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Conjunctival Invasive Squamous Cell Carcinoma Presenting as Necrotizing Sclerokeratitis in a Young Patient

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INTRODUCTION

Our goal is to report a case of atypical Ocular Surface Squamous Neoplasia (OSSN) manifestation in a young, immunocompetent patient, as well as raise awareness to how atypical presentations may delay the correct diagnosis and treatment, leading to increased morbidy and even mortality.

CASE REPORT

H.P., 21 years old, male, farmer, presented red right eye (RE) and mild discomfort for 4 months. History of previous conjunctival flap due to peripheral ulcer 2 months before in the same eye.

Examination revealed nasal peripheral corneal thinning with uveal tissue prolapse in the RE (Fig. 1), with visual acuity of 20/200. Left eye was normal.

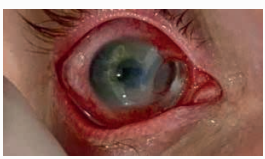

Fig. 1: RE at presentation, showing redness, corneal thinning and perforation with uveal prolapse.

A sclerocorneal patch was performed at the moment and systemic evaluation was negative.

One month later, he developed inferior necrotizing sclerokeratitis (SK), requiring a second patch. Mooren's ulcer was considered and immunosuppresion initiated. After two months, a tectonic transplant was necessary.

Six months later, the patient returned with fixed esotropia and a new perforation with loss of intraocular contents. Ocular ultrasound was carefully performed, showing choroidal thickening.

Anatomo-pathologic study evidenced poorly differentiated OSSN, and post-operative orbital CT (Fig. 2) showed a mass in the RE with orbital invasion.

Orbital exenteration was performed, confirming the diagnosis, showing extension to the conjunctival fornix, sclera, ciliary body and choroid.

A 24 month follow-up so far, showed no reccurence.

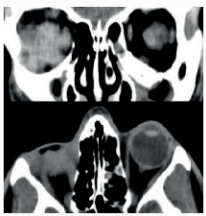

Fig. 2: orbital CT showing a hyperdense image in the right eye, measuring 1.6cm in its largest diameter and orbital invasion.

CONCLUSION

OSSN average age at diagnosis is 53-71yo, with no reports in young patients without HIV or immunosupresion history. It can mimic SK and autoimune diseases due to ocular inflammation, leading to late or wrong diagnosis. Invasion is rare (1-13%), with orbital extension in 2-16%, more common in immunocompromised patients.

Our patient was young, healthy and had mutiple visits to the emegency, what contributed to diagnostic delay. So, its important to think about OSSN when atypical corneal or scleral thinning, perforation are diagnosed, specially in young patients with no sistemic disease.

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