CASE REPORT

Unusual localization of a common cutaneous neoplasm: basal cell carcinoma

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Abstract
Basal cell carcinoma (BCC) is the most common form of the skin carcinomas and ultraviolet radiation is the major risk factor in the etiopathogenesis. However, reports of unusual sites for BCC are increased in the literature. Authors draw attention to possibility of other etiological agents for BCC like local trauma, ageing, ionizing radiation, arsenic, chronic inflammation, and immune deficiency. Here, we reported a 74-year-old male patient with nodular BCC on groin. We thought that ageing or local trauma may have a role in its formation.

Keywords: Basal cell carcinoma, skin tumor, unusual localisation

Introduction
Basal cell carcinoma (BCC) is the most common form of skin carcinoma differentiated from non-keratinizing cells of epidermal basal layer (1). The tumor typically originates from sun exposed head and neck region of light skinned population (65–83%) (1–3). Key factor of BCC pathogenesis is exposure of ultraviolet B spectrum which leads to mutations of tumor suppressor genes (1). However, BCC may also diagnose relatively sunlight protected sites such as axillae, buttocks, groin and completely sunlight protected sites such as the perianal and genital regions. Increasing number of unusual sites for BCC reports in the literature has taken attention to the possibility of other etiological agents (4). In this case, nodular BCC on groin was valuable to be reported for its uncommon localization.

Case
A 74-year-old man was referred to our dermatology clinic with history of a painless, non-healing tumor located on the right groin for 20 years. Tumor had grown slowly and bled occasionally. The patient had no history of trauma and skin carcinoma previously. In dermatological examination, a well-marginated 35 × 30 mm tumor on the right groin was remarkable. The center of tumor was crusted, the edge of the lesion was raised and hyperpigmented, and there was papillomatosis on the surface (Figure 1). There was no regional lymphadenopathy. Dermoscopic examination did not reveal a diagnostic feature. Physical examination and routine laboratory tests were normal. Tumor markers CA125, CA15.3, CA19.9, CEA, and AFP were in normal range. Total prostate specific antigen (PSA) and free PSA were resulted higher than normal values. The patient was consulted to urology department and was diagnosed as benign prostate hyperplasia. Histopathologic examination of the incisional biopsy material showed the islands of basaloid cells with peripheral palisading and disorganized central cells in dermis accompanied by slit-like retraction from the adjacent stroma. On the basis of both clinical presentation and histopathologic findings, the tumor has been diagnosed as nodular BCC. Residual tumor was totally excised and same histopathologic findings were recognized (Figures 2 and 3).
Scrivener et al. reported that 13,457 BCCs occurred in 10,245 patients from 1967 to 1996. BCC lesions were located on the head (83%), on the trunk (11%), on the upper limb (3%), on the lower limb (2%), and on the genitalia (0.2%). Histopathological subtypes of the BCC were 78.7% nodular, 15.1% superficial, and 6.2% morpheiform. BCCs of the trunk were more frequent in males than in females (5). Betti et al (6) reported 18 of 1050 cases with BCC located on hand, axilla, areola or nipple, buttock, perineal, and genital regions. In their series, tumors were nodular-ulcerative type, which were located on the groin (2). Unusual localization of BCC is more common in male population (6). Aktürk et al (7) reported a case with basal cell carcinoma on the lower lip in our country. Raasch et al (3) noted the importance of genetic factors that predispose to development of the different subtypes of BCC. Vincenzo de Giorgia et al (4) draw attention to possibility of other etiological agents for BCC occurred on sunlight protected areas. This literature suggests that local trauma and ageing may contribute to BCC development on these sites. Besides sunlight, recently defined risk factor such as exposure to artificial ionizing radiation, arsenic, chronic inflammation, hamartomas, and immune deficiency are remarkable for BCC etiopathogenesis (4).

In our case ageing was the unique proposed factor existed for BCC etiology. In addition, we suggested that chronic trauma may have a role in the formation of BCC because of the localization of the tumor. It is significant to detect nodular type BCC in our patient’s inguinal region which is an unusual localization for BCC. Although the lesion looks like BCC, it could be easily missed in clinical prediagnosis due to unusual localization. It should be considered that BCC may be localized in atypical sites notably in elderly male population.

Discussion

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Declaration of Interest

The authors report no conflict of interest.
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References


