

CASE REPORT

LATE PRESENTATION OF BASAL CELL CARCINOMA - A CASE REPORT

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HOW TO CITE THIS ARTICLE:

Phani Kumar Sarkar, Umakanta Acharjee. "Late presentation of Basal Cell Carcinoma - A case report". Journal of Evolution of Medical and Dental Sciences 2013; Vol. 2, Issue 52, December 30; Page: 10154-10157

ABSTRACT: PURPOSE: To present a case of basal cell carcinoma with late presentation. **METHODS:** A 55-year-old woman with gradual progressive, nodular, small brown lesion at the left lower eye lid for past 3 years was examined with computed tomography (CT) and then excisional biopsy was done. **RESULTS:** The presenting symptoms of the patient were gradual progressive, nodular, small brown lesion at the left lower eye lid. Excisional biopsy with frozen section of the lesion was performed. Histopathologic evaluation of the eyelid lesion disclosed Trichoblastic (basal cell) carcinoma of lower eye lid with large nodular and cribriform (adenoid) patterns without any lymphovascular and perineural invasion. Post-operative period was uneventful. **CONCLUSION:** We are hereby reporting this case of eyelid BCC, with no history of skin cancer, or radiation treatment but exposure to sunlight. With early adequate treatment the prognosis is good.

KEYWORDS: Basal cell carcinoma, Excisional biopsy, Trichoblastic carcinoma.

INTRODUCTION: Basal cell carcinoma (BCC), a malignant tumour derived from cells of the basal layer of the epidermis constitutes 85–90% of all malignant epithelial eyelid tumours. The etiology of BCC is linked to excessive ultraviolet light exposure in fair-skinned individuals. Although metastases are rare, local invasion is common and can be very destructive. BCC from its clinical appearance initially leads to its diagnosis. Definitive diagnosis, however, can be made only on histopathological examination of biopsy specimens. The goal of therapy is the complete removal of tumour cells with preservation of unaffected eyelid and periorbital tissues. Although nonsurgical treatments such as cryotherapy, electrodesiccation, and laser ablation are advocated by some, surgical therapy is generally accepted as the treatment of choice for removal of BCCs. We are hereby reporting this case of eyelid BCC, with no history of skin cancer, or radiation treatment but exposure to sunlight.

CASE REPORT: A 55-year-old lady from a remote village of Khowai, farmer by occupation presented at Agartala Govt. Medical College and GBP Hospital Ophthalmology OPD with a gradual progressive, nodular, small brown lesion at the left lower eye lid for past 3 years. Lesion started 3 years back for which she has not consulted any doctor. There was occasional itching over that area. She had dryness over the face, with loss of appetite and weakness. The lesion started out as a flat, well-defined lesion below her left lower eyelid. Then it became a small bump that was pearly, light pink in colour. It eventually collapsed in the middle. Gradually it started to darken. Then a small skin sore developed, that bled easily. The sore didn't heal and there appeared a sore like scar without any injury to the area. She was a smoker by habit, nonalcoholic, nonvegetarian, worked in the outdoor and was exposed to sun light on an average of 4-6 hours. The patient had no medical or surgical problems. There was no family history of skin cancer.

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Fig. 1: Patient with gradual progressive, nodular, small brown mass at the left lower eye lid

Visual acuity both eyes were 6/6. On Ocular examination there was a brown black nodular mass measuring about 3cm x 4 cm in the left lower eye lid. The surface was rough, fixed to underlying lower eye lid. The regional lymph nodes were not palpable.

Her general physical examination was within normal limit.

CECT brain, orbit and PNS revealed no metastasis.

Patient was admitted in the eye ward on April 2013. Excisional biopsy with frozen section control was done. Safety margin of 3mm was marked in the skin and the tumour was excised. There was no extension of tumour along the margin of the specimen. Hence further excision was not done. Sutures were given with 6-0 vicryl. Post-operative period was uneventful.



Fig. 2: post-operative picture after excision biopsy

Histopathological report showed the specimen to be a Trichoblastic (basal cell) carcinoma of lower eye lid with large nodular and cribriform (adenoid) patterns without any lymph-vascular and perineural invasion.

