

Slide 1

2025
AFOS/SECO
**EDUCATION
DESTINATION**
San Antonio

Course # 101

Hands-on Workshop:
In-Office Surgical Procedures

Michelle Welch, OD
Jeff Anastasio, OD

Please Silence All Mobile Devices.

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San Antonio

Michelle Welch, OD

Disclosure statements:
No financial relationships to disclose

All relevant relationships have been mitigated.

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Lumps and Bumps:
In Office Optometric Lid Procedures

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 **Choctaw Nation**
Faith•Family•Culture

Malignant Tumors of the Eyelids

"Pearls"

- Most periocular tumors are derived from epidermis or adnexae
- Main goal – rule out malignancy
- Identify characteristics of malignancy (HABCDs)
- BIOPSY ALL SUSPICIOUS LESIONS!



BCC

Epithelial Malignancies

Basal cell carcinoma

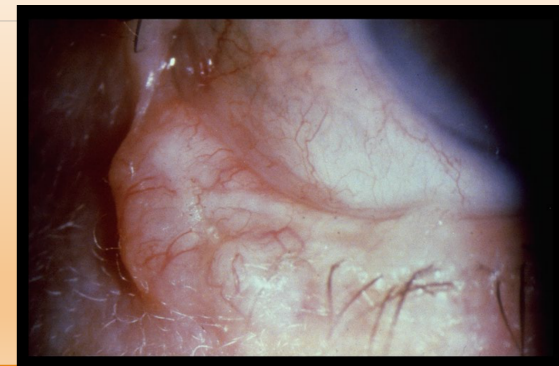
- Most common malignancy of the eyelid (90%+)
- Types
 - Nodular
 - Ulcerative
 - Sclerosing, morpheaform

Basal Cell Carcinoma

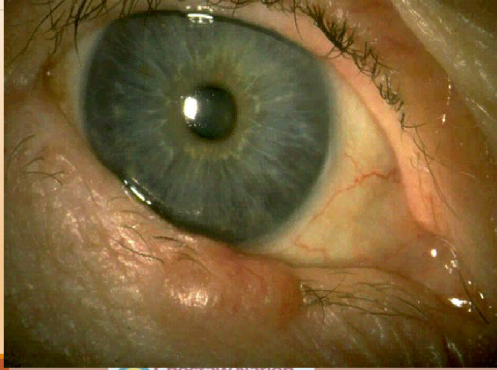
Rarely metastasize

- Medial canthal area most dangerous
- Mortality rate unknown, quoted 1-3%
- Orbital invasion
 - Iowa series (1992) 1.7%
 - Mayo clinic series 2.4%
 - Extentation necessary 1.4 – 3.8% of cases

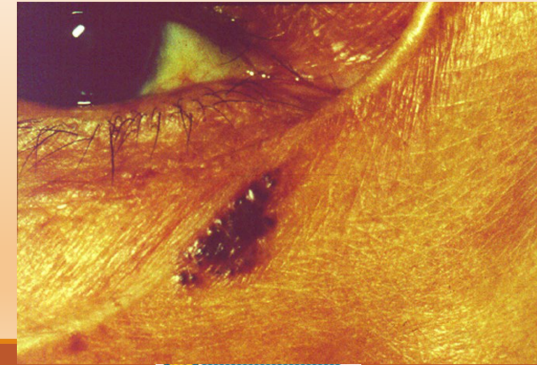
BASAL CELL CARCINOMA



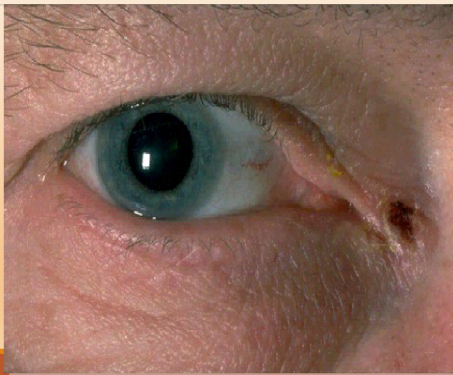
Nodular Basal Cell Carcinoma



PIGMENTED BASAL CELL



Ulcerative Basal Cell Carcinoma



Epithelial Malignancies

Squamous cell carcinoma

- Relatively rare, Wilmer series 4.2% (Doxanas 1987)
- Small tendency to metastasize (0.23 – 0.25%)
- Frequently misdiagnosed clinically

