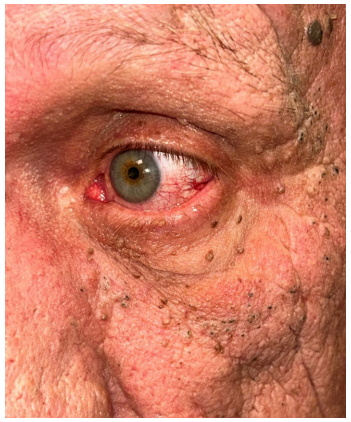
Local anesthesia

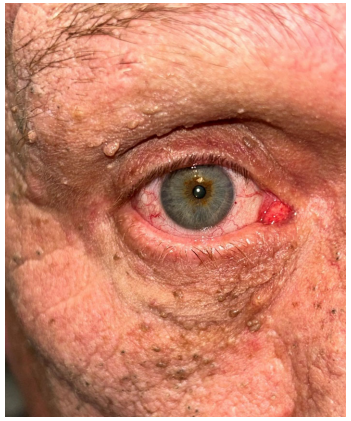
Snip off flush with adjacent skin

Pinpoint cautery

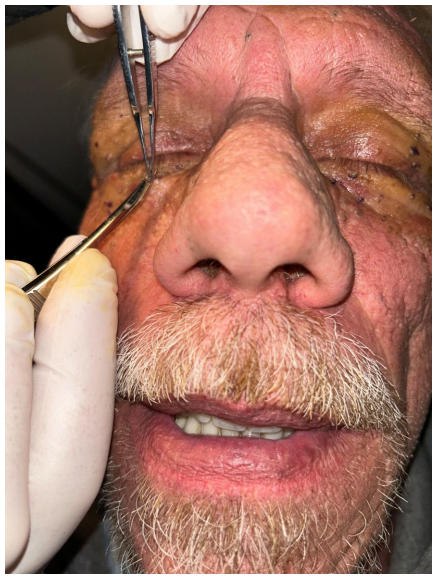
Antibiotic ointment

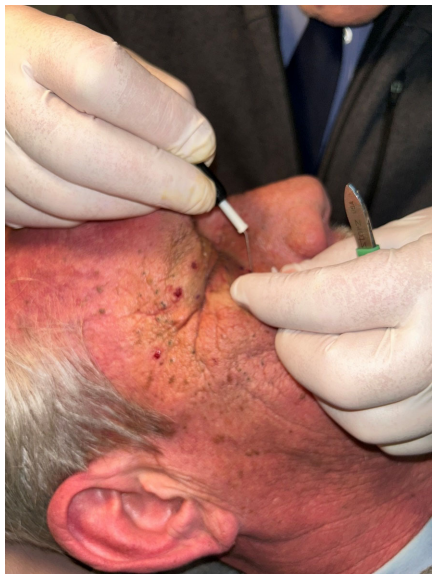


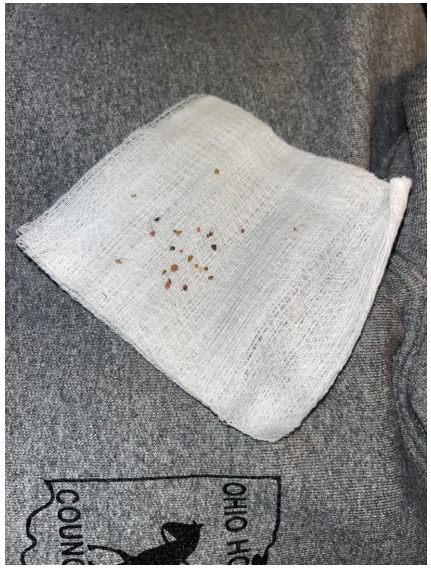


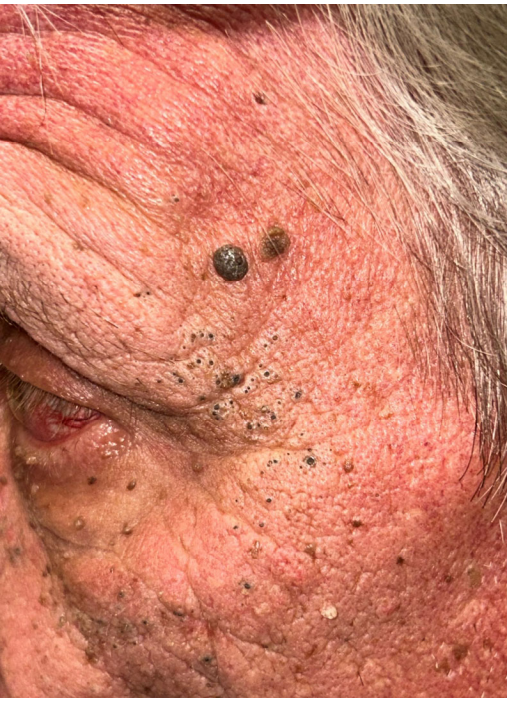
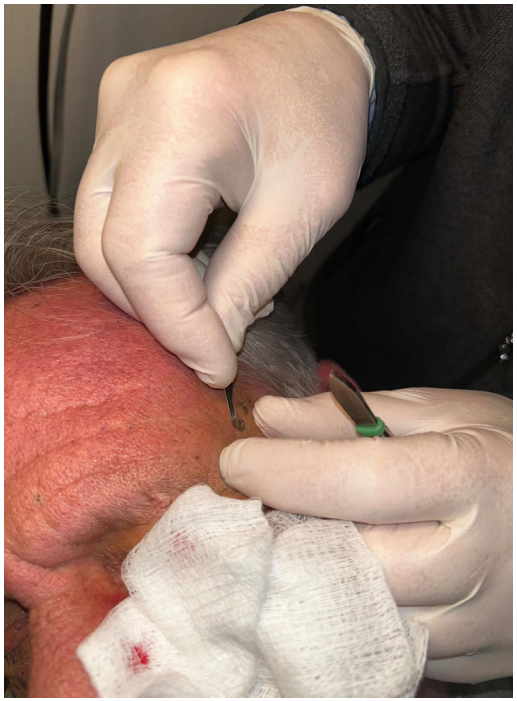
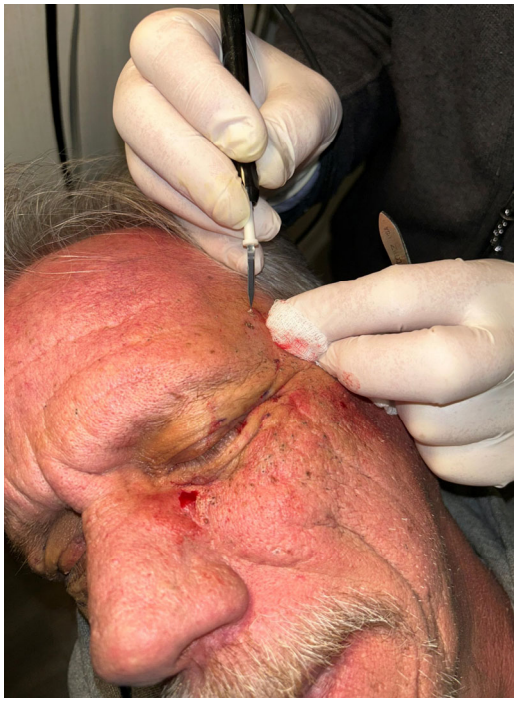


Squamous Papillomas, “skin tags



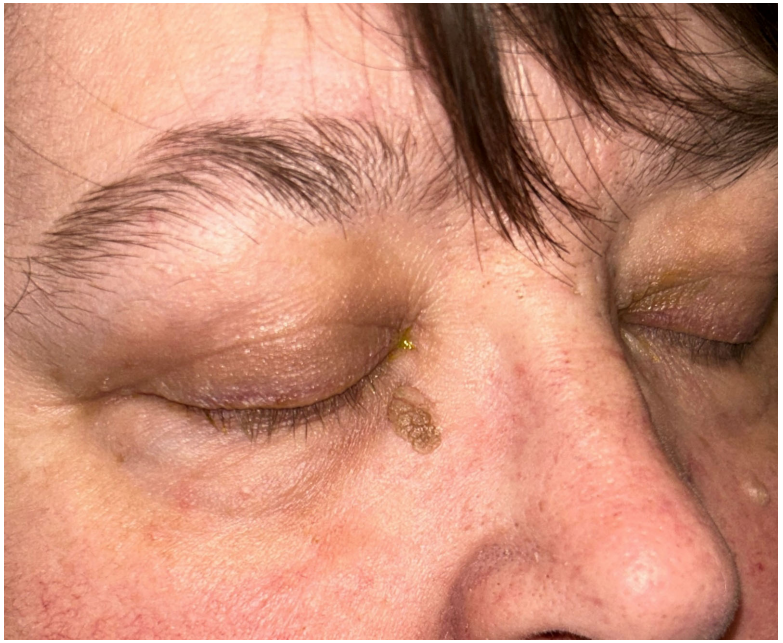


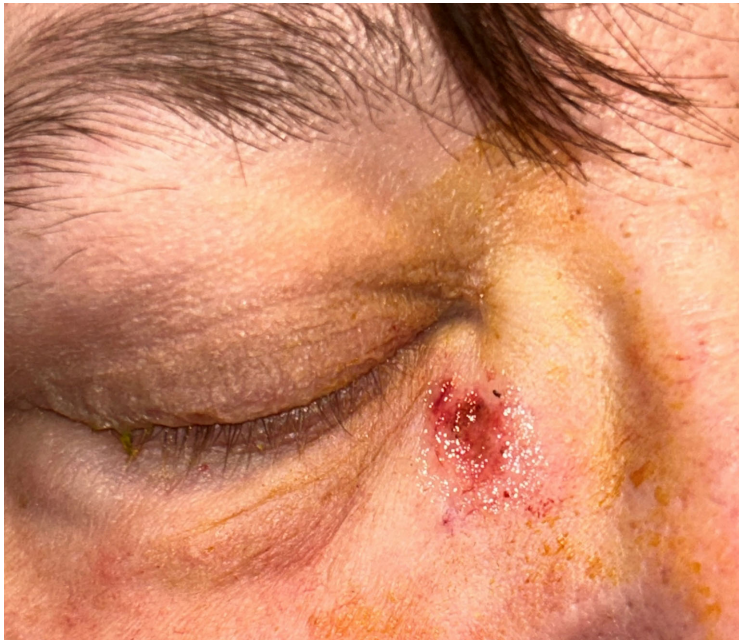


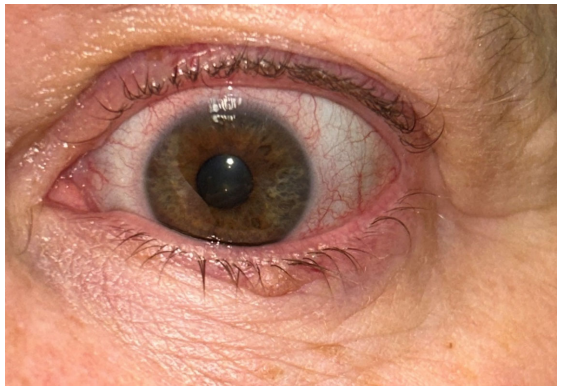
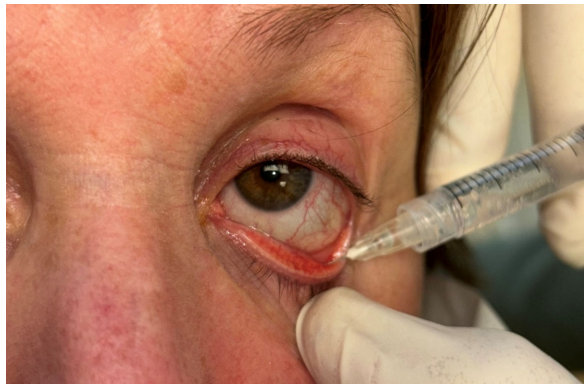
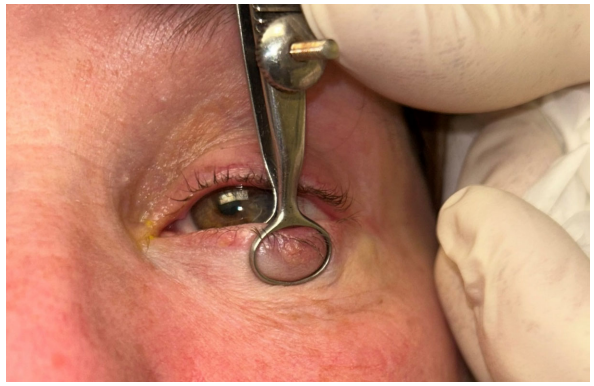
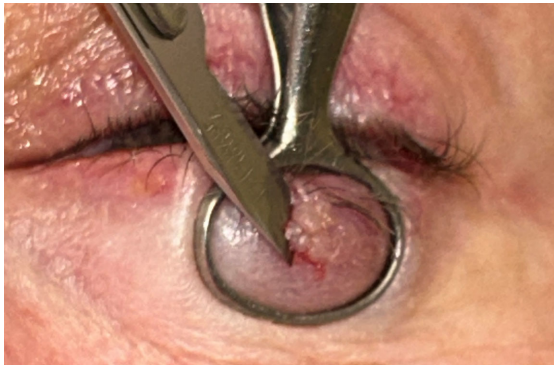
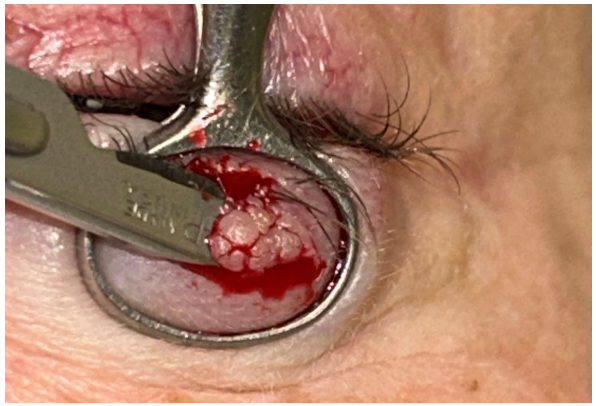
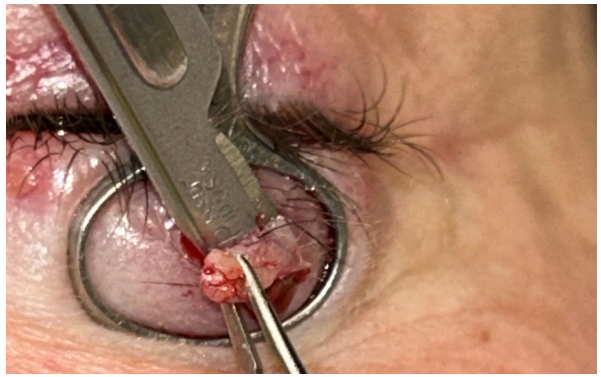
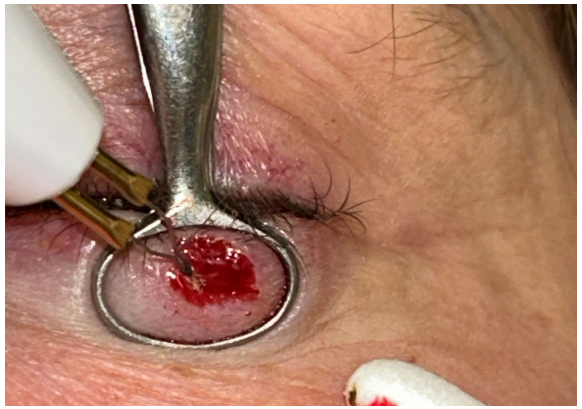
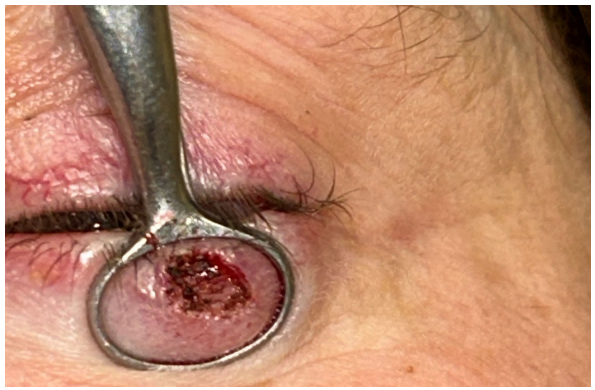
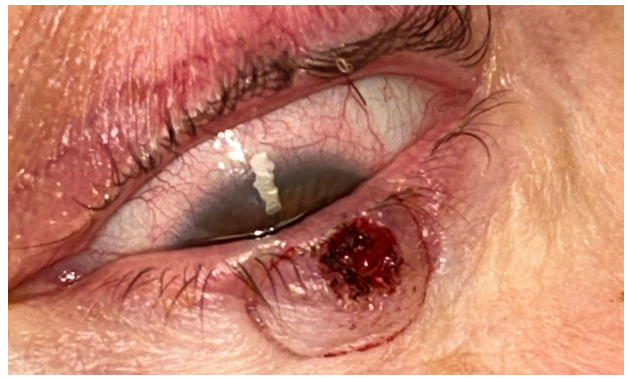

