



23. DIAGNOSTIC AND TREATMENT FEATURES OF PALPEBRAL XANTHELASMA.

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Introduction. Xanthelasma palpebrarum is the most common manifestation of cutaneous xanthoma, with a prevalence of approximately 0.3% in men and 1% in women. This benign proliferation presents as soft, semi-solid, yellow papules or plaques resulting from infiltration of histiocytes with intracellular lipid deposits into the reticular dermis. Palpebral xanthelasma can occur in the context of both primary (type II and IV) and secondary hyperlipidemia (hypothyroidism, diabetes mellitus), as well as in association with a normal lipid profile. Various treatment methods, including simple surgical excision, cryotherapy, trichloroacetic acid chemical peels, radiofrequency, and laser, are used for the treatment of palpebral xanthelasma.

Case statement. A 62-year-old female presented to the oro-maxillo-facial surgery department with aesthetic disorders and the presence of an upper eyelid formation. During the clinical examination, a yellow, painless papule with a semi-solid consistency was identified in the medial canthus area of the upper eyelid. Differential diagnosis was performed with necrobiotic xanthogranuloma, atheroma, syringoma, and palpebral sarcoidosis. Based on the clinical examination, the presumptive diagnosis of upper eyelid xanthelasma was established. Laboratory tests (hemoglobin, glucose, cholesterol, triglycerides, HDL, liver function tests) showed no pathological changes, thus excluding the systemic cause of dyslipidemia. A surgical intervention through simple excision was recommended. Histopathological examination confirmed the preoperative diagnosis, revealing the specific features of xanthelasma: the presence of a perivascular inflammatory infiltrate in the reticular dermis composed of mono- and multinucleated foamy histiocytes, characterized by cytoplasm with lipid vacuoles.

Discussions. Opting for surgical excision as the most optimal method of treatment, normal lipid profile, deep dermal involvement, size >5 mm, semi-solid consistency, onset >1 year, and the presence of skin laxity and blepharochalasis were considered. Postoperatively, the wound was covered with sterile strips and a compressive dressing. The patient was prescribed antibiotic prophylaxis with Ciprofloxacin, Tobrex eye drops and wound treatment with chlorhexidine. No postoperative complications were reported.

Conclusion. The surgical approach to palpebral xanthelasma requires special attention due to its direct location on the medial canthus, with increased potential for epicanthus development. To minimize this risk in cases with excess skin, it is recommended to perform two semilunar incisions and skin detachment without applying excessive traction.