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Case Report

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Sclerodermiform basal cell carcinoma: rare form in a young patient

Abstract

SBCC is a rare form of CCB with invasive architecture and potentially aggressive evolution

The diagnosis is based on clinical and dermoscopic features; whereas the confirmation is histological.

Early diagnosis and surgical management is the main method to reduce disfiguring surgical excisions. We report one case of SBCC.

Keywords: basal cell carcinoma, clinical, treatment, evolution

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Case report

Sclerodermiform basal cell carcinoma (SBCC) is an aggressive type of basal cell carcinoma (BCC) with risk of deep invasion, rapid growth, and risk of metastasis. Early diagnosis is the main method to reduce disfiguring surgical excisions. We report one case of SBCC.

We report the cases of one 34-year-old, phototype 3, the delay of consultation was 4 years, and the factors risk was mainly sun exposure, the symptoms leading to consultation were ulceration. The clinical examination found sclerodermiform plaque, poorly limited, and erosion at the forehead. The dermoscopy revealed telangiectasia and vascularization in tree trunks, as well as ulceration. The rest of the somatic examination was normal. The diagnosis of basal cell carcinoma scleroderma was confirmed by histology. Surgical excision with margins was performed (Figure 1 & 2).

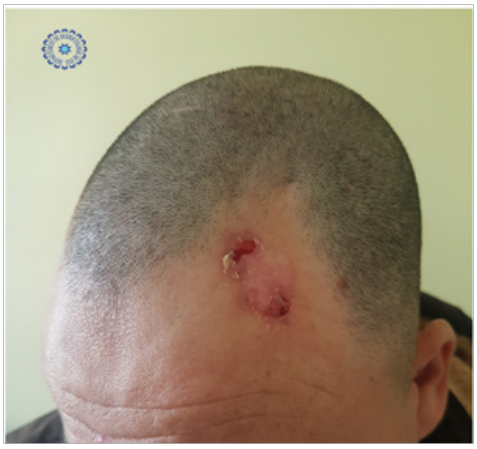

Figure 1 Sclerodermiform plaque, poorly limited, and erosion.

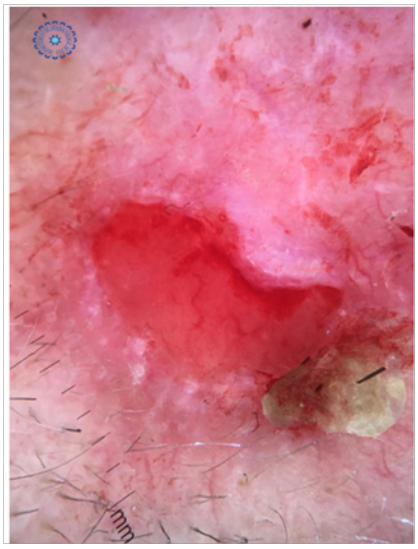

Figure 2 Dermoscopy revealed telangiectasia and vascularization in tree trunks, as well as ulceration.

Discussion

Aggressive BCCs are not uncommon ranging from 2.5 to 44%.[1–3] Some behavioral or environmental factors other than UV radiation, such as kidney transplant recipients, have been associated with a higher incidence of aggressive BCC subtypes.[4,5] Among these aggressive lesions, scleroderma-like basal cell carcinomas (SBCC) are the most common type.

The sclerodermiform subtype is clinically defined by its sclerous appearance, sometimes nacreous, crusty, with fuzzy boundaries,

with the presence of telangiectasia and often ulceration.[2] It has been reported that SBCC dermoscopy, consisting of whitish, shiny, non-structural areas and smaller, less branching arboreal vessels, is finer than those seen in nodular BCC.[6]

The diagnosis is based on clinical and dermoscopic features; whereas the confirmation is histological objectifying the fusiform cell tumor cords without pallisadic border.[7] The management is surgical. High recurrence rate if management is not surgical, if margins of excision are insufficient.[8]

Conclusion

SBCC is a rare form of CCB with invasive architecture and potentially aggressive evolution, justifying radical surgical treatment to prevent recurrence and terebrante evolution.

Acknowledgments

None.

Conflicts of interest

The authors declare there is no conflict of interest.

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