Perianal Basal Cell Carcinoma

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Citation

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Abstract

Surgeons frequently care for patients with perianal skin lesions. The majority of these lesions are related to fistula or fissure disease. Less common skin lesions include fungal and viral sources, Crohn's disease and other granulomatous disease. In this article, we present three patients who were treated for perianal basal cell skin cancer including images of the gross appearance of the skin lesions.

BACKGROUND

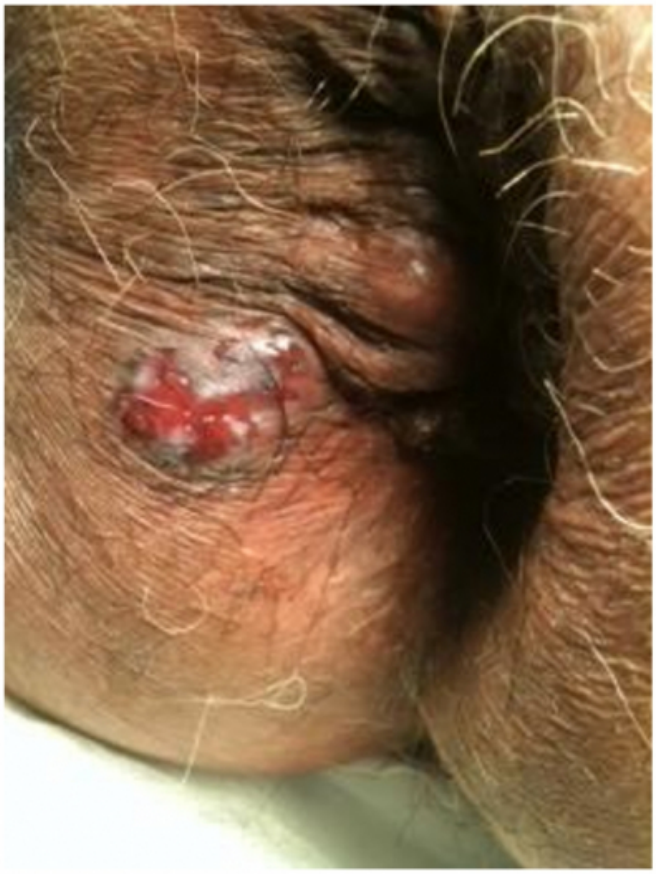
Over a several year period, three patients with peri-anal skin lesions were found to have basal cell carcinoms. Digital images of these lesions were created for our extensive surgical teaching file. In this manuscript, we illustrate the gross appearance of these lesions and recommend complete surgical removal as the treatment of choice.

CASE ONE

The first patient was a seventy-six-year-old man with perianal irritation for two years. He had occasionally seen blood when he wiped and had burning if he used moist wipes. Incisional biopsy demonstrated ulcerated pigmented basal cell carcinoma. The lesion was subsequently excised with narrow margins. It has not recurred with a two year followup.

Figure 1

Ulcerated pigmented basal cell carcinoma.



