Abstract:
Basal cell carcinoma (BCC) is the most common non-melanoma skin cancer. It has a predilection to exposed body parts like the head and neck. Its occurrence in the perianal region is very rare. Contrary to earlier reports, it is no more aggressive in this site than the usual sites of occurrence, and thus wide local excision provides adequate control. Herewith reporting a rare case of BCC of the perianal region in a 69-year-old male, treated adequately by wide local excision.

Keyword: Basal cell carcinoma, perianal, wide local excision

Introduction:
Cutaneous malignancies are the most common cancers in humans. Basal cell carcinoma is the commonest non-melanoma skin tumor with a predilection for occurring in the head & neck (75-86%), which is attributed to solar exposure. Its occurrence in non-exposed areas such as the perianal region is rare. Only 3 small case series of perianal BCC have been reported in the Western literature, and its incidence is as yet unreported from the Indian subcontinent.

Case Report: A 65-year-old male, a manual labourer by occupation, presented with complaints of an ulcer in the perianal region for past 2 months. The ulcer was insidious in onset and gradually progressed to attain the present size. There was no associated pain, bleeding from the ulcer or any alteration in bowel habits since the onset of the ulcer. He is a known hypertensive on drugs. There was nothing contributory in the family history. There was no history of any addictions.

Examination revealed a 3X3 cm ulceroproliferative lesion in the perianal region from 7 o’clock to nine o’clock position towards the right buttock with the medial margin situated 4cm away from the anal verge (Figure 1).
Figure 1 - Appearance of the lesion
Edges of the ulcer were raised and beaded, the floor was covered with pink protuberant granulation tissue (Figure 2).

Figure 2 - Characteristics of the ulcer
Multiple right superficial inguinal lymph nodes were palpable, largest measuring 1x1cm, firm, nontender, mobile. The lymph nodes showed decrease in size following a course of antibiotics. Per rectal examination was normal, sphincter tone was normal. There were no skin lesions elsewhere in the body. His haemogram and biochemical investigations were within normal limits. A dermatologist opinion was sought for the lesion and a venereal disease work up done by them (including blood VDRL) also came back negative. Thus differential diagnoses of tuberculous ulcer, cutaneous malignancy (squamous cell carcinoma or basal cell carcinoma) and Crohn’s ulcer were arrived at. Subsequently, to confirm the diagnosis, a wedge biopsy was taken from the ulcer including the margin, a part of base and a portion of the adjacent normal skin. Histopathological examination revealed features of basal cell carcinoma with adenoid cystic pattern (Figure 3 Figure 4).

Figure 3 - Histopathology (preoperative)

Figure 4 - Histopathological report (preoperative)
Fine needle aspiration cytology done from the inguinal lymph nodes showed no evidence of malignant infiltration (Figure 5).

Figure 5 - Lymph node FNAC report
Due to proximity of the tumor to the anal sphincter complex, a surgical gastroenterologist opinion was taken regarding the possibility of sphincter involvement & sphincter saving options. They suggested that since the outer margin of the tumor was 4cm away from the...
anal sphincter, adequate clearance could be given without sacrificing the sphincter and a colostomy could be avoided. Hence a wide local excision of the lesion was proceeded with. Intraoperatively, the lesion was 1.5cm in depth and there was no invasion into the anal sphincter (Figure 6).

Figure 6 - After wide local excision, finger inside the anus demonstrates the intact anal sphincter
A wide local excision was done with a 1cm margin of surrounding normal tissue. The post excisional defect was covered by a V-Y advancement flap by the plastic surgery team (Figure 7, Figure 8).

Figure 7 - V-Y advancement flap being created

Figure 8 - Final result
Post operative recovery was good and wound healing was satisfactory. Post operative histopathological examination of the resected specimen confirmed the diagnosis and also showed that the resected margins were free of tumor invasion (Figure 9, Figure 10).

Figure 9 - Histopathology (postoperative)

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The patient received no adjuvant chemo- or radiotherapy as suggested by the medical oncologist. Regular follow-up over last 6 months has shown no evidence of tumor recurrence.

Discussion:
BCC usually occurs over the sun-exposed body parts like head and neck. It can occur in sporadic and syndromic form. The latter is associated with multiple lesions at other sites in the body. Though factors like ultraviolet-B exposure, regulatory gene mutations, arsenicals and polynuclear aromatic hydrocarbons have been associated with its occurrence in the usual sites, the cause of these tumors in the perianal region is unknown. Ionizing radiation to the pelvic region has been implicated. Unusual sites of occurrence of BCC include hand, axilla, areola or nipple, buttocks, perineal and genital regions. Only a few more than 100 cases of BCC of the perianal region have been reported so far. Any suspicious ulcer in this region should be subjected to biopsy and histopathological examination. Since syndromic BCC is associated with multiple lesions at other sites, the diagnosis should prompt examination of all cutaneous surfaces. Treatment options include wide local excision, electrodessication and curettage, Mohs micrographic surgery, cryotherapy, topical application of 5-fluorouracil, intralesional therapy (using 5-fluorouracil, bleomycin and interferons), radiation therapy and phototherapy. Being non-aggressive, these lesions are adequately treated by wide local excision. Alertness about this rare site of occurrence thus helps to prevent delay in diagnosis and treatment and to avoid morbid aggressiveness in surgical management of the disease.

References:
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