Squamous Cell Carcinoma

Confused with:

- Sebaceous cell carcinoma, basal cell carcinoma
- Seborrheic keratosis, inverted follicular keratosis, papilloma
- If rapid onset and inflammation present, think of:
 - Keratoacanthoma, pseudoepitheliomatous hyperplasia

Squamous Cell Carcinoma

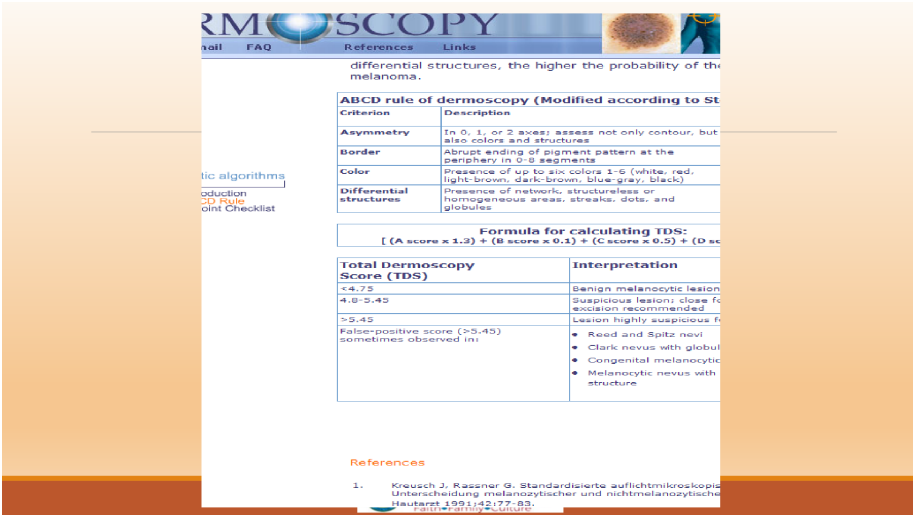
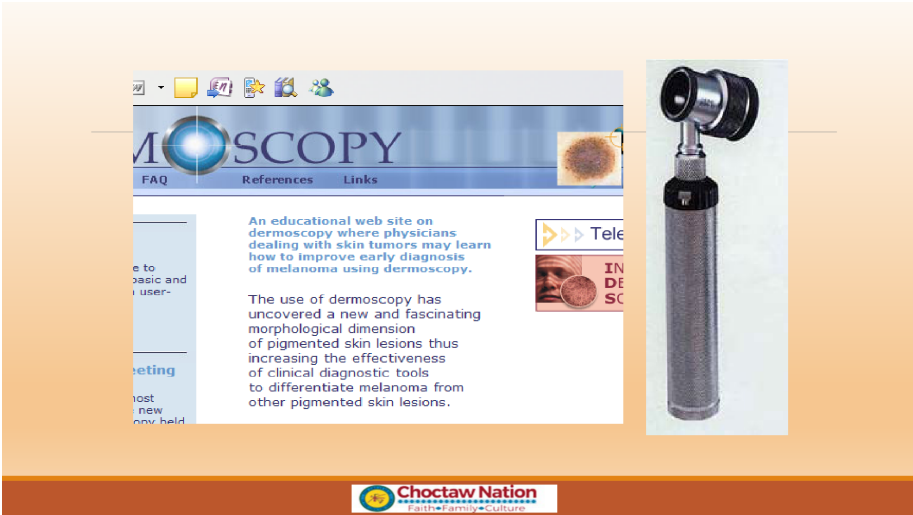
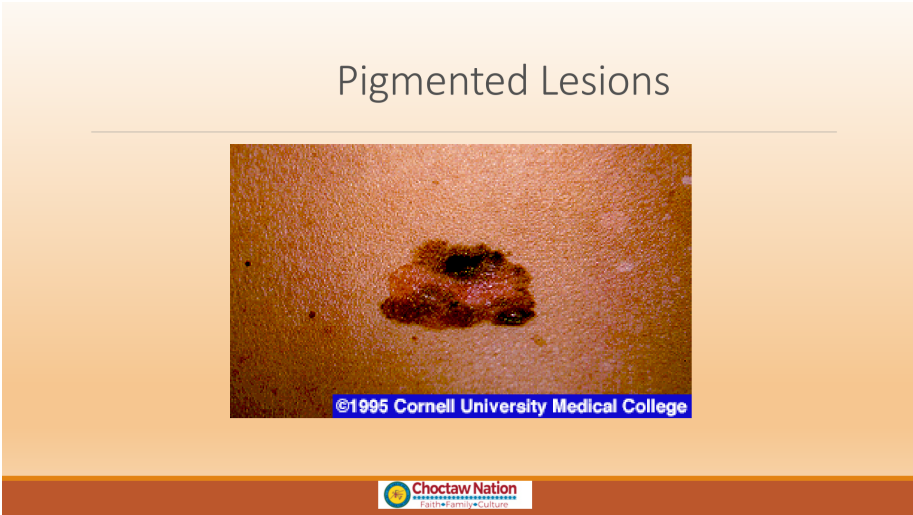
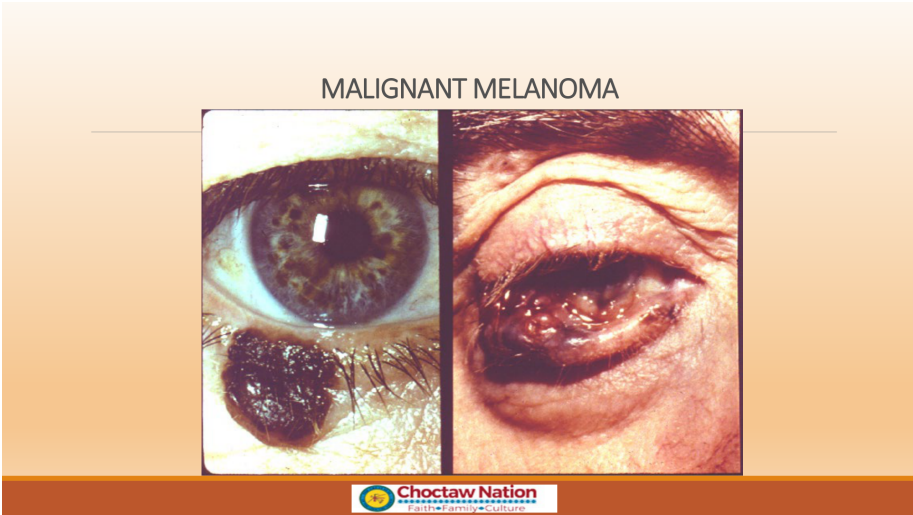


