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BCC Buttock:- A Case Report

Medical Science

KEYWORDS :

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Introduction

Basal cell carcinoma is the most prevalent malignant neoplasm, including all other skin cancers[1,] and account for more about 70-80% of the skin tumours.

Usually BCC tends to occur in the sun exposed area and is also known as the rodent ulcer because of its aggressive nature and habit to involved the deeper structure

Less case has been reported about the BCC over nonexposed area to sun. BCC around the perianal case has been reported to be very less

Case report

A 60 years old male farmer presented with chief complaint of itching over the left buttock for the last 15 years and blackening of the affected area for the last 10 years. Following this he went to a homeopathy doctor and had medication for 2 years. The wound was not healed and he started having bloody discharge from the wound off and on for the last one year. After that he attended our institute for further treatment. Patient presented with ulcer over left buttock and small wound over the anterior chest about 0.cm x05 cm. O/E an ulcerative wound with macular changes about 8cm above the right trochanter and measuring about 4x 5 cm2. There is bloody discharge from the wound and crusted floor, tender on touch and freely mobile. Incisional biopsy was taken from the buttock ulcer as it was suspected to be skin tumour like SCC. Microscopic examination shows small nest of basoloid cells attached to the epidermis. These nests show peripheral pallisading and retraction artifact from underlying dermis. The cells exhibit mild to moderate anisonucleosis and mitotic figures. Upper dermis shows moderate chronic inflammation. No dermal extension of the tumour cells seen and diagnosis consistent with the superficial type of BCC.

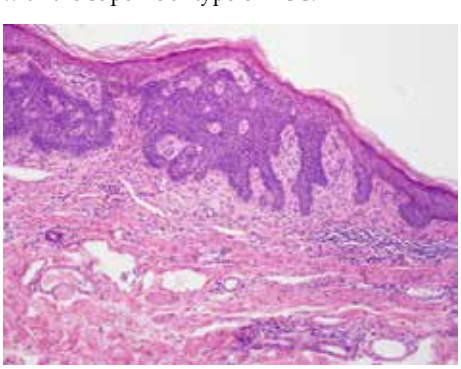

Fig. 1: Histopathogical finding of pre-operative incisional biopsy.

Following that patient was admitted in our department on 28th march 2016. Routine preoperative investigations were within normal. Intraoperatively the underlying fascia looks normal and the tumour was totally excised with 1cm margin and defect cover with local flaps. The wound over the chest was also excised with 0.cm x0.5cm and closed primarily. There is no recurrence till now and patient is still in the follow up.

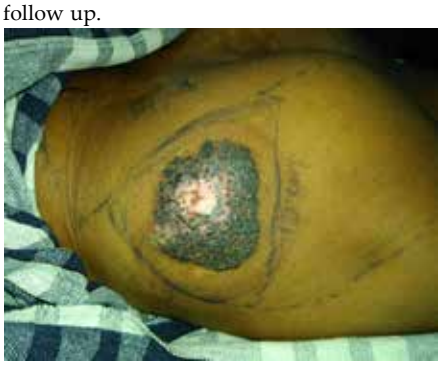

Fig 2: BCC buttock preoperative and after excision of tumour

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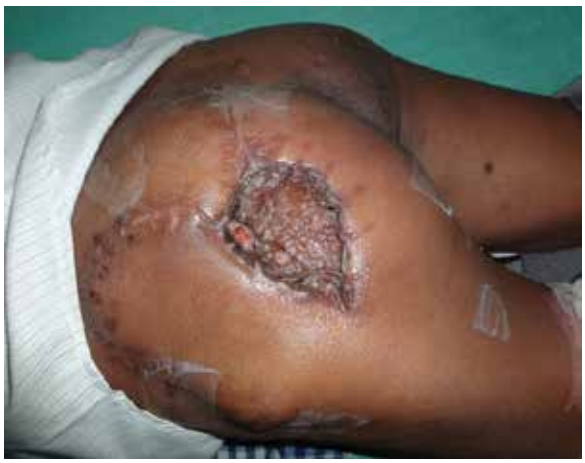

Fig 3: After excision of BCC and transpositional Flap and during follow up after 2weeks

Discussion

Chronic exposure to ultraviolet light (UVL) is an important predisposing factor for BCC, and more than 80% of BCCs are found in sun-exposed areas of the body, such as the face. Consequently, BCCs of the non-sun-exposed areas, such as axilla, nipple, or the genital and perianal areas are extremely rare2. Only few cases have been reported in the literature of BCC on chest wall.5,6

Betti, *et al*. reported 6 cases of nodular BCCs on the buttocks3. The diseased predominantly affects people with white skin, and the male to female ratio is 3:2 4. Other etiological factors for BCC include exposure to the ultraviolet light, chemical carcinogens, ionizing radiation, xeroderma pigmentosum, Gorlin syndrome, chronic irritation or ulceration.

Histologically basal cell carcinoma arises from the basal layer of the epidermis and classically has raised borders and a pearly central area with associated telangiectasias. Histological diagnosis can be obtained by either a biopsy or after definitive surgical excision. Treatment of basal cell carcinoma includes complete removal of the lesion. Simple surgical excision is effective for all types of BCCs. The cure rate approaches 99% when the histological margins are clear7. Recommended margin is 5 mm; recurrence is more when the margin of resection is less than 4 mm.8,9

Conclusion:

Lesion in the non sun exposed area should not exclude the possibility of BCC and proper investigation must be done prior to the excision for proper tumour clearance. Complete excision with tissue coverage by either local or regional should be done. Regular follow up of the patient to exclude tumour recurrence or residual has to be done. The usual treatment for BCC is wide excision; the 5-year recurrence rate after wide excision of BCCs, with clear excisional margins, is 3 to 14%.2

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