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Case Presentation

A Hyperpigmented Perianal Nodule

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Abstract

Basal cell carcinoma (BCC) is the most common cutaneous malignancy. Ultraviolet light is an important risk factor for the pathogenesis of BCCs; the vast majority are found in sun-exposed areas. BCCs occurring in the perianal or genital regions are seldom seen. Less than 1% of all BCCs occur at these sites. Etiologic factors other than solar exposure must be taken into account for such cases. We report a rare case of BCC that was initially detected during a routine colonoscopy.

Keywords: basal cell carcinoma, bcc, perianal

Introduction

Basal cell carcinoma (BCC) is the most common cutaneous malignancy [1]. Ultraviolet light is an important risk factor for the pathogenesis of BCCs; the vast majority occur in sun-exposed areas [2]. BCCs occurring in the perianal or genital regions are seldom seen. Less than 1% of all BCCs occur at these sites [3,4]. Etiologic factors other than solar exposure must be taken into account for such cases. We report a rare case of BCC that was initially detected during a routine colonoscopy.

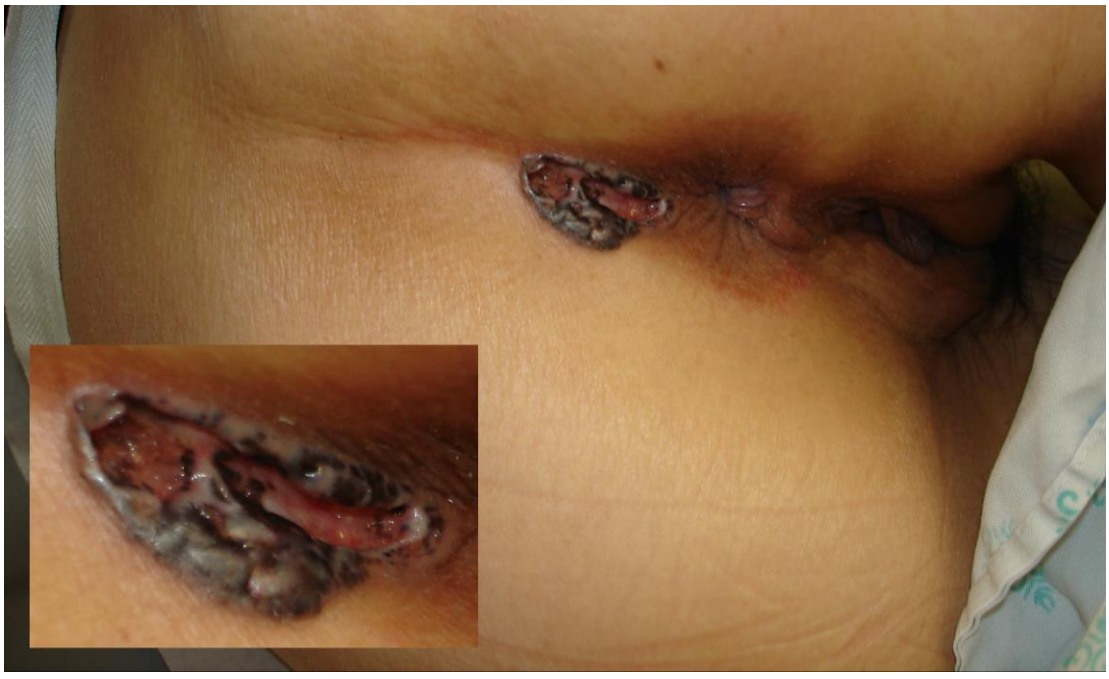

Figure 1: Hyperpigmented, nodular plaque with central ulceration

Case Synopsis

During a routine colonoscopy, a 62-year-old female was found to have a firm, hyperpigmented ulcerated nodule in the perianal region. The lesion had been present for about 7-8 years and had been growing slowly over the last few years. She recalled no trauma to the area. The patient had no significant past medical history and denied any personal or family history of skin cancer. On examination, she had a 2.5cm hyperpigmented irregular ulcerated plaque, approximately 2cm from the anus at the 12 o'clock position (Fig. 1). Aside from this perianal lesion, colonoscopy results were normal. A biopsy was performed of the perianal region, revealing a nodular, pigmented and focally ulcerated BCC.

