

# DERMOSCOPY OF GIANT MORPHEIC BASAL CELL CARCINOMA

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## BACKGROUND

Basal cell carcinoma (BCC) is a malignant epithelial neoplasm of the skin which accounts for 80% of skin cancers. Its frequency is increasing substantially and regularly.

Clinical forms of BCC include nodular, superficial, ulcerating, pigmented, morpheic and fibroepithelioma of Pinkus. Each form varies in terms of clinical presentation, histopathology and aggressive behavior.

The morpheic basal cell carcinoma (mBCC) is uncommon, accounting for about 2% of BCCs, and appears almost exclusively on the face.<sup>1</sup>

Most BCCs are less than 1 cm in diameter. Giant BCC was defined as a tumor more than 5 cm in the greatest dimension according to the classification of the American Joint Committee on Cancer.<sup>2,3</sup> Less than 1% of all BCCs reaches this size.<sup>2</sup>

We present dermoscopy of rare, giant morpheic BCC.

## CASE REPORT

A 51-year-old man presented with a single, asymptomatic, nonpigmented lesion on the left side of the mandibula (Figures 1,2). The lesion had been slowly enlarging over the past several years. It was diagnosed as discoid lupus and treated with corticosteroid ointment without improvement. The patient had no history of BCC, any other skin tumors or treatment with irradiation. Clinical examination revealed the irregular oval plaque, approximately 7cm in diameter, but the exact margin of the plaque was impossible to define. Palpation revealed the firm skin texture with smooth surface. No local or regional lymph nodes were palpable.

Digital dermoscopic images of the lesion were taken and evaluated according to two-step dermoscopy algorithm. The lesion had four dermoscopic features (Figures 3,4,5) characteristic for BCC (nonpigmented and pigmented), namely, arborizing vessels, many short, fine telangiectasias, white to red structureless background and irregularly disseminated blue-gray globules in some parts of the lesion. Furthermore, the lesion had the zones of hypopigmentation (central and upper parts of the lesion) and hyperpigmentation (lower part of the lesion). A dermoscopic diagnosis of BCC was based on the absence of pigment network and the presence of four positive features of BCCs.

The tumor was treated surgically (Figure 7) and examined histologically. Histopathologic examination (Figure 6) showed strands and small islands of the basalioid cells with peripheral palisading, interspersed in densely packed, fibrous connective tissue which confirmed diagnosis of morpheic BCC.

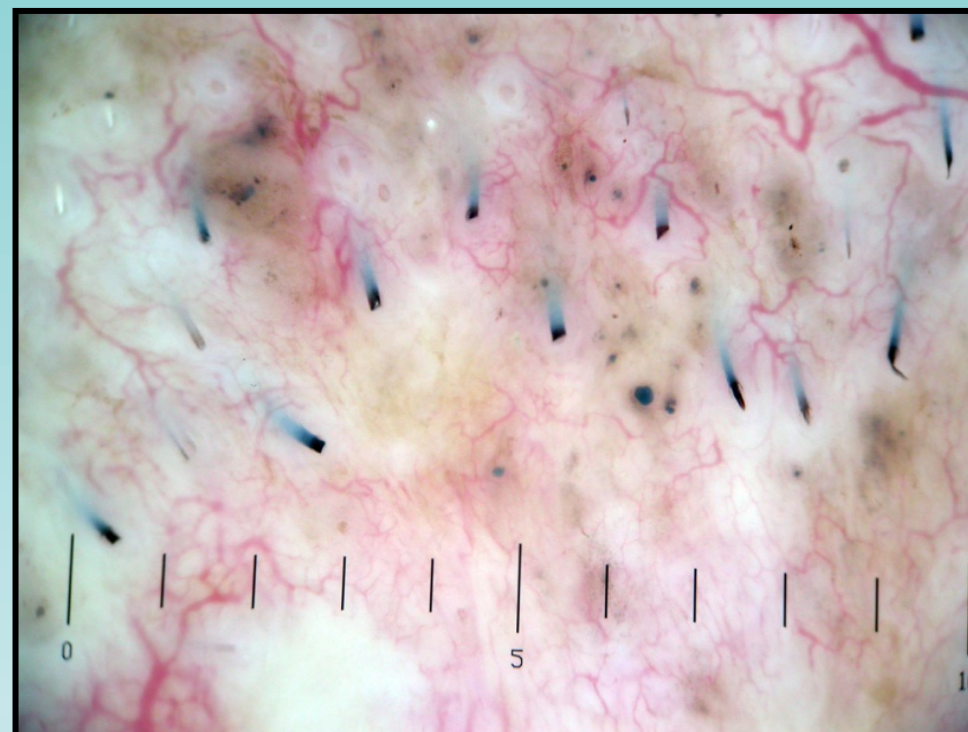
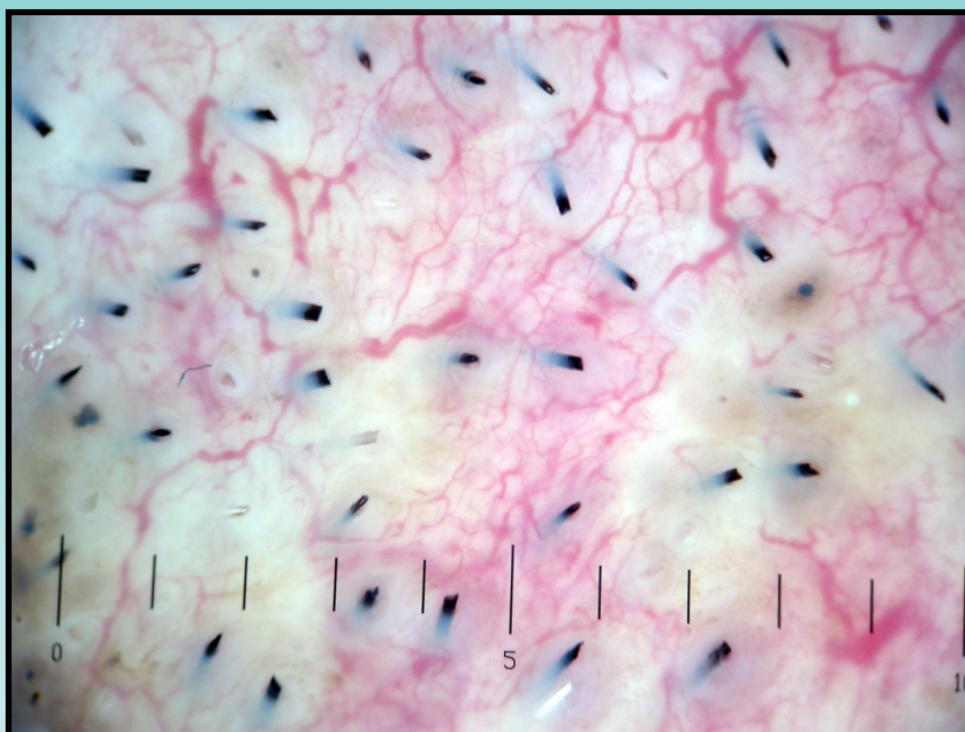
Because the histologic borders may extend well beyond those seen clinically, the recurrence rate may be as high as 60%.<sup>4</sup> In our case neither recurrence nor metastasis has been observed during one-year follow-up examinations.



