SQUAMOUS CELL CARCINOMA OF THE RIGHT LOWER EYELID

An Ancient Indian Approach dating back about 2000 years.

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Initial Presentation
22 September 1982

60 year old male with a very large malignant ulcer on the right lower eyelid, which had undergone rapid growth over the last 8 weeks.

The size of the lesion was such that adequate clearance necessitated excision of virtually the entire lower lid.

Initial Treatment (29 September 1982):

The lid was amputated and the wound allowed to granulate. The whole procedure took 5 minutes.

The eyelid was picked up in 2 curved artery forceps and a scapel blade was made to run immediately below them. Bleeders were diathermied.

Why amputate??

This decision was undertaken because of a past medical history of multiple skin malignancies of the head and neck, with previous treatments such as radical neck dissections and radiotherapy.

It was considered unwise to rotate tissues which could quite likely be a source of further malignancy.

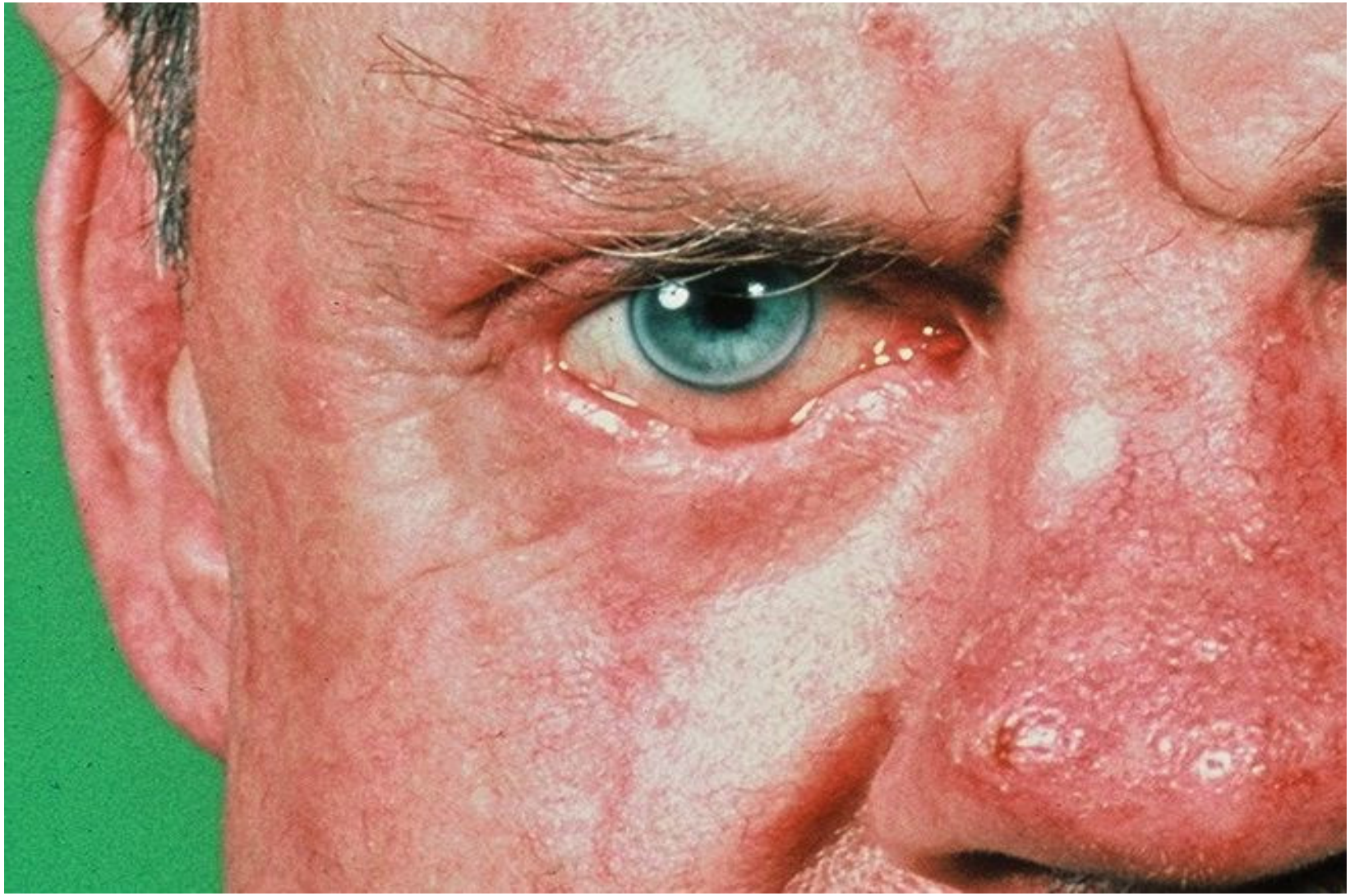
This patient, incidentally, after this procedure, lived, without a recurrence, for another 30 years.

