

BASAL CELL CARCINOMA NOSE (VESTIBULAR REGION) SIMULATING SCLEROMA

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Although in this part of our sub continent we are very familiar with the clinical presentations of scleroma and basal cell carcinoma of the nose, yet in the case going to be reported we erred in making a correct diagnosis in the first instance, even two consecutive biopsies from the tumourous mass failed to reveal its true identity. It was only on the third occasion that the true nature of the swelling could be known. Insidious onset, slow growth and nodular swelling in the vestibular as well as in the alar regions made the similarity between the two conditions very close. In going through the literature we failed to find scleroma, among various conditions mentioned, which should be differentiated from basal cell carcinoma of nose. In the present case the lesion was a basal cell carcinoma (nodular type) and it resembled scleroma of the nose (Fig. 1).

Mrs. B. 65 years of age, widow, was admitted with the complaint of a gradually increasing swelling in the anterior nares, duration being 2 years. To start with it was a small nodule in the left nasal vestibule. It had been growing slowly but progressively since then and had now completely obstructed the anterior nasal orifices. It had also involved the gingivo-labial sulcus at the philtrum and the anterior part of the hard palate and caused a swelling there.

On general examination she was fairly well nourished. Her heart and lungs

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were normal. There was no lymph adenopathy. Liver and spleen were not palpable. The colour of skin and mucous membrane was natural.

Local examination of the nose showed the presence of an extensive nodular growth filling up both the nasal cavities anteriorly and completely occluding the anterior nares. The growth had infiltrated the vestibular region and also the bases of both the alae nasi. The growth had caused considerable amount of widening of the anterior surface of the nose. It had infiltrated into the gingivolabial sulcus at the philtrum of the upper lip and had also involved the anterior part of the hard palate (premaxillary region) where it had caused a swelling of the size of an almond.

It was very firm in consistency and was tender only on deep pressure. The whole mass was fixed to the deeper structure and immobile. Skin over the tumourous mass was stretched and adherent. At one or two places it showed signs of ulceration.

It was not well demarcated and tended to diffuse out at the naso-labial junctions. Even at the periphery the consistency of the tumour was firm. The surface was nodular.

The posterior nares were clear and so was rest of the naso-pharynx. Ear and Throat examinations were normal.

The regional lymph nodes were not palpable.

The routine laboratory examination showed:—

Hb. 12 gm.%
 T.L.C. 8000/cu.mm.
 E.S.R. 25 mm 1st hr. (W.G.)
 Screening Chest - Clear
 Urine Examination—normal
 Blood Serology for Syphilis was negative.

Skiagram of nose and para-nasal sinuses showed the soft tissue shadow of the growth. The nasal cavities were full. The floor of the nose anteriorly (pyriform region) showed signs of bone destruction (Fig. 2). Frontal and ethmoidal sinuses were clear.

Biopsy of the tumour - Basal cell carcinoma (Fig. Nos. 3 & 4).

She was treated by tele cobalt therapy. Total dose of radiation administered was 5400 r. Exposures given were 5 days in a week. The response was very favourable resulting in complete regression of the growth. (Fig. 5).

Variable incidence of the disease has been reported by different workers. Vender and Herendi, (1951) reported 69% basal cell carcinoma among skin tumours. T. Venkie, (1965), found the percentage of basal cell carcinomas as high as 76.7%. Monhallin, (1968) studied 633 basal cell carcinomas from 478 patients. In his series the sex ratio was 55% males and 45% females. In males the average age being 59 years while in female it was 61 years. He emphasized the importance of histopathological examination because clinical diagnosis was not always certain.

Schrire (1960) reported a 30% error ratio even in the most experienced hands. Main (1963) gave misdiagnosis rate as 17.5%. In the present case also first two biopsies were negative and report was nonspecific granulation tissue. The biopsy taken third time was diagnostic of basal cell cancer.

The multiplicity of lesion also varies. Belisario (1959) reported 1.9% as against 16.31 quoted by Monhallin (1968).

The neoplasm may be associated with other types of tumours e.g. squamous cell carcinoma, melanoma, mixed parotid tumour.

Most of the lesions are of small size, their diameter ranging from . mm - 19 mm (Monhallin, 1968). In the present case the lesion was much more extensive.

Regarding the distribution of the lesion these commonly involve forehead, nose, cheek, temple, lower lid, and inner canthus.

Belisario (1959) reported 123 cases of involvement of nose out of a total number of 478 patients studied by him.

