A Delayed Diagnosis On Scalp: The Case Of Giant Basal Cell Carcinoma

Saçlı Deride Gecikmiş Tanı: Dev Bazal Hücreli Karsinom Olgusu

ABSTRACT
Basal cell carcinoma is a slowly growing tumor and it usually shows local invasion and rarely metastasis. According to description of American Joint Comittee on Cancer describes Giant Basal Cell Carcinoma as the diameter of tumor is 5 cm or above. Giant Basal Cell Carcinoma usually occurs on neglected cases. Giant Basal Cell Carcinoma can be destructive and more aggressive and Giant Basal Cell Carcinoma can cause mortality and morbidity. In this case report, the patient was a 75 years old neglected woman who was living alone. She had Giant Basal Cell Carcinoma for many years on scalp and its diameters was 16x12 cm. She had dura mater metastasis but nothing other.

Keywords: carcinoma, basal cell, negligence

ÖZET
Bazal hücreli karsinom yavaş büyuyen bir tümör olup cildin malign tümörleri arasında en sık görülenidir. Yedinci dekatta pik yapar ve genellikle lokal invazyon, nadiren de metastaz yapar. American Joint Comittee on Cancer’e göre 5 cm ve üzerindeki boyutlardaki bazal hücreli karsinomlar dev bazal hücreli karsinom olarak tanımlanır ve daha çok ihmal edilmiş vakalarda görülür. Dev bazal hücreli karsinom daha destrüktif ve daha agresif seyrederek mortalite ve morbidite nedeni olabilir. Bu olgu sunumunda 75 yaşındaki yalnız yaşayan bir kadın hastada, saçlı deride, 16x12 cm çapında, dura metastazı olan uzak metastazı bulunmayan bir dev bazal hücreli karsinom olgusu sunulmuştur.

Anahtar kelimeler: karsinom, bazal hücre, ihmal

Introduction
Basal cell carcinoma (BCC) is a slowly growing tumor and it usually shows local invasion. Caucasians especially are affected by BCC and it is the most common form of malignant skin tumor (1). It shows peak incidence in seventh decade (2). Although BCC is commonly seen on head and neck region, it can be seen on trunk and extremities. It can be cause of erosion, plaque, incrustation, destruction on these regions and it may show infiltration to adjacent tissues, and can reach some adjacent tissues like muscle, bone and cartilage (3). BCC rarely shows metastasis. However it does metastase to the lymph nodes most often. Lungs, bone, skin and liver metastases follow it respectively. Incidence of BCC is rapidly increasing. Risk of developing of BCC is 30% in lifetime (4). BCC’s are defined as “Giant BCC” when tumors diameter bigger than five cm’s (2).

In this case report, 75 years lonely women be presented who has neglected giant BCC for many years on scalp and its diameters was 16x12 cm and it has dura mater metastasis with no distant metastasis.

Case
The 75 years old female patient was hospitalized to palliative care inpatient service with wide and bleeding wound on scalp and exhaustion. Because of her limited cooperation, it can not be possible to gain sufficient information on the onset of the lesion. But the patient did not have any previous treatment for the lesion.

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In her physical examination, a lesion was founded on temporofrontoparietal region. The lesion was ulcerated, necrotic and bleeding. The lesions diameter was 16x12 cm (Figure 1,2). Also there was bone defect. The biopsy result reported a giant basal cell carcinoma. Metastatic lesions were not detected on computerized tomography of thorax and abdomen; chemotherapy was not planned for the patient. There were mass lesions that invaded left side of the frontal bone, frontal skin and left side of zygomatic bone and there were metastasis of dura mater on magnetic resonance imaging (Figure 3).

Erythrocyte count of patient was 3.510.000/mm³, hemoglobin was 6.5 gr/dL and haematocrit level was 21.1%. Total iron binding capacity was 264 μmol/L, iron level in serum was 4 mg/dL, transferrin saturation was 1.52% and ferritin level was 14.5 ng/mL. Transfusion was administrated to the patient with two units of erythrocyt suspension. Nutritional solution which contain 1200 kcal/day added to the patients diet to support her nutrition.

