

Report of Two Patients with Nonsyndromic Facial Multiple Basal Cell Carcinoma

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Abstract

Basal cell carcinoma is the most common skin cancer in which UV exposure is the main etiological factor. The incidence of basal cell carcinoma rises with age and disease is common between the 40-80 years of age. Tumors may be more than one. But, multiple tumors at same time are infrequent and usually they are a part of a syndrome. Herein, reported two cases with multiple basal cell carcinomas on the face. However, no symptom of any known syndrome was observed, in both. To best of our knowledge, a few case reports of nonsyndromic multiple BCC exist in the literature. Since increasing effect of ultraviolet-B with aging may cause multiple tumors, the follow up of these patients is important.

Key Words: Basal Cell Carcinoma; Nonsyndromic; Multiple, Facial.

Yüzde Yerleşimli Çok Sayıda Bazal Hücreli Karsinomalı Non Sendromik İki Olgunun Sunumu

Özet

Bazal hücreli karsinoma başlıca sebebi UV maruziyeti olan derinin en sık gözlenen kanseridir. Bazal hücreli karsinoma sıklığı yaşla birlikte artış gösterir ve hastalık en sık 40-80 yaşları arasında yaygındır. Tümör birden fazla olabilir. Fakat eş zamanlı olarak çok sayıda bazal hücreli karsinoma oldukça nadirdir ve genellikle bir sendromun parçası olarak gözlenmektedir. Burada; yüzünde çok sayıda bazal hücreli karsinoması olan, bununla birlikte hiçbir sendromun parçası olmayan iki olgu sunuldu. Bizim bildiğimize göre, non sendromik çok sayıda bazal hücreli karsinoma literatürde oldukça nadir olarak rapor edilmiştir. Uzun süreli UV maruziyeti, çok sayıda bazal hücreli karsinoma sebep olabileceği için bu hastaların takibi önemlidir.

Anahtar Kelimeler: Bazal Hücreli Karsinoma; Non Sendromik; Multiple; Yüz.

INTRODUCTION

Basal cell carcinoma (BCC) is a malign skin cancer which is thought to be derived from cells of the basal layer of the epidermis and outer root sheath of the hair follicle. It is the most common skin cancer of white populations and consists of 75-80 %of non-melanoma skin cancers (1,2). The incidence of BCC rises with age and disease is common between the 40-80 years of age (3). Predisposing factors are UV and X-ray exposure, scar tissues, nevus sebaceous, contacts with arsenic, immunosuppressive drugs and diseases (4). Exposure to long term UV light has been accepted as the principal risk factor for BCC. So, this explains high incidence of BCC with outdoor occupations or hobbies. Tumors may be more than one, but rarely multiple tumors present together. However, BCC may be multiple in some syndromes (5,6). Multiple BCC is generally hereditary and may participate in nevoid basal cell carcinoma syndrome

(Gorlin syndrome), xeroderma pigmentosum, Basex-Dupre-Christol syndrome and Rombo syndrome (3). To best of our knowledge, a few case reports of nonsyndromic multiple BCC exist in the literature (7). Herein, for its rarity, two cases of nonsyndromic multiple BCC were reported and discussed through the literature.

CASE REPORT

Patient 1

A 65-year-old female was referred to dermatology department suffering from unhealing wounds on her face for over 1 year. She had been working as an agricultural laborer for long years. Physical examination was normal. The skin type of the patient was type 3 as Fitzpatrick skin type. In dermatological examination, we observed ulcerated and crusted, two lesions on the right and three lesions on the left zygomatic area and two lesions on the nose with

differing diameters between 0,2-0,5 cm in size. Border of the lesions was elevated with telangiectatic surface (Figure 1a). In histopathological examination; under multilayered epithelium, there were solid areas in which peripheral cells arranged in palisade and also groups of basaloid cells resembling small nodules (Figure 1b).



Figure 1a. In patient 1; nodular and ulcerative variants of multiple BCC lesions on the face.

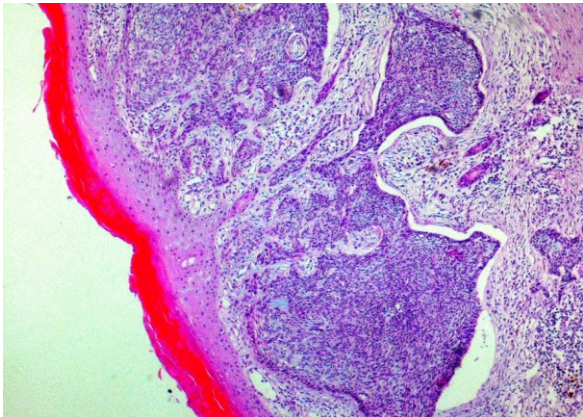


Figure 1b. Histopathology of case1: solid islands with palisade arrangement of peripheral cells and groups of basaloid cells resembling small nodules under the multilayered epithelium.