Pre-existing associated conditions may be mole, trauma, scar, lupus vulgaris, senile keratosis, radiation dermatitis and calcinosis cutis.

Clinically the lesion has been classified as:—

- a) Typical - nodular, ulcerated,
- b) Atypical - multiple, cystic, cicatricial, pigmented terebrant and cylindrical.

The differential diagnosis should be from squamous cell carcinoma, early lesions of tuberculosis luposa cutis, psoriasis, lupus erythematosus, Bowen's disease, sub acute and chronic cocco-genous eczema. Scleroma should be added to this list to be differentiated from the nodular variety. The pathological and the surgical aspects are not discussed here and can be referred to any of the standard text books.

Summary :

A case of basal cell carcinoma of nose, nodular variety is reported. Clinically it resembled scleroma and was actually mistaken for it. Only repeated biopsies revealed the true nature of it.



Fig. 1

Clinical photograph showing growth in the nasal cavity

Fig. 2

Skiagram of nose and paranasal sinuses showing soft tissue shadow of the growth. The floor of nose shows signs of bone destruction anteriorly

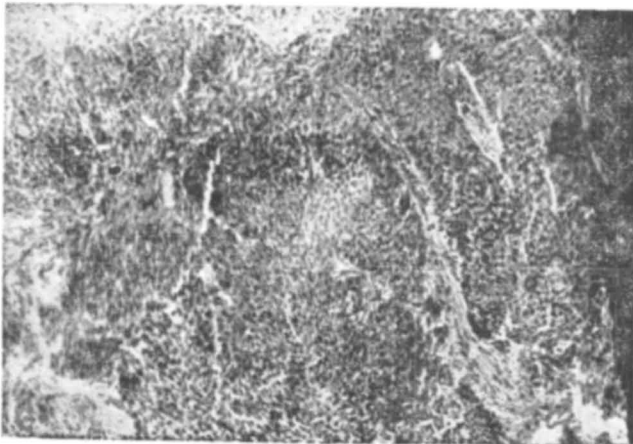
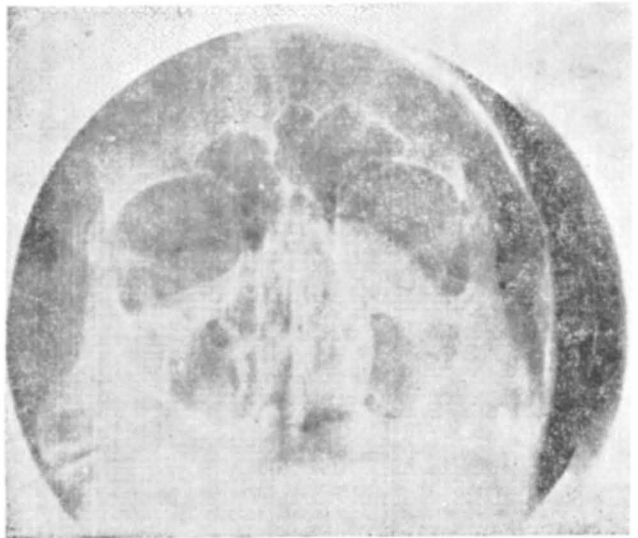


Fig. 3

Microphotograph (x 10) showing histological features of basal cell carcinoma showing enlarged hyper chromatic nucleus and mitotic figures

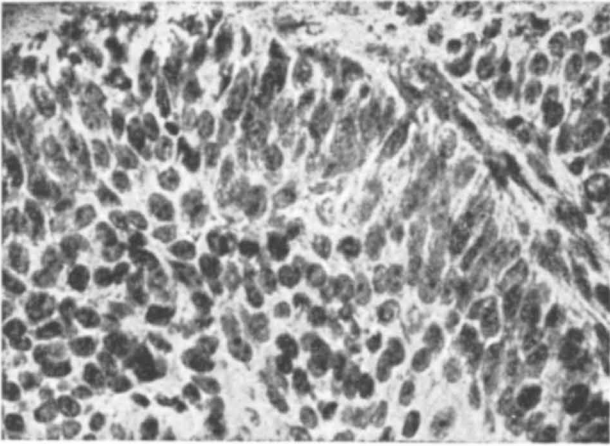


Fig. 4
Microphotograph of the same under high power magnification (x 45)



Fig. 5
Clinical photograph after a course of cobalt therapy shows complete regression of the growth

Clinical variants and differential diagnosis of basal cell cancer is discussed. The nodular type of basal cell carcinoma of the nose (vestibular region) should be kept in mind to be differentiated from scleroma of the nose.

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