realized that the patient had a pressure ulcer on his lower lip that seemed to be National Pressure Ulcer Advisory Panel category II (Fig. 1). The ulcer was treated conservatively, and a slightly noticeable scar remained at 6 months after surgery (Fig. 2).

**Patient 2**

A 23-year-old man had a deviated nose and nasal obstruction. Surgery was performed under general anesthesia in the same fashion as for patient 1. The surgery time was 273 minutes. The patient had a mucosal pressure ulcer on his lower lip on the second postoperative day. Fortunately, the ulcer healed within a few weeks without any scar formation (Fig. 3).

**DISCUSSION**

Device-related pressure ulcers are not rare. All surgical patients undergoing prolonged procedures should be considered at risk for intraoperative device-related pressure ulcer. Previous reports have suggested that these ulcers are becoming increasingly prevalent. For many years, intraoperative nasal pressure ulcers caused by prolonged nasotracheal intubation are well known as common complications of craniofacial surgery, and prophylaxis has been reported. However, few studies have reported pressure ulcers of the lower lip.

Our 2 cases involved prolonged rhinoplasty. One of the reasons for these ulcers appears to be excessively strong securing using polyvinyl chloride, which can apply pressure to soft tissue. The lower lip may be easily compressed between a tube and the lower incisal teeth. We usually pay attention in nasotracheal intubation to avoid alar rim necrosis in craniofacial surgery. The same care must be taken for the lower lip in rhinoplasty patients. Generally, the anesthesiologist checks the position of endotracheal tube. In rhinoplasty, the lower lip is always exposed in the surgical field. The endotracheal tube should be checked and repositioned by the surgeon. Dressings may be helpful to avoid pressure ulcers of the lower lip as well as other device-related ulcers.

**REFERENCES**


**Primary Orbital Melanoma Combined With Giant Divided Nevus of the Eyelid**

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**Abstract:** The authors report a rare case of primary orbital melanoma (POM) combined with giant divided nevus of the eyelid. An 8-year-old Chinese girl is referred for evaluation of 2-month duration of exophthalmos with decreased vision, epiphora, and pain on her right eye. His presentation, imaging, biopsy, histopathology, and management are...
presented. The possible cellular origin of the POM and the relationship of POM and divided nevus are discussed. We presume that divided nevus may be one of rarely preexisting lesions of POM.

Key Words: Primary orbital melanoma, divided nevus, eyelid

Primary orbital melanoma (POM) is a rare subset of malignant melanoma often associated with other pigmentedary conditions, such as blue nevi or congenital melanosis, and usually represents a rather poor prognosis. Divided nevus is a rare form of melanocytic nevus involving both the upper and lower eyelids, and only a few cases have been reported in the literature. Until now, there has been no literature documentation about POM combined with divided nevus. We are the first to report a case of POM combined with divided nevus of the eyelids in the ipsilateral orbit.

CLINICAL REPORT

An 8-year-old Chinese girl without a family history of malignant melanoma was referred for evaluation of a 2-month duration of exophthalmos with decreased vision, epiphora, and pain on her right eye. On clinical examination, she had finger count/1 m in the right eye, and a black pigmented plaque affected both the upper and lower right eyelids at birth and enlarged to 3 × 4-cm² area as the child grew. There was a circumscribed, indurated lesion behind the right globe. Exophthalmometry measured 24 mm OD and 14 mm OS with temporal displacement. The right upper eyelid was ptotic with swelling contour, and the globe had complete ophthalmoplegia (Fig. 1A). Pigmentation was found on the whole conjunctiva, and the temporal conjunctiva was exposed with erosion (Fig. 1B). There was no evidence of ectropion, entropion, or relative afferent pupillary defect. Slit-lamp biomicroscopy demonstrated melanin pigmented irregularly on the whole conjunctiva. Funduscopic examination revealed normal optic disc and retinal striae in the nasal and paramacular retina. All other physical examinations including chest radiograph, color Doppler imaging of the abdomen, dermatological evaluation, and brain magnetic resonance imaging did not show abnormalities in respect of another primary tumor or of tumor dissemination outside the orbit. No evidence of congenital melanocytosis, blue nevus, or cellular blue nevus was found.

