An audit was undertaken of the patients operated on from the period May 2009- June 2015 where surgery was undertaken for malignancy on the lid area. A single surgeon GMW was involved.

Two patients with malignant melanoma were excluded and referred for tertiary specialist opinion in Melbourne. There were thirty females and fifteen males. The ages vary between 40 and 94. This may reflect the demographics of the practice with more females than males in the older age group. This is an unusual preponderance of females with the greater exposure of men to solar damage.

There were forty one lower lids operated on, two upper lids and two at the inner canthal area.

The surgery area was routinely resected with a 3mm margin from the edge of the clinical lesion. Histologically twenty five were either macro or micro nodular BCCs reported on by pathology. 14 of the patients had infiltrative or morphea like pathology at the time of surgery.

Three SCCs were found.

Twenty two patients had a wedge excision and a tarsoconjunctival slide involving the lower lid and extending into the malar region to mobilise enough tissue for closure.

In 3 cases simple excision was used leaving the lid margin edge.

16 cases required a wedge resection and usually a lateral cantholysis.

In twelve cases the excision was not complete and that is judged in the fact that the tumour may have extended to an edge. These were observed and none recurred. It may well be that the tumour was fully excised but some cells remain. When frozen section was undertaken the results were demonstrably more certain and 5

patients had the area of resection increased after report on the frozen section.

Follow up was difficult but 2 cases of recurrence were found.

1 occurred after 4 years. This may have been a new lesion.

The surgeon is often not certain of the pathological edge with morphea and infiltrative lesions which leads to under resection of the pathology

Closure of the resected area was achieved by lateral lateral tarsoconjunctival slide in nearly 50% of the patients which represents and extremely effective way of reconstructing a lower lid with a good final cosmetic appearance. 50% of the lid margin can be resected and closed with this technique. There was a high instance of using lateral cantholysis even with simple wedge resections.

A Wendell Hughes technique was used in 4 cases with opening of the tarsorraphy at 3 weeks. In each case upper lid skin was used.

Summary

The high instance of infiltrative of morphea like lesions suggest that great care has to be taken if the edge of the lesion is not certain. In this situation a larger than usual excision increasing the margin to 4mm as opposed to 3mm would seem to be justified.

Frozen section should be used if there is any doubt regarding the extent of the pathology and if the appearance is clinically of an infitrative or mophea pattern