

Letter to the editor regarding the article, “young lady with bilateral yellowish lesions on her eyelids”

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Dear Editor-in-Chief,

We read the “test your knowledge” article by Ishak et al.¹ with great interest. We commend the authors for their educative discussion about the case of a 26-year-old woman with bilateral xanthelasma palpebrarum (XP).¹ We frequently encounter patients with XP in our plastic surgery clinic and feel that it is important to add several points regarding the treatment of this condition.

The authors correctly state that “Previously common practices used to remove this type of lesions were cautery and laser ablation. Nowadays, chemical cauterization using TCA is being practiced by most physicians.” However, they omitted surgical excision from the list of treatment options for XP despite it being the method preferred by most plastic surgeons,^{2–4} including those in our clinic. The advantages of surgical excision include a more inconspicuous scar, the prevention of eyelid deformation, a specimen for histopathological analysis, the complete removal of the XP, the minimization of clinic visits, and a lower recurrence rate.^{3,4}

Surgery is warranted for lesions more than 5 mm in height, lesions involving the deep dermis or the underlying muscle, and longstanding lesions with an onset exceeding a year; of course, patient preferences must also be considered.³ There are several surgical excision techniques currently available for XP management, including *en toto* excision in an elliptical fashion, staged serial excision, excision with blepharoplasty incision, and “uncapping surgery,” in which the lesion is “uncapped” and the cholesterol deposit is removed.² A combination of simple excision and local flaps or skin grafts are also available for more advanced stages of XP.³ All of these techniques can be performed as an office-based procedure under local anesthesia.

Specifically, regarding the titular case, the patient received three treatments of trichloroacetic acid (TCA). We applaud the authors for their partial success (40% improvement) without any reported complications. However, chemical cauterization with TCA is generally reserved for lesions under 3–4 mm in diameter, as emphasized by some of the authors cited by Ishak et al.^{2,5} We feel that the use of TCA in cases with large xanthelasma such as this one could lead to suboptimal treatment and, more severely, increase the likelihood of excessive scarring and ectropion. These complications can be far more disfiguring and problematic than the original lesion and require a more complicated reconstructive treatment.

The various therapeutic methods available to treat XP all have advantages as well as limitations. However, we argue that, for large or refractory XP, surgical management should be the mainstay of treatment.

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