Squamous Cell Carcinoma

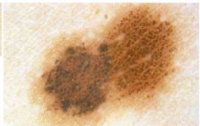
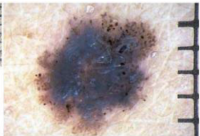


Characteristics of Pigment Cell Malignancy (Melanoma)

- New onset or recent change
- Asymmetric shape
- Irregular margins
- Color change or multiple colors
- Large size - > 5mm



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DERMOSCOPY			
Home	E-mail	FAQ	References Links
1 Step 2 Step 3 Step 4 Step 5 Step 6 Step Glossary	Dermoscopic criteria > Introduction > Global features - Pigment Network - Brown and Globules - Streaks - Blue-white veil > Pigmentation - Asymmetry/Structure - Vascular Structures - Other Criteria		
The striking aspect of this globular Clark nevus is the dark-brown gray color of otherwise regular dots/globules in the lower left part of the lesion   At the periphery of this melanoma, several irregularly shaped dots/globules can be noted   Numerous dots/globules of various sizes and shapes are present in the upper part of this melanoma			

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Differential Diagnosis



verruca



molluscum



Basal cell carcinoma



Squamous cell carcinoma

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Pick your lesion carefully!

A close-up photograph of a person's upper eyelid. A small, firm, reddish-brown nodule is visible on the eyelid margin, just above the eye. The surrounding skin appears slightly inflamed.

Chalazion

A close-up photograph of a person's upper eyelid. A small, white, dome-shaped lesion with a central umbilication is visible on the eyelid margin, near the eye.

Molluscum

A close-up photograph of a person's upper eyelid. A large, irregular, cauliflower-like growth is visible on the eyelid margin, extending over the eye.

Verruca

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Pick your lesion carefully!



Squamos Cell Carcinoma **Basal Cell Carcinoma**

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Pick your lesion carefully!



Excision with Radiofrequency

Advantages of Radiosurgery

- Quick and easy (to do and to learn)
- Nearly bloodless field
- Minimal Post-op pain
- Rapid healing
- Fine control with variety of tips
- No muscle contractions or nerve stimulation from radiowaves (Faraday effects)

Contraindications

Do NOT perform shave excision on pigmented lesion unless certain is not melanoma!!!

Don't use in presence of flammable fumes/liquids

Pacemaker

- "Do not work near the heart and place the antenna (or grounding) plate well away from the heart. Use the least power possible. Activate the handpiece intermittently rather than continuously. The cutting mode is the most risky, so avoid it if possible. Use another form of treatment if it is an option. The pacers are purportedly "shielded" and the current in the ESUs should not affect them, but all things are not perfect! Therefore caution is needed. Asystole and tachycardia are potential adverse outcomes."

• Pfenninger and Fowler's Procedures for Primary Care, 3rd Edition. John L. Pfenninger, MD, FAAP and Grant C. Fowler, MD



<https://vimeo.com/1100286278/24b0e076e8>



Epithelial inclusion cyst video

[HTTPS://VIMEO.COM/1100286002](https://vimeo.com/1100286002)

Informed Consent

- Indications for treatment
- Description of treatment in layman's terms
- Alternatives to treatment
- Risks and benefit of treatment
- Expected and unexpected outcomes
- Patient must request procedure



Units I have used/have experience with

Pre-Operative Activities

- check patient allergies
- check vital signs (pulse, respiration, BP)
- informed consent
- handling patient fear
- set up equipment
- Inspection of equipment
- Inspection of medication - discard if cloudy, expired, or container damaged
- Photodocument lesion

Procedure Technique

Pre-op (photos, consent, BP and Pulse, VA)

Anesthetize (infiltrative usually)

Clean area, drape if needed

- Betadine needs 3 mins on skin!

Turn on Ellman unit: warm up for at least 30 seconds

Choose appropriate waveform

Choose initial power setting (will often need to adjust depending on tissue response to energy level chosen)

Procedure Technique

Have assistant turn on/position vacuum unit— USE vacuum and masks!

- Have isolated HPV and HIV in smoke

Place yourself in comfortable/stable position to do procedure

Brace your handpiece wrist on patient for stability

Procedure Technique

Electrode tip should be applied perpendicularly to allow even distribution of energy

Press footplate activator when ready to begin procedure

Move in expeditious but controlled fashion: always keep electrode moving when contacting tissue

Procedure Technique

Keep surgical site moist (saline gauze) to avoid tissue drag; also wipe energized tip to remove tissue stuck to it

For removing mass lesions, use loop electrode/grab with opposite hand forceps/have specimen jar ready for lab submission

When feathering down a lesion with a loop, keep perpendicular--remove until healthy tissue seen (particularly helpful with lesions on gray line)

Can use forceps closed tips to touch end of area of bleeding, touch electrode to forceps to transfer energy to area to stop bleeding

Procedure Technique

Clean area of betadine

Apply antibiotic ung

Don't let patient jump and run as you sit them up!

