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Case report

Basal cell carcinoma presenting with profound anaemia

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Dermatological malignancy is the commonest form of cancer in the United Kingdom.[1] Basal cell carcinoma accounts for approximately 80% of all non-melanocytic tumours, with a similar percentage affecting the head and neck.[2] Tumour growth patterns are variable in this condition,[3] with most interest focusing on 'rodent ulcers' affecting the head and neck. Little is known about the inherent biological behaviour of truncal basaliomas.[4] We present a case of a giant exophytic basal cell carcinoma affecting the trunk, which presented with profound anaemia and generalised debility.

CASE REPORT. A 50-year-old male was referred to our surgical unit with a tumour mass on the left anterolateral chest wall which had been present for at least 12 years. For two months prior to this, bleeding and a foul smell from the lesion had caused him social embarrassment. He also complained of extreme lassitude, palpitations, dyspnoea on exertion; he had lost two stones in weight, despite having a normal appetite and well-balanced diet. On examination the patient was pyrexic (38·5°C) and had signs of marked weight loss and of anaemia. He had sinus tachycardia, but no sign of cardiac or respiratory embarrassment. There was a mobile, ulcerated exophytic tumour 15 × 15 cm on his left anterior chest wall (Figure), which was superficially necrotic, ulcerated and bleeding. There was no evidence of regional lymphadenopathy or systemic dissemination of this tumour. The patient was of retiring disposition and reluctant to volunteer information. His affect was consistently incongruous; however, when challenged he admitted to having a deep-seated fear of cancer. Bacterial swabs grew a heavy mixed population of *E. Coli, pseudomonas* and *bacteroides spp.* Haematological investigation confirmed a microcytic anaemia (Hb 7·0 g/dl, MCV 64·4 fl, MCHC 27 g/dl, WCC 4·5 × 10^9/l, platelets 408 × 10^9/l) and hypoalbuminaemia (19 g/dl) with a rise in the serum globulin fraction to 49 g/dl (normal range 20–37). The ESR was 85 mm/hr. Radiological investigations were within normal limits.

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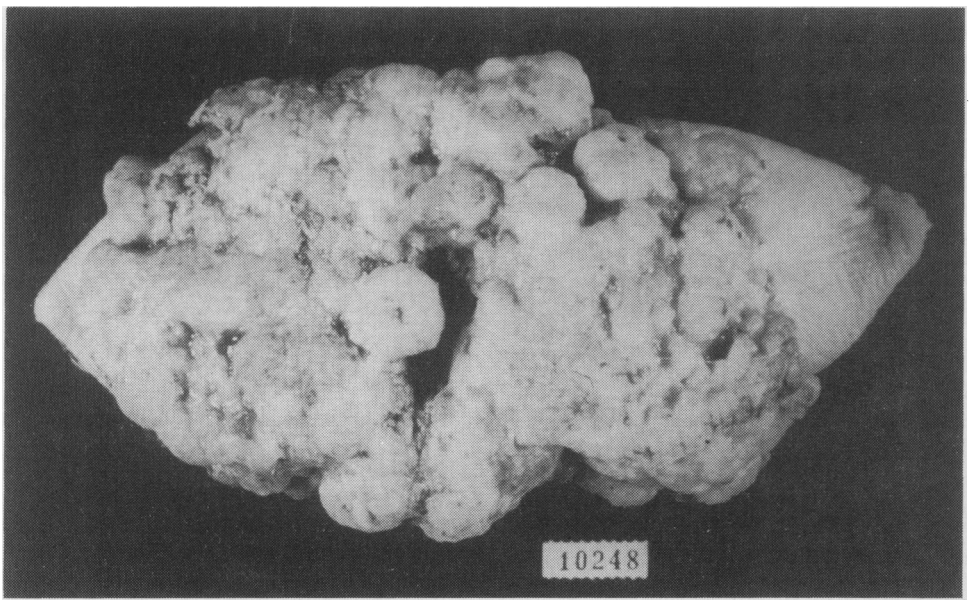

Figure. Tumour mass removed from the chest wall.

The tumour was widely excised and a split skin graft applied to the defect. He made an uncomplicated postoperative recovery and was discharged after ten days. At follow-up his condition had improved, he had recovered one stone in weight; all haematological parameters had returned to normal one year post-operatively. Histopathological analysis revealed a giant exophytic basal cell carcinoma with no evidence of malignant squamous elements. The lesion had been entirely excised with clear margins and there was no evidence of invasion beyond the interface of the reticular dermis and subcutis. Despite a very mature blood supply, areas of this tumour were necrotic and heavily contaminated.

DISCUSSION

Only 4% of all basal cell carcinomas occur on the trunk,[2] most being superficially erosive in character.[5] The disease process is usually terminated in the early stages[6] and it is rare nowadays to see the complete natural history. Over 200 cases of metastasising basal cell carcinomas have been reported to date, and of these 16·5% were primary truncal.[7] It is generally felt that metastatic basal cell carcinomas originate from large tumours present for may years.[8]

Giant exophytic basal cell carcinomas are very uncommon. No other cases presenting with anaemia have been recorded. Controversy remains over the malignant potential and immunological effects seen in this type of lesion.[4] In the present case, which was allowed to follow its natural course for over 12 years, we could detect no evidence of metastatic spread, despite the obvious systemic effects of the tumour through anaemia and debilitating chronic sepsis.

The lesion had ulcerated and bled persistently for two months prior to admission. Although blood loss was the most likely cause of the anaemia, it is possible that chronic sepsis with bone marrow suppression and non-metastatic biological

effects of the tumour may have contributed to its development. These secondary sequelae were clinically misleading and consequently did not reflect the indolent neoplastic potential of this lesion.

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