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Cash Report

Basal cell carcinoma: recurrence?

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ABSTRACT

Basal cell carcinoma (BCC) is a nonmelanocytic skin cancer (i.e., an epithelial tumor) that arises from basal cells. The prognosis for patients with BCC is excellent, but if the disease is allowed to progress, it can cause significant morbidity. Very few cases almost none have been reported to show metastasis. in this case report we describe an extremely rare case of recurrent BCC with metastasis.

Keywords: Basal cell carcinoma, Nonmelanocytic skin cancer, Recurrent BCC with metastasis

INTRODUCTION

BCCs are abnormal, uncontrolled growths or lesions that arise in the skin's basal cells, which line the deepest layer of the epidermis (the outermost layer of the skin). BCCs often look like open sores, red patches, pink growths, shiny bumps, or scars and are usually caused by a combination of cumulative and intense, occasional sun exposure.

BCC almost never spreads (metastasizes) beyond the original tumor site.[1] Only in exceedingly rare cases can it spread to other parts of the body and become life-threatening. It shouldn't be taken lightly, though: it can be disfiguring if not treated promptly.

CASE REPORT

32/M presented with complain of pain in scalp region for last one month, was operated in December 2010 elsewhere; HP-Pilar sheath acanthoma of the scalp. Recurrence in August in 2012 operated elsewhere; HP-left post auricular-Basal cell carcinoma. First seen at our clinic in December 2013 with pain in the operated area along with a left lymph node mass around 3cm in the parotid region. FNAC of the node was reported as metastatic basal cell carcinoma.

Treatment Plan

Superficial Parotidectomy to remove intraparotid lymph node and modified neck dissection (MND).

Surgery

Superficial Parotidectomy with modified neck dissection was done under general anesthesia. Under general anesthesia, Blair's lazy 'S' incision with modified McFee's incision for neck dissection. A superficial parotidectomy was performed. Facial nerve main trunk was identified and preserved. Modified radical neck dissection was done. Level III, IV, V lymph nodes were removed en block preserving the spinal accessory. Sternocleidomastoid was resected along with the parotid mass.

Histopathology Report

Sections from the parotid showed involvement by a poorly differentiated carcinoma. Intraparotid lymph nodes were involved by tumour. The differential diagnosed was suggested between: Squamous carcinoma and Basal cell carcinoma. 2 out of 8 lymph nodes from posterior triangle showed metastatic carcinoma. Extra nodal extension was not seen. Lymph nodes found in the neck dissection were negative for metastasis.

Figure 1: Pre-operative- lymph node mass in the parotid & neck Primary lesion in the scalp was controlled.

Immunohistochemistry Report

Basal cell carcinoma involving the parotid gland, surrounding muscles and intraparotid lymph nodes with metastasis to 2 out of 8 posterior triangle lymph nodes. Tumour cells express CK and weakly express Bc12.Tumour cells were negative for EMA and SMA.

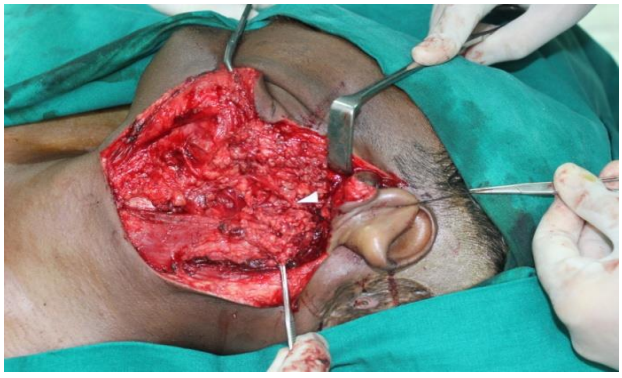

Figure 2: Intraoperative photograph showing exposure of the main trunk of facial nerve before removal of the metastatic disease in the neck and parotid region.

Follow up

January 2014 patient reported back to the clinic developed nodular recurrence at the primary site, biopsy reported as Recurrent BCC. Excision of lesion with underlying bone saucerisation was performed. Defect was covered using split thickness skin graft.

