Shiny Facial Lesion

Samir N. Gupta MD, FRCPC, DABD; and Anil Kurian MN

A 70-year-old male presents with a 9-month history of developing a smooth papular lesion localized to the left side of his forehead. He worked as a truck driver for 30 years.

What is your diagnosis?

a) Keratoacanthoma
b) Seborrheic keratosis
c) Sebaceous hyperplasia
d) Basal cell carcinoma
e) Squamous cell carcinoma

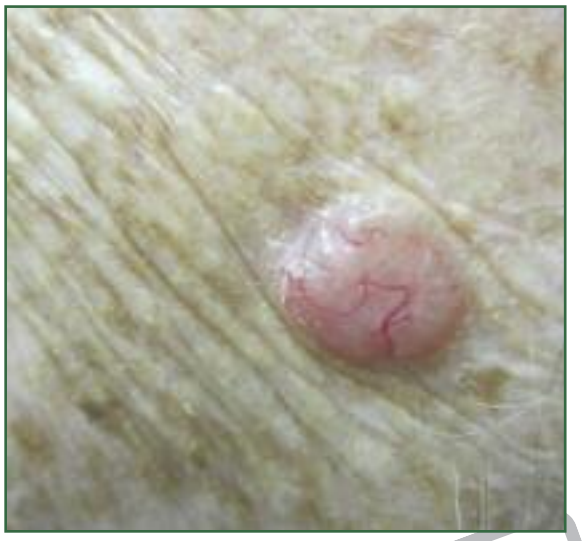

Figure 1: Shiny facial lesion

Answer "d" basal cell carcinoma (BCC) is a slow-growing, malignant epidermal tumour of the skin. It is the most common malignancy seen in humans.

BCC is commonly found in adults on sun exposed areas of skin. It is much more common in fair skinned individuals, however, it is reported in skin of colour. The skin sites most commonly affected are the head and neck (80%), trunk (15%), arms and legs.

Risk factors for BCC include fair complexion, red or blond hair, light eye color, increased childhood sun exposure, exposure to ionizing radiation and UVA radiation and immunosuppression. Exposure to sun is by far the major contributing risk factor to the development of BCC. Familial BCC syndromes (Gorlin Syndrome, Bazex Syndrome) are well documented but extremely uncommon.

There are several types of BCC. Nodular BCC is the classic and most common form and represents 80% of clinical presentations. It typically presents as a pearly telangiectatic papule with a characteristic rolled border. Superficial BCC represents 15% of all BCC's and presents as a scaly erythematous patch or plaque often mimicking an area of dermatitis. Both nodular and superficial BCC's may contain melanin, which give them a brown or black color and the designation "pigmented BCC's." The morpheaform type of BCC is also known as sclerosing or infiltrative BCC and represents 5% of BCC's. It is the most aggressive form and typically presents as an indurated, white scar-like plaque with indistinct margins.

The diagnosis of BCC is often suspected clinically, however, biopsy should be performed for confirmation. Laboratory testing or imaging is not required. The differential diagnosis of BCC includes actinic keratosis, sebaceous hyperplasia, seborrheic keratosis, angiofibroma, melanocytic nevus, molluscum contagiosum, Bowen's disease, keratoacanthoma, and squamous cell carcinoma. BCC rarely metastasizes and is fortunately a highly treatable form of skin cancer.

The definitive treatment of BCC is surgical. However, non-surgical approaches can be effective for very small or superficial BCCs.

Mohs micrographic surgery is the most effective treatment for BCCs. This specialized procedure is not available everywhere and is usually reserved for BCC's located on cosmetically sensitive areas such as the face. Direct excision, electrodessication, curettage and cryosurgery are also commonly employed surgical treatments.

Nonsurgical approaches for the treatment of BCC include topical imiquimod, photodynamic therapy and radiation therapy.

Prevention of BCC focuses on sun avoidance during peak hours, sun protection with the regular use of broad-spectrum sunscreens and routine surveillance.

cme

Dr. Samir N. Gupta, FRCPC, DABD, completed his Dermatology Fellowship training at Harvard University and currently practices in the Toronto area subspecializing in Laser Dermatology

Anil Kurian MN is a medical student at