Pseudomonas aeruginosa detected in wound culture and two grams of ceftazidime administrated to the patient three times per day. Patient was lonely and she had no social support. Because of that she had been consulted by social service and her personal requirements had been given. After that she had been consulted by plastic and reconstructive surgery and reported that there was no efficient condition for excision of tumor and regenerative surgery. Daily medical dressings have been suggested by surgeons. Therefore patient had referred to university hospital.

**Conclusion**

According to description of American Joint Comittee on Cancer (AJCC), Giant Basal Cell Carcinoma (GBCC) is the tumor with a diameter of 5 cm or above. But several authors reported that it should be getting a diagnosis as GBCC when tumor diameter is above 10 cm. Although AJCC describe the GBCC as the tumor that above 5 cm, 1% of the BCC’s can reach these diameters (2). In this case tumor diameters measured as 16x12 cm and it was a GBCC that is rarely seen.

Incidence of BCC is increasing continuously. It reached highest rates as 30% in USA and Australia. BCC is most common at 40-80 years of life (4). Our case was 75 years old.

Most common etiological factors are genetic predisposition and exposure to ultraviolet radiation. Exposure to sunbeam is an important risk factor for BCC, especially in childhood. To be an elder, to be male, to be a caucasian, to be an immunsupressive, exposure to arsenic and to have a family history of skin cancer are risk factors that related with BCC. Also it is reported that consuming a diet including foods with high fat ingredients is related with BCC.

BCC may be related with Gorlin’s Syndrome and Xeroderma Pigmentosum. Also environmental factors, such as trauma, smoking, may be a causal factor for the tumor. BCC is typically seen on regions that are sensitive for sunbeam, such as scalp or midline of the face (4-6). But in our case we couldn’t get sufficient history for risk factors because of the patient’s limited cooperation with us.

**Figure 1,2.** Diameters of the lesion on the scalp.
GBCC usually occurs on neglected cases. Causes of neglection are cognitive impairment of patient and ignorance. Also only low education level can be cause of neglection.

Risk of GBCC and invasion of tumor are more likely on patients who lives in solitude and neglected. In 30% of GBCC cases, it has been founded that the tumors were related with neglection (2,18).

Our case was lonely and lives in solitude. There was no relation with anybody. Her cognitive status was poor and her cooperation was limited. It was assessed that these factors were playing an important role for the tumor in reaching these sizes.

Finally, although risk of local invasion and metastasis of BCC are low, misdiagnosis, mistreatment, delay on diagnosis and neglection of patient can all be causes of GBCC, of being destructive and more aggressive, and even be a cause of mortality and morbidity.

In this case report, we emphasize that living alone, not to have a caretaker, lack of education and knowledge can be cause for growing BCC and GBCC. Therefore improving of home care services are important for prevention of GBCC and early diagnosis and treatment of BCC cases.

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Table 1. Giant Basal Cell Carcinoma cases that were seen in scalp and have metastasis of dura

<table>
<thead>
<tr>
<th>Age/Gender</th>
<th>Origin</th>
<th>Size</th>
<th>Invasion</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>79/F</td>
<td>Frontal Region</td>
<td>Not Defined</td>
<td>Bone and Dura</td>
<td>8,9</td>
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<tr>
<td>63/F</td>
<td>Left Parieto-oksipital scalp</td>
<td>15x15</td>
<td>Dura</td>
<td>10,18</td>
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<td>36/M</td>
<td>Oksipital Region</td>
<td>1.8x1.2</td>
<td>Dura</td>
<td>11,18</td>
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<td>Dura</td>
<td>12,18</td>
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<tr>
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<td>Frontoparietal</td>
<td>15x15</td>
<td>Dura</td>
<td>13,18</td>
</tr>
<tr>
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<td>Frontoparietal</td>
<td>11x10</td>
<td>Dura</td>
<td>14,18</td>
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<tr>
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<td>Frontoparietal</td>
<td>10x7</td>
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<td>15,18</td>
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<td>Dura</td>
<td>16,18</td>
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<tr>
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References