Seborrheic Keratosis

- Lobular
- Exophytic
- May be stalked, folded over, or sessile
- Local anesthesia
- Shave off flush with adjacent skin
- Light cautery
- Ointment bid for 1 week



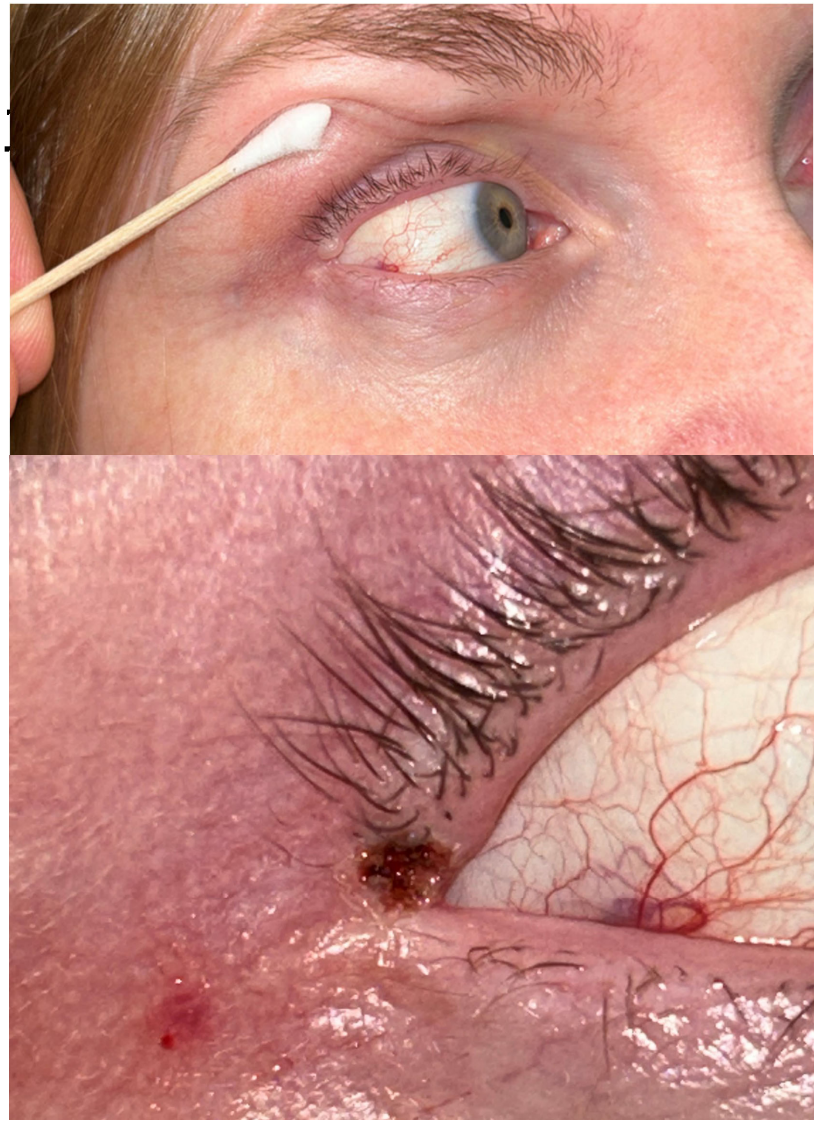


Seborrheic Keratosis

Nevi – on lid margi

- I usually send for pathology
- Usually smooth
- May have lashes growing thru
- Often without increased pigment
- Rarely irritate the globe
- Can shave off at desired contour
- Use chalazion clamp for control
- Light cautery
- Lashes usually survive
- Regrowth infrequent



Nevi – away from the lid margin

I usually send for pathology

Usually sessile

Variable amounts of pigment

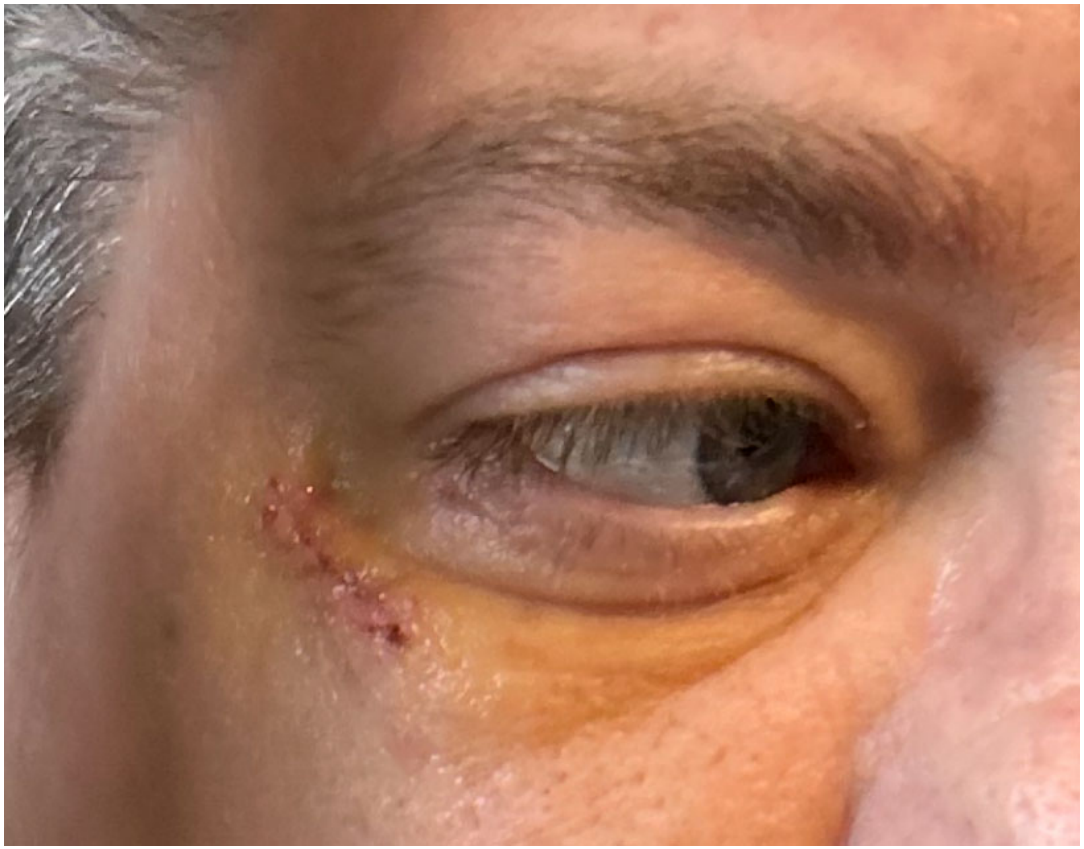
Shaving may leave an undesirable scar

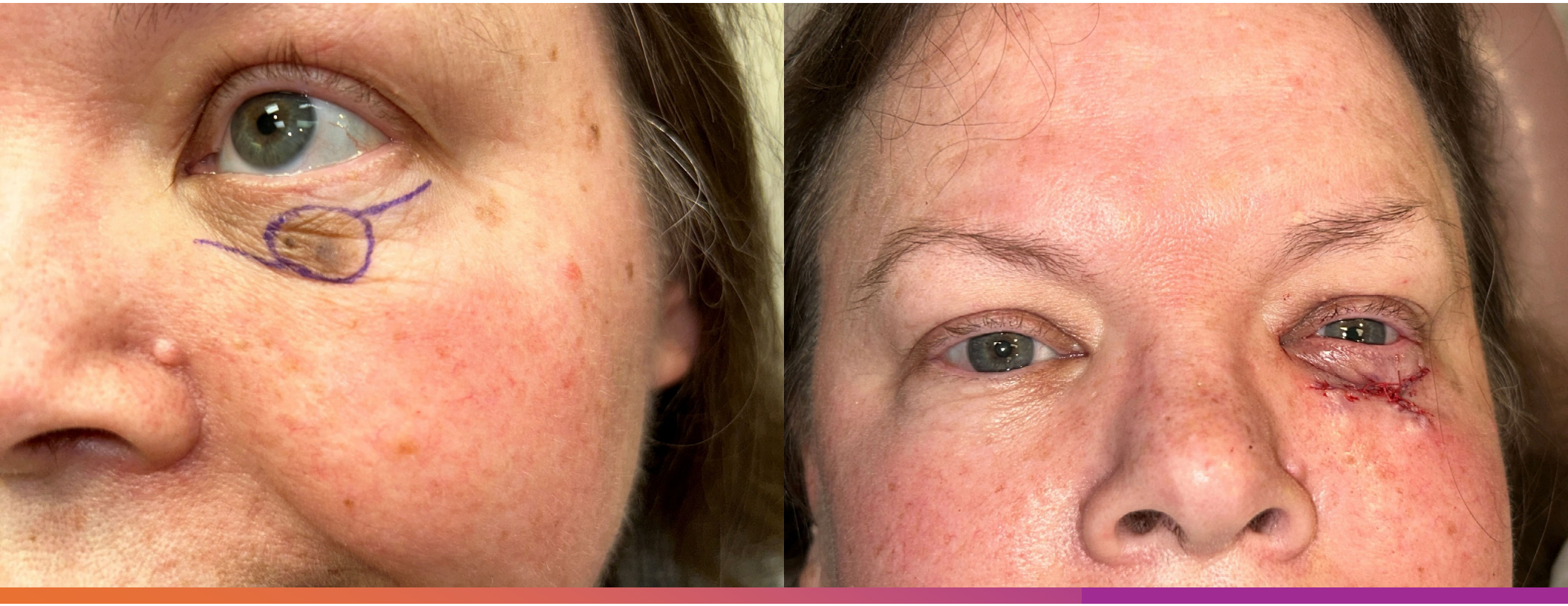
May need to do full thickness skin resection and suturing

