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RESEARCH ARTICLE

SCROTAL BASAL CELL CARCINOMA: A CASE REPORT

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Abstract

Basal cell carcinoma is the most common malignant skin tumor. It's frequent in photo-exposed areas. Scrotal localization is exceptional, so we recommend analyzing any nodule evolving for more than 3 months outside professional exposure.

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Introduction:-

Basal cell carcinoma (BCC) is the most common malignant skin tumor. Sun exposure is the most important risk factor, which explains its frequency in photo-exposed areas, particularly the face, neck and alopecic scalp. Scrotal localization is exceptional, with a few sporadic cases reported in the literature. On the other hand, the scrotum is known to be a frequent site of squamous cell carcinoma in the context of occupational exposure to hydrocarbons.[1,2]

We report a case of scrotal BCC with an atypical clinical presentation.

Clinical case:

66 years old male, with no notable pathological history and no professional exposure, presenting a scrotal lesion.

The history of the disease goes back more than 10 years, with the appearance of a nodule in the scrotal midline that has increased in size over the past 6 months. The patient has used traditional treatments, which have resulted to a rapid increase in size and a change in appearance: the lesion is 5cm by 3cm and has become budding, inflammatory, with ulcerated areas and a narrower base than the fleshy part of the lesion (figure 1). The lesion is not deeply adherent, and there are no signs of bursal infiltration. The testicles were mobile and sensitive, with no hydrocele.

A biopsy was performed under local anaesthetic, with microscopic findings consistent with basal cell carcinoma. Given the atypical location and macroscopic appearance of the lesion, an immunohistochemical study was performed, confirming the diagnosis.

The patient was admitted for surgery under general anaesthetic.

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An exeresis with 1 cm lateral margins was taken with preservation of the skin muscle: theDartos in depth (figure 2) with direct closure after a simple detachment (figure 3).

The specimen was oriented and sent to anatomopathology for a complete study, confirming the diagnosis.

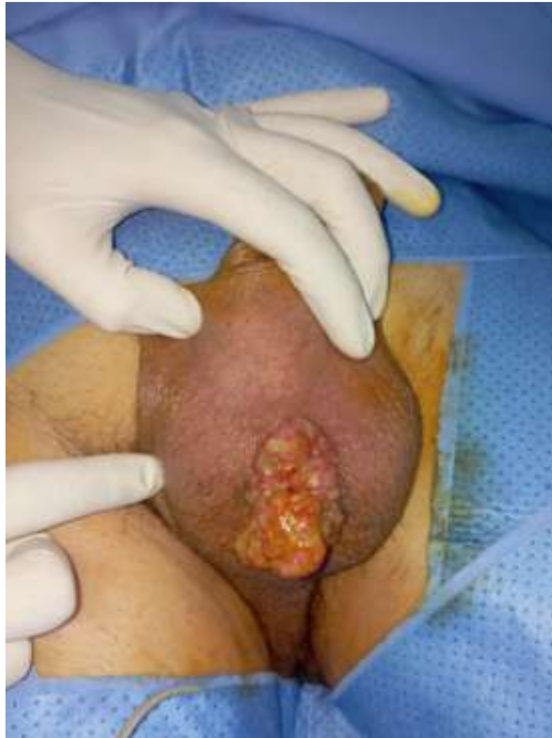

Figure 1:- Macroscopic appearance of the scrotal lesion.

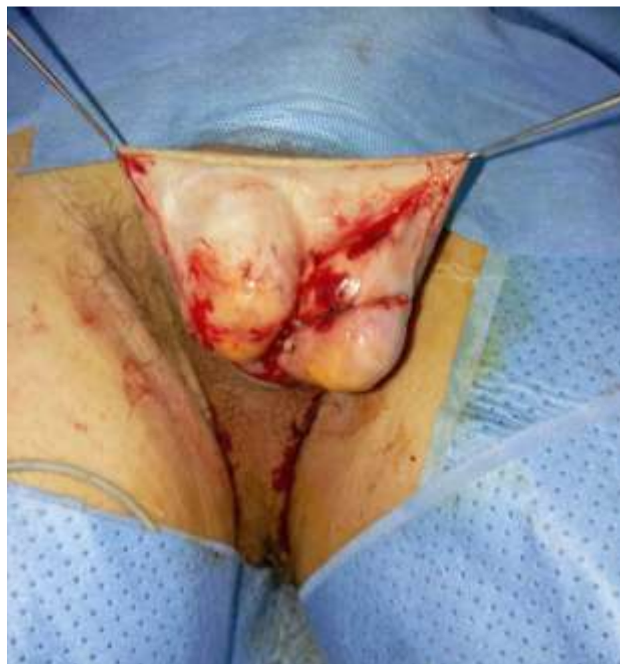

Figure 2:- Removal of the scrotal lesion.

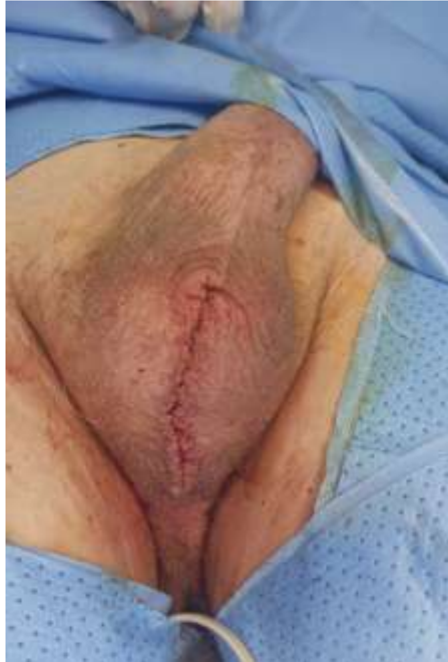

Figure 3:- Substance loss closure.

Discussion:-

Basal cell carcinoma (BCC) is the most common skin tumour worldwide, occurring mainly in sun-exposed areas [1]. However, cases of basal cell carcinoma have been reported in non-photoexposed areas such as the perineal or axillary regions [2]. Compared with squamous cell carcinomas, basal cell carcinomas are rarely reported in urology literature.

As UV radiation is not a risk factor for scrotal BCC, several theories have been put forward to explain this location. A recent study showed that genetic polymorphisms in loci coding for certain detoxifying enzymes could increase the risk of occurrence of these skin cancers [3]. Genital localization is considered a high-risk site for recurrence and distant metastases [4].

Surgical management consists of excision with healthy lateral and deep margins, ideally verified by Mohs surgery or conventional pathological examination [1].

Scrotal localization does not differ from other localizations in terms of therapeutic management, but closer surveillance is imperative in view of the greater risk of recurrence.

Conclusion:-

Our case study underlines the importance of evoking the diagnosis of carcinoma in the presence of any lesion that has been evolving for several months, regardless of location.

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