May 2014: Patient reported back with a 1.5 cm node in the left cervical region, an USG was advised and was reported as multiple neck nodes largest 23*6*3mm, to be metastatic in nature. Patient was thereafter sent for radiotherapy.

Figure 3: En-bloc resection of the metastatic lymph nodes at level 3, 4 & 5 and superficial lobe of the parotid gland.

DISCUSSION

Metastasis is relatively rare with a metastasis rate of 0.0028% to 0.5%. However, there is a 2% incidence of metastasis for tumours larger than 3 cm in diameter, 25% for tumours larger than 5 cm and 50% for tumours larger than 10 cm in diameter.[2]

Likely the recurrent lesion is a new primary BCC. 'Recurrent' basal cell carcinomas may represent new primary neoplasias: differences between aggressive and nonaggressive histologic subtypes.

Figure 4: Microphotograph showing metastatic basal cell carcinoma.

Criteria for distinguishing a new primary BCC arising in a skin flap or full-thickness skin graft at a previous treatment site for BCC from a truly recurrent BCC are presented. The distinction between a new primary BCC and true tumor recurrence is important for accurate clinical assessment and may have a dramatic impact on the type of subsequent treatment. In addition, there may

be less medico legal liability in the case of a new primary BCC arising at the site of a previously treated BCC than for a BCC that is determined to be recurrent.

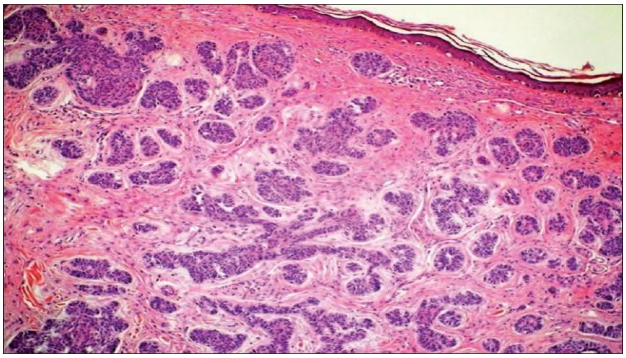

Figure 5: Immunohistochemistry: Tumour cells express CK and weakly express Bc12 and were negative for EMA and SMA.

Types of basal cell carcinoma[3]

1. Nodular[3]

A. Solitary, shiny, red nodule with large telangiectatic vessels.
B. Commonly on the face.
C. Cystic, pearly, telangiectasia.
D. May be ulcerated.
E. Micro nodular and micro cystic types may infiltrate deeply.

2. Superficial[3]

A. Often multiple, usually on the upper trunk and shoulders. Equal distribution over the face, trunk and limbs, although the site of predilection seems to vary according to sex (the head in women, the trunk in men).
B. Erythematous well-demarcated scaly plaques, often larger than 20 mm at presentation. Central clearing and a thread-like border. A rolled edge can be seen if stretched. The lesion may bleed or weep.
C. Slow growth over months or years; usually not aggressive, rarely become invasive and extremely rarely metastasise. Less likely to erode and ulcerate than nodular BCCs.
D. May be confused with Bowen's disease or inflammatory dermatoses.
E. Particularly responsive to medical rather than surgical treatment.

3. Morphoeic[3]

A. Also known as sclerosing or infiltrative BCC.
B. Usually found in mid-facial sites.
C. More aggressive and have poorly defined borders.
D. Characterised by thickened yellowish plaques.
E. Often present late and may become very large and then require extensive plastic surgical reconstruction. May infiltrate cutaneous nerves (perineural spread).they are prone to recurrence after treatment.

4. Pigmented[3]

A. Brown, blue or greyish lesion.
B. Nodular or superficial histology.
C. Seen more often in individuals with dark skin.
D. May resemble malignant melanoma.

CONCLUSION

Patient had sclerosing or infiltrative BCC. MOHS surgical technique (used for treating skin cancer).[4] There are always chances of formation of new primary / recurrence.[5] Like this case it's extremely rare to find a locally recurrent bcc with recurrent metastatic lymph nodes.

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