



Giant basal cell carcinoma of the face

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ARTICLE INFO

Article Type:

Case Report

Received: 2 Jun 2014

Revised: 17 Jul 2014

Accepted: 21 Aug 2014

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ABSTRACT

This case report describes a 59-year-old woman with a giant basal cell carcinoma on the face neglected for 11 years. Surgical resection of the lesion resulted in a 13 × 11 cm defect. Issues regarding the adequately safe surgical margins and the management of the resultant defect through modern wound dressing technologies are discussed.

Keywords: Giant Basal Cell Carcinoma, Modern Dressing, Gel Dressing, Silver Dressing, Safe Margin

Introduction

Basal cell carcinoma (BCC) is the most common malignant cutaneous neoplasm, predominantly found in the head and neck. Although BCC rarely metastasizes, it is capable of causing significant destruction by invading the surrounding tissues [1]. Therefore, a delay in diagnosis and treatment may result in extensive invasion with potentially life-threatening outcomes [2].

Case Report

A 59-year-old woman was referred to our department for evaluation of a massive lesion on the left side of the face (Figure 1). The lesion had first appeared 12 years ago as a small lesion on the left lower eyelid. At that time, the lesion was totally removed but recurred 1 year later. The patient had neglected the lesion and refused to receive any treatment for 11 years primarily due to fear of surgery.

Clinical examination revealed an exophytic, ulcerated lesion measuring 9 × 7 cm. The left eye had been blind in the last 5 years. Computed tomography (CT) showed erosion of the underlying bone structures including the floor and lateral rim of the orbit, the anterior part of the maxilla, and the zygomatic bone.



Figure 1. The patient at the time of admission

A preoperative incisional biopsy revealed BCC. The lesion was totally excised under general anesthesia with a safe margin of about 2 cm. Intraoperative frozen section analysis revealed involved margins. Consequently, a further 5 mm of tissue was resected from the involved areas, giving rise to a 13 × 11 cm tissue defect (Figure 2). A second frozen section showed clear

margins on all sides. The histopathological analysis revealed mixed nodulocystic and infiltrating types of BCC.

Immediately after surgery, the defect was covered by a Silvercel (Johnson & Johnson Pharmaceutical, New Brunswick, NJ) antimicrobial wound dressing. Furthermore, NU-Gel (Johnson & Johnson Pharmaceutical, New Brunswick, NJ) was applied to the margins of the wound in order to provide and keep a moist environment. Every other day, the dressing was removed, the area was irrigated with normal saline, and a fresh dressing was placed as described above. After 2 weeks, the dressing was replaced on a daily basis, using only NU-Gel and moist gauze pads.

A few weeks after surgery, the previously exposed areas of bone were completely covered with granulation tissue, and the margins of the wound showed progressive epithelialization. Moreover, 6 months after surgery, the remaining wound was significantly smaller, and the newly formed skin showed rather acceptable texture and color (Figure 3). The patient was then referred for construction of a temporary maxillofacial prosthesis.

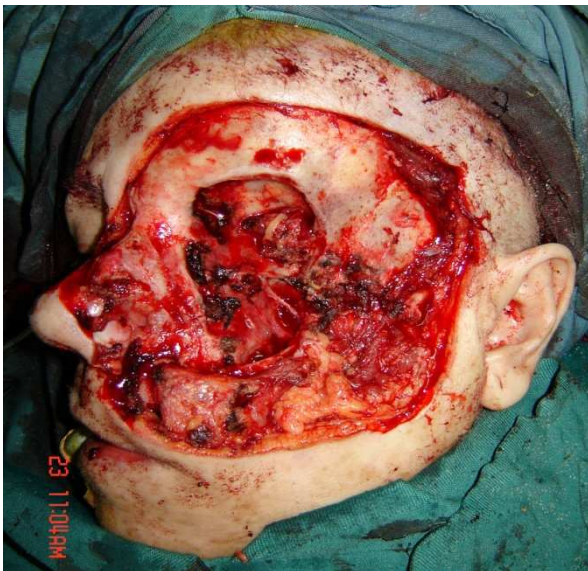


Figure 1. The patient immediately after surgery



Figure 3. The patient 6 months after surgery

Discussion

Although occurrence of giant BCCs have been reported almost frequently in the literature, they have rarely been reported on the face [3-6]. This is probably because lesions of the face are easily noticeable to the patients and they are far less likely to be neglected. Those patients who neglect large BCCs on their face may be in poor socioeconomic status, or suffer from physical or psychiatric disabilities that restrict their access to and demand from health services. The main reason that our patient refused to treat her tumor for 11 years was an extreme fear of surgery.

We planned a surgical resection with 2 cm safe margins. This decision was made on the basis of the tumor size, as well as the facts that it was a recurrent lesion and the skin around the lesion was apparently bulging out. It has been reported that an initial safe margin of 4 mm will clear 98% of nodular BCCs, and more generous margins of 8 to 10 mm have been suggested for more aggressive BCCs [7]. Compared to these recommendations, our 20 mm initial margin seemed to be rather radical; however, it proved to be inadequate. Therefore, a giant BCC may extend far beyond the apparently intact tissues and may require more extensive initial surgical margins than that recommended for small and moderate sized lesions.

Conflict of Interest: 'None declared'.

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Please cite this paper as: Bayat M, Abbasi AJ, Garajeji A, Ahmadi N.

Giant basal cell carcinoma of face. *J Craniomaxillofac Res* 2014; 1(1-2): 28-29.