Patient 2

A 72-year-old female was referred dermatology department suffering from persistent wounds on her face for over 3 years. According to her history, first wound appeared on her forehead 3 years ago, and by time, especially during the last year, wounds have spread all over her face. Working as an agricultural laborer for long years was the only remarkable finding in her history. Physical examination was normal. The skin type of the patient was type three as Fitzpatrick skin type. In her dermatological examination, we have found multiple ulcerated and crusted lesions. Borders of the lesions were elevated with telangiectatic surface.

There was one lesion on the forehead, two lesions on right maxillary area, one on the border of right nares and one on left mandibular area with differing diameters of 0,3-1,0 cms in size (Figure 2a). We performed a biopsy from one of the lesions which revealed superficial ulcerations and solid areas consisted of basaloid cells (Figure 2b).

According to our dermatological examination and histopathologic evaluation the diagnosis of the lesions the diagnosis of the two patients BCC. For surgical treatment, both patients were consulted by Plastic and Reconstructive Surgery. Total excisions of tumors and split thickness grafting were performed for each patient.



Figure 2a. In patient 2; ulcerated and hemorrhagic crusted multiple BCC lesions on the face.

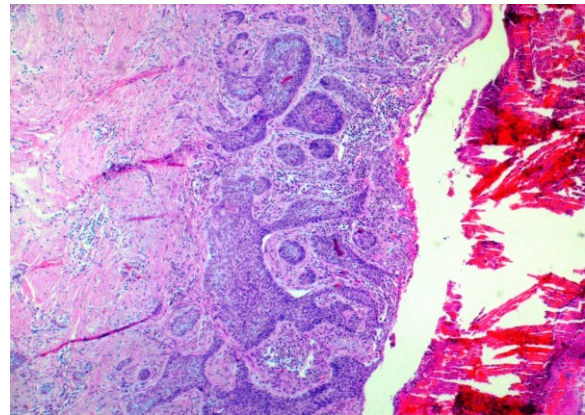


Figure 2b. Histopathology of patient 2, solid islands of basaloid cells at the bottom with overlying ulceration

DISCUSSION

Diseases with multiple BCCs are Gorlin syndrome, xeroderma pigmentosum, Baze-Duprè-Christol syndrome and Rombo syndrome. Chronic arsenic and X-ray exposure cause multiple BCCs (6). In arsenic exposure, lesions occur especially on the trunk (8).

In the Gorlin syndrome, multiple BCC lesions appear in the early life with many clinical findings; cysts of jaws, rib anomalies, palmar or plantar pits, calcified falx cerebri, hypertelorism, spina bifida, fibromas of heart and over, epidermal cysts and etc. Tumors locate face, neck and upper trunk with resembling all histopathological types (3). In our elderly patients, tumors had begun only on the face. No symptom of any syndrome was determined in physical examination. Results of cardiovascular examination and all of the radiological imagings showed any pathology. Diagnosis of Gorlin syndrome was eliminated.

In xeroderma pigmentosum, BCC occurs in the first two decades of the life with actinic keratosis (3). Rombo syndrome is characterized mainly by atrophoderma vermiculatum of the face, multiple milia, telangiectases, acral erythema and peripheral vasodilatation with cyanosis (3). Bazex-Duprè-Christol syndrome is a very rare condition inherited in an X-linked dominant fashion. Physical findings typically include follicular atrophoderma, multiple basal cell carcinomas, hypotrichosis and hypohidrosis (6). These symptoms of syndromes or similar complaints were observed neither in our patient nor in their family.

In histories of our patients there was neither arsenic nor X-ray exposure. Face locations of the lesions also differentiated from truncal location of BCC with arsenic exposure. After checking all etiological factors mentioned above, we underscore cumulative UV exposure for each patient had worked as agricultural laborer for long years. Recently, fewer reports of multiple BCC after UV exposure have been published in the literature (3,8).

Treatment of BCCs is usually surgical and effective. Between 95-98% of patients are cured. Surgical excision, Mohs' micrographic surgery, cryotherapy, curettage and cautery are surgical methods. We preferred surgical therapy in our patients. Total excisions of tumors and split thickness grafting procedures were performed for each patient. Other

choices of therapies are radiotherapy, photodynamic therapy, Nd-YAG laser, CO2 laser vaporization, intralesional interferon injection and topical 5-fluorouracil creams (9).

We emphasize that UV exposure may be the only factor for nonsyndromic and multiple BCCs. Continuing exposure to UV light may lead new tumors after treatment of a BCC lesion. So it is worthwhile to inform health personnel and patients, especially who have outdoor activities as a hobby or an occupation. Sun protective clothing and sunscreens may save from difficult and costly therapies.

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