Lid Suturing-horizontal closure

Follows relaxed skin tension lines

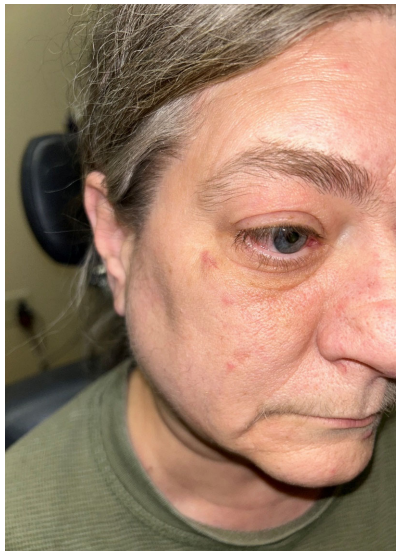
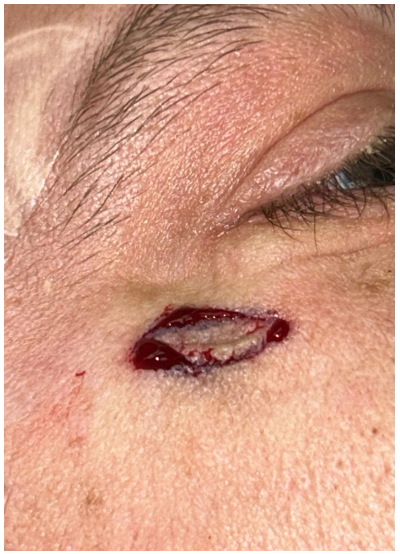
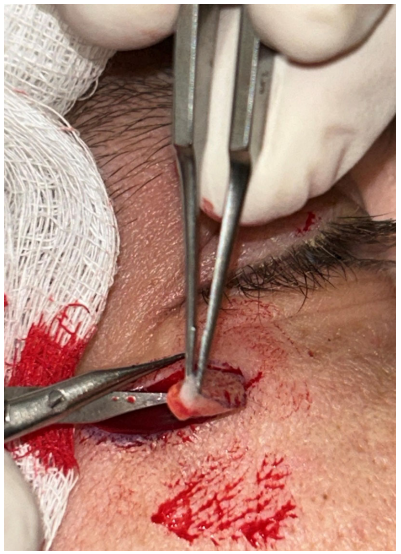
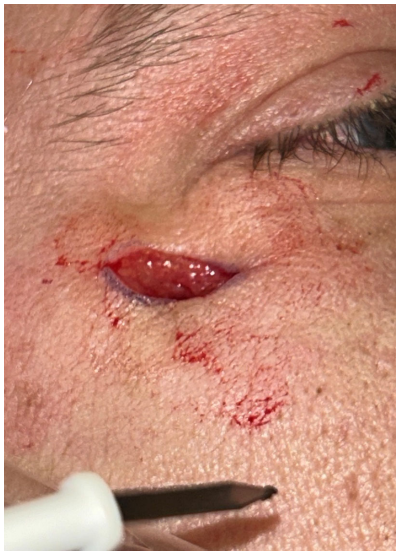
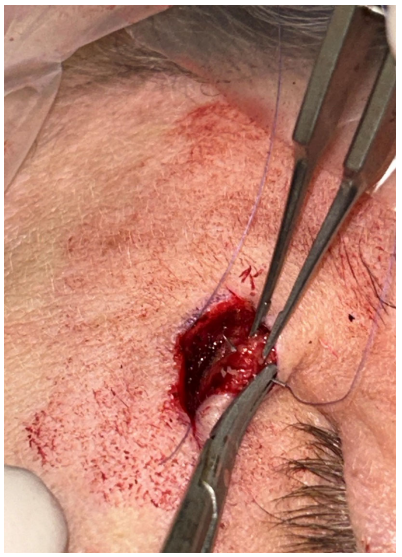
More likely to cause lid retraction





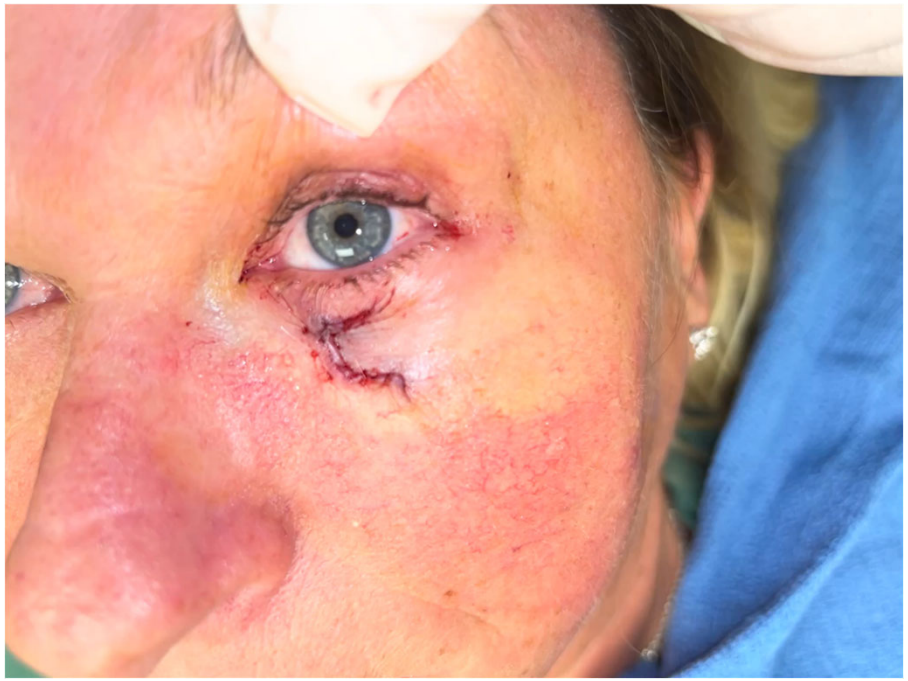
Lid Suturing-horizontal closure

Lid Suturing-horizontal closure

Lid suturing-vertical closure

- Usually gives adequate cosmesis
- Doesn’t cause lid retraction
- Single layer suffices unless defect is:
  - Deeper than orbicularis muscle
  - Under tension



Sutures

Absorbable sutures

- 5-0 fast absorbing plain gut
- 6-0 express gut

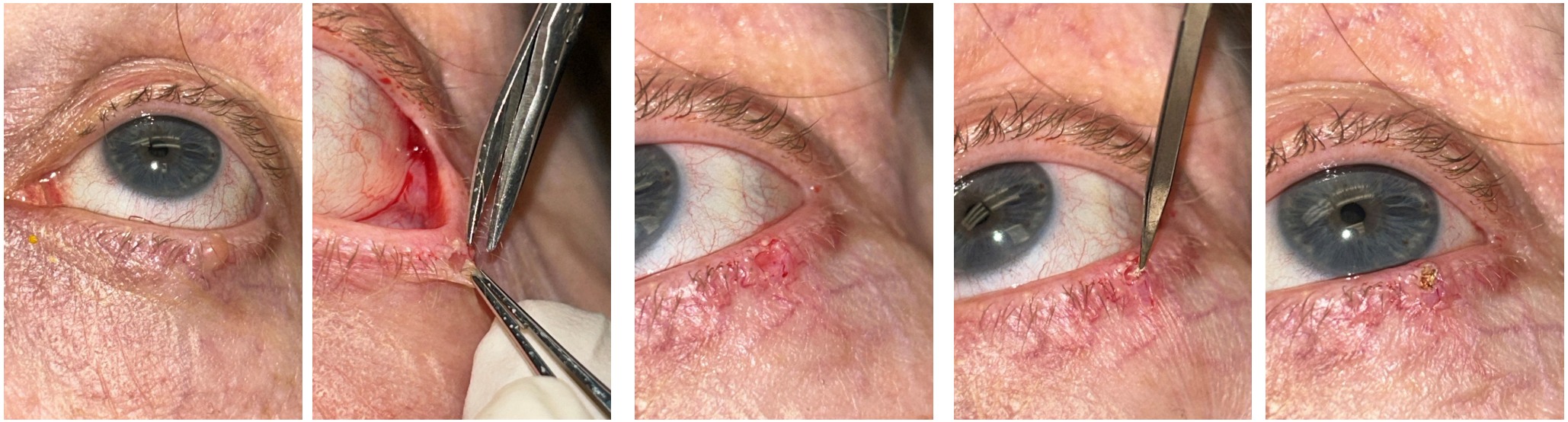
Removable sutures

- 5-0 or 6-0 polypropylene or nylon
  - Remove in 1 week

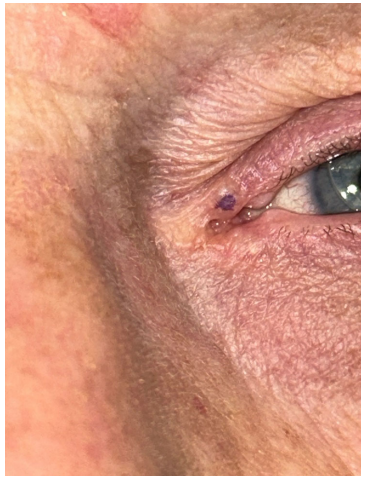
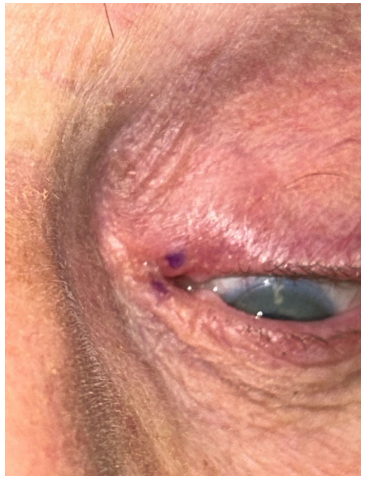
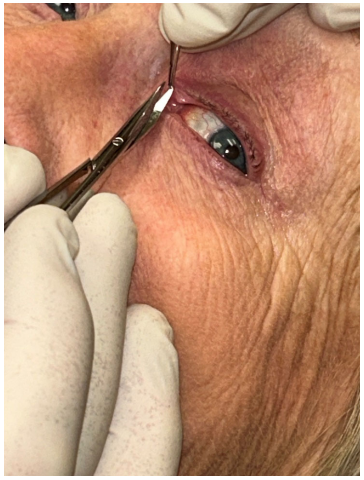
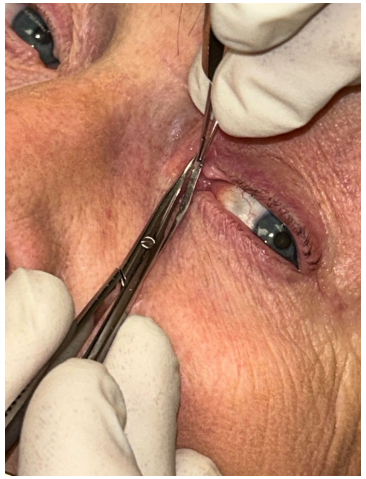
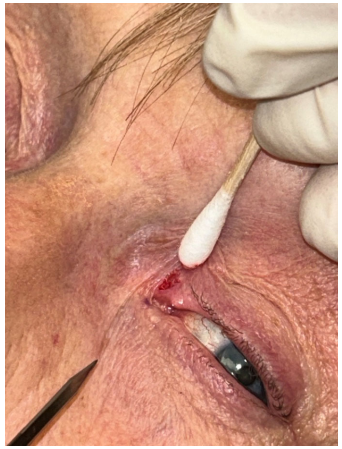
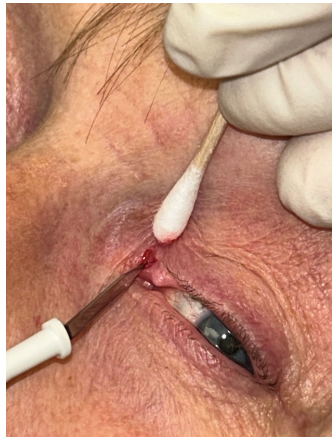
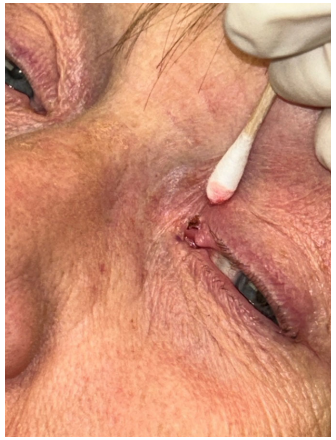
Cysts

- Sebaceous, squamous, serous
  - Frequent in the lash line
  - “unroof”, evacuate, light cautery
  - Use chalazion clamp for control

