



Steven Tomas

The 'ultra slow' BCC

Two case studies

Most basal cell carcinomas (BCCs) can be diagnosed readily on the basis of a medical history and clinical examination, particularly when various 'red flags' are taken into account. The purpose of this article is to show two cases in which BCCs have apparently remained unchanged for over 20 years, masking one of the major indicators of malignancy: change. A general practitioner must maintain a high degree of vigilance so as not to miss those BCCs that behave in an atypical manner.

Keywords: skin neoplasms; carcinoma, basal cell



Basal cell carcinoma (BCC) is the most prevalent cancer in humans,¹ and is commonly seen in general practice.

Discussion of the speed at which BCCs grow is poorly covered in the literature and a lack of knowledge in this area can impede diagnosis. However, a skin lesion that is new or changing, exhibits an important 'red flag' for the clinician.²

Diagnosis may become difficult when skin lesions do not display the usual red flags (*Table 1*), it may become even more so when a lesion displays signs in contrast to red flags. For example, when a BCC presents as an old, well established lesion that has been present for many years without apparent change. Diagnosis can also be difficult with a BCC that develops in a pre-existing scar or from trauma.

The following case studies of 'ultra slow' BCCs where the skin lesions have apparently been present for more than 20 years with no appreciable change noted by the patients. In both cases, the BCC was present on the face (a highly visible area) and in women (who may have a greater degree of self awareness, compared to males, of facial changes). Both patients were aware of the presence of the skin

lesions (the lesion in *Case study 2* followed trauma) and neither had any obvious sensory or cognitive problems (except for wearing glasses) to confound the history. The attention of neither family nor friends was raised, as would be expected with an obviously new or changing lesion.

One might assume that a BCC that is not undergoing any appreciable clinical change over such a long period of time would be 'low grade' and therefore, missing such a diagnosis would not be overly hazardous. However, there is evidence in the literature that BCCs may evolve from less aggressive to more aggressive growth patterns over time. That is, from superficial and/or nodular to infiltrative, micronodular and morphoeic.³ The latter types are more difficult to treat, and require potentially more destructive and disfiguring management.

It is also important to remember that aggressive BCC subtypes may infiltrate deeply and widely with minimal or subtle clinical evidence.² Therefore, what is happening on the skin surface may not be indicative of what is happening deeper in the tissues.

Case study 2 raises the interesting relationship between skin cancer and trauma and scars. It is well documented that BCC can develop within scars.² A MEDLINE search will quickly reveal numerous articles written about BCCs that have developed in scars of various aetiologies (eg. thermal⁴ and radiation burns,⁵ and surgery⁶ and vaccination scars⁷). Anecdotally the author found it not uncommon for a patient to note a BCC as arising directly from a known injury without any particular history of an intervening scar. Trauma has been reported as being a possible aetiological agent of BCC,⁸ and this may be the situation in *Case study 2*.

Table 1. Red flags when assessing skin lesions and BCCs

High risk patients

- Advancing age
- Fair skin
- Visible sun damage
- Large amounts occupational and/or recreational sun exposure
- Organ transplant recipients
- History of multiple skin cancers and/or solar keratoses

Clinical history of the skin lesion

- New onset
- Changing
- Nonhealing or recurring ulcer or erosion
- Proximity to previous skin cancer treatment
- Proximity to an incompletely excised or nonsurgically treated skin cancer

Case study 1

Mrs ML, 66 years of age, presented for a routine skin check and was noted to have a skin lesion on her midline forehead that she believed had been present for at least 20 years. The lesion was a pearly nodule with a 9 mm diameter and with prominent telangectasia (*Figure 1*). The patient denied any appreciable change of the lesion, and later presented a wedding photo taken 8 years earlier which showed the lesion to be present. Subsequent biopsy and excision revealed a BCC with mixed nodular and micronodular patterns. Excision was complete on the first attempt and no tumour recurrence has occurred to date.



Figure 1. Skin lesion present for 20 years

Case study 2

Mrs VB, 67 years of age, was referred by her general practitioner regarding a skin lesion on her hand. During the consultation the patient was noted to also have a 7 mm diameter, pearly nodule on the right inferolateral orbital margin. The lesion had prominent telangectasia (*Figure 2*). Apparently the lesion developed following a long weekend 24 years earlier when the patient fainted and fell, injuring her face on a brick. The wound was not sutured and



Figure 2. BCC showing pink-white amorphous background and tree-like vessels

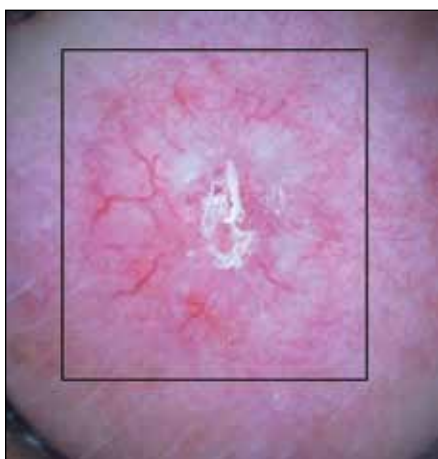


Figure 3. Skin lesion that had developed after trauma 24 years earlier

healed with a prominent scar which had not changed since it first developed. Under dermoscopy, the BCC had typical features, ie. a pink-white amorphous background and fine arborising (tree-like) vessels (*Figure 3*).^{9,10} No associated scar was noted. The lesion was subsequently biopsied and excised and found to be a nodular BCC.

Discussion

Basal cell carcinoma is a common condition which the GP will encounter in day-to-day practice. While usually not life threatening, these cancers can be locally destructive and treatment can be disfiguring. Being aware of red flags will assist accurate diagnosis. However, as with every other aspect of medicine, the GP needs to maintain a high degree of vigilance and clinical skill in order to diagnose lesions which have developed in a manner totally contrary to what is usually expected.

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