Blood pressure and pulse post-op

Write op report in chart along with patient instructions on wound care and follow-up schedule

Chalazia Management Options

Give each patient all options for treatment!

- Conservative Approach
 - Hot compress with digital massage
 - Can add Doxycycline if not contraindicated
- Intralesional Steroid Injection
- Incision and Curettage

Differential Diagnosis

Sebaceous Gland Carcinoma

- Must r/o in any recurrent chalazion
- May be lash loss
- Appearance can be varied – be cautious



Conservative Approach

Indications

- Small lesion (< 6 mm)
- Less present less than 6 months
- Lesion in medical aspect of lid where would not want to perform I & C
- Patient choice of treatment

Contraindications

- Doxycycline allergy, liver and/or kidney dz

Risks and Complications

- No resolution of lesion

Intralesional Steroid Injection

Indications

- Over 6 months old
- Large (4 – 6 + mm)
- Located in medial aspect of lid (won't be able to do I & C)
- Patient choice

Contraindications

- Allergy/sensitivity to steroid

Risks and Complications

- Depigmentation
- Infection
- No resolution of lesion

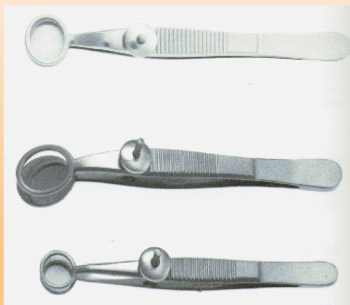
Intralesional Steroid Injection Technique

Multiuse Vial

- Alcohol top
- Put air in syringe
- Push air into vial
- Load syringe with med
- Alcohol top of vial
- Dilute kenalog 40 to 20 or 10

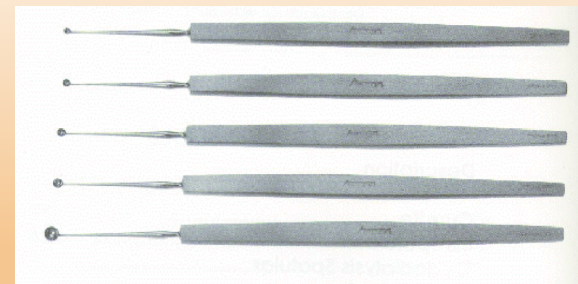


Instruments



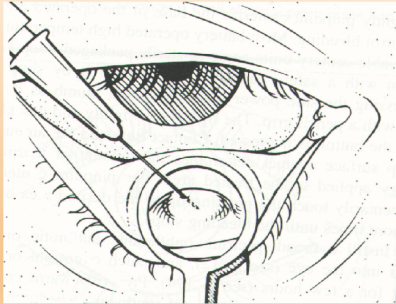
Chalazion Clamp

Instruments

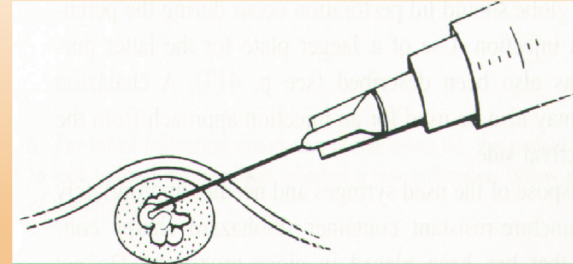


Curette

Intralesional Steroid Injection Technique



Intralesional Steroid Injection Technique



Chalazion Incision and Curettage

Indications

- Same as for injection plus:
- Failure of injection to resolve lesion

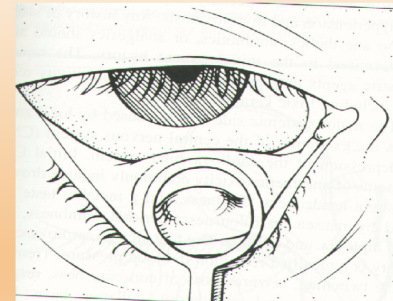
Contraindications

- Allergy/Sensitivity to anesthetic

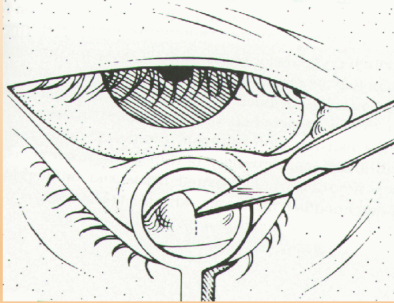
Risks and Complications

- Incomplete removal
- Infection
- Risks associated with injection of anesthetic
- If recurs in same spot will need biopsy could be sebaceous gland carcinoma!