Magnetic resonance imaging revealed a complex, lobulated lesion in the right orbit. The lesion was approximately 2.2 × 3 × 2.5 cm³ in diameter and occupied almost the whole sector of the orbital cavity. The heterogeneous lesion had irregular contour and expanded into the orbit; T1-weighted imaging was isointense-hyperintense; T2-weighted imaging (T2WI) was isointense. The medial globe and posterior globe were compressed and deformed (Figs. 1C–F). Color Doppler imaging showed abundant blood flow signal in the lesion. Computed tomography illustrated no evidence of bone erosion.

The lesion showed malignant properties; therefore, a cryosection biopsy of the lesions was performed intraoperatively. The cryosection histopathology revealed orbital malignant melanoma and intradermal nevus in the eyelid and conjunctiva. The family, in consultation with the ophthalmology team, opted for the complete exenteration of the right orbital content. Radiotherapy and chemotherapy were used as additional treatment after operation. Unfortunately, the patient developed local recurrence and liver metastasis and died about 10 months after excision of the tumor.

The exenteration of orbital content consisted of several parts including eyelid, conjunctiva, the orbital mass, eyeball, and extraocular muscle. Grossly, the lesion in the orbital cavity, which was surrounded by pseudocapsule, appeared black, lobulated, and fibrotic and loosely adhered to peripheral soft tissue. On light microscopy, the specimen taken from the right eyelid revealed several nests of nevus cells in the dermis, some of which contained intracytoplasmic melanin, and was diagnosed as intradermal nevus (Fig. 2A). Pathology report of the conjunctiva confirmed compound nevus, which possesses features of junctional (arising from the deeper layers of the epidermis) and intradermal nevus. The eyelid and conjunctiva specimens stained positive to S-100 protein and focally negative to melanoma-specific antigen (HMB-45) (Figs. 2B, C). The specimen taken from the orbital mass showed irregularly arranged tumor cells, some of which were pigmented (Fig. 2D). At higher magnification, mitotic figures and cellular pleomorphism could be seen notably. Immunoreactions for HMB-45 and S-100 protein were positive (Figs. 2E, F). Malignant melanoma cells invaded into the superficial sclera and extraocular muscles; the optic nerve was normal.

DISCUSSION

Although ophthalmologists occasionally encounter cases of secondary orbital extension of uveal melanoma, primary malignant melanoma of the orbit is exceedingly rare. In the Wills Eye Hospital series of 1264 diagnosed orbital tumors, there were only 10 (<1%) POMs. The series of 3476 orbital tumors of He et al included 1 case of POM. More than half of POMs tend to occur in patients with predisposing melanocytic lesions such as congenital orbital melanocytosis, blue nevus, or cellular blue nevus. However, in our patient, there were no predisposing melanocytic lesions from which primary malignant melanoma usually arises. Instead, a giant divided nevus was seen in the right globe. Divided nevus of the eyelid was also a rare form of congenital melanocytic nevus on adjacent parts of the upper and lower eyelid, giving the appearance of a single lesion when the eye was closed. Until now, about 150 cases of divided nevus...
have been reported in the literature since the first case report by Von Micheal in 1908, but there was no literature about divided nevus associating with POM.