Cyst

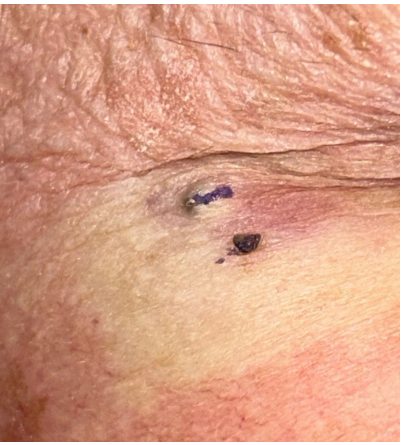
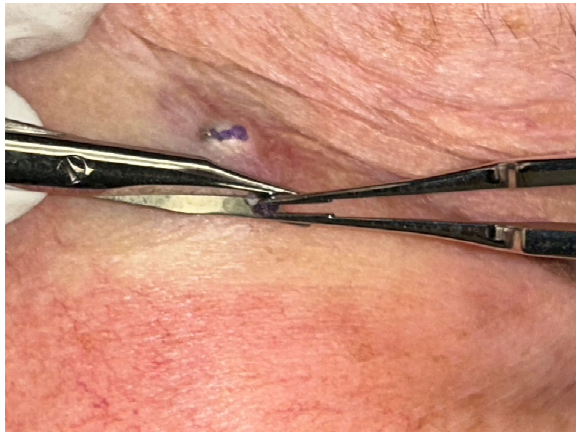
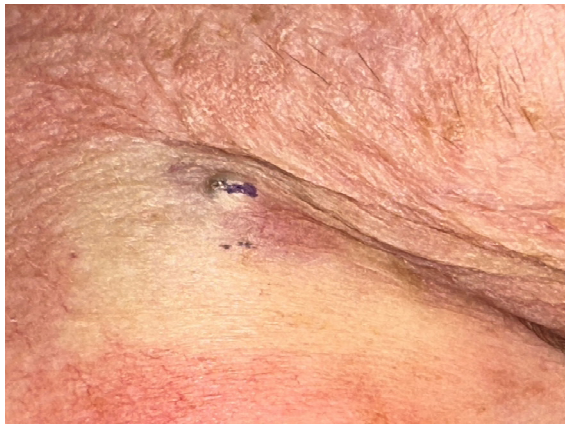
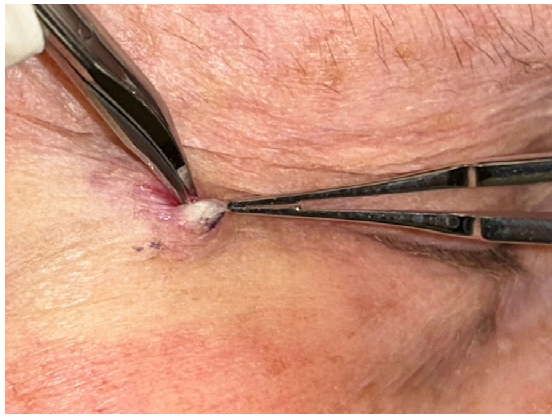
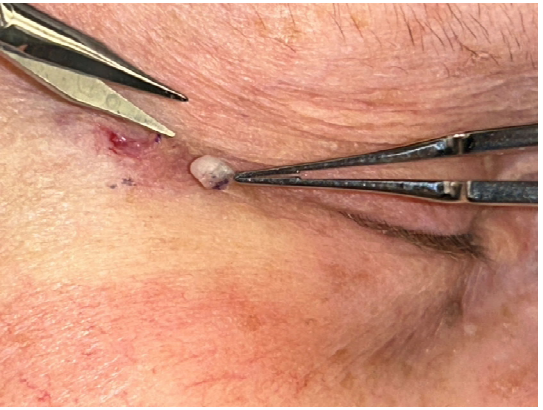
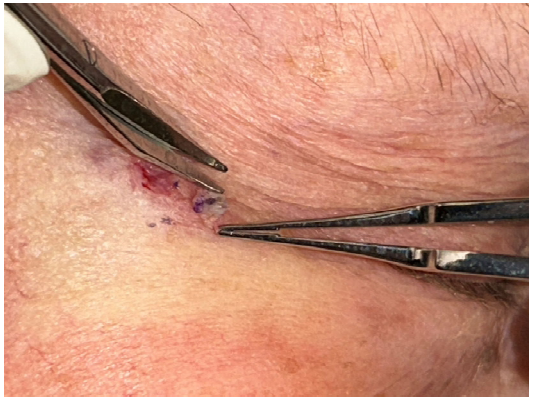
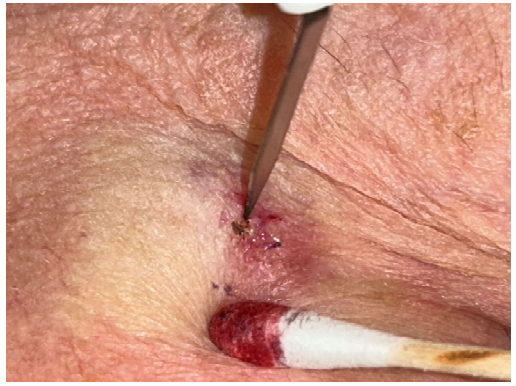
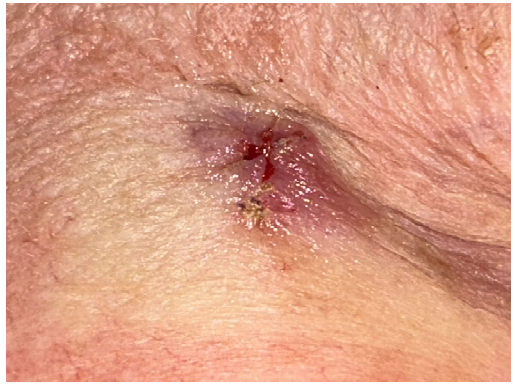


Cyst in lash line

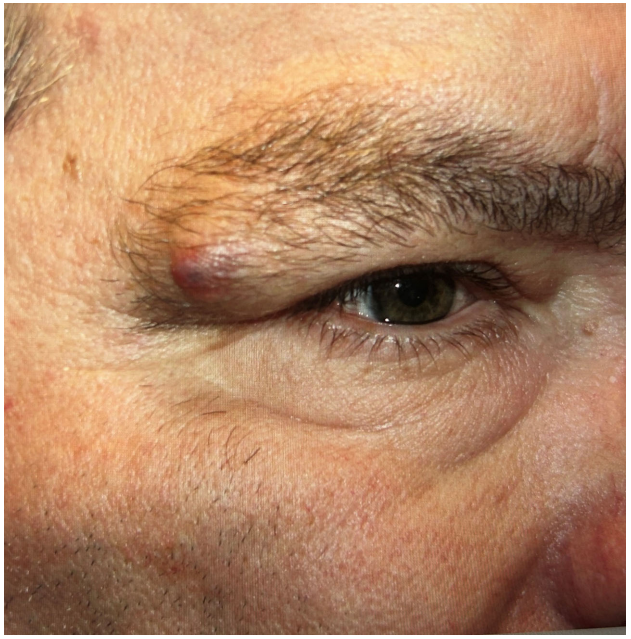
Cysts away from the lid margin

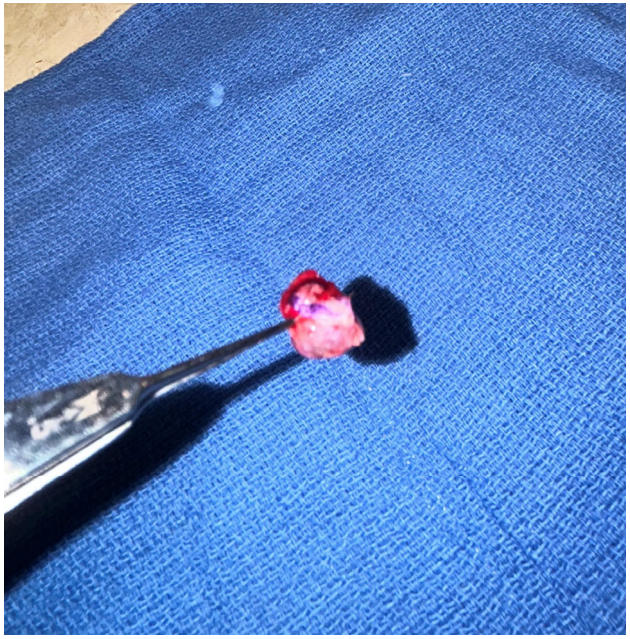
- Remove entire cyst if larger or deeper
- Suture closed
- If not extremely thin walled, consider cystic basal cell cancer

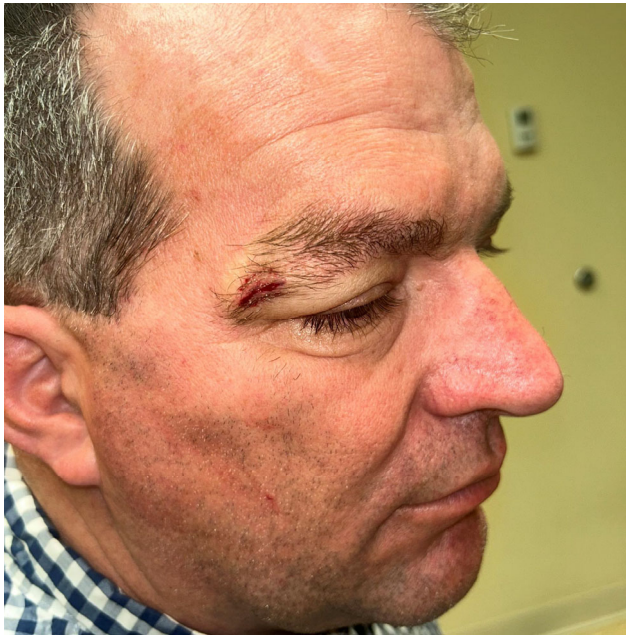









Cysts-deep

- Sebaceous inclusion, ? ruptured
- Excise completely with adherent skin
- Close with skin edge eversion
- Path if not classic “dermoid” appearance







Chalazion

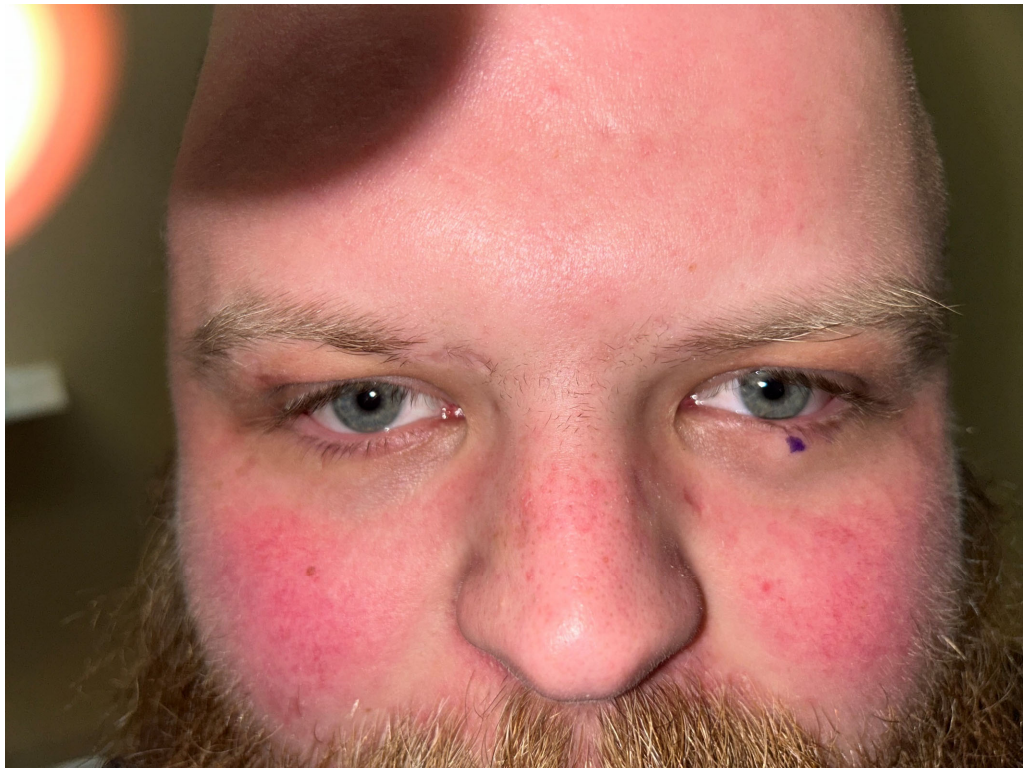
- "Acute" ?1st week
  - Warm moist compresses
  - Nighttime antibiotic ointment
  - Doxycycline, oral (or cephalexin, Bactrim DS)
  - Local anesthesia doesn't work well, recurrence likely

Chalazion

- “Subacute” ?1-3 weeks
- “acute” care
- Intralesional injection of Kenalog and/or 5-FU
- Minute dose into cyst
- Kenalog particles can go retrograde in vessels & cause blindness
- Local anesthesia doesn’t always work well, recurrence can occur

Chalazion

- "Chronic" 3+weeks
- Inject or
- Incise & curette
  - Mark location
  - Local anesthetic, except young children
  - **In lower lid try to inject transconjunctival inferior to tarsus**
  - Wait for local to work
  - Go transconjunctival when possible
  - I like the smallest clamp and largest curette that fit
  - Curette thoroughly, then curette one more time
  - Biopsy if recurrent or atypical
  - Cautery
  - Palpate to assure complete removal
  - Ointment
  - Pressure patch 15mins to 2hrs
  - Warm soaks & H.S. ointment 1 week



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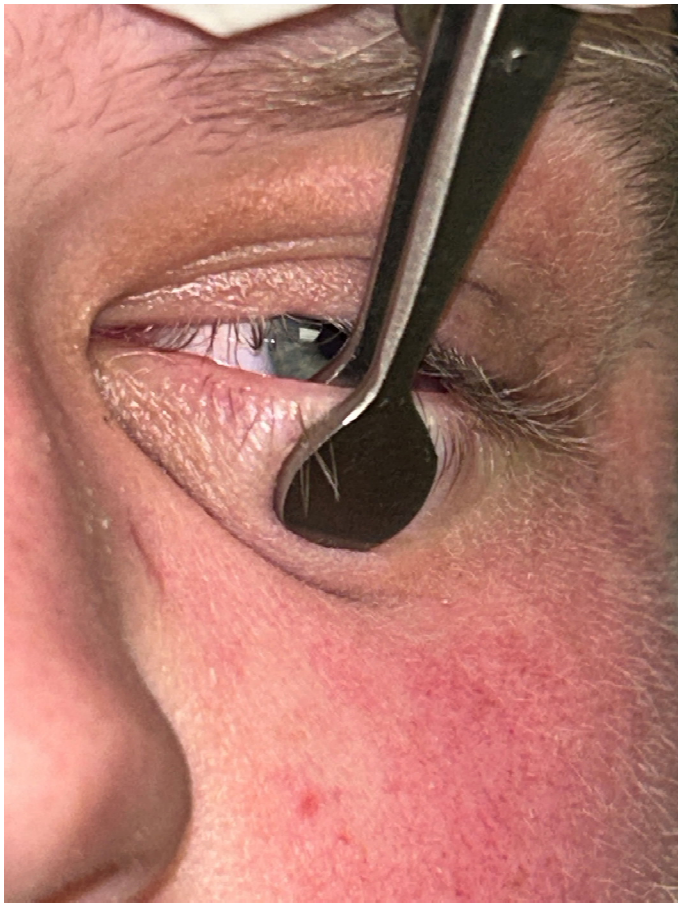

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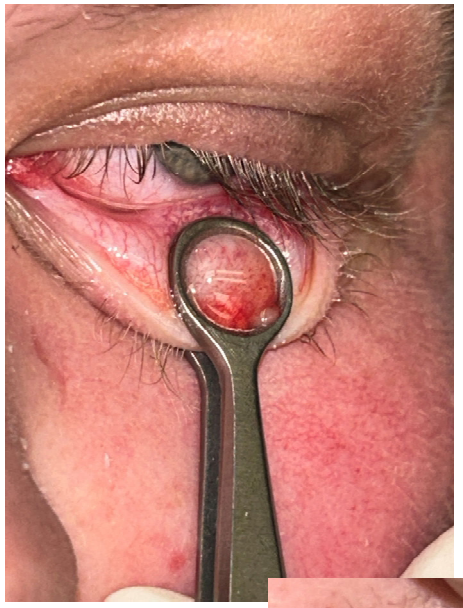

