



Basal cell carcinoma mimicking pilonidal sinus: A case report with literature review



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ABSTRACT

INTRODUCTION: Pilonidal sinus is a common benign disease that accounts for almost 15% of anal suppurations while basal cell carcinoma is the most common malignancy of the sun-exposed area occurring mainly on the head and neck. We report a case of basal cell carcinoma presented with signs and symptoms of PNS. A 40-year-old male presented with swelling of the lower back for 2 years. On examination, there was a round, mobile, soft 4 × 2.5 cm mass on the sacrococcygeal area. Ultrasound showed subcutaneous cystic lesion. Clinical diagnosis of PNS was done and excisional biopsy was performed under local anesthesia. The result of the histopathological examination was suggestive for basal cell carcinoma.

CONCLUSION: Basal cell carcinoma should not be forgotten in differential diagnosis of superficial mass and abscesses.

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1. Introduction

Pilonidal sinus (PNS) is a common benign disease that accounts for almost 15% of anal suppurations. It is a sinus that contains hairs and occurs mainly in the sacrococcygeal region. Its diagnosis is rarely difficult on clinical bases [1]. On the other hand; basal cell carcinoma (BCC) is the most common malignancy of the sun-exposed area. About 80–85% occur on the head and neck [2]. BCC of the other area rarely mentioned in literature like nail, palm, vulva and nipple. Both condition best diagnosed by histopathological examination [2–5]. We report a case of BCC presented with signs and symptoms of PNS. The work has been reported in line with the SCARE criteria [6].

1.1. Patient information

A 40-year-old Kurdish driver man presented with swelling of the lower back for 2 years associated with occasional pain and increasing in size.

1.2. Clinical findings

On examination, there was a round, mobile, soft mass on the sacrococcygeal area (intergluteal region) just right to the midline. It was 4 × 2.5 cm in size with slight tenderness.

1.3. Diagnostic assessment

Hematological tests were normal. Ultrasound showed subcutaneous cystic lesion with 41 × 26 × 1.4 cm in size, just distal to terminal part of the coccyx containing heterogenous fluid content.

1.4. Therapeutic intervention

Clinical diagnosis of PNS was done and excisional biopsy was performed under general anesthesia. Fig. 1 shows the gross appearance of the specimen. The result of the histopathological examination showed focal erosion of the epidermis overlying multiple clusters of polygonal basaloid cells with dark hyperchromatic ovoid uniform nuclei extending from epidermis into superficial dermis, displaying peripheral nuclear palisades and artefactual separation stromal cleft (Figs. 2 and 3). The picture was suggestive for BCC.

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Fig. 1. The specimen after resection.

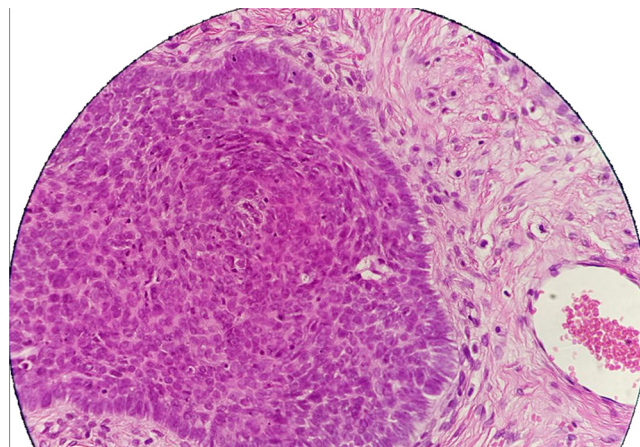


Fig. 3. Polygonal basaloid cells with dark hyperchromatic ovoid uniform nuclei displaying peripheral nuclear palisades and artifactual separation stromal cleft.