Perhaps the most puzzling aspect of the case reported here is whether the melanoma is a metastatic focus from an occult primary site or whether it is a localized malignant transformation of nevus cells. Melanoma metastatic to the orbit almost always occurs in patients who have a known primary melanoma, in whom it generally is a part of widespread melanomatosis. Our patient has no history of other primary melanoma, and all physical examinations are negative in respect of another primary tumor outside the orbit or of tumor dissemination. Thus, we consider it unlikely that our patient has melanoma metastatic to the orbit. Another puzzling problem is the possibility of localized malignant transformation of nevus cells. Desai et al reviewed 150 cases of divided nevi reported in the literatures. There were no described cases of malignant transformation of nevus cells. Kharel et al reported a very rare case of malignant transformation of kissing nevus with ocular and extraocular spread. So far, this case was the only malignant transformation reported in the literature. In our patient, the histopathology and immunohistochemistry revealed intradermal nevus in the eyelid and compound nevus in the conjunctiva. As such, the nevus cells were unlikely to invade into the orbit and transform into malignant melanoma. Accordingly, we believed the lesion in the right orbit to be POM.

The origin of POM cells is not very clear. Greater than 90% of POMs are probably originated from congenital melanocytes in the neural crest, and they may be found along the ciliary nerve, uvea, scleral emissary veins, or the leptomeninges of the optical nerve. Because the POM in our patient showed tight connections with optic nerve and eyeball, we considered that melanocytes in the optic nerve sheath or sclera emissary veins can proliferate and undergo malignant transformation. Divided nevi originate from melanocytes, of the neural crest, which migrate to epidermal level in gestation at a time when the eyelids have just joined. Subsequent opening of the eyelid at 24th weeks of gestation gives rise to division of the nevus. On the basis of the possible same cellular origin of melanocytes, we presumed that the divided nevi may be one of rarely pre-existing lesions in POM. However, more reported cases are needed to confirm this.
Heminasal proboscis, a rare craniofacial cleft

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Abstract: Craniofacial clefts are extremely rare congenital anomalies, the importance of which lies in their great range of variety of anatomic forms and their complex management. Proboscis is one of the rare cases of this kind in which half of the nose is separated from the face and it is only edged on the right or left medial canthal regions by a nose-like, rudimentary tubular structure. This article reports the case of a 3-month-old infant with left-sided proboscis. Left lower eyelid coloboma was also present. The proboscis was treated with local flaps at the age of 3 months, and at the age of 10 months the coloboma was managed.

Key Words: Craniofacial cleft, heminasal proboscis, nasal repair, nasal reconstruction

It may only happen once in the professional life of every plastic surgeon to come across a proboscis case. Proboscis is a kind of facial malformation in which half of the bifid nose is not fused to the other half and also the face. This very half is located off the center of the nose’s vertical midline.

In most cases, lateral nasal proboscis occurs with some other anomalies such as other central nervous system and facial bone system anomalies, as well as soft tissue association. Proboscis is characterized by soft tissues and skin imbrications of a tubular structure whose blood vascular system is through the connection of the upper part to the face.

A specific standard technique of surgery for the reconstruction of this kind of deformity has not been established because of its great anatomic variety and rarity of its occurrence. The case of a 3-month-old infant with proboscis and lower eyelid coloboma has been studied in this article, and the operation treatment has been illustrated.

CASE PRESENTATION

The patient, a female infant of 3 months with proboscis, was presented to the plastic surgery clinic (Fig. 1). The patient was the third child of the family with 2 other normal children. The case of giving birth to a dead fetus with anencephaly was observed among the first-degree relatives’ history. The mother had not taken any drugs, has not used alcohol, has not been exposed to any radiations, did not have a familial marriage, and did not have any specific disease during her pregnancy.

The physical examinations showed that the left half of the nose was a tubular structure with equal length of the other normal half except that it was separated from the face and the other half and that it was located in front of the left medial canthal area. There was a pit at the lower end of the proboscis. There was also a pit at the base of the columna in the medial third of the lower eyelid. The other parts of the face were normal. Facial computed tomography scan imaged a leftward nasal sepal deviation and that there was no evidence of a nasal airway on the same side. It was also revealed that the nasal septum was attached to the maxillary sinus medial wall. The computed tomography scan did not show encephalocele or any other skeletal defects, as well.

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