Abstract I:

What do you need to know about rare eyelid malignancies

Rare non-melanotic eyelid malignancies presented in this lecture are cutaneous squamous cell carcinoma, sebaceous carcinoma, and Merkel cell carcinoma.

Clinical diagnosis of cutaneous squamous cell carcinoma is challenging even among ophthalmologists and often misdiagnosed as basal cell carcinoma. Extensive sun exposure, old age and fair skin type are typical risk factors. Of histopathological risk factors, perineural invasion and higher grades are important to consider in surgical treatment; sufficient margins, preferably slow Mohs technique should be considered. Systemic immunosuppression as risk factor for cutaneous squamous cell carcinoma should notice.

In the periocular region sebaceous carcinoma arises from Meibomian glands, glands of Zeis, or sebaceous glands of the caruncle, eyebrow, and surrounding. Sebaceous carcinoma often mimics benign conditions such as chalazion, blepharitis, and less aggressive tumours and therefore the diagnosis of sebaceous carcinoma is often markedly delayed. The longest diagnostic delay is related to misdiagnosis as chalazion. This emphasizes the importance of biopsy when chalazion or other diagnosed as benign at onset do not heal as expected. A biopsy must be taken through the eyelid. The histopathologic diagnosis is challenging to general pathologists. Sebaceous carcinoma is associated with Muir-Torre syndrome with mutations in the MSH2 and MLH1 genes and coexist with visceral malignancies, usually colonic.

Merkel cell carcinoma is a rare neuroendocrine carcinoma that typically appears in sun-exposed areas of the elderly. It has aggressive behavior and surgical treatment must be done urgently and with wide margins.

Abstract II:

Oculoplastic emergencies – what you need when you are on call

The acute orbit threatens vision and requires quick treatment. Inside the orbit the pressure increases suddenly. If left untreated, the increase in pressure can cause vision loss. The most common etiological reasons are infection, inflammation, retrobulbar hemorrhage (e.g. injury, retrobulbar injections, leaking orbital tumor/vascular malformation), tumour, and a foreign object. Treat pain, blood pressure, check anticoagulants, treatment of infection/inflammation, initiation of cortisone. Imaging must not delay the start of initial treatment. Lateral canthotomy in acute orbital and optic neuropathy (reduced vision, reduced color vision, RAPD+, tight orbita and elevated TA). Recognize life-threatening diseases and direct immediately intensive care unit.

Orbital cellulitis can spread from adjacent tissues such as sinuses, teeth, and skin or inside the orbit: infection of the lacrimal sac, endophthalmitis, after trauma or surgery. Orbital cellulitis can also develop through the sepsis. The causative agent depends on the port of infection. Check underlying diseases, immunodeficiencies (filamentous fungi, aspergillus, and mucormycosis), diabetes, trauma, surgery. Remember evaluating meningism, level of consciousness, vital signs. Radiological imaging CT/MRI with contrast. Take a photo and draw the borders. If necessary, consult various specialties.

Necrotizing fasciitis is a rare bacterial infection caused by *beta-hemolytic streptococci +- S.aureus* that spreads quickly in the body and can cause a death. Pain out proportion, very ill patient, and rapid progression in hours. Risk factors are minor trauma, surgery, i.v drug use, diabetes, immunocompetency, young age. Mortality > 32%, depends on if associated myositis or toxic shock. Always requires i.v. antibiotics, intensive care unit and emergency surgical treatment with plastic surgeons (debridement, specimens).