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Case report

BASAL CELL CARCINOMA OF ALA OF NOSE – A CASE REPORT

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ABSTRACT

Skin cancers contribute very less to the total number of carcinomas. Especially when on the face or exposed parts affect cosmetically more than functionally. One of that is Basal Cell Carcinoma over face; which rarely metastasize. Case is reported in an adult male in a rural setup who came for cosmetic purpose. Who was treated with best modality available in setup, wide local excision with local naso-labial flap reconstruction with follow up for oncotherapy.

Keywords: Skin Cancer, Basal cell carcinoma, Flap Reconstruction, Metastasize.

INTRODUCTION

Basal cell carcinoma is cancer of skin, especially of non-melanocytic origin may be of an epithelial tumor that arises from basal cells;¹ which are small, round cells found in the lower layer of the epidermis.^{2,3}

Most common sites for BCC are face; head mainly scalp, neck and hand. BCC is the commonest skin cancer in human beings, which accounts for less than 0.1% of deaths in cancer. These tumors are predominant in sun-exposed skin with its slow growing nature it metastasizes rarely (less than 0.55%).^{4,5} On appearance BCC is a small in size, raised above skin, pink or red, translucent, shiny or waxy lesion and the area may bleed with minor trauma. 65 - 70% of BCCs occurred on the head (most frequently on the face), 20-25% on the trunk, and 5% on the penis, vulva or peri-anal skin. Unusually other organs may get affected.

CASE REPORT

Presenting a case of 90 years normotensive non diabetic male, farmer by occupation resident of Sangamner with complaints of Nodular friable

growth over Right Lateral aspect of Ala of Nose of Right nostril since 2 years, gradually progressive to current size, associated with itching and bleeding on touch. It is not associated with difficulty in breathing, difficulty in swallowing with no discharge from growth. No history of preceding trauma. No history loss of appetite and weight. There was no history of similar lesion over other body parts, no past surgical history, and no alteration of bowel and bladder habits, sleep and diet. No history of backache, cough, fever, headache, vision abnormalities. No history of treatment taken for same. On general examination patient was averagely built with stable vitals. No evidence of pallor cyanosis icterus, clubbing pedal edema and lymphadenopathy. On local examination the lesion was 3×1 cm nodular firm growth over lateral edge of right ala of nose which was roughly oval black in color, slightly tender, bled on touch with minimal surrounding induration. No palpable lymph nodes on clinical examination. Patient was evaluated investigated for same to detect Basal Cell Carcinoma of Right ala of nose. Patient and relatives counseled about the nature of disease and after

written and verbal informed consent, patient underwent wide local excision with Naso- Labial flap cover over the area, postoperative period was uneventful successful acceptance of naso-labial flap.

Histopathology reports suggestive of basal cell carcinoma. Patient was counseled and discharged for further oncological adjuvant therapy.

DISCUSSION

Table 1: Clinico-pathologic types of BCC, each of which has a distinct biologic behavior. ^{3,5}

Type	Features
Nodular	The most common type of BCC. Cystic, pigmented, keratotic and flesh colored with telangiectases.
Infiltrative	Margins not defined as tumor infiltrates the dermis in between the fibrous collagen
Micro-nodular	Non ulcerative. Well defined margins.
Morpheaform	Firm in consistency. Sclerotic plaques. Rarely ulcerates
Superficial	Erythematous, well circumscribed lesion. Most commonly over trunk and proximal extremities.

Table 2: Histologically, BCC is divided into the following 2 categories. ^{3,5}

Type	Features
Undifferentiated	Solid BCC. Includes superficial, Sclerosing and Infiltrative.
Differentiated	Differentiated BCC often has slight differentiation toward hair (keratotic BCC), sebaceous glands (BCC with sebaceous differentiation), and tubular glands (adenoid BCC); noduloulcerative (nodular)

Table 3: 5-Year Recurrence Rates for Primary (Previously Untreated) BCCs With Respect To Various Treatments⁶

Treatment Modality	Recurrence Rate
Surgical excision	10.1%
Radiation therapy	8.7%
Curettage and electro desiccation	7.7%
Cryotherapy	7.5%
All non-Mohs modalities	8.71%
Mohs micrographic surgery	1%

Primary aim of treatment is elimination of the tumor with maximal preservation of function and physical appearance. In all cases of BCC, surgery is the recommended treatment modality. Techniques used include Electro desiccation and curettage, Excisional surgery, Cryosurgery, Mohs micrographically controlled surgery. Recurrence in these cases shows that the distance to the closest resection margin is an important predictor.^{6,7}

Photodynamic therapy (PDT) as an adjunct is a reasonable choice in the following cases:⁸

1. Tumor recurrence with tissue atrophy and scar formation.
2. Elderly patients or patients with medical conditions preventing extensive oncoplastic reconstructive surgery.

3. Tumor with poorly defined borders based on clinical examination.

4. Tumor requiring difficult or extensive oncoplastic surgery.

Radiation therapy: BCCs are usually radiosensitive; radiation therapy (RT) is used in patients with advanced and extended lesions, as well as in those for whom surgery is not suitable. Postoperative radiation can also be a useful adjunct when patients have aggressive tumors that were treated surgically or when surgery has failed to clear the margins of the tumor.

Pharmacologic therapy: Topical 5-Fluorouracil 5%, Imiquimod, Tazarotene. The Oral Agent Vismodegib are topical agents used in the treatment of superficial BCC.

The prognosis for patients with BCC is 100% survival rate for cases that have not spread to other sites.⁹ If BCC is allowed to progress, it can result in significant morbidity, and cosmetic disfigurement may occur. Though BCC is a malignant neoplasm, metastasize is rare. The incidence of metastatic BCC is estimated to be less than 0.1%. After treatment BCC may develop in new sites after primary curative treatment.⁶

On follow up, regular skin screenings are recommended as chances of developing another tumor is as high as 35% in 3 years while 50% in next 5 years if etiology not cured.¹⁰

Patient and relatives are counseled for further prevention of recurrence and spread of basal cell carcinoma. Patients should avoid possible potentiating factors like sun exposure, ionizing radiation, arsenic ingestion, tanning beds. The regular use of sun-protecting clothing with wide-brimmed hat, long-sleeved shirts and sunglasses with ultra-violet [UV] protection is advised.¹¹

CONCLUSION

Wide local excision with naso- labial flap cover can be considered for local basal cell carcinoma over nasal ala which gives excellent cosmetic results which can be further given topical agents.

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