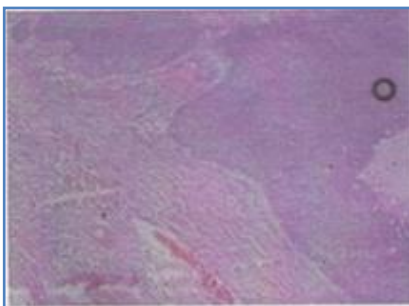


Fig. 3: histopathology showing Trichoblastic (basal cell) carcinoma

Follow up of the patient was done at 1, 3 and 6 months. There was no recurrence.

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DISCUSSION: Skin cancer has the potential to disfigure the eyelids, and often does. When the eyelid is affected by skin cancer, the primary goal is of course to remove the immediate threat of the cancer before it spreads or worsens. Early intervention improves chances of being cured, and in all cases surgical excision is key to eliminating or at least controlling the cancer. Of the different types of skin cancers that affect the eyes, basal cell carcinoma is unlikely to spread or metastasize to a distant site, but it does damage local tissue¹.

Basal cell carcinoma is the skin cancer that most commonly affects the eyelids, and the lower eyelid is most commonly affected. Arising from the basal layer of the epidermis, it is responsible for 85–90% of lid malignancies, two-thirds of which are seen in the lower lid, followed by medial canthi (25%), upper eyelid (10%) & outer canthi (5%)². BCC arises from a pluripotential stem cell in the epidermis that proliferates, amplifies, and eventually terminally differentiates.

Basal-cell carcinoma is a common skin cancer, but when solar (actinic) keratoses are also considered, basal cell carcinomas are second in prevalence. Basal cell carcinoma occurs mainly in fair-skinned patients with a family history of this cancer. Sunlight is a factor in about two-thirds of these cancers; therefore, doctors recommend sun screens with at least SPF 30. One-third occurs in non-sun-exposed areas; thus, the pathogenesis is more complex than UV exposure as the cause. Other predisposing factors include ionizing radiation, arsenic exposure, and scars³.

Clinical misdiagnoses are not uncommon. It is the most common cancer among Caucasians, being three to six times more frequent than Squamous cell carcinoma. Approximately 5%–10% of all skin cancers occur in the eyelid and BCC accounts for ~80%–90% of all Nonmelanoma skin cancers affecting the periocular area.

Clinical behaviour of BCC is highly variable. It can present as nodular, ulcerative, chronic dermatitis, atypical nevi etc. Baker has reported a case of BCC that presented as ectropion, then entropion, and finally medial canthal dystopia.

The usual course of the disease is a gradual enlargement of the lesion with underlying tissue destruction necessitating treatment. Treatment options include cryotherapy, radiation, chemotherapy, laser ablation and electrodesiccation, but surgical excision is the most widely accepted treatment of choice⁴.

Non-infiltrative BCC excision with 4 mm margins gave a zero recurrence rate; Surgery, either Mohs micrographic surgery or wide excision, is an established primary treatment for eyelid carcinoma and produces local control rates of 95% to 98%⁵. However, because of its location, eyelid carcinoma may produce severe dysfunction and can be associated with poor cosmesis after surgical treatment of large tumours or disease that involves multiple anatomic units.

Other type of flaps like tunnelled forehead flap, Triple-flap medial canthal reconstruction, glabellar flap modification "flap in flap" technique, Radix nasi transposition flap have been described. Complications of surgery are incomplete excision, metastasis, and tumour recurrence.

Extension into the orbit and sinuses typically requires more extensive surgery (exenteration, sinusectomy) with subsequent radiation therapy.

CONCLUSION: We are hereby reporting this case of eyelid BCC, with no history of skin cancer, or radiation treatment but exposure to sunlight. With early adequate treatment prognosis is good.

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REFERENCES:

1. Marco CE, Waltz K. Basal cell carcinoma of the eyelid and periocular skin. Survey Ophthalmol 1993; **38**: 169-192.
2. Khurana A K (2008) Comprehensive ophthalmology. New Age International (P) Limited Publishers: p. 360-361.
3. Yanoff M, Duker J S, Augsburger J J (2008). Ophthalmology 3/e. Mosby.
4. Warren RC, Nerad JA, Carter KD. Punch biopsy technique for the ophthalmologist. Arch Ophthalmol 1990; **108**: 778-779.
5. Tildsley J; Diaper C; Herd R; Mohs surgery vs primary excision for eyelid BCCs. Orbit (Amsterdam, Netherlands), 2010, vol. 29, issue 3, p 140.

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Date of Submission: 05/12/2013.
Date of Peer Review: 06/12/2013.
Date of Acceptance: 14/12/2013.
Date of Publishing: 24/12/2013