

History

A 58-year-old female patient was referred with a 2-year history, gradually enlarging, painless left upper lid lump. There was no bleeding or ulceration. She had no other eye symptoms and no other skin lesions.

- Her past medical history included: hypertension and gastro-oesophageal reflux disease, which were controlled by medication.
- On examination: vision in both eyes was 6/9 aided; there was a left upper lid non-mobile, non-tender nodular lesion on the lid margin with madarosis. Anterior segments and fundoscopy were otherwise normal.
- A left eyelid shave excision biopsy was performed and sent for ophthalmic pathology assessment.
- Macroscopic examination showed a lash-bearing skin measuring $5 \times 5 \times 4$ mm with a nodule measuring 3mm in diameter and 1mm from the peripheral margins.

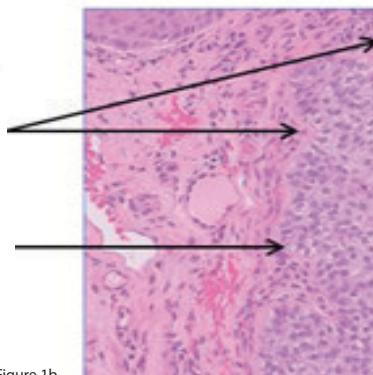


Figure 1b

Questions

1. Figures 1a and 1b show representative H&E sections of the lesion. How can this be described?
2. What are the differential diagnoses?
3. What is the most likely diagnosis and what further stains may help?

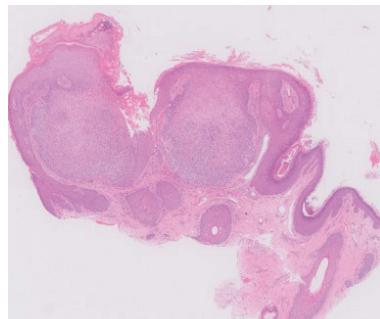


Figure 1a

SECTION EDITORS



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ANSWERS