

# ENDGAMES

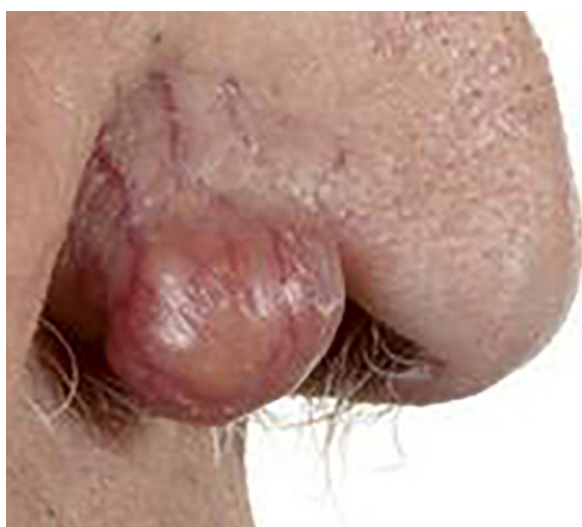
## CASE REVIEW

# A pedunculated nasal nodule

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A 92 year old man presented to his primary care doctor complaining of a lesion on his right nostril (.). The lesion had been present for 10 or more years, however recently it had increased in size. His only history was of chronic renal impairment. Examination revealed a 10 mm pink, pearly, pedunculated nodule with telangiectasia arising from the right nasal ala.



A pearly nodule with telangiectasia arising from the right nasal ala

## Questions

1. What is the most likely diagnosis?
2. What is the most appropriate management for patients with this condition?
3. What post-treatment/follow-up instructions are important for the primary care doctor and patient?

## What is the most likely diagnosis?

### Short answer

Basal cell carcinoma.

### Discussion

The lesion is a pearly nodule with telangiectasia arising from the right nasal ala. The clinical appearances are characteristic of basal cell carcinoma, which is the most common cutaneous malignancy.<sup>1</sup> The main risk factor is ultraviolet light exposure; other risk factors include having fair skin, exposure to radiation, and various genetic syndromes including naevoid basal cell carcinoma (Gorlin) syndrome and xeroderma pigmentosum. A history of slow growth over several years makes a diagnosis of a malignant lesion such as a squamous cell carcinoma, sebaceous carcinoma, or amelanocytic melanoma less likely. In general, the differential diagnoses of a nodular basal cell carcinoma can also include an intradermal naevus, seborrheic keratosis, actinic keratosis, or sebaceoma. Other forms of basal cell carcinoma can be mistaken for scars or inflammatory skin disease, however these would not usually present as a nodular lesion.

The major histological subtypes of basal cell carcinoma are nodular, superficial, and infiltrative. Nodular basal cell carcinoma typically manifests as a pearly nodule with telangiectasia. This can ulcerate centrally to give the characteristic rolled edge. Superficial basal cell carcinoma has the appearance of a crusted or scaly papule or plaque that may be associated with pigmentary change. Infiltrative basal cell carcinoma is characterised histologically by infiltrating cords of tumour that can spread a considerable distance beyond the extent of the clinically apparent tumour. In the latter case, standard surgical excision can be associated with a high risk of recurrence.

2.

1.

## What is the most appropriate management for patients with this condition?

### Short answer

Referral to dermatology where biopsy can be performed, after which the patient should either undergo surgery (including Mohs micrographic surgery and reconstructive surgery), or radiotherapy.

### Discussion

While metastatic spread of a basal cell carcinoma is rare, there is the potential for extensive local tissue destruction. In this case, growth is slow and a routine referral to the dermatology clinic is appropriate. If there is diagnostic uncertainty, particularly if the primary care doctor is concerned about the possibility of a squamous cell carcinoma, then the patient should be referred urgently. The only required investigation is a skin biopsy, which is usually performed by the dermatology team.

Treatment options include surgical excision or radiotherapy. Standard surgical excisions tend to extend 4-5 mm beyond the tumour.<sup>2</sup> This is to capture any subclinical extension beyond the clinically apparent margins. Mohs micrographic surgery is a form of histologically controlled excision. It is particularly suited to cosmetically sensitive sites and other locations where it is desirable to preserve healthy tissue. The tumour is excised with narrower margins and margins are examined histologically immediately after excision. If the tumour remains then further levels are taken until the tumour is clear. The defect is subsequently reconstructed.

A second treatment option is radiotherapy. This is generally more suitable for older patients or for patients who do not wish to proceed with surgery. Disadvantages include a more prolonged treatment, the potential for poorer cosmetic results in the long term, and an increase in the risk of subsequent skin cancers. At other sites, according to the histological subtype of the tumour, treatment options include standard surgical excision, curettage or cryotherapy. Superficial basal cell carcinomas can additionally be treated with topical imiquimod, 5-fluorouracil, or photodynamic therapy.

In recent years, an understanding of the genetic aetiology of basal cell carcinoma<sup>3,4</sup> has informed the development of targeted inhibitors of the Hedgehog pathway that may be appropriate for the treatment of advanced basal cell carcinomas that are not amenable to conventional treatments.<sup>5,6</sup>

3.

## What post-treatment/follow-up instructions are important for the primary care doctor and patient?

### Short answer

Monitor for signs of infection if surgery was performed. Inform the patient to monitor the treatment site in the future because of the small risk of recurrence

### Discussion

In the short term, the risks of Mohs surgery include bleeding, infection, and pain. In the longer term, the risk of recurrence for primary basal cell carcinoma treated by Mohs surgery is less than 1%.<sup>7</sup> Nevertheless, patients should be counselled about the small risk of recurrence and advised to monitor for features such as the development of a nodule, ulcer, or crusting at the treated site. In our department, patients are reviewed around three months after treatment to assess wound healing and cosmetic appearance, however unless there is a high risk of subsequent skin cancer, routine follow-up after this time is not usually indicated.<sup>2,8</sup> All patients should additionally receive advice regarding lifelong photoprotection including sun avoidance, photoprotective clothing, and the usage of sunscreen to reduce the risk of subsequent skin malignancy and self monitoring of the skin.

### Patient outcome

The patient elected to undergo Mohs surgery with subsequent reconstruction of the ala. Follow-up review at three months revealed a good cosmetic result with no evidence of recurrence.

We have read and understood BMJ policy on declaration of interests and declare we have no competing interests.

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