

## GIANT BASAL CELL CARCINOMA IN ATYPICAL LOCATION : A CASE REPORT AND REVIEW OF THE LITERATURE

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### Abstract

Basal cell carcinoma is the most common cutaneous malignancy, and is most exclusively seen in the head- neck with rare involvement of the trunk and extremities. Dermoscopy is a non-invasive technique used to increase the sensitivity of the clinical diagnosis of Basal cell carcinoma especially in atypical forms and unusual localizations. In this paper, a case of a giant basal cell carcinoma in the back of an 80-years-old woman is reported.

**Key words:** Basal Cell Carcinoma,Giant, atypical location.

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### Introduction:

Basal Cell Carcinoma (BCC) is the most common cutaneous malignancy and the most common human malignancy in general. Out of all basal cell carcinomas, giant basal cell carcinoma represents less than 1%. Only 10% of all basal cell carcinomas are located on the trunk and majority is located on the head and neck. (1.2.3)

We describe with a 10cm exophytic giant basal cell carcinoma located in the back of an 80 years old woman. One year after the lesion has occurred; diagnosis was made by pathohistological analysis. The patient was treated surgically, by excision. Review of the literature that refers to giant basal cell carcinoma was carried out.

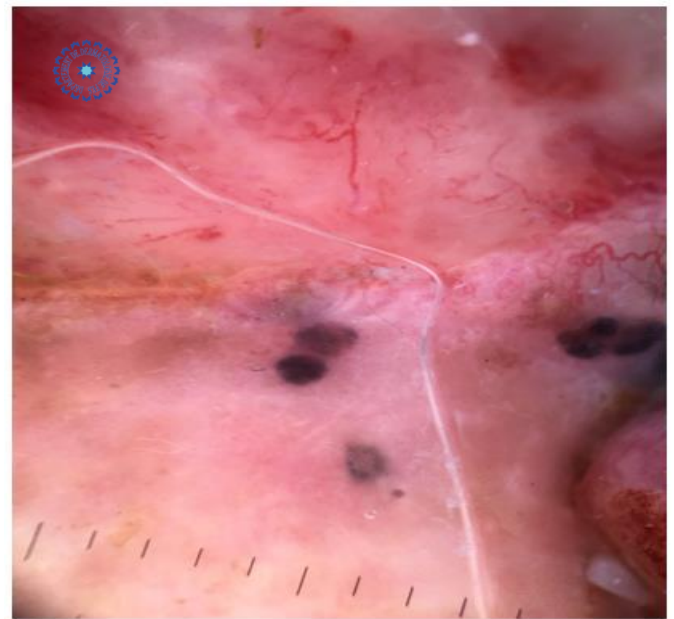
### Case report :

An 80-years-old female patient with a types II skin and and a large cutaneous tumor on her back (10cm) is presented. The lesion was mostly asymptomatic. From time to time she felt itching and little discomfort. She was convinced that the lesion was very small, not more than 0.5 cm.

Physical examination revealed exophytic ulcero-budding tumor size 10cm\*5cm which easily dripped serum and blood, of firm consistency with an infiltrated base (figure1). The surface of the tumor was partially ulcerated, with small necrotic areas. Dermoscopic evaluation of the lesion revealed the presence of dermoscopic features typical of basal cell carcinoma: central ulceration with Arborizing vessels, spoke-wheel areas and Blue-grey ovoid nests which pleaded in favor of a basal cell carcinoma (figure2). There was no evidence of lymph node involvement. Laboratory tests were made preoperatively and were all negative. However, scan revealed an expansive tumor measuring 10cm\*3cm on the back, on the skin in level with 7-8th thoracic vertebra. Tumor was well vascularized, without signs of necrosis.

Excision of the tumor with the surrounding skin measuring 10\*5 cm was made. Excision margins were 1 cm from the macroscopic border of the tumor.

Pathohistological findings revealed nests of atypical epithelial basaloid cells with peripherally palisading cells. Stroma surrounds nests of tumor cells and in some nests, keratinization is presented. Infiltration of skin was 1.5 cm and the surgical margins were negative. Tumor was completely removed.



**Figure1: Exophytic ulcero-budding tumor on her back**

**Figure2: Dermoscopy: central ulceration with Arborizing vessels, spoke-wheel areas and Blue-grey ovoid nests**

### **Discussion :**

The etiology of BCC is unknown. Indeed, various endogenous and exogenous factors, single or joined, may be responsible for the development of BCC. However, the chronically sun-exposed skin is the main predisposing factor to the occurrence of basal cell carcinoma. Fair-skinned persons (red or blond hair, freckling, skin types I and II) are especially at risk.

The existence of BCCs in non-sun-exposed areas is rare and suggests the existence of new etiologic factors. Approximately 80% of BCCs are in the head or neck, 15% in the trunk and less than 5% in areas considered unusual such as the abdomen, the genitals, the perianal skin, the back etc, as the case in our patient.

Abeldaño et al. (4) established the proportion of BCCs in different anatomical regions. The results showed that 65.4% occurred in the head or neck, of which 59.1% were located solely on the face. Less than 2% of lesions appeared in infrequent locations, such as abdomen, perianal region, groin, among others.

Although the clinical aspect makes it possible to suspect the diagnosis, this rare location makes it difficult. Currently, dermoscopy has found its place as a means of diagnosis. The dermoscopic characteristics are well known in the literature. The BCC's dermoscopic diagnosis is defined by the presence of at least one of the criteria defined by Menzies et al. In our patient, dermoscopy had objectified a central ulceration with Arborizing vessels, spoke-wheel areas and Blue-grey ovoid nests what was in favor of basal cell carcinoma.

Histological hallmarks of basal cell carcinoma are cells with elongated ovoid nuclei with a large nucleus-to-cytoplasm ratio, abnormal mitoses, and variable peripheral palisading (5).

Giant BCC is a rare variant that infiltrates dermis and frequently involves extradermal structures such as bone, muscle and cartilage. However, carelessness is an important factor in achieving that large sizes (6). This is, to our knowledge, the first report of a giant BCC on the back. (7)

Treatment of GBCC is generally surgical by excision, with margin depending on the prognostic group. This atypical localization at the level of the back is classified as low risk of recurrence, as it is the case of our patient, no sign of recurrence during the 12 months follow-up.

In case there is a contraindication for a surgical intervention (e.g. older age, poor surgical candidate due to ongoing medical condition, recurrent tumors, incomplete excision with residual positive surgical margins) radiotherapy can be used.

#### **Conclusion :**

Giant basal cell carcinoma with atypical location is a rare form of BCC. Actually, there is a lack of data concerning this clinical type of BCC, especially in covered parts of the body. In the literature, a systemic dermoscopic examination is proposed for the cutaneous lesions to all patients at risk (type of skin), even for the photo-hidden zones.

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