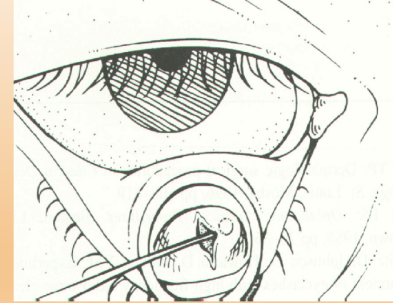
Chalazion Incision and Curettage



Chalazion Incision and Curettage



Chalazion Incision and Curettage



Chalazion #1 video

<https://vimeo.com/1100282107?share=copy>



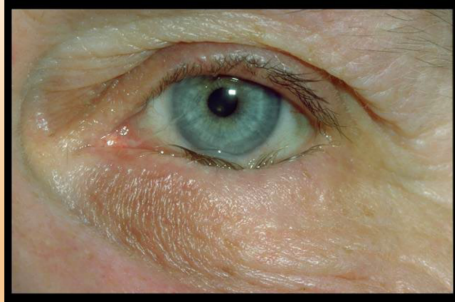
Chalazion #2 Video

<https://vimeo.com/1100282171?share=copy>

Entropion

Inward turn of eyelid – usually lower lid

For mild entropion, repair by suture is a viable option



Quickert Suture Technique

Entropion Repair by Suture Video

<https://vimeo.com/1100282207?share=copy>

BLEPHAROSPASM

- The initial recommended dose is 1.25 Units to 2.5 Units (0.05 mL to 0.1 mL volume at each site). The recommended dilution to achieve 1.25 Units is 100 Units/8 mL; for 2.5 Units it is 100 Units/4 mL¹⁶
- The cumulative dose of BOTOX® treatment for Blepharospasm in a 30-day period should not exceed 200 Units¹⁶
- Reconstituted BOTOX® is injected using a sterile, 27- to 30-gauge needle without electromyographic guidance¹⁶
- Avoiding injection near the levator palpebrae superioris may reduce the complication of ptosis¹⁶
- Avoiding medial lower lid injections may reduce the complication of diplopia. Ecchymosis can be prevented by applying pressure at the injection site immediately after injection¹⁶
- Initial effect of the injections is generally seen within 3 days and reaches a peak 1 to 2 weeks posttreatment. Each treatment lasts approximately 3 months, following which the procedure can be repeated¹⁶
- At repeat treatment sessions, the dose may be increased up to two-fold if the response from the initial treatment is considered insufficient, usually defined as an effect that does not last longer than 2 months. However, there appears to be little benefit obtainable from injecting more than 5 Units per site. Some tolerance may be found when BOTOX® is used in treating Blepharospasm if treatments are given any more frequently than every 3 months, and it is rare to have the effect be permanent¹⁶

Orbicularis oculi

Muscle action

Closes eyelids; palpebral part closes lids gently; orbital part closes lids tightly¹⁶



