the LAD coronary artery was good before the intervention, but after the dissection despite good anastomosis with patch angioplasty, quality of the LAD coronary artery was not satisfactory. If this case had been operated before dissection, postoperative LAD quality would have been better. So, after this complication we began to think that the results of surgery would be better in severe ISR treatment.

In conclusion, ISR remains a challenging problem and optimal management is yet to be determined. Despite better percutenous coronary interventional results, restenosis and complication risk are still high in most cases. In patients having ISR with low potential success and high complication rate, CABG surgery seems to yield the best outcome.

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Case Report

CONJUNCTIVAL SQUAMOUS CELL CANCER

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ABSTRACT

With advancing age immobile amelanotic conjunctival lesions of the interpalpebral area may often be seen. Considering these lesions, we should think of papilloma, leukoplaki and also conjunctiva cancer. In this case report we present an 80-year-old patient who was admitted to our clinic with the complaint of a mass in her right eye.

Key Words: Conjunctival cancer, Differential diagnosis

INTRODUCTION

Conjunctival squamous cell cancer (CSCC) characteristically occurs as an amelanotic, fleshy, often papillamotous mass near the corneascleral limbus or, occasionally, in the forniceal or palpebral conjunctiva (1). It frequently displays white ceratin on its surface (1). In the conjunctiva, SCC occurs about ten times more frequently than the basal- cell type (2). They usually arise at the limbus and spread to the cornea and adjacent bulbar conjunctiva. A limbal carcinoma sometimes invades the sclera and, very infrequently the cornea but usually Bowman's membrane acts as a barrier to the corneal invasion (3,4). In extremely rare cases the tumor extends through the sclera into the intra ocular structures. Ophthalmic, especially conjunctiva tumors are not often seen in clinics and their differential diagnosis is usually made by inspection. It is sometimes difficult to differentiate benignant lesions from malignant ones.

CASE REPORT

An 80-year –old woman was admitted to the hospital with a progressively enlarging, painless fleshy lesion in her right eye. Her history was otherwise noncontributory. In the right eye, there was a lesion superotemporally arising from the limbal conjunctiva and invading the cornea (Fig.1). Dilated conjunctiva blood vessels around the lesion were also observed.

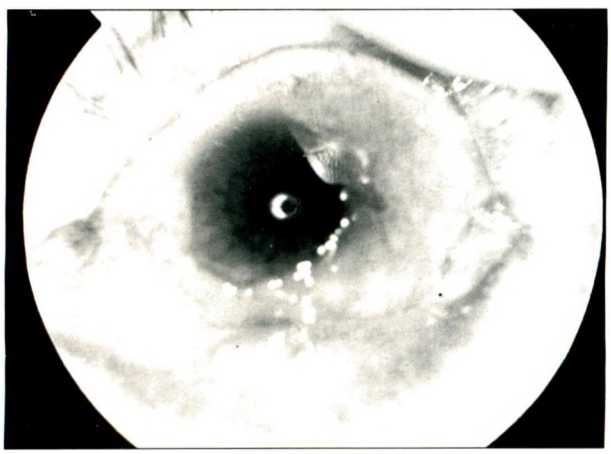

Fig.1: Conjunctival fleshy lesion invading the cornea.

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The lesion was removed by partial keratoconjunctivectomy, marking the conjunctiva border elevated from the limbal cornea with subconjunctival serum physiologic injection. Postoperatively, there was no limbal insufficiency due to surgery.

Microscopically, the tumor was confined to the epithelium, and the basement membrane was intact. Nonceratinized squamous epithelia showed loss of its chromaticity and polarity, features of actinic keratozis, and underneath it had a layer of lymphocytic infiltration (Fig. 2, grey arrow). In the stroma, there was an island of (Fig.2, black arrow) intensive atypical molecular cell infiltration which belongs to CSCC. (Fig. 3)

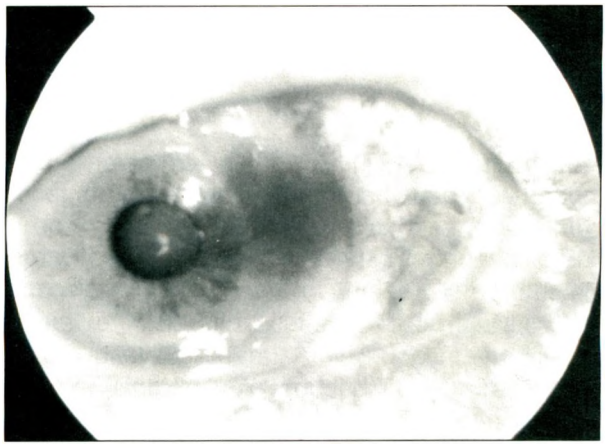

Fig.2: The lesion after excision.

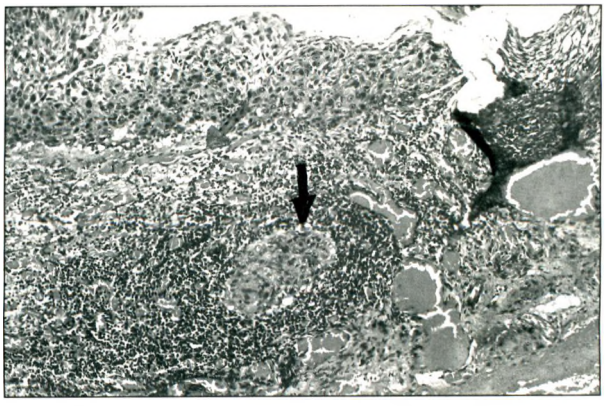

Fig.3: Nonkeratinised squamous cell epithelia, underneath this an island of CSCC.

DISCUSSION

The decision on how to manage conjunctiva lesions is based on assessment of relevant history and the clinical features of the lesion. Information is limited on how well ophthalmologists process this information in order to make a correct diagnosis (5). The lesions which come to mind when faced with a conjunctiva lesion should include; papilloma, neoplastic papilloma, Bowen disease and leukoplaki (6).

A papilloma may at times be confused with a SCC: in the transitional stage it may be difficult to determine, even on histological examination, whether it is a papilloma or early CSCC. But later on, the elevated appearance and the location (caruncular or forniceal not limbal) help in the differential diagnosis. Neoplastic papilloma which is often seen in older people, is usually one-sided and like bulbar conjunctiva and limbus. It may change to CSCC. Neoplastic papillomas may be misdiagnosed as CSCC due to the limbal localization of both lesions, but pathologically abundant core vascular structures surrounded by atypical cells of neoplastic papillomas help in differential diagnosis. Bowen disease most commonly appears in the interpalpebral fissure, especially at the limbus. Clinically, these lesions may be covered by a white scale (keratin). The term leukoplaki literally means white plaque and conveys no information about the underlying problem which produced the excess keratin. In the differential diagnosis, reached by pathological examination, atypical cells present only in epithelia in carcinoma in situ and cells spread to the stroma passing basement membrane in CSCC.

Although a CSCC may not show progression or metastases over some years, surgery is often necessary. Cryotherapy, excision, intra lesional alpha-interferon injection or combined surgery with Mitomycin-C has been reported to be successful in treating these lesions (6). During surgery the malignant neoplasm of the conjunctiva should be removed by meticulous microsurgery, taking great care not to disrupt the tumor.

In conclusion, conjunctiva cancers are rarely seen in clinics. It is possible to excise these lesions like in our case. Adjunctive therapy such as cryotherapy or Mitomycin C should not be used as a first line of treatment (6). In the follow-up of our patient for the first 3 years, we did not see any recurrence.

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