

Basal cell carcinoma at an eccentric location: A rare case report

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Abstract

Basal cell carcinoma (BCC) is the most common form of skin cancer, which presents with local invasion, has low metastasizing potential and a cure rate of 100% after surgical excision. BCC commonly involves sun-exposed areas with approximately 80%–85% of BCC located on the head or neck, 15% on the trunk, and <2% in unusual areas such as the abdomen, genitals, perianal skin, lateral edge of the foot, axilla, superior or inferior lip.

Key words: Basal cell carcinoma, excision, groin folds

Introduction

Basal cell carcinoma (BCC) is the most common form of skin cancer,^[1] which presents with local invasion, has low metastasizing potential^[2] and a cure rate of 100% after surgical excision. It has been attributed to be the most prevalent cancer type among white-skinned populations and is uncommon in Asians and Black African races. BCC commonly involves sun-exposed areas with approximately 80%–85% of BCC located on the head or neck, 15% on the trunk,^[3] and <2% in unusual areas such as the abdomen, genitals, perianal skin, lateral edge of the foot, axilla, superior or inferior lip.^[4] The main etiology in the development of BCC is ultraviolet (UV) radiation, however, others like immunosuppression, ionizing radiation, genodermatoses, and arsenic exposures are also proposed.^[5]

Case Report

A 71-year-old male, a known case of diabetes and hypertension for 10 years presented with a solitary red raised lesion along his right groin fold that appeared 3 years back and gradually progressed to its present size. As it was asymptomatic and did not trouble the patient, he did not consult any medical practitioner. There was no history of trauma, injury, or radiation exposure to the site. On examination, he had a solitary, well-defined erythematous plaque of approximately size 02 cm × 02 cm with rolled-out edges and irregular margin with few areas of peripheral hyperpigmentation and erosions over the plaque in the right groin [Figure 1]. Dermoscopy (×10) showed the absence of a pigment network with linear and arborizing (branch-like) telangiectasias. Structureless or leaf-like areas on the periphery of the lesion were also appreciated suggesting of BCC [Figure 2]. Excisional biopsy of lesion was taken and diagnosed to be a case of BCC (nodular variant) on



Figure 1: Solitary well-defined erythematous plaque of approximately size 02 cm × 02 cm with rolled-out edges in the right groin

histo-pathological examination (HPE). HPE [Figure 3] showed an infiltrating tumor seen arising from the epidermis forming branching islands, and clusters of basaloid cells with peripheral palisading of cells. These cells were mildly pleomorphic, with round-to-oval hyperchromatic to vesicular nuclei and scant cytoplasm. Clefting artifacts around these islands and nests of cells noted. Surrounding stroma appeared myxoid. Mitosis was low. Peritumoral mixed inflammatory infiltrate comprising lymphocytes, plasma cells, and few neutrophils were seen. He was managed with wide local excision and margins were free of tumor deposits on the HPE of excised tissue.

Discussion

BCC of the groin is an uncommon presentation of a common malignancy. Although rare, it is seldom reported. In the retrospective study by James Tidwell *et al.* where they did a chart review of all BCCs between 2007 and 2017, only 0.094% of all BCCs occurred in the groin or buttocks.^[1] The varied manifestation gives rise to various clinical subtypes and is classified into superficial, nodular, pigmented, ulcerating, cystic, sclerosing,^[6] and polypoid^[7,8] patterns. Histological variants are nodular, micronodular, fibroepithelial, adenoid, morpheaform, infiltrative,^[7] and polypoid^[8] types. Our case was diagnosed to be a case of nodular BCC [Figure 3].

Conclusion

We report this case of BCC occurring in a patient of Asian ethnicity at a rare site (groin) to emphasize that we as dermatologists should consider the diagnosis of BCC in

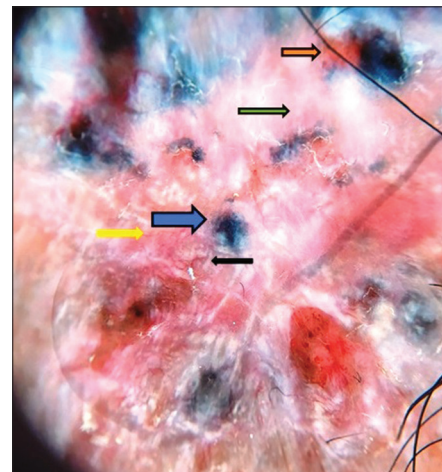


Figure 2: Dermoscopy findings with ×10: Arborizing vessels (black arrow), short fine telangiectasia (yellow arrows), blue-gray globules and dots (blue arrow), small erosions (orange arrow) and shiny white red structureless areas (green arrow)

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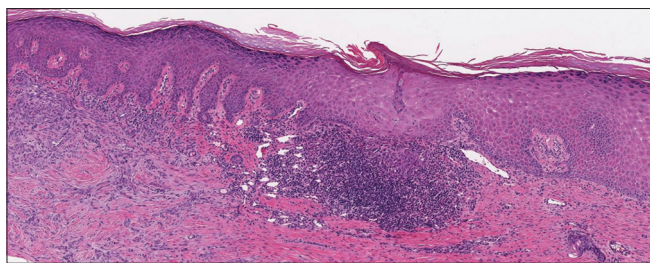


Figure 3: Hematoxylin and eosin stain $\times 40$: An infiltrating tumor seen arising from the epidermis forming branching islands, clusters of basaloid cells with peripheral palisading of cells

such lesions occurring in any patient population, even in the atypical nonsun-exposed areas of skin and to enlighten on the possibilities of other etiological factors than UV radiation for causing BCC.^[1,9]

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given his consent for his images and other clinical information to be reported in the journal. The patient understands that name and initials will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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