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BASAL CELL EPITHELIOMA WITH ECCRINE DIFFERENTIATION– A CASE REPORT

Dermatology

Dr. Archana. M Junior Resident Department of Dermatology,Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India.

Dr. Shreya Moozhiyil* Junior Resident Department of Dermatology,Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India.*Corresponding Author

Dr. Jayakar Thomas HOD & Professor Department of Dermatology,Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India.

ABSTRACT

Basal cell epitheliomas usually occur on hair bearing areas like the face. They occur as solitary lesions, slowly growing, locally invasive and destructive. Recurrence rate is known to be very high. We hereby report a rare case of Recurrent Basal cell epithelioma with eccrine differentiation. Such basal cell epitheliomas with eccrine differentiation are known as eccrine epithelioma and these entities are not clearly defined previously.

KEYWORDS

Basal cell epithelioma, eccrine differentiation

INTRODUCTION:

Basal cell epithelioma is one of the most common types of skin cancer in light skin individuals. It occurs mainly on sun exposed areas, like the face. They rarely metastasize but recurrence is very common[1]. Basal cell epitheliomas are derived from incompletely differentiated immature keratinocytes of epidermis or cutaneous appendages[2]. Eccrine differentiation is generally regarded as a rare feature of Basal cell epithelioma.

CASE REPORT:

A 52 year old male patient presented to Surgery OPD with a raised pinkish lesion over the left cheek, it gradually increased in size over a period of 1 year, associated with slight pain on and off. It was suspected to be sebaceous cyst; excision was done and sent for histopathological studies, which revealed Basal cell epithelioma.

After 8months, he developed a similar lesion at the tip of the surgical scar, for which a repeat excision was done and the specimen was sent for histopathological examination. The specimen showed nests of basal cells with peripheral palisading. It also showed presence of tubular structures similar in morphology to eccrine ducts and lined by flattened eosinophilic epithelium and surrounded by atypical basaloid cells. It was consistent with Basal cell epithelioma with eccrine differentiation.

DISCUSSION:

Basal cell carcinoma is the commonest skin malignancy and comprises 80% of the nonmelanoma skin cancers[3]. The various causes UV radiation, Ionizing radiation, Arsenic exposure[4] and Immunos uppression. Many syndromes like Xeroderma pigmentosa, Albinism, Nevoid BCC syndrome, Bazex syndrome, Rassmussen syndrome, Rombo syndrome and linear unilateral basal cell nevus have been found to be associated.

Most common type is Nodular/Noduloulcerative form, characterized by pearly waxy papules with central depression, rolled out or thready translucent borders, with erosion or ulceration, bleeding, crusting and telangiectasias over the surface. Other variants include Micronodular, Pigmented, Superficial, Morpheaform and Fibroepithelioma of Pinkus. Histopathological types are solid nodular type, Micronodular, Sclerosing morpheaform, Adenoid, Basosquamous, Cystic, and Pigmented. Rare variants like Schwannoid, Trichilemmal and those with Eccrine, Apocrine and Sebaceous differentiation have been described[5]. On Histopathology, the dermis shows well circumscribed nodular tumors of basaloid cells. These tumour cells are arranged in nests of cells with peripheral palisading of nuclei and a clefting artifact between the islands of tumor cells and surrounding dermis. The cells show cytologic atypia and mitotic activity with hyperchromatic multiple nuclei. The strands of epithelial cells within the tumor have a lace like pattern. Basal cell carcinoma with eccrine differentiation shows basal cell carcinoma with interspersed aggregates of eccrine structures.

Mainstay of treatment is Surgery, for lesions less than 2cm Electrosurgery, Curettage and Cryotherapy are useful. For lesions more than 2cm, Mohs' Micrographic Surgery is preferred. Other modalities of treatment include Radiotherapy, Lasers, Photodynamic therapy, and Medical treatment by 5-fluorouracil, Imiquimod and Interferon-α2b have been tried[6].

CONCLUSION:

Although basal cell carcinoma is known to be a locally destructive tumor, it has an excellent cure rate. It is not uncommon for patients to develop multiple recurrences during their lifetime. Avoidance of risk factors like sunlight exposure should be advised. We are reporting this case for its rarity in occurrence and its rarity in presentation.

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CONFLICT OF INTEREST: The authors declare that they have no conflict of interest.

LEGENDS TO FIGURES:

Figure 1: Clinical photographs showing well defined erythem atous nodule at the tip of the surgical scar on the left cheek.

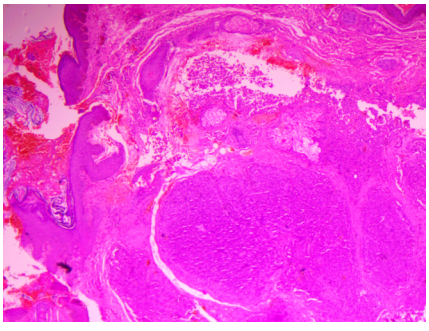

Figure 2: Histopathological section in scanner view shows well circumscribed tumour masses with basaloid cells occupying the dermis. Retraction artifact is seen. Eccrine structures are seen to be interspersed in the upper dermis.

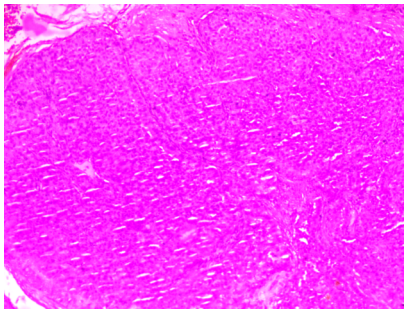

Figure 3: Higher magnification showing basaloid cells with cytological atypia and increased mitotic activity. The nuclei are arranged in a peripheral palisading pattern.

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