

MEANS AND THERAPEUTIC METHODS IN BASEL CELL CARCINOMA DEPENDING ON THE PARTICULARITY OF THE CASE. CLINICAL CASE

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Summary

The basal cell carcinoma is a form of curable, tegumentary cancer which does not kill but, due to its infiltrative evolution, with tissular destruction and its recurrency rate, it has a very bad cosmetic prognosis, with negative impact on the patient and important costs. The approach treatment differs, depending on clinical characteristics, but also on the histological subtype.

We are presenting the case of a female patient with basal cell carcinoma which was approached by surgery followed by non-surgical treatment.

Key words: basal cell carcinoma, local relapse, individualized treatment.

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Introduction

The basal cell carcinoma (BCC) represents the uncontrolled proliferation of the keratoblastoma and of the tegumentary annexes (walls and follicle matrix, pilosebaceu ostium). First described by Jacob in 1827, the studies identified disfunction at the genes level, at the signaling ways level, as well as at the tumoral cell level, but continues to show some unknown issues, thus remaining research subject issues.

The BCC has a very good vital prognosys, but due to neglectation can determine mutilations. The BCC must not be underestimated, although it has a slow evolution, with numerous therapeutical methods.

The solar exposures do have a key role in its etiology, although the latency period of the carcinogenetic process may last years from the

moment of the exposure until the appearance of the tumor.

The establishment of the therapeutical conduct must keep count of the clinical and histological characteristics of the tumor, but also of the patient's wishes.

All treatment methods do have a recurrency rate.

Clinical case presentation

We are presenting here the case of a 79 years old female patient, from the rural environment, household keeper, which presents herself for the appearance of some ulcerative, asymptomatic lesions, at the level of the left cheek, at the external edge of the postoperative scar, with an over 4 month evolution. She is known for BCC personal pathologic antecedents, cardio-

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vascular pathology (arterial hypertension, painful ischemic cardiopathy, therapeutically controlled), digestive pathology (gastrical, therapeutically controlled ulcer). She does not smoke, nor consumes alcohol, but presents an historic of prolonged exposures to ultraviolet (UV), due to open air activity.

In November 2010, she presents with a superficial, but ulcerative tumor, located on the left cheek. Due to the clinical aspect, she decided for the surgical excision. After the excision of the tumoral process (dimensions of the operatory piece: 4,7/1,1/0,5 cm), with bounds for surgical safety, the histopathological exam (request code 750802) confirms the diagnosis of superficial BCC. The lateral section cut is included in the lesion and its decided that in February 2011 shall complete the BCC excision (dimensions of the operatory piece: 2,5/1,2/ cm, request code 767020). The histopathological exam confirms the BCC diagnosis. The excision is complete, there are no edges included in the lesion. The patient follows the recommendations: avoid the sun and cold exposure, clinical monitoring. Following the consulting from May 2012, we found a cutaneous tumor, located on the left cheek, inaccurately delimited. Then, the surgical intervention

follows. The histopathological exam (request code 895917) reveals the diagnosis of epidermoidal cyst. After four years, in August 2016, she presents with a cutaneous tumor located on the left cheek, this being followed by surgical intervention. The histopathological exam (number 1349359) confirms the BCC diagnosis. The excision is complete: lateral cut at 1,5mm, deep cut at 3 mm.

Knowing the patient's history, the clinical exam (phototype II, located on photoexposed areas, ulceration without healing) and dermatoscopic exam (dilatated, arborized capillary, ulceration and small epitheliomatous pearls) were the elements on which basis was established the diagnosis of BCC relapse certitude. The Imiquimod creme was the therapeutical option. In September 2017 the therapy has begun with the application of the creme for eight hours, five days a week. The appearance of a severe eritema, with the development of some superficial erosions has determined us to apply it 3 days a week. The evolution was favorable after 2 treatment cycles, obtaining the healing after three months. The clinical and dermatoscopic exam at three and six months confirmed the healing (fig. 1, fig. 2, fig. 3).



Fig. 1. Clinical appearance of cutaneous lesion prior to treatment



Fig. 2. Clinical appearance of the skin lesion during treatment



Fig. 3. Clinical aspect of skin lesion six months after treatment

Discussions

We respected the Helsinki Declaration principles, the patient giving his agreement for participation and the use of personal data by signing an informed consent form.

The BCC relapse was considered as being the lesions appeared due to some cuts with negative edges.

The BCC with over 20 cm diameter, with inaccurately delimited edges and among the clinical forms, the morpheiform, micronodular and atypical subtypes do have a relative high relapse rate. [1]

Is it the surgical reintervention compulsory in the case of positive edges? The opinions are divided. The BCC recurrency rate varies in the literature between 10 and 67 percent. The recurrency rate of completely excised tumors is between 5 and 14 percent. [2] The surgical reintervention, with the obtaining of the negative edges does not warranty the absence of relapse, but submits the patient to suffering. A conservative attitude spares the patient of the appearance of a scar. The uncomplete resection does not implicate the tumor recurrency. [3]

The facial locations, notably the facial and perioral ones, do have a higher recurrency rate comparing to other locations. The morpheiform

histologic type and excised BCCs with positive edges do have a 26 percent recurrency rate, comparing to 14 percent the recurrency rate of the excised tumors with negative edges, at 5 years. [3]

The recurrencies do appear most frequently after more years: 50 percent after 2 years, 66 percent after the first three years; so, the recurrency rate after ten years is double comparing to the recurrency rate after two years, no matter the treatment mode used. [4]

The percentage difference in the relapse appearance between classical surgery-approached and Mohs surgery-approached (MMS) BCCs is not significant, although the percentage is favourable to MMS surgery. [5]

The aggressivity of tumoral relapse is, sometimes, more accentuated than the primary tumor. [6]

The nodular BCC, which does not have a "pushing", but infiltrative aspect on the histopathological exam, has a higher relapse risk.

I decided to present this case due to the frequency of the situation in the medical practice. The BCC's evolution to relapse is well known to specialists, but the patient, although informed, still considers it a therapeutic failure. The BCC, although does not represent the main cause of decease, still remains, however, a form of cancer.

Conclusions

1. All BCC cases do necessitate clinical monitoring.
2. The treatment must be personalized accordingly to the tumor location and the histologic type.
3. The early BCC diagnosis has a good prognosis.
4. The treatment of the positive-edged BCC do have, as purpose, the relapse reduction, but with the minimizing of the patient's suffering.
5. The BCC's polymorphism does not allow a standardization of the therapeutical approach.
6. The diminution of the BCC's incidence is represented by the implementation of a prevention program, so that the financial resources shall not be directed to the treatment of the tumor.

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Conflict of interest
NONE DECLARED

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