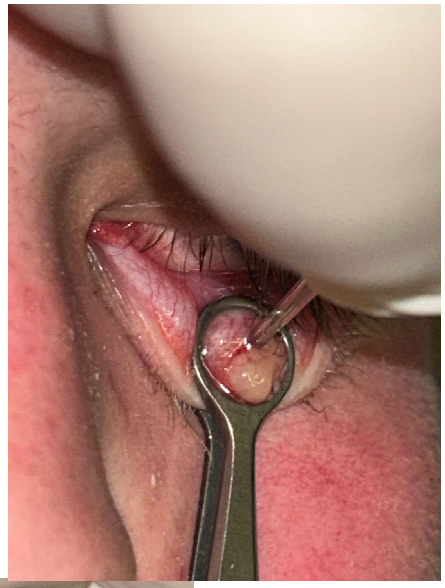

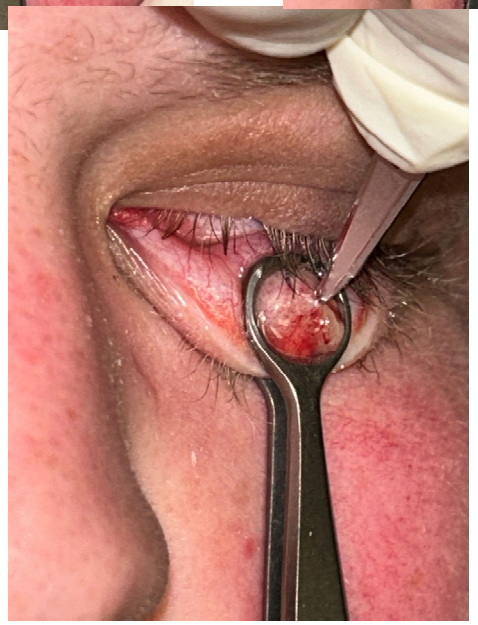

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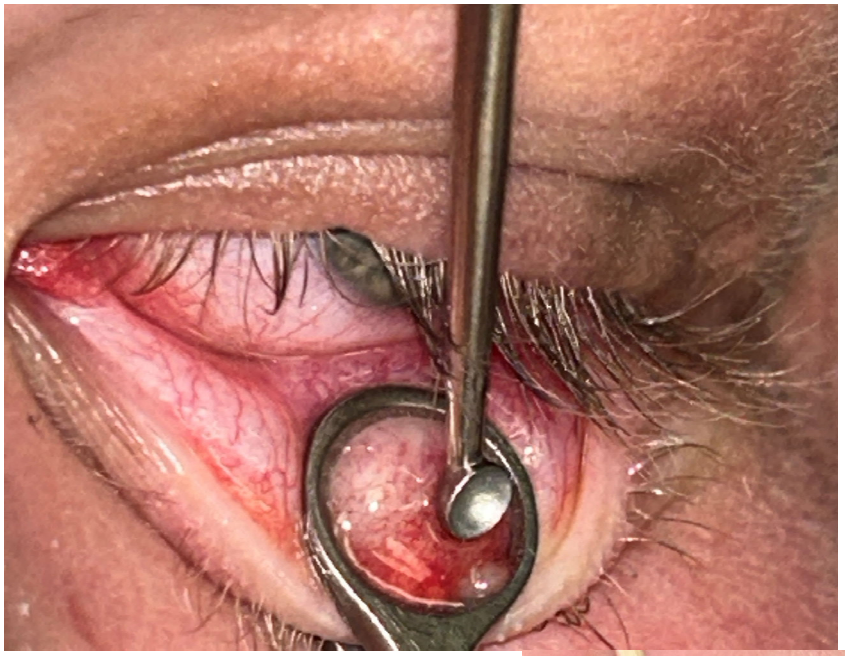

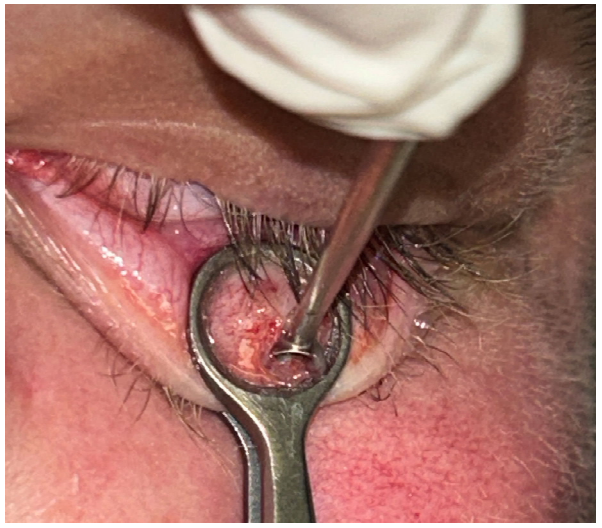

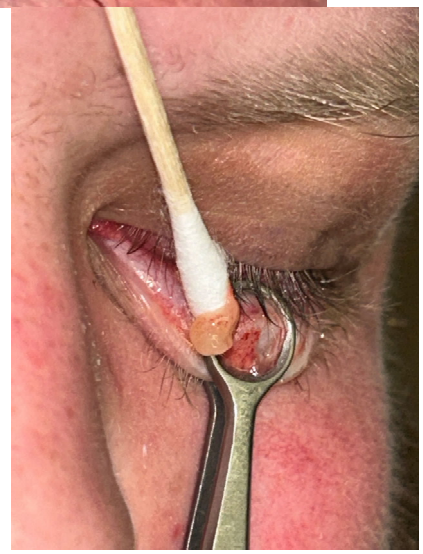

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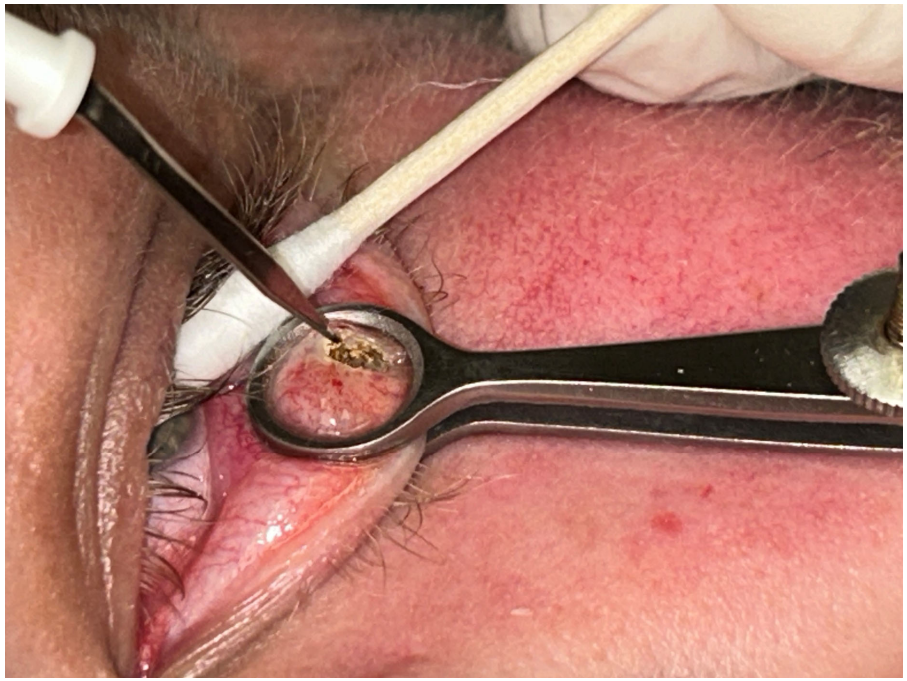

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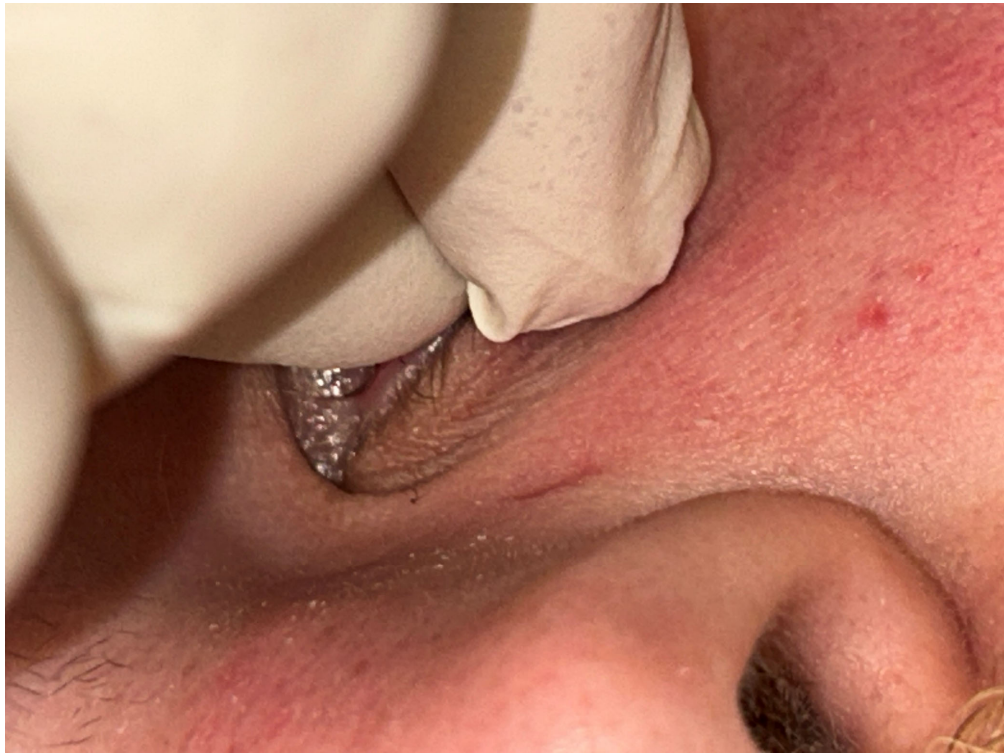
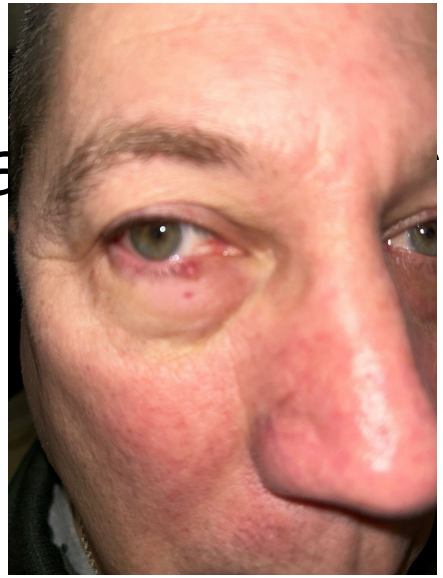
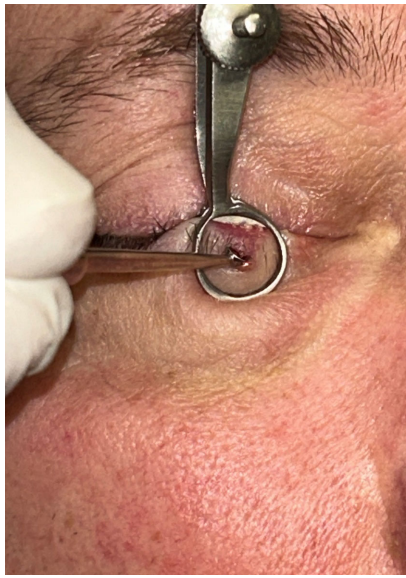
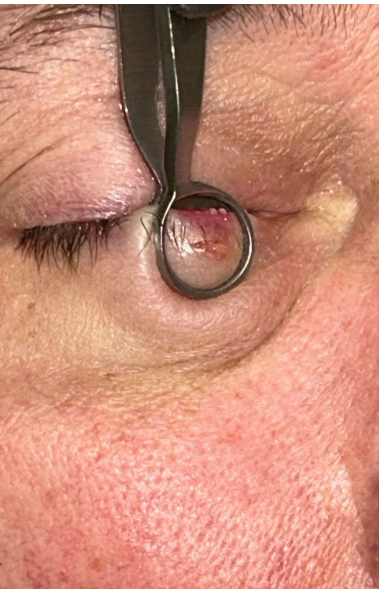
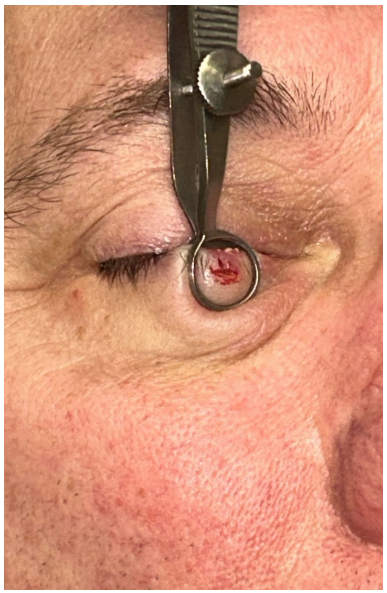


