Pyogenic granuloma–like basal cell carcinoma on the abdomen: A deceptive presentation

Sir,

Basal cell carcinoma (BCC) is the most common malignancy of skin worldwide. Many clinical morphologies of BCC exist. Clinical diagnosis depends on the awareness and knowledge of the varied presentations of BCC. This not only facilitates an early diagnosis of uncommon morphologies of the malignancy, but also ensures prompt intervention and treatment. The morphological variants include nodular, cystic, morpheaform, infiltrative, micronodular, superficial, pigmented, polypoid, pore-like, aberrant, and fibroepithelioma of Pinkus (FEP).[1]

A 60-year-old man presented with a solitary, nonhealing fragile mass over the abdomen of 6 months duration. To start with, the lesion was an asymptomatic pea-sized nodule, which gradually increased in size to attain the present dimension. There was history of bleeding from the lesion—both spontaneously and on minor trauma. Past medical, surgical, and family history were unremarkable. There was no history of trauma, chronic arsenical exposure, or exposure to radiation. Cutaneous examination revealed bright-red, dome-shaped fragile tumor that had a glistening moist surface, covered with hemorrhagic crust [Figure 1]. There was no associated lymphadenopathy of inguinal or cervical region. Hairs, nails, and mucosae were absolutely normal, and systemic examination was noncontributory. Pyogenic granuloma, squamous cell carcinoma, and nodular melanoma were considered in clinical differentials. Routine biochemistry panel, including serology for Hepatitis B virus, Venereal Disease Research Laboratory test, and Human immunodeficiency virus (HIV) were nonreactive. The tumor was excised and sent for histopathology. There was basaloid cell proliferation in nodular pattern with peripheral palisading of cells and cleft-like space around it at places. The cells were elongated with an elongated oval nucleus and scanty cytoplasm. The cells showed increased pigmentation in some areas [Figures 2–4]. Histopathological findings were diagnostic of BCC.

BCCs are the most common cutaneous tumors, accounting for approximately 70% of all malignant diseases of the skin. It is slow growing, locally invasive malignancy, which arises from pleuripotent cells within the basal layer of the epidermis or follicular structure. The malignancy predominantly affects

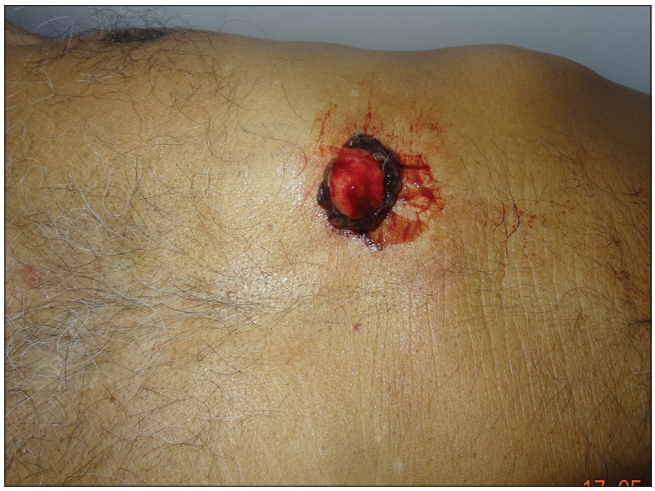

Figure 1: Nodular growth with moist surface and covered with hemorrhagic crust

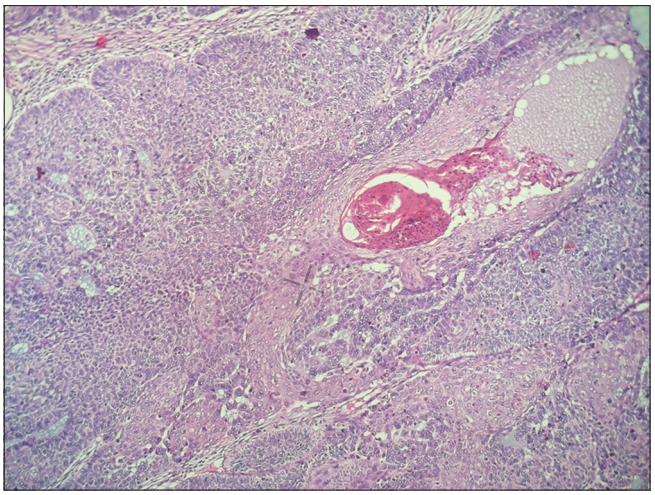

Figure 2: Proliferation of basaloid cells showing peripheral palisading (H and E, 100×)