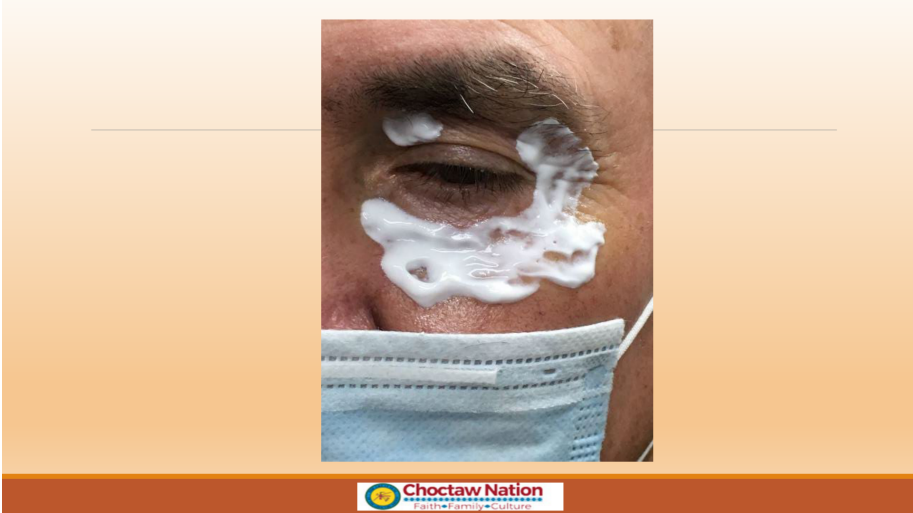
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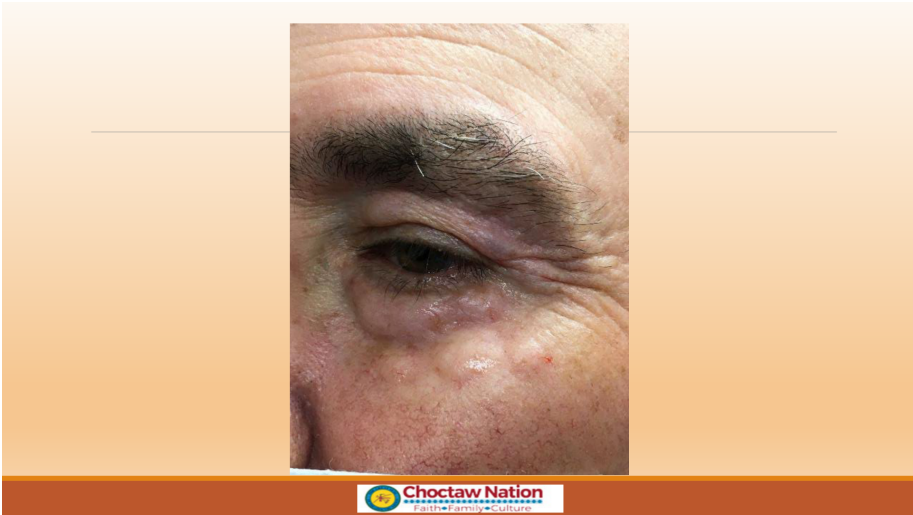


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Patient Education

- May be small amount of bruising
 - Can use ice pack if needed
- Pain Relief
 - Use same meds use to alleviate headache
- Keep area clean and dry
 - Don't wash for 24 hrs
 - No make up, lotions, powders for 5 – 7 days
- Use medication as directed
 - Usually topical antibiotic ung
 - Thin film over area for 4 – 5 days
 - Keep moist – don't want hard dry scabs

Patient Education

- Watch for signs of infection
- As scab forms, don't rub, scrub or pick– keep moist. Don't use agents that will dry it - alcohol, peroxide, etc.
- Discuss suture removal timeline
- Limit exposure to sunlight
- Long term moisturizer use (with spf)

PROCEDURE CODES

Approximate Allowables 6/2025:	
	<u>AOA CODING TODAY</u>
◦ 67840 Total Exc lid lesion	\$264.59
◦ 67810 Biopsy/Part Exc lid lesion	\$174.99
◦ 11200 Removal <16 skin tags	\$90.25
◦ 11310 Shave Exc < .5 cm	\$110.30
◦ 11900 Chal injection	\$55.64
◦ 67800 Chal I & C	\$125.18
◦ 67801 Chal Mult S Lid	\$157.85
◦ 67805 Chal Mult D Lid	\$196.67
◦ 67921 Repair of entropion, suture	\$454.14
◦ 64612 Botox for blepharospasm	\$134.24