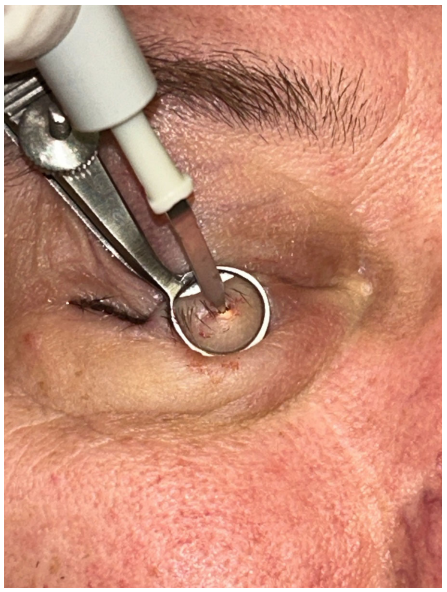
Chalazion – very a

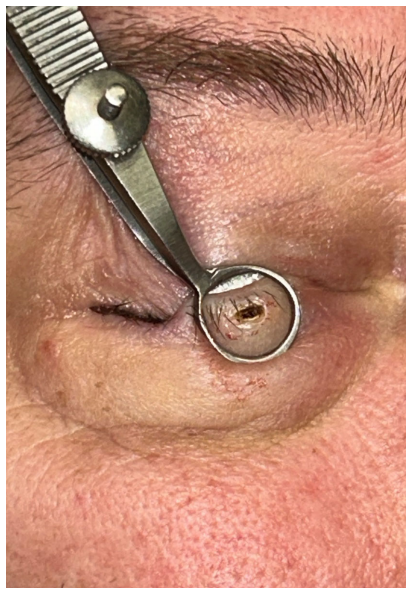


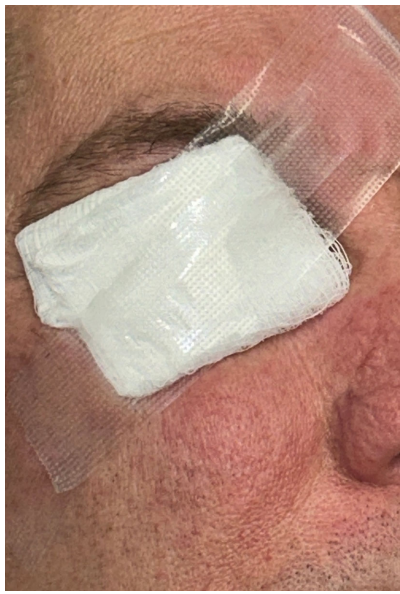












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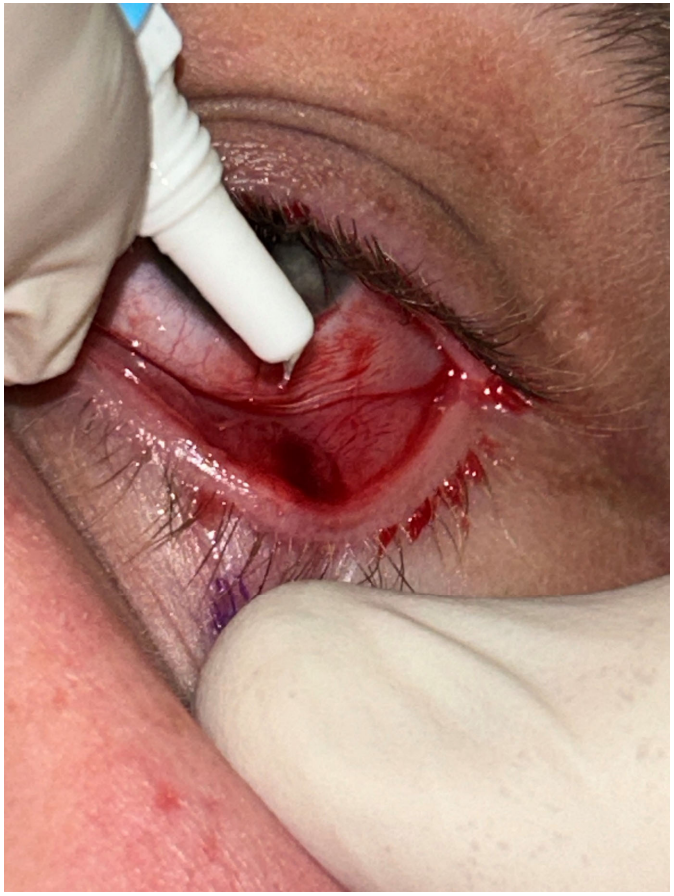

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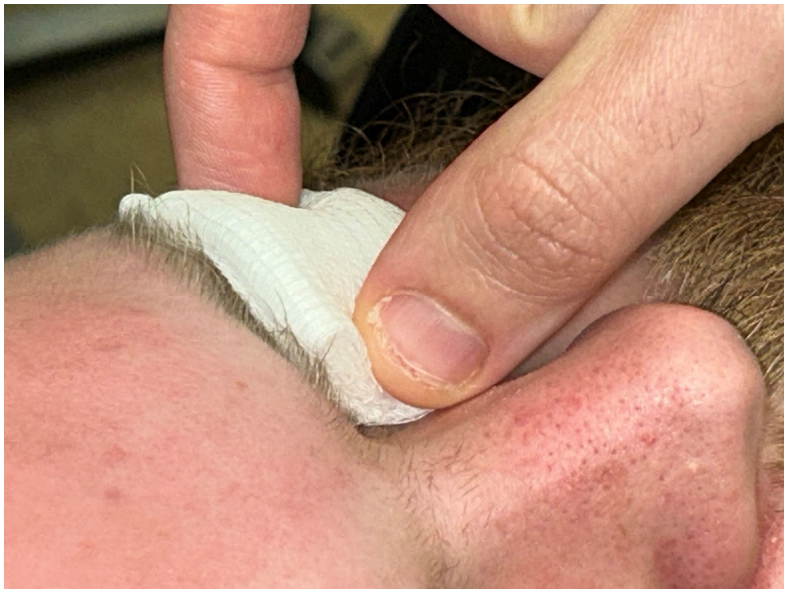
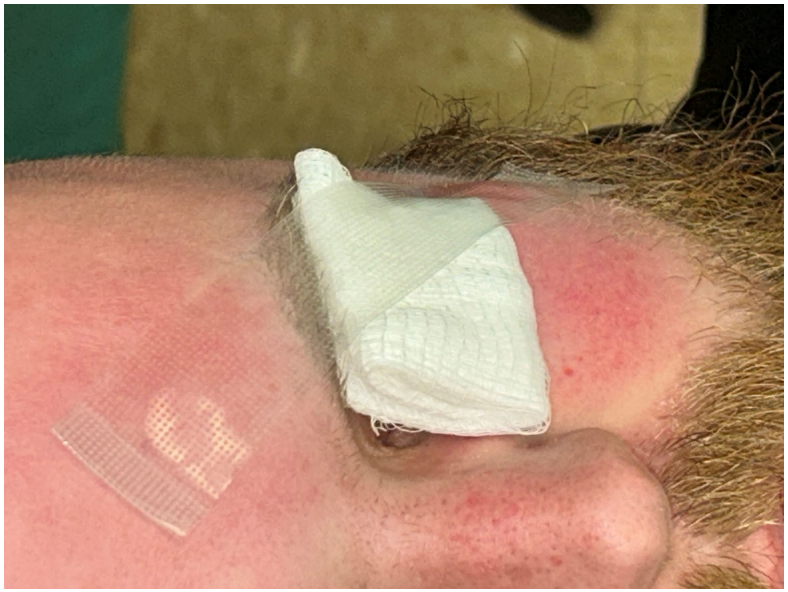
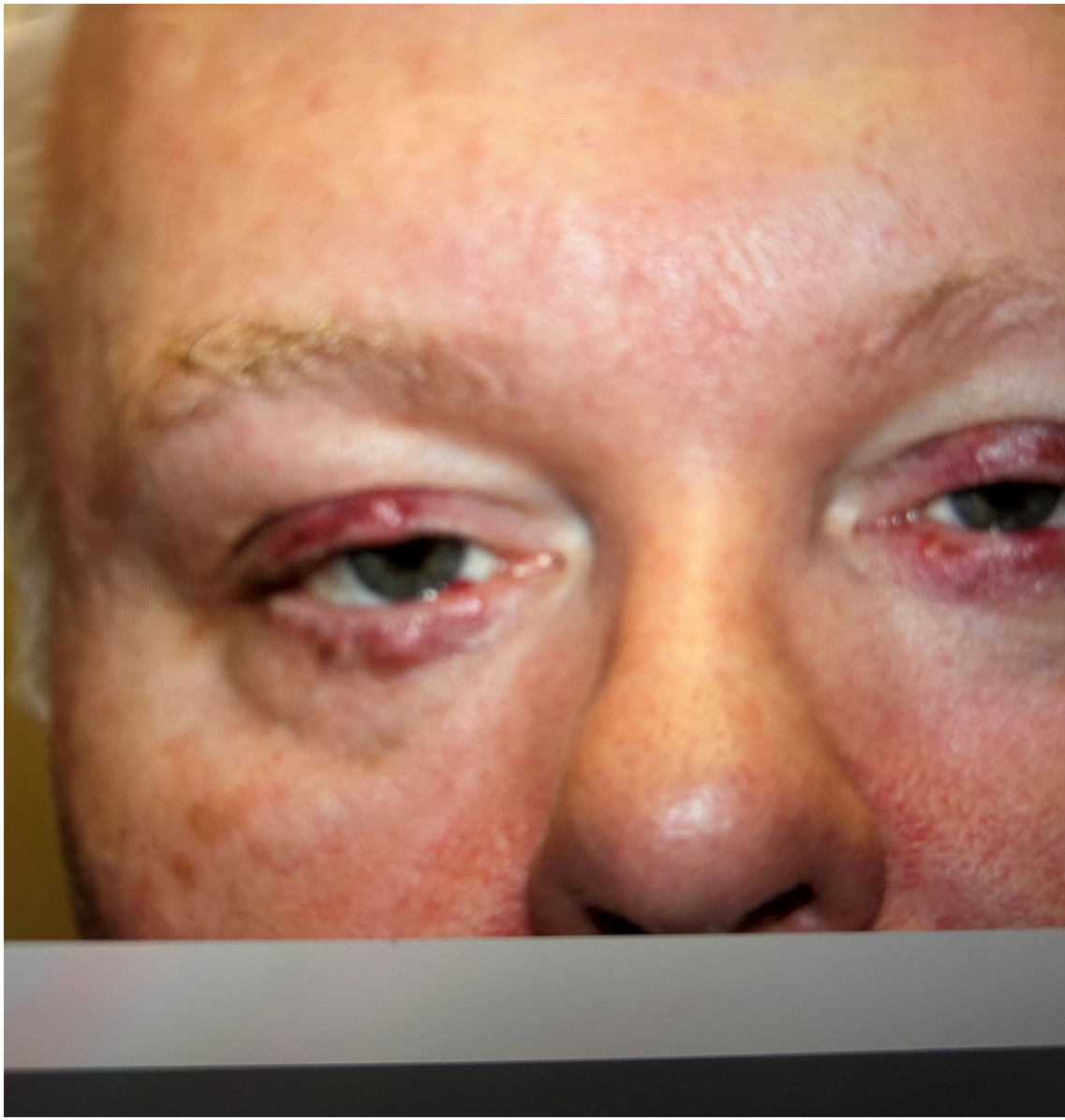




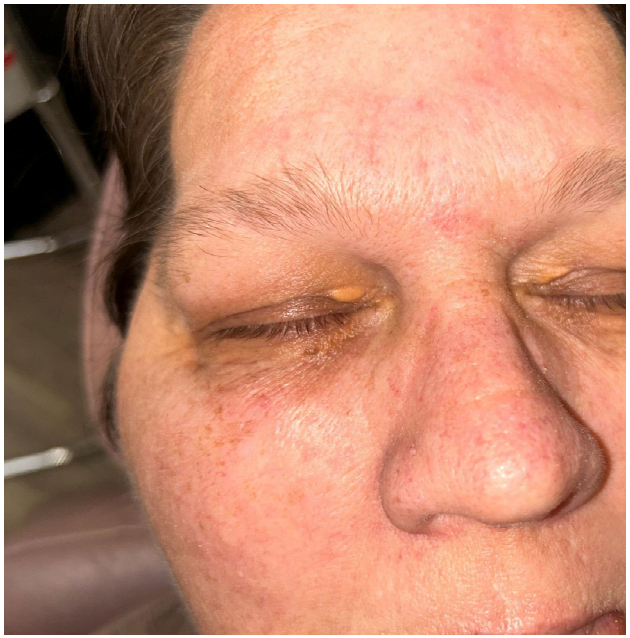
Multiple chalazia

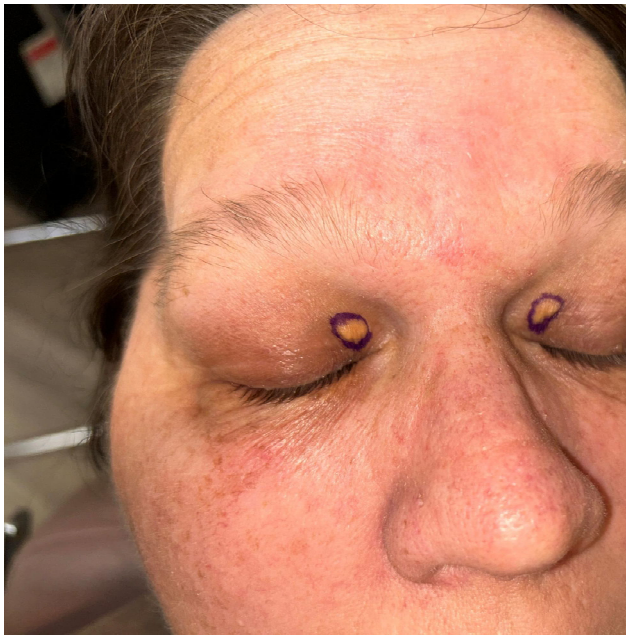
- Consider long term prophylaxis with doxycycline
- Rosacea
- ? Demodex

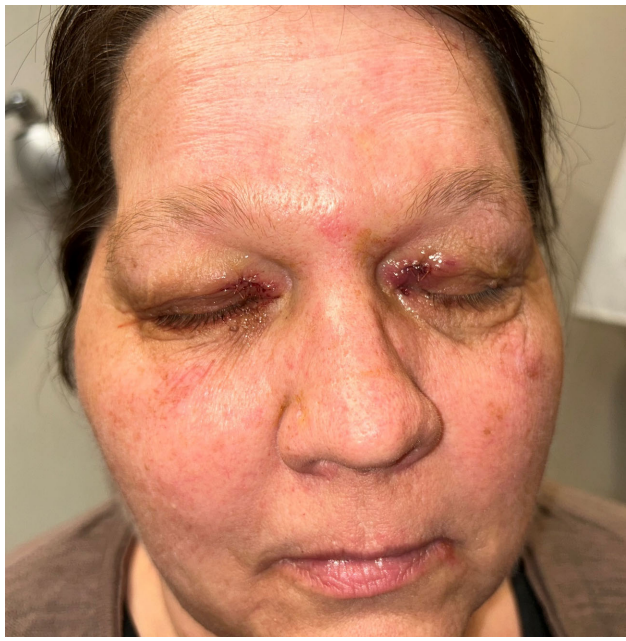


Xanthelasma

- ? Association with elevated cholesterol and/or triglycerides
- Excise completely
- Make sure no tension pulls on lid margin
- Risk of recurrence
- Beware of re-operations

