Perianal Basal Cell Carcinoma: A Case Report and Review of the Literature

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ABSTRACT
Perianal skin tumors are rare and are frequently mistaken for either inflammatory or infectious diseases. Squamous cell carcinoma is the most frequent type, with less common lesions including Bowen's, Paget's disease and melanoma. Perianal basal cell carcinoma (BCC) is rare, with less than 100 cases reported in the literature. The authors report a case of perianal BCC in a 48-year-old man presenting with a six-month history of perianal itching and soreness. A review of the literature was performed, outlining clinical and histologic characteristics of this type of tumor as well as treatment options. Awareness of these tumors in non-sun-exposed areas may lead to earlier diagnosis and treatment.

Key words: Basal cell carcinoma, Skin cancer, Perianal

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ÖZET
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INTRODUCTION
Perianal tumors are uncommon lesions comprising 3% of all ano-rectal neoplasms. The most frequently found types include Bowen’s disease (intraepithelial squamous cell cancer), perianal Paget’s disease (intraepithelial adenocarcinoma), invasive squamous cell cancer, and malignant melanoma[1]. Perianal basal cell carcinoma (BCC) is rare, and only isolated case reports and two small series have been reported in the literature[2,3]. In fact, BCC usually occurs in sun-exposed areas, with 80% of cases presenting in the head and neck. However, BCC can arise, albeit rarely, in other areas including the axilla, nipple, genitals, and perineum[4]. The authors report another of these unusual presentations of BCC and review the literature, with particular emphasis on the clinical and histologic characteristics as well as treatment options.

CASE REPORT
A 48-year-old man presented with a six-month history of perianal itching and soreness. He had no complaints of abdominal or anorectal pain and had normal bowel movements with no rectal bleeding. His medical and surgical histories were unremarkable, and he was on no medications. He denied any history of local trauma or family history for cancer.

On examination, his abdomen was soft and nontender. There was no lymphadenopathy. Examination of the perianal region showed a 2 cm chronic ulcer with raised margins (Figure 1). The lesion was mobile and not fixed to underlying structures. A rigid proctoscopy and anoscopy were performed and no abnormalities were detected. A thorough examination of the other skin areas was carried out and did not reveal any further lesions. Examination under general anesthetic was done, and an excision biopsy with a 1 cm margin was performed. The wound was primarily closed with interrupted 2/0 Prolene sutures. The patient made an uneventful recovery and was discharged on the same day of surgery. Histology showed the lesion to be a BCC with clear resection margins (Figure 2). At the two-month follow-up, the wound had healed well with no sign of recurrence.

DISCUSSION
Perianal BCC is rare, and less than 100 cases have been reported in the literature[1-3]. Local trauma seems to be a main predisposing factor[3,4]. However, other factors should be considered, including radiation therapy, advanced age, immunosuppression, coal tar or arsenics exposure, sexually transmitted diseases, burns, traumatic scars, and chronic skin irritation[5]. Perianal BCC arising from benign tumors has also been reported[6]. A male predominance has been found, with a mean age of 67 years[2]. Patients generally present with slow-growing lesions between 1-10 cm with a characteristic crater-like center and raised margins. Lesions usually originate from the perianal region, but may extend into the anal canal[7].

Perianal lesions tend to be neglected by patients, and tumors may grow larger than lesions located in other parts of the body. Common complaints include...
itching, burning, bleeding, pain, discharge, or a mass. Accurate diagnosis requires a high index of suspicion. Any patient with persistent complaints of a rash or chronic irritation should be considered at risk until proven otherwise. All patients should be scheduled for a follow-up appointment and persistence of lesions should warrant biopsy for tissue diagnosis[8].

At histology, perianal BCC shows multiple foci of irregular basophilic cells with pleomorphic nuclei. It is characterized by peripheral palisading arrangement and crevices. Among the cells, some amount of stromal mucin can be found[2,9]. The most frequent histopathologic type is the nodular variety, as in the reported case. This is characterized by discrete large or small nests of basaloid cells in either the papillary or reticular dermis accompanied by slit-like retraction from a stroma in which the fibroblasts do not appear to be plump or proplastic[3,10]. In cases where lesions extend to the anal canal, it is essential to differentiate BCC from basaloid (cloacogenic) carcinoma. The latter is a subtype of non-keratinized squamous cell carcinoma of the anal canal, arising from the transitional epithelium. Immunohistochemical staining usually shows highly positive Ber-EP4, and this is most important in the differential diagnosis with BCC[11].

The treatment of choice of perianal BCC is local excision with wide margins. Large lesions may require excision with rotation skin flap or skin graft to cover the defect[12-14]. Limited data exist on the correct deep surgical margin, but excision through subcutaneous tissue is usually advised. Studies with Mohs micrographic surgery have suggested that a 3-mm margin clearance may be appropriate for small well-defined lesions (< 2 cm). A 4-5 mm resection margin would increase the clearance rate to 95%[15]. In cases of positive margins, re-excision alone or in combination with radiotherapy is usually recommended because of the high risk of recurrence and the possibility of the lesion showing a more aggressive behavior[16,17]. Abdominoperineal excision of the rectum or radiotherapy should be reserved for extensive lesions involving the anal canal and sphincters above the dentate line[17].

The five-year local recurrence rate after excision with clear margins has been reported as between 3% and 14%[8]. Recurrences should be treated by further local excision when possible. Risk factors for BCC recurrence include a size greater than 2 cm, history of previous failed treatment, histologically infiltrative pattern, and micronodular or morphea-like lesions[2]. There has been no mortality reported in association with perianal BCC. Most authors believe that these lesions do not have the capacity to metastasize, although there is one report of anal BCC with regional lymph node metastasis[18].

In conclusion, perianal BCC should be considered in the differential diagnosis of perianal lesions. Awareness of this type of tumor may allow for early diagnosis and treatment.

REFERENCES


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