

MULTIPLE CYSTS OF MEIBOMIAN GLAND: A RARE PRESENTATIONSaumya saxena*¹ and Sanjeev verma²¹Department of ophthalmology, St Stephens hospital, New Delhi, India.²Department of ophthalmology, JNU IMSRC, Jaipur India.***Corresponding Author: Saumya saxena**¹Department of ophthalmology, St Stephens hospital, New Delhi, India.

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ABSTRACT

This report describes the case of a hydrocystoma in young male affecting bilateral eyes involving both the eyelids. Diagnosis is clinical and the surgical technique offers good aesthetic result and the low risk of reoccurrence. The objective of presenting this case report is to describe the surgical management of cases of cystic tumours of the eyelid with the respective surgical technique.

KEYWORDS: eyelid neoplasms, hydrocystoma, sweat glands.**INTRODUCTION**

Eyelid Hydrocystoma also known as cyst adenoma, moll gland cyst or sudoriferous cyst. These cysts most commonly appear as solitary soft dome shaped translucent papules or nodules and most frequently located on the lower eyelids specially the inner canthus.

Their pathogenesis appears to result from an obstruction of the sweat gland ducts immediately above the glandular coil within the deep dermal layer following an inflammatory process or trauma.^[1]

Hydrocystoma are benign lesions of the eyelid that are differentiated in two histological types: apocrine and eccrine.^[2,3] The apocrine hydrocystoma or cyst of Moll affects the eyelid border and generally appears following an obstruction of the apocrine secretory duct of the gland of Moll (apocrine and eccrine sweat glands).^[4] They consist of small, painless, round, translucent, fluid-filled vesicles.^[5,2,6]

The eccrine hydrocystoma or cyst of the eccrine sweat glands originates from the eccrine sweat gland, also known as the gland of Moll, and is a rare disorder. It generally presents as multiple cutaneous vesicles on the lower eyelid.^[2]

The most common site for cysts of Moll is close to the eyelashes, the route of lacrimal drainage, while the most common site for eccrine hydrocystoma is on the skin of the eyelid.^[7]

The time between the first appearance of the lesion and reaching clinical diagnosis varies from one to five years; however, it should be emphasized that this figure is

imprecise since in many cases onset of the lesion's growth was not observed by the physician, given that the lesion is usually asymptomatic.^[8] Consequently, the majority of patients seek treatment for aesthetic reasons.^[3]

The initial diagnosis is clinical, followed by histopathological confirmation.^[3,7]

Histologically, apocrine hydrocystoma present with various large cystic spaces and papillary projections in the dermis, covered by two layers of secretory cells. The innermost cells are columnar-shaped with eosinophilic cytoplasm with typical apical projections and decapitation secretion, periodic acid-Schiff (PAS)-positive and diastase-resistant granules.^[9]

CASE REPORT

We present a case history of a 36 years old male patient presenting to the outpatient department of ophthalmology St Stephens hospital New Delhi. With the chief complaint of multiple symptomless cystic tumours in and around the free margin of both eyelids since 6 years.

Patient was apparently alright 6 years back when he had first small painless lesion on the medial side of the left eye which increased in size following which the patient got it punctured from a local practitioner but the lesion reappeared in the same area and eventually increased in size again. After 2 years he developed more lesions in and around both eyes which have been continuously increasing in size since then.

Ophthalmological examination revealed normal visual acuity in both eyes and no abnormalities in extrinsic ocular motility. Pupillary reflexes were preserved. Bio microscopy revealed the presence of multiple translucent cysts ranging from 1mm to 4mm mostly around the medial canthus and medial 1/3rd of both the eyes. (Figure.1). Diagnostic hypothesis was hydrocystoma. Management consisted of surgical removal and histopathological evaluation and cytology. Surgical procedure/technique: Anaesthesia was achieved by perilesional infiltration of 2% Xylocaine with adrenalin at a solution of 1:200,000 after which an incision was made in the skin above the cystic lesion along the lines of Langerhans, the edges of the skin were opened and the lesion was completely dissected up to its base, always by stretching (divulsion) with scissors rather than by cutting. Finally, the lesion was removed in Toto without perforating the cystic capsule. Next, the wound was cauterized, the excess skin was excised and the wound was sutured using 6-0 vicryl thread and subcutaneous stitches (Figure 2). 2ml colourless clear fluid was sent for cytology which revealed amorphous material. Histology revealed an apocrine hydrocystoma.



DISCUSSION

According to the results of a study conducted at the Botucatu School of Medicine in Brazil, hydrocystomas predominantly affect females from the fourth decade of life onwards, usually in the form of a single lesion, a finding that is in agreement with other reports in the literature.^[3,7,10] The most usual site is on the lower eyelids.^[8] Whereas in our study a young male in his 3rd

decade of life has presented with multiple cysts in bilateral eyes involving both eyelids.

CONCLUSION

Eccrine hydrocystomas are retention cysts histologically characterized by a single, partially collapsed cystic cavity in the dermis, with no papillary projections, surrounded by one or two layers of small cuboid epithelial cells. Sometimes the content of the cysts has a brownish coloring due to the lipofuscin secreted by the neighboring cell, giving it a clinical appearance of blue nevus or melanoma.^[9]

Differential diagnoses include: contagious mollusk, nodular or cystic basal cell carcinoma, hidradenoma, nevocytic nevus, blue nevus, disseminated syringoma, hordeolum, chalazion and epidermal cyst.

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