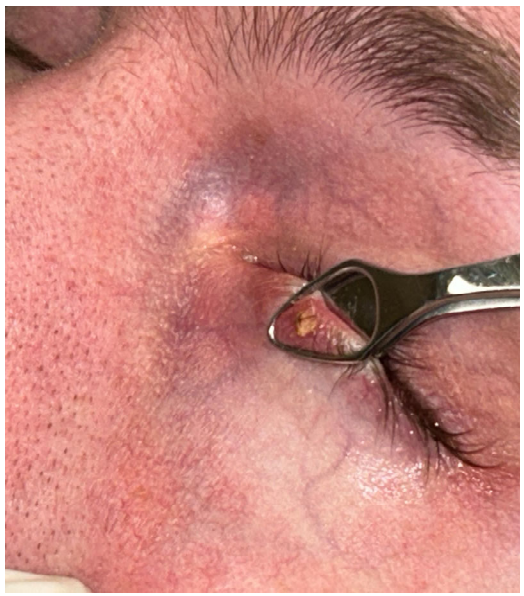
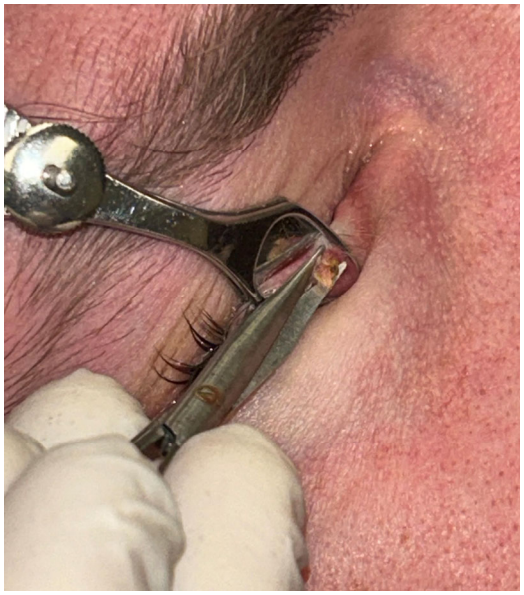
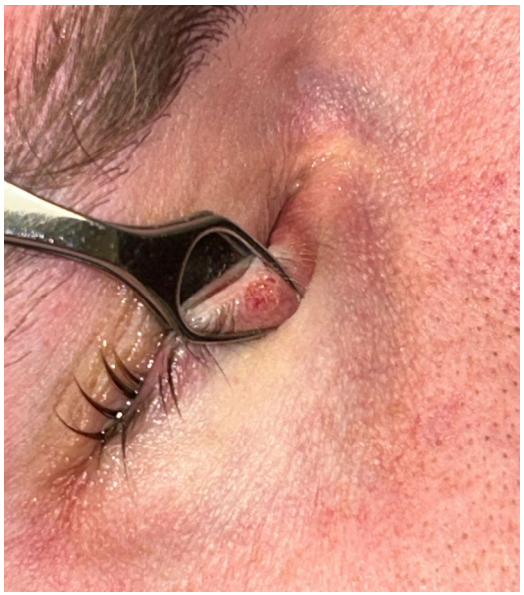
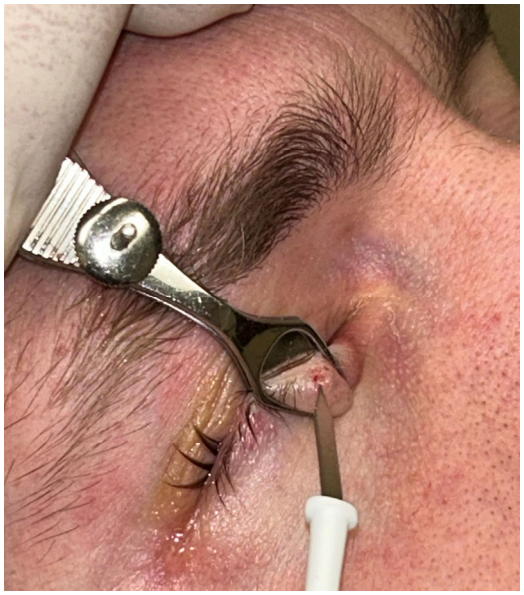
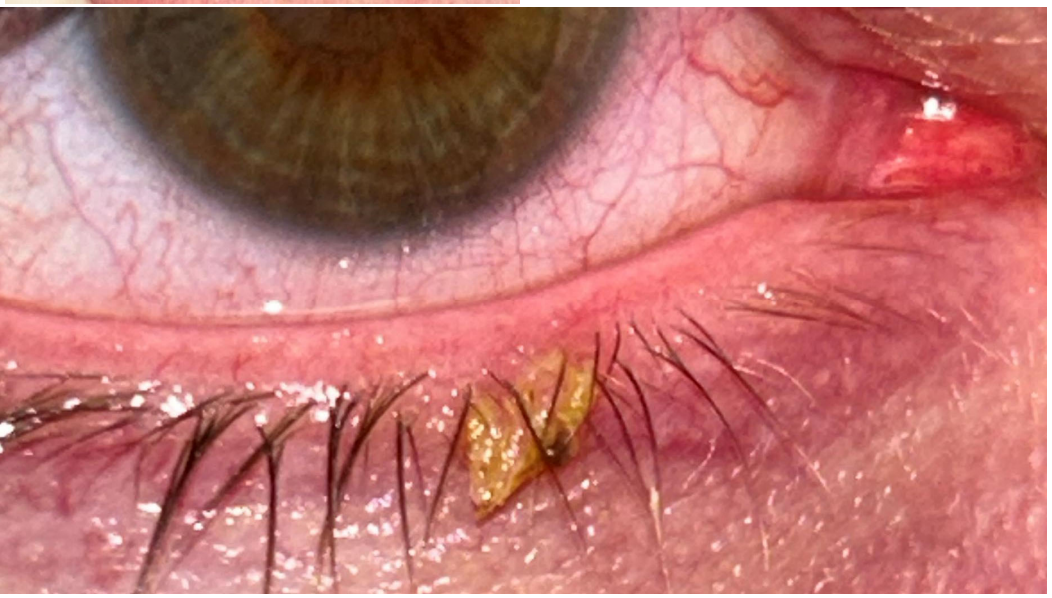






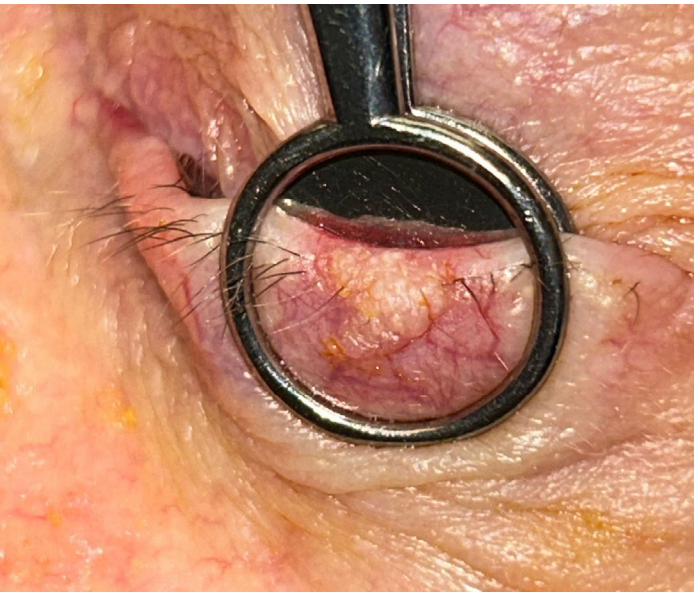
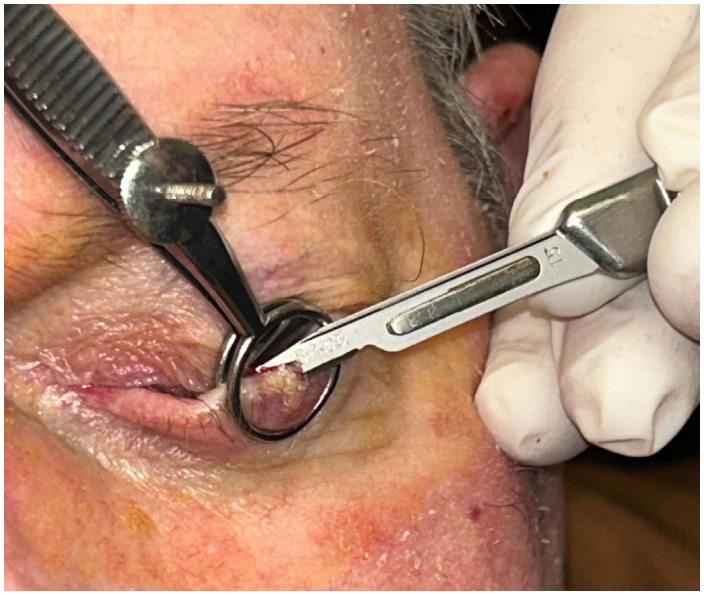
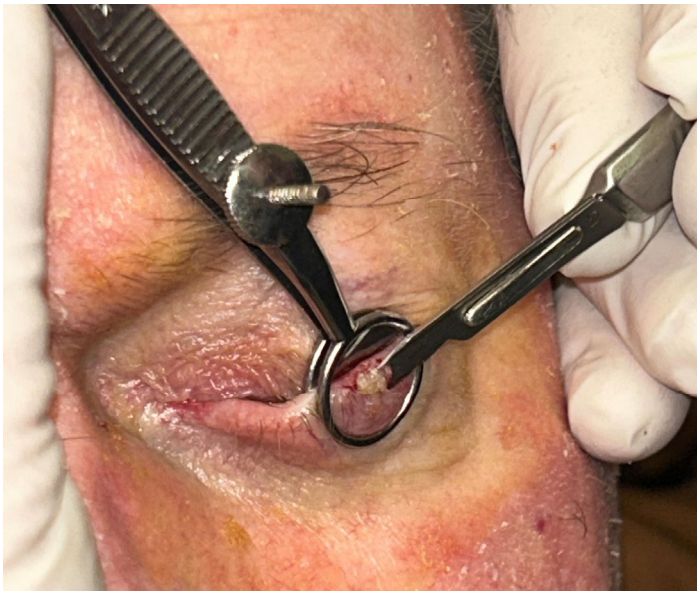
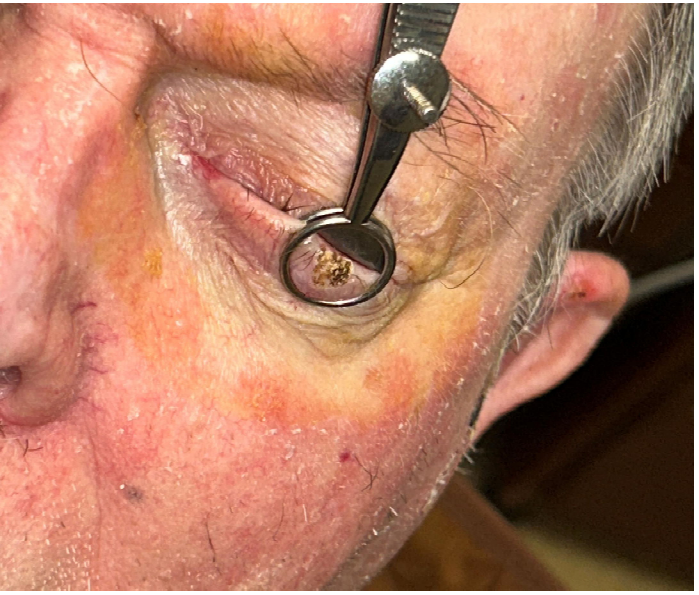
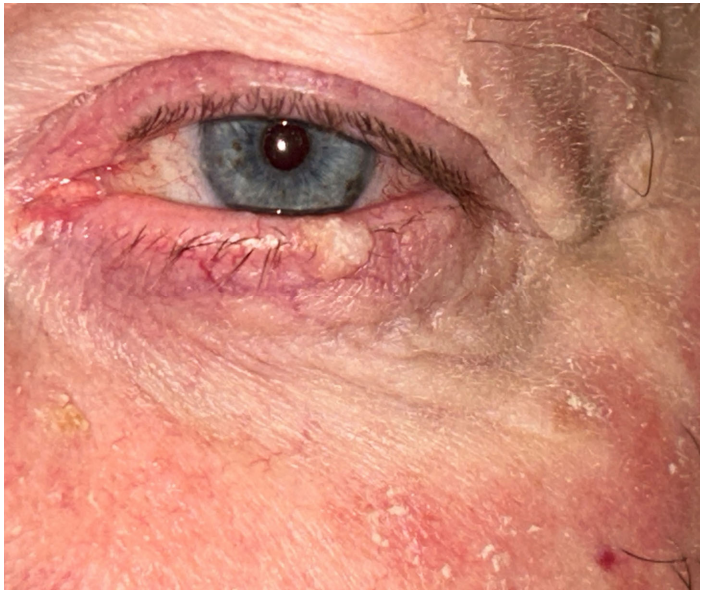
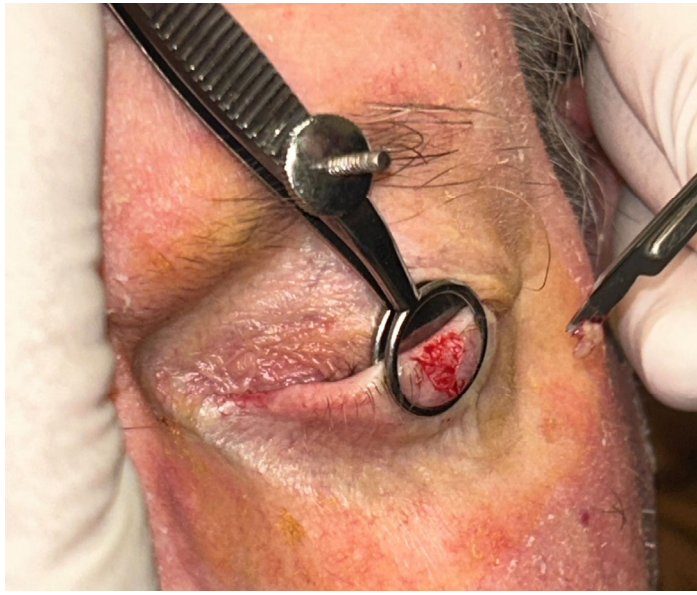
Actinic keratosis