Two Precautions!!

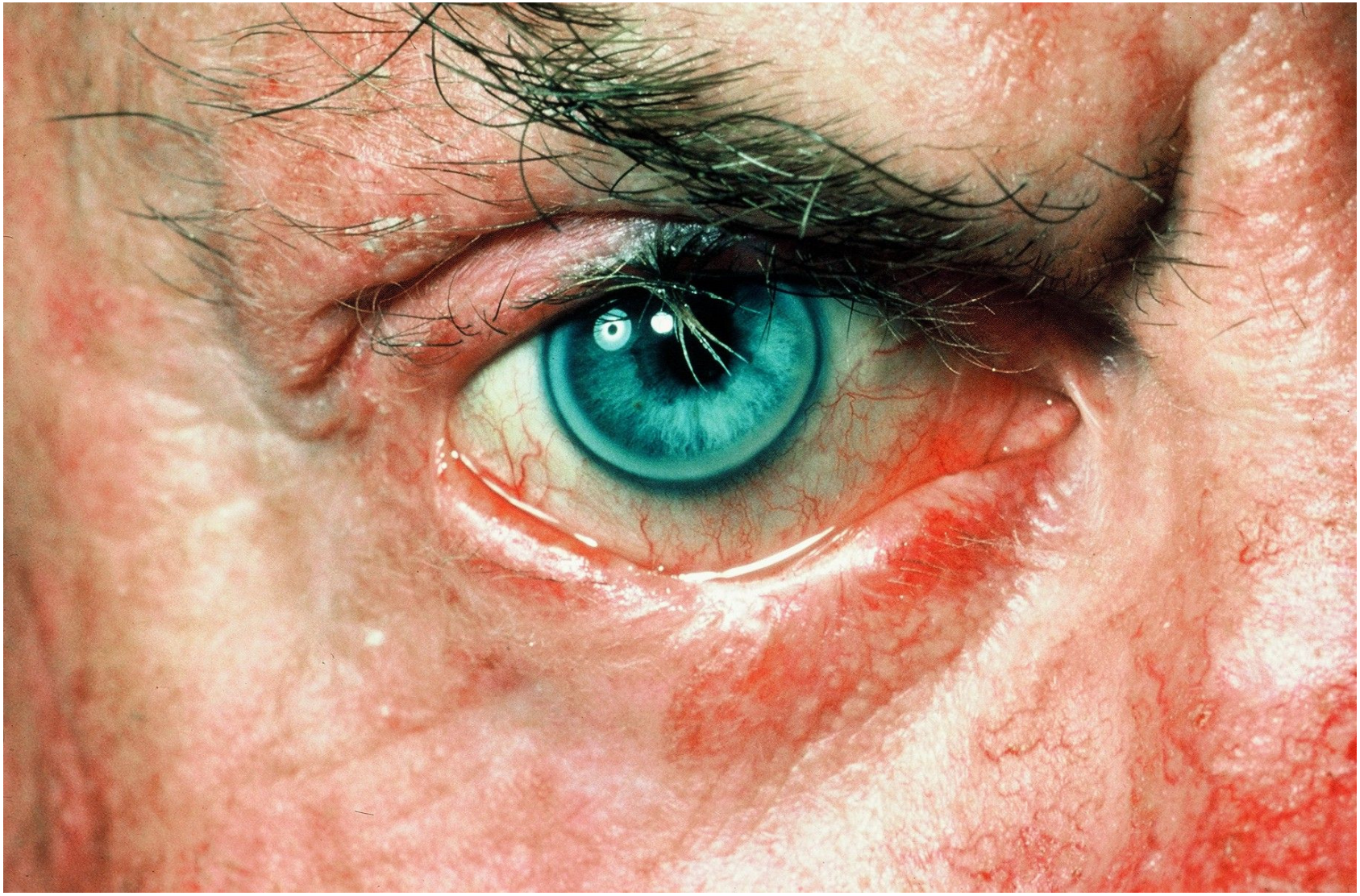
(1) Each end of the lid, (including the lacrimal punctum), was spared. These ends remained fixed to bone, and as the wound contracted helped to elevate the tissues of the upper cheek to reform a new eyelid.

(2) Also spare the lower fornix. If you don't healing will extend backwards under the eyeball and no eyelid will form.

2 days after excision of right lower lid for squamous cell carcinoma.



Twenty-two days after excision of right lower lid for squamous cell carcinoma.



Four months after excision of right lower lid for squamous cell carcinoma.