Wide local excision with 1cm margins was subsequently performed. Histology of the excision specimen revealed nodular proliferation of basaloid cells with peripheral palisading and brisk mitosis (Fig. 2 and 3). The scattered individual melanocytes in the basaloid nests had thickened dendrites. There was markedly increased deposition of melanin throughout the entire lesion. The adjacent uninvolved epidermis was histologically unremarkable. There was no evidence of nesting of melanocytes.

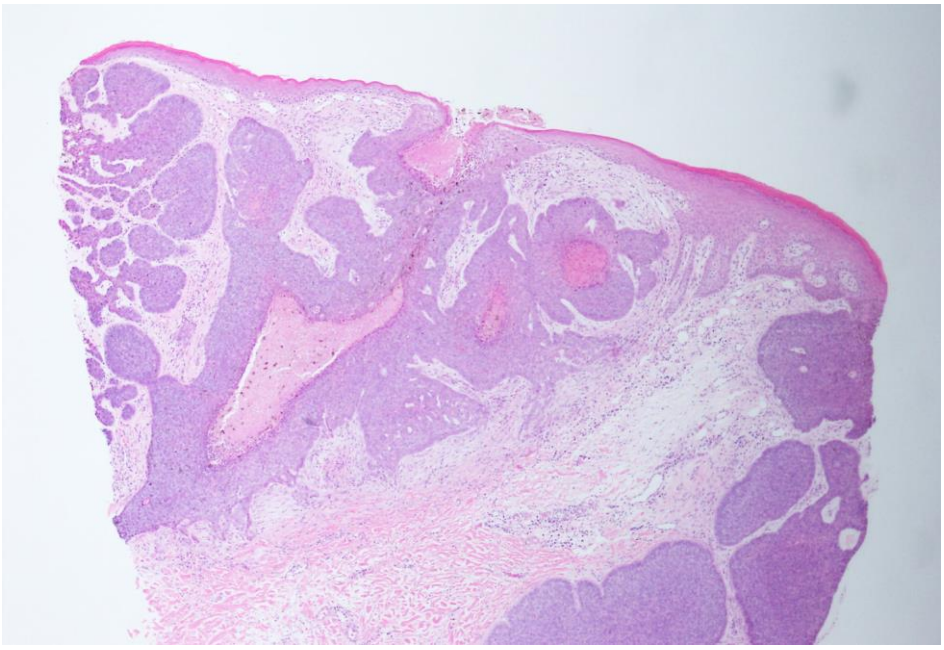

Figure 2: Nodular proliferation of basaloid cells with peripheral palisading

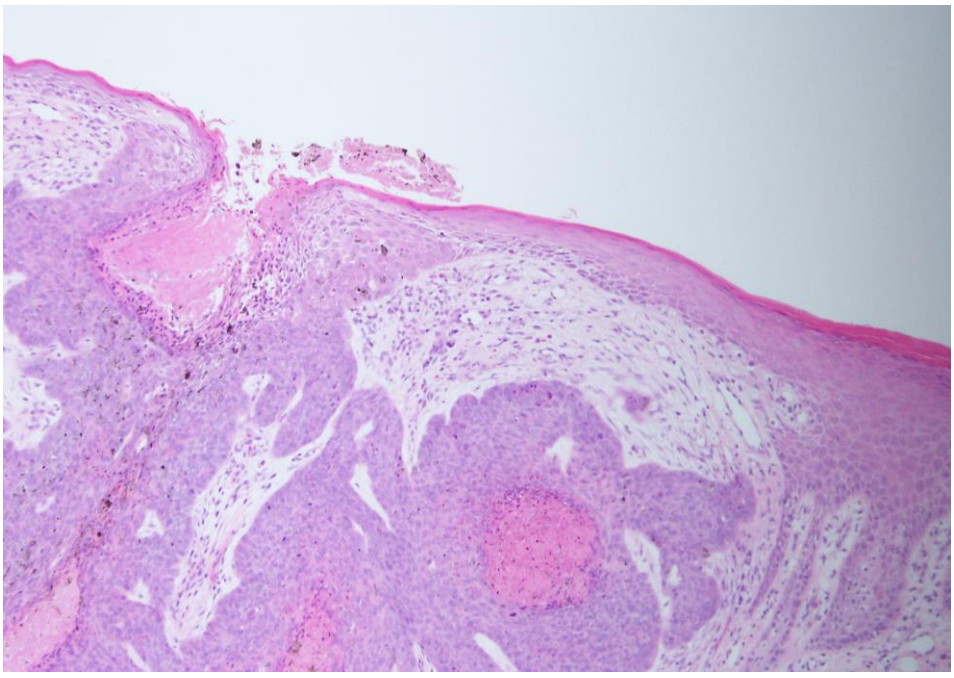

Figure 3 Nodular proliferation of basaloid cells with peripheral palisading

There were no complications during the procedure, and postoperative recovery was uneventful. No adjuvant radiotherapy or chemotherapy was given. The excised tissue revealed extension of the BCC to within 1mm of the inferior margin. A second excision procedure is currently pending.

Discussion

Perianal BCCs are very rare, occurring mainly in the middle-aged to elderly patient population [5]. Patients often present with large, ulcerated lesions owing to a delay in diagnosis. Diagnosis may be delayed because of a variety of reasons: patients may be embarrassed to seek treatment; physicians may overlook the perianal region during a total body skin exam; perianal lesions may be initially mistaken for inflammatory or infectious dermatoses. A low threshold for biopsy should be considered for perianal lesions because many may appear innocuous.