- Flat or low
- Crusty
- May progress to squamous cancer
- May prove to be squamous cancer instead
- Shave off with local anesthesia
- Send for pathology
- Light cautery
- Ointment 1-2x/day until healed
- Consider 5-Fu cream after healed

Elevated and crusty lesions

- Verruca
- Squamous adenoma or carcinoma
- Shave excision
- Send for pathology
- Antibiotic ointment
- May need additional resection

Follow up with patients on all pathology reports

Best to photo document all lesions

Educate patient to return if they have any problems or recurrence

If you suspect malignancy

- Photo document
- Prompt biopsy and/or referral
- 2- or 3-mm punch

- Signs
  - Progressive growth
  - Loss of normal cilia
  - Fragile, bleeds easily
  - Doesn’t look like the benign lesions you have come to recognize

Basal cell

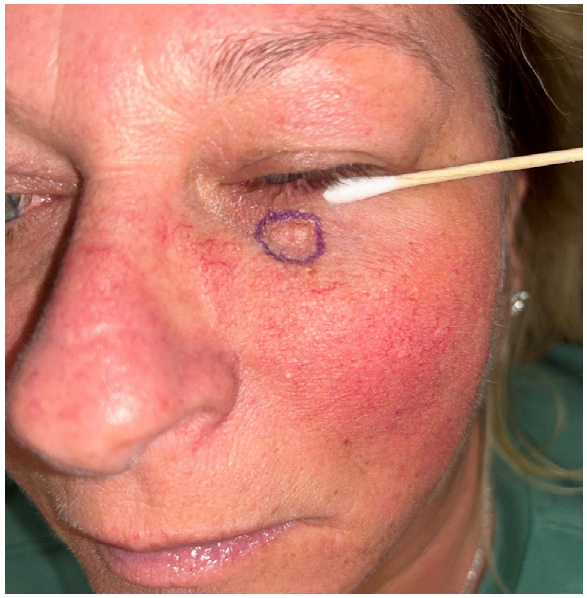
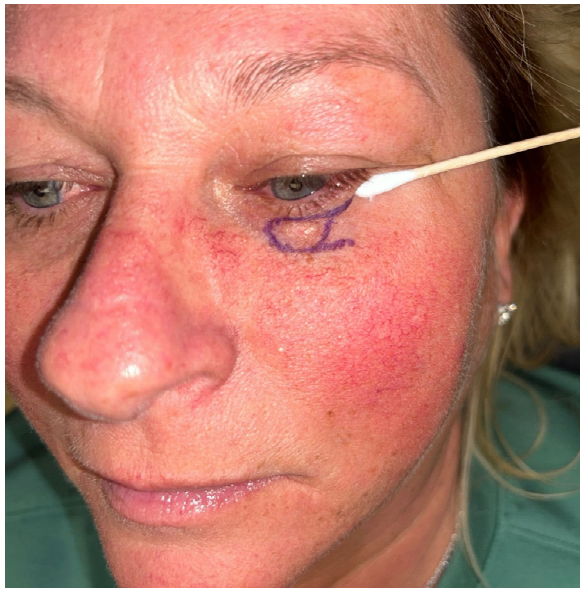
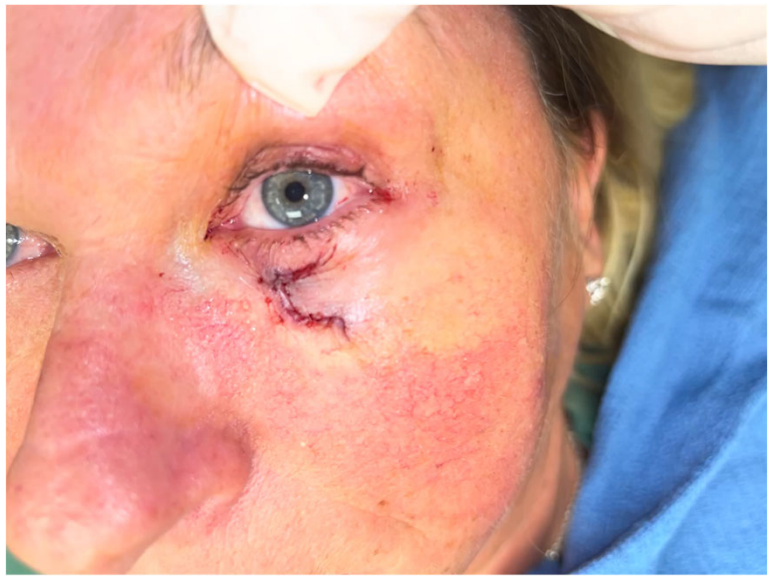
Squamous cell

Sebaceous cell

Melanoma

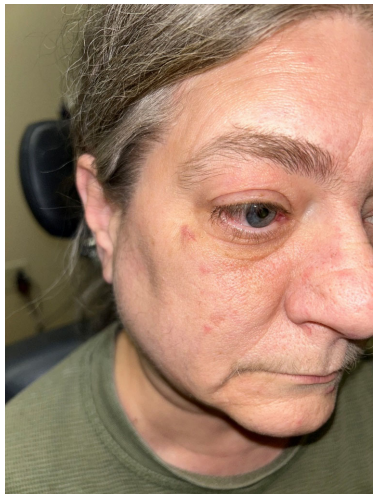
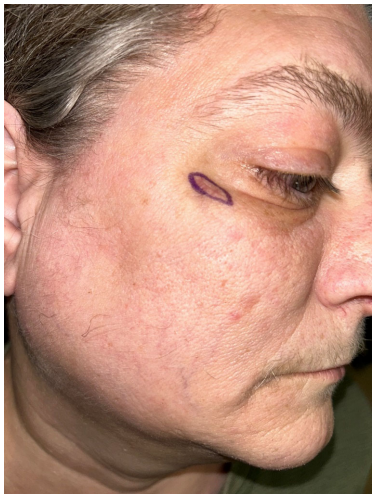
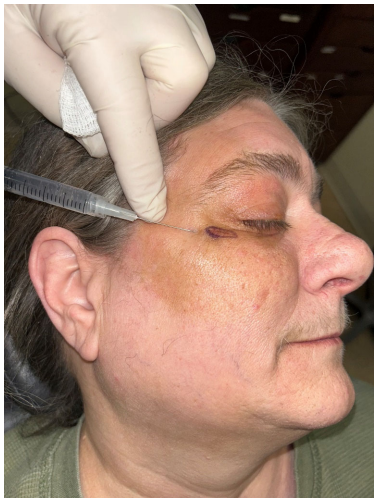
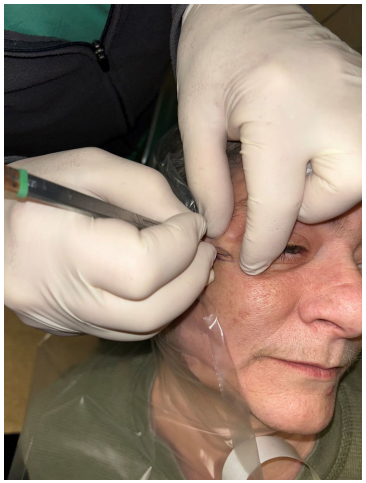
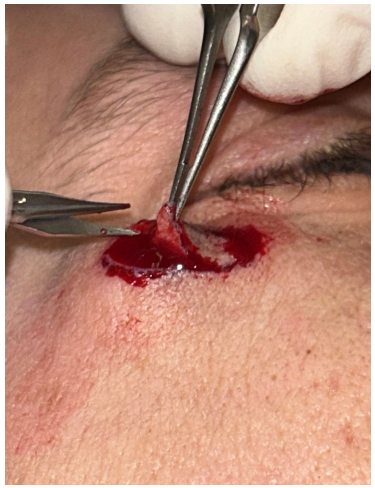
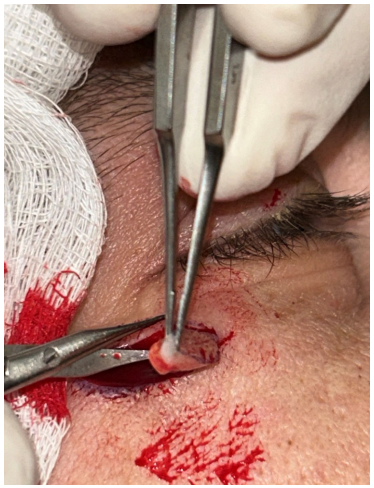
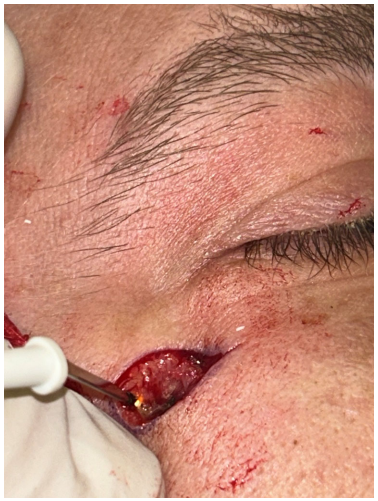
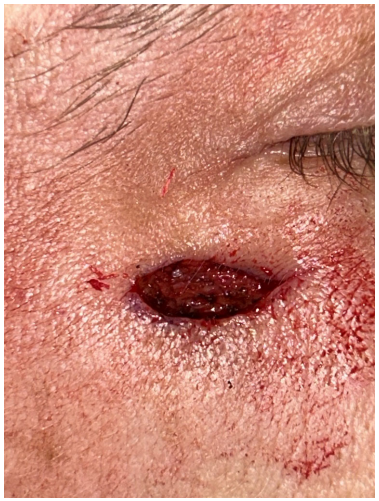
Merkle cell

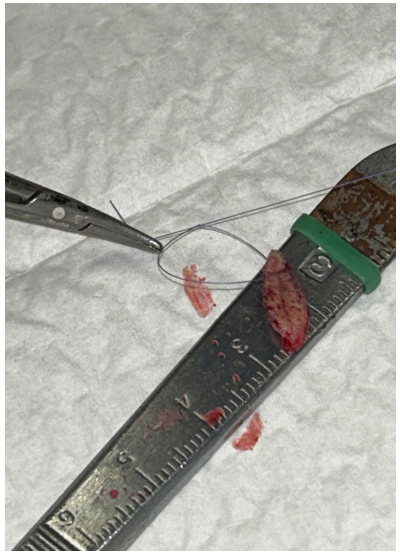
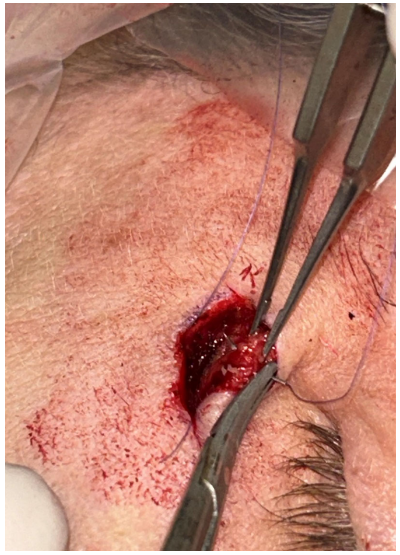
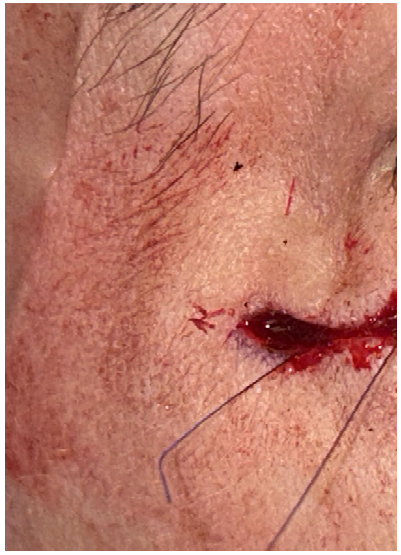
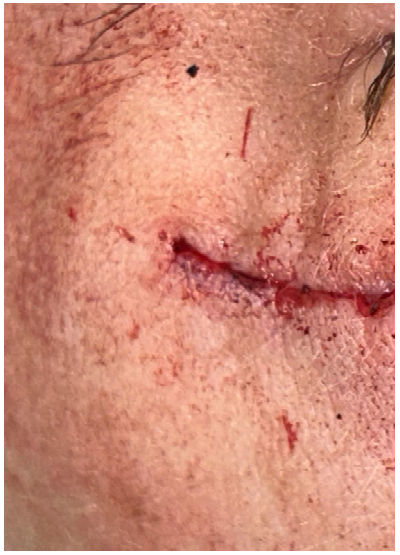
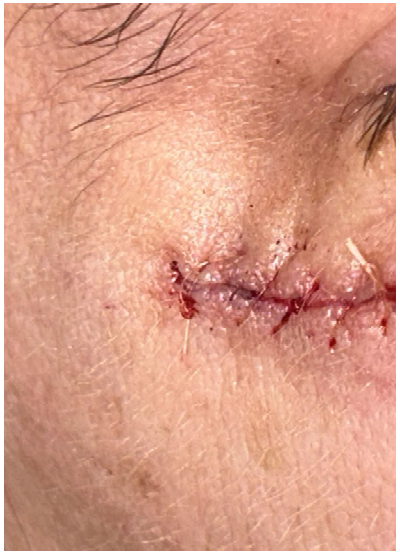
Etc.

Basal cell carcinoma

Basal cell – margins not clear

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