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Short communication

A new OCT sign of invasive squamous cell carcinoma of the cornea[☆]



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ABSTRACT

Case report: A case is reported of an unusual progressive corneal opacification and neovascularization caused by a squamous cell carcinoma (SCC) of the cornea. A patient with a white stromal infiltrate, consistent with herpetic stromal keratitis, showed a very particular image in optical coherence tomography (OCT), resembling a “tongue of lava” sliding between corneal lamellae. Histopathological analysis confirmed the diagnosis of SCC.

Discussion: To our knowledge this is the first report in the literature of this peculiar image with OCT. Squamous cell carcinoma is an extremely rare cause of progressive corneal opacification and neovascularization, and a delayed diagnosis may lead to unsuccessful treatment and loss of the eyeball.

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Garcinoma de células escamosas en la córnea: un nuevo signo de invasión corneal en la tomografía de coherencia óptica

RESUMEN

Caso clínico: Presentamos un caso de inusual opacificación corneal y neovascularización progresiva, causada por un carcinoma de células escamosas (CCE). El infiltrado estromal blanquecino sugestivo de queratitis estromal herpética, mostró una imagen en la tomografía de coherencia óptica (OCT) semejante a una «lengua de lava» deslizándose entre las lamelas corneales. El análisis histopatológico confirmó que se trataba de un CCE.

Palabras clave:

Carcinoma corneal de células escamosas

Queratitis estromal

Infiltrado corneal

Neovascularización corneal

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Discusión: A nuestro conocimiento, es la primera descripción en la literatura de esta peculiar imagen. El CCE es una causa extremadamente infrecuente de opacificación corneal progresiva y neovascularización, y el retraso en el diagnóstico y tratamiento puede conducir a fracaso del tratamiento y pérdida del globo ocular.

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Introduction

Ocular surface squamous neoplasia ([OSSN]) includes several neoplasia of epithelial origin: squamous papilloma, intraepithelial carcinoma (CIN, ICE), carcinoma in situ (CIS) and squamous cell carcinoma (SCC). OSSN is more frequent in elderly and male patients, particularly in areas exposed to intense ultraviolet B radiation. Other risk factors include infection by human papilloma virus (HPV), immunosuppression, tobacco and poorly pigmented skin. In young patients it is required to discard infection by human immunodeficiency virus (HIV) and *Xeroderma pigmentosum*.¹

A case of progressive corneal opacification with neovascularization is presented, caused by squamous cell carcinoma (CCE) in the cornea, with a peculiar OCT sign as yet undescribed.

Clinic case report

A male patient, aged 76 years, intervened for cataracts without complications 3 months earlier, visited the practice after observing a whitish spot in his right eye with slight irritation. The patient was undergoing systemic deterioration and his general history included malign prostate neoplasia intervened 9 years earlier, severe bronchopathy, thromboembolic disease in treatment with acenocumarol (Sintrom®, Novartis Farmacéutica SA, Barcelona, Spain) and wearing a urinary probe due to incontinence. Biomicroscopy revealed nasal whitish infiltrate with superficial and deep vascularization (Fig. 1A). Uncorrected visual acuity was of 20/20 in both eyes, and OCT-Visante® (Carl Zeiss Meditec, Jena, Germany) showed a dense image which, starting from the limbus, seemed to extend between corneal lamellae (Fig. 1B). All the ocular diagnostic tests (corneal scrapings with culture, herpes polymerase chain reaction and aqueous exploration) as well as systemic tests were negative both for the detection of infectious agents and self-immune disease or other distant infectious locations. The first clinical diagnosis was herpetic disease without discarding possible indolent bacterian or fungal infection. Treatment was initiated with oral antivirals, Valacyclovir® 500 mg (Valtrex®, GlaxoSmithKline, S.A., Tres Cantos, Madrid, Spain) twice a day, and topical drugs with corticoids (Dexametasona fosfato, Maxidex® Alcon Cusí S.A., El Masnou, Barcelona, Spain) and antibiotics (Moxifloxacin Vigamox® Alcon Cusí S.A., El Masnou, Barcelona, Spain) 4 times a day.

Initially, a slight subjective improvement took place but in the following months the infiltrate and superficial and deep vascularization in the nasal sector slowly grew, involving

the entire cornea. Confocal microscopy (HRT-II, Heidelberg Engineering, GMBH, Heidelberg, Germany) revealed an accumulation of stromal amorphous material, without abnormal cells or fungi. Corneal biopsy was performed on 3 occasions utilizing a 4 mm diameter punch and cover with amniotic membrane (Fig. 2A). Anatomopathological reports indicated intra-epithelial lymphocytes and benign stromal fibrosis suggesting stromal keratitis. Fungi were not observed in the sample. Conjunctival biopsy mapped in 4 quadrants was negative and finally the fourth biopsy of the corneal superior temporal area (Fig. 2B and C) at 600 µm, gave a diagnosis of well-differentiated squamous cell corneal carcinoma (Fig. 2D). Imaging studies did not reveal extraocular immigration or metastatic disease. In June 2014, the eye was enucleated. The surgical margins were free of malignity, without rupture of Descemet's membrane or invasion of the anterior chamber. Eight months after enucleation there is no evidence of

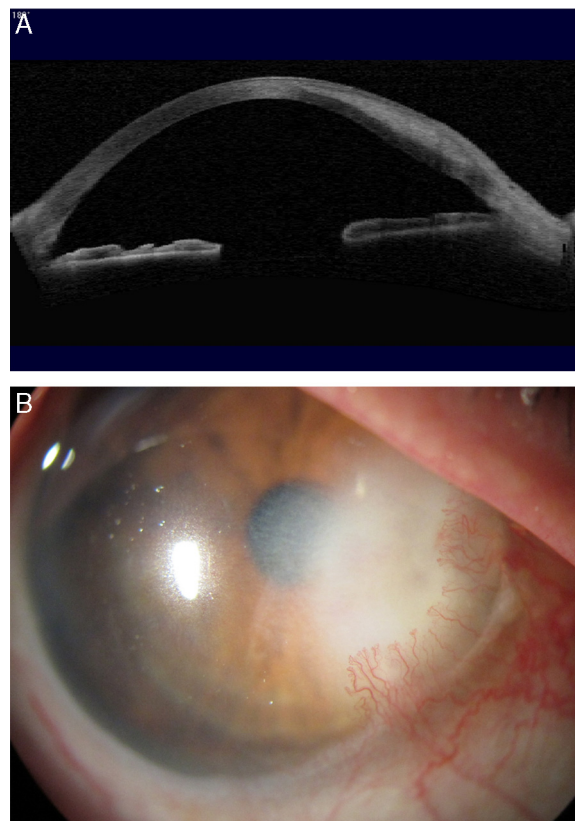


Fig. 1 – (A) October 2012 BMC. Whitish stromal infiltrate with superficial and deep neovascularization. (B) OCT-Visante® October 2012. Increased density image in the form of a “river of lava”, between corneal lamellae.

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