Ultraviolet radiation is a well-known and important causative factor for sun-exposed BCCs. Etiologic factors for perianal and genital BCCs have not yet been clearly defined, although previous reports have given consideration to radiotherapy in the pelvic region, chronic dermatitis, immunosuppresion, advancing age, genetics, previous trauma, and decreased immune surveillance caused by ultraviolet light at distant sites [6,7,8,9]. Investigators have been unable to implicate HPV in BCCs of the perianal and genital skin as an associated factor [10,11].

The differential diagnosis in our patient included melanoma and squamous cell carcinoma. In addition, histopathology is required to distinguish BCC from cloacogenic carcinoma, which is a more aggressive and malignant basaloid small cell carcinoma. Characteristics of BCC, as opposed to cloacogenic carcinoma, include the absence of pronounced polymorphous nuclei, keratinization centers with a spindocellular appearance, eosinophilic necrosis, and typical palisading [12]. Whereas cloacogenic carcinomas portend a worse prognosis, perianal BCCs behave like those on sun-exposed skin.

Treatment options for perianal BCCs include wide local excision, electrodessication and curettage, and Mohs micrographic surgery [13,14]. The patient presented in this case was treated with wide local excision but had positive margins, requiring an additional excision. Whereas previous reports have indicated a nonaggressive behavior of perianal BCCs and adequate treatment with local excision, the delay in diagnosis in this case may have led to a more extensive tumor [4]. Further studies are needed to determine if Mohs micrographic surgery leads to better outcomes in patients with long-standing perianal BCCs.

This case highlights the importance of performing a complete total body skin exam, including the perianal and genital regions. Any cutaneous lesion of uncertain nature in these areas should be biopsied. Awareness of the rare occurrence of BCCs at perianal sites may prevent delay in diagnosis.

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