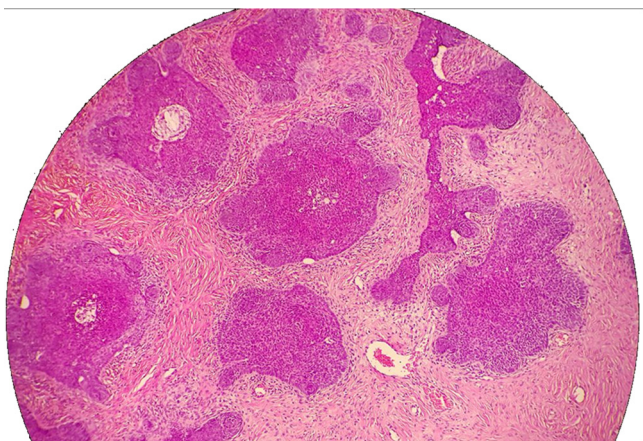


Fig. 2. Multiple clusters of polygonal basaloid cells.

are mostly pigmented which resembling malignant melanoma [7]. Several histological types of BCC are recognized including: pilar (keratotic), primordial (solid or medullary), morphea-like (sclerosing or fibrotic), adenoid (adenoid cystic), superficial spreading, and pigmented (melanotic). Usually one type appears, but a mixture of two or more may co-exist [8]. The aetiology of BCC is not clear, but excessive exposure to ultraviolet radiation is implicated. Other etiological factors are old age, male gender, immunosuppressed patients, specific phenotype (freckling, blonde or red hair), environmental causes such as exposure to polycyclic aromatic amines and genetic syndromes [2,9]. BCCs develop from the adnexal structures and basal layer of the epidermis. large nucleus to cytoplasm ratio, elongated ovoid nuclei, variable peripheral palisading with abnormal mitoses are the histological hallmarks of BCC [2]. BCC presents mainly with either one of three types; nodulo-ulcerative lesion, flat lesion or polypoid tumor with an intact surface [10]. Our case presented with mass like lesion with intact overlying skin. BCC rarely metastasize ranging from 0.0028 to 0.5% [4,11]. Definitive diagnosis and treatment usually done by excisional biopsy with histopathological examination. Among perineal and genital BCC, vulva affected most commonly, accounting for about 1% of all BCCs which may present with bleeding, palpable vulvar mass, ulceration, irritation, pain, and pruritis [10]. Table 1 shows important reported cases of BCC occurred in perineal and genital areas.

Although BCC is a rare disease in covered area of the body especially perineal and genital regions, it should not be forgotten in differential diagnosis of superficial mass and abscesses. Its main line of treatment is complete resection.

1.5. Follow-up and outcomes

The patient was lost from follow up.

2. Discussion

BCC is 4 to 5 times more common than squamous cell carcinoma of the skin and it is reported to be continuously increasing [7]. Most frequently arises on sun exposed area. However, it may occur in other covered regions of the body, including the axillae, inguinal region, and nipple [3]. In Japanese and black people, BCCs

Table 1
Summary of important reported cases of BCC occurred in perineal and genital areas.

References & Authors	No. of cases	Average Age(Year)	Site	presentation
12/Roger	45	76	vulva	Mass, pruritis, ulcer
11/Breen	17	59	Left labium majus (9 patients), Right labium majus (6 patients)*	Mass (2 patients), mass and pruritis (4 patients), sore (5) ulcer (3 patients) pruritis (2 patients)*
13/Goldminz	12	69	penis	Nodule (7 patients)Scaly plaque(3), ulceration (2)
8/Jimenez	11	59	labium majus (9 patients), posterior fourchette (2 patients),	Mass (6 patients), ulcer (2 patients), pruritis (2 patients), induration (1 patient)
14/Piura	8	70.5	labium majus	Mass (4 patients), ulcer (4 patients)
15/Ward	5	69.8	vulva(4 patient) right labium majum (1 patient)	Soreness (1 patient) mass (4 patients)
16/Karim	1	83	anal verge	Ulcer
17/Misago	1	88	9 o'clock perianal region	Polypoid nodular lesion

Conflicts of interest

There is no conflict to be declared.

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Ethical approval

Approval has been taken from bioscience center.

Author contribution

Abdulwahid M. Salih: Surgeon performed the operation and follow up. Fahmi H. Kakamad: writing the manuscript and follow up. Goran M rauf: Examining the specimen, follow up.

Informed consent

Informed consent was taken from the patient for publication.

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