Figure 1: Morpheic BCC on the left side of the mandibula



Figure 2: Higher magnification of the clinical lesion



Figures 3,4,5: Dermoscopy of the lesion

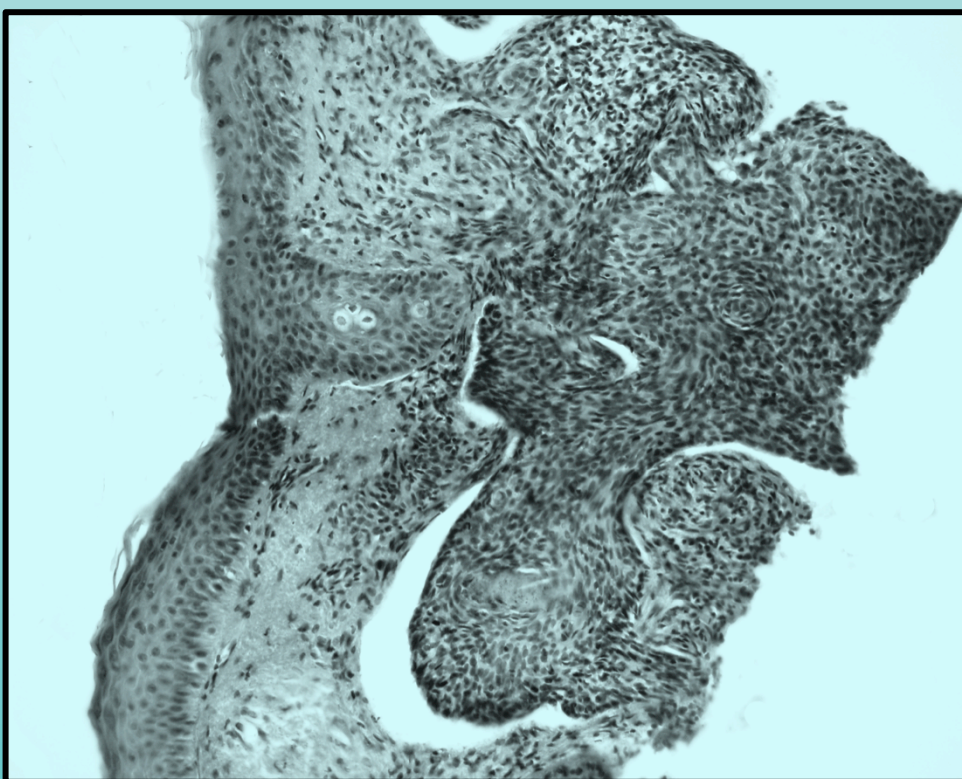


Figure 6: Histopathology of the lesion (H&E, 200x)



Figure 7: Cosmetic result after surgery

## CONCLUSION

Although rarely metastatic, malignant nature of mBCCs is emphasized by local tissue destruction, disfigurement and even death if left untreated. Despite the fact that the mBCC has unique clinical and histological findings, which separates it from other types of BCCs, there is no difference in dermoscopic findings distinguishing it from other forms of BCCs.

Our intent was to highlight the significance of applied dermoscopy in diagnosis of any suspected lesion, even the giant one.

## REFERENCES

1. MacKie RM and Quinn AG. Non melanoma skin cancer and other epidermal skin tumours. In: Burns T, Breathnach S, Cox N, Griffiths, editors. Rook's textbook of Dermatology 7th ed. Massachusetts: Blackwell Science; 2004.p.36.19-36.26.
2. Handa Y, Kato Y, Ishikawa H, Tomita Y. Giant superficial basal cell carcinoma of the scrotum. Eur J Dermatol 2005;15(3):186-8.
3. Randle HW, Roenigk RK, Brodland DG. Giant basal cell carcinoma (T3): Who is at risk? Cancer 1993; 72: 1624-30.
4. Nadiminti U, Rakkhit T, and Washington C. Morpheiform Basal Cell Carcinoma in African Americans. Dermatol surg 2004; 30: 1550-52.