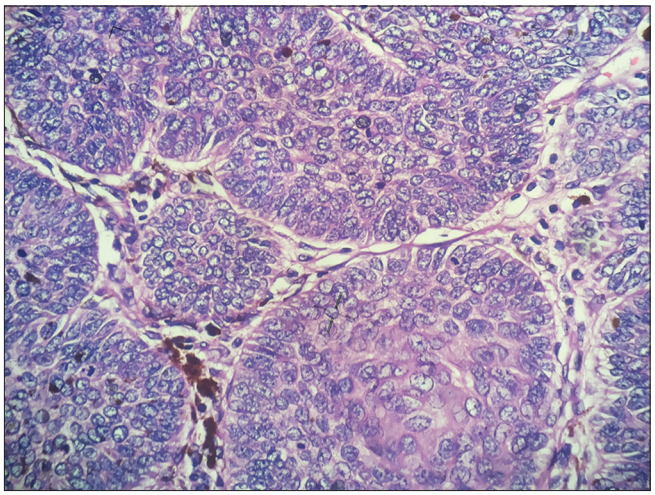

Figure 3: Higher magnification (H and E × 400)

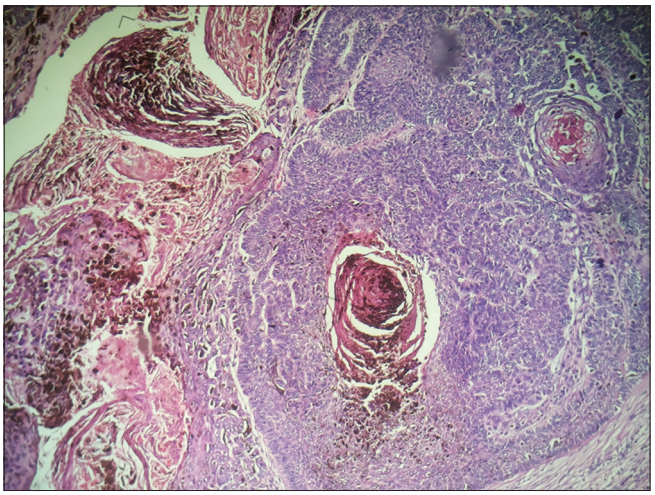

Figure 4: Increased pigmentation in tumor mass (H and E × 400)

fair-skinned individuals above the age of 40 years. Usually it is caused by a combination of cumulative ultraviolet (UV) exposure and intense, occasional UV exposure, especially on areas of chronic sun exposure, such as the face, head, and neck. Other known risk factors include chronic exposure to arsenic, chronic inflammation, and genetic conditions such as xeroderma pigmentosum, albinism, and basal cell nevus syndrome. However, occurrence of BCC in covered areas and also in persons without any of the aforementioned predisposing factors, as exemplified in our case indicates that etiopathogenesis is still elusive and more studies are needed to identify other contributing factors. Uncommonly, BCC may develop over atypical locations such as axilla, nipple, scrotum, pubis, and perianal region.[2,3] According to some authors, patients with truncal BCCs were significantly at a higher risk of multiple BCCs.[4]

There are different clinical and histological variants of BCC. The clinical variants are nodular (most common), pigmented, morpheaform, superficial, and FEP. Some may manifest as nodules, patches, plaques, ulcers, or rarely, a pyogenic granuloma like.[5] Very few cases of BCCs mimicking pyogenic granuloma have been reported. A unique case of polypoidal BCC on the face of an elderly lady masquerading as pyogenic granuloma, was reported from India.[5] Besides, Kim *et al*. reported a case of BCC on the dorsolateral side of the ring finger, which clinically simulated pyogenic granuloma.[6] The treatment in such cases essentially consists of surgical excision and a systemic workup to exclude any metastatic deposit, followed by periodic follow-up.

Thus, a rare presentation of BCC along with uniqueness in the site prompted us to report the case. Our report highlights the noteworthiness of taking into consideration BCC in the clinical differentials of lesions, which have a tendency to bleed, even if the classical features of BCC-like pearly border, telangiectasia, and others are absent.

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Conflicts of interest

There are no conflicts of interest.

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