International Journal of Research in Dermatology
Soni AN et al. Int J Res Dermatol. 2024 Sep;10(5):282-284
http://www.ijord.com

DOI: https://dx.doi.org/10.18203/issn.2455-4529.IntJResDermatol20242362

Original Research Article

Multiple, non-syndromic and non-metastatic pigmented basal cell carcinoma mimicking nodular melanoma: a rare presentation in Indian patient

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Received: 15 June 2024
Revised: 22 July 2024
Accepted: 23 July 2024

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ABSTRACT

Basal cell carcinoma is most common cutaneous malignancy having exposure to ultraviolet radiation as the most important predisposing factor. It could be solitary or multiple, in which case they can be associated with variety of syndromes. Out of various clinical types of BCC pigmented bcc can mimic sometimes malignant melanoma and in which case dermoscopy and skin biopsy can be helpful to differentiate. Metastasis of BCC is a rare phenomenon and it depends on various factors like tumour size, site, depth, histological type etc. Here we describe an interesting case of primary, non-syndromic, multifocal BCC which was initially diagnosed as melanoma but later on based on dermoscopy and histology diagnosed and successfully treated as BCC.

Keywords: Multicentric BCC, Non-syndromic nonmetastatic multiple BCC, Nodular BCC mimicking melanoma

INTRODUCTION

Basal cell carcinoma is a locally infiltrative, slow growing commonest cutaneous malignancy.[1] The most common risk factor for it includes ultraviolet radiation but also includes radiation therapy, immunosuppression etc. multiple syndromes like Gorlin syndrome, bazex syndrome, schopf schultz passarge syndrome etc. can present with BCC and differentiated on the basis of their inheritance pattern and clinical features. Pigmented BCC presents as a nodular or plaque like pigmented lesion which can sometimes mimic both clinically and dermoscopically malignant melanoma and pose diagnostic challenge and one need histopathology to confirm the diagnosis. Here we present an interesting case of multicentric, non-syndromic BCC in Indian patient which was mimicking melanoma.

CASE REPORT

A 67-year-old female patient working as a farm labour, coming from lower socio-economical background was referred to us for a swelling near right eye since, 4 years. Similar lesion was present near inner canthus of left eye which was operated outside and tissue was sent for histopathology examination. Her histopathology report read-plump spindle cells arranged in nesting pattern showing prominent nucleoli and scanty cytoplasm with many atypical mitoses, few tumour cells show melanin pigment and fragments of slough necrotic material. Based on these findings the possibility of poorly differentiated malignancy with possibility of malignant melanoma was raised. On asking history, she reported presence of the lesions on both the sides of nose near eyes since last 4 years.

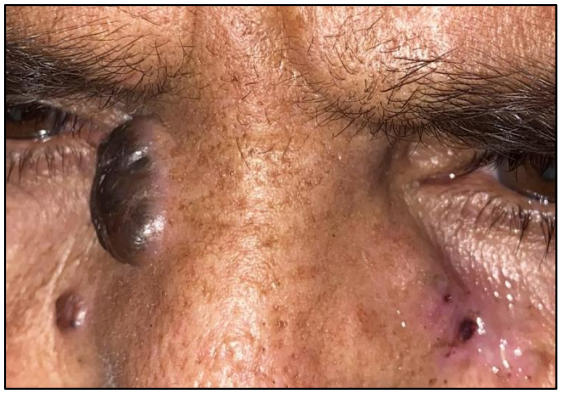

Figure 1: Clinical pic of patient showing a nodular hyperpigmented lesion near inner canthus of left eye.
Note a smaller satellite kind of lesion below it.

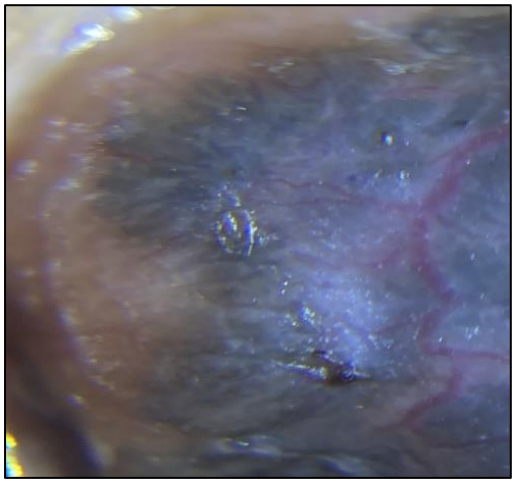

Figure 2: A dermoscopic image of large lesion showing various features.
Note the arborising and polymorphic vessels, white structureless areas, spoke wheel appearance, maple leaf pattern and pigment variation.

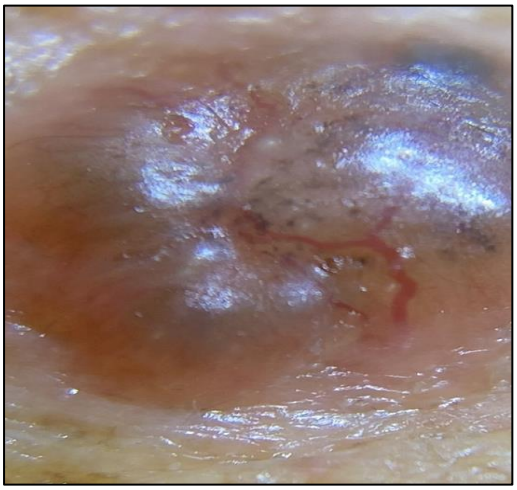

Figure 3: The arborising vessels with peripheral fine telangiectasia in dermoscopy image of small lesion.
Also, multiple brown dots with structureless areas are visible.

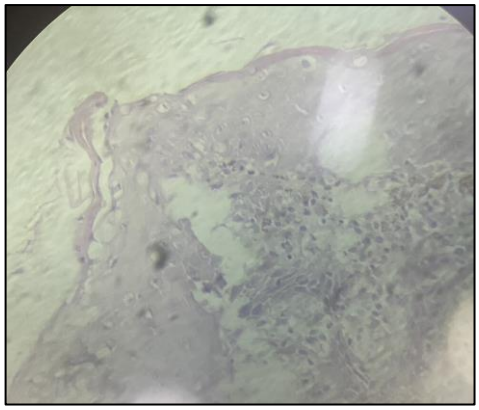

Figure 4: Histopathological images of lesion showed nests and cords of atypical basaloid cells with alteration of stroma.
Cells showed small cytoplasm with atypical nuclei.

Initially lesions were smaller, but later on they started increasing gradually. There was a tiny lesion developing near it on right side of face. The lesion was asymptomatic and patient didn't have any history of radiation therapy or immunosuppression, no any systemic complaint or family history of same disease. Patient didn't bother to visit doctor until it started interfering with her vision.On examination, her vitals included following. BP-126/78, pulse-80/minute, temperature was normal, respiratory rate of 14 per minute and oxygen saturation on room air (Spo2) was 99%. On cutaneous examination, a large 3 cm sized shiny black nodule without ulceration noted on face near inner canthus of right eye. On palpation, lesion was nontender and indurated. Basal skin didn't show any induration and regional lymph node examination was normal. A tiny pigmented papule was noted below the main lesion.

Dermoscopy was performed which revealed presence of multiple pigment globules, mapple leaf appearance, arborizing vessels, fine telangiectasias, spoke wheel vessels, multiple blue-grey ovoid globules and nests, multiple blue grey dots, polymorphous vessels, blue-black pigmented areas and absence of pigment network. Few structureless areas and blue white veil was also noted. Based on clinical and dermoscopic features a clinical differential diagnosis of pigmented BCC and nodular melanoma was put. Patient was advised biopsy with wide excision of lesion and specimen was sent for histopathological examination. Smaller lesion adjacent to main lesion was also excised along and sent for histopathology.

On histopathology, primary findings showed multiple aggregates of atypical basal cells in strands with small cytoplasm and large, hyperchromatic nuclei, few areas of apoptotic cells and retraction spaces and melanin pigment in stroma. Along with these findings patient was diagnosed as having BCC. As patient was having multiple BCC, a PET scan was advised to rule out distant metastasis which was normal. Post excision patient was

followed up and no active intervention was needed as margins of tumour were disease free.

DISCUSSION

Clinically there are various variants of Basal Cell Carcinoma which includes superficial, nodular, pigmented, sclerosing, cystic, infiltrated and micronodular. The clinical presentation varies depending upon site and risk factors. Our case was characterised by pigmented nodular lesion which on first hand can be misdiagnosed as melanoma. Also, in this case histopathologist also misdiagnosed it as melanoma by mere presence of anaplastic and melanin cells.

Dermoscopic findings described by Menzies are categorized in three parts- Vascular findings includes arborizing vessels, fine telengiectasias, dot, hairpin or comma vessels, Pigment findings include- blue-grey ovoid nests, blue-grey dots, maple leaf appearance, spoke wheel areas, brown dots and white structureless areas and other findings which includes ulceration, erosions, crusting, yellow white globules, shiny red structureless areas etc.[2-5] Apart from it, other described findings include white- red structureless areas, short white streaks, spoke wheel areas etc.[6]

The dermoscopic features described in menzies method of melanoma includes- atypical networks, blue-whitish veils, atypical vascular patterns, irregular dots/globules, irregular streaks, irregular blotches, and regression structures.[7] However. Nodular melanoma apart from above stated features can also have blue black colour with homogenous pigment areas and polymorphous vessels according to Argenziano et al8. Our patient apart from having specific features of nodular BCC like arborizing vessels, blue-grey ovoid nests, structureless areas also contained features like brown dots, polymorphous vessels and regression structures. These also led to confusion between BCC and Melanoma. Also, her initial histology report favoured melanoma adding to our clinical confusion. However, excisional biopsy findings finally showed nests of atypical basaloid cells with small nuclei and abundant cytoplasm. Also, PET scan helped to rule out any distant metastasis which could be present if the lesion were to be melanoma. The patient showed good healing after surgical excision and was followed up for 1 year during which she did not showed any recurrence. We presented this case because of its features mimicking malignant melanoma and also rarity of non-syndromic multicentric BCC in Indian patients.

CONCLUSION

To conclude, malignant melanoma can be a differential diagnosis in a patient of pigmented nodular BCC but biopsy and dermoscopy should always be done to differentiate both. Also, this case was presented due to unique features associated with it both histologically and clinically.

Funding: No funding sources
Conflict of interest: None declared
Ethical approval: Not required

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Cite this article as: Soni AN, Patel K, Chauhan V. Multiple, non-syndromic and non-metastatic pigmented basal cell carcinoma mimicking nodular melanoma-a rare presentation in Indian patient. Int J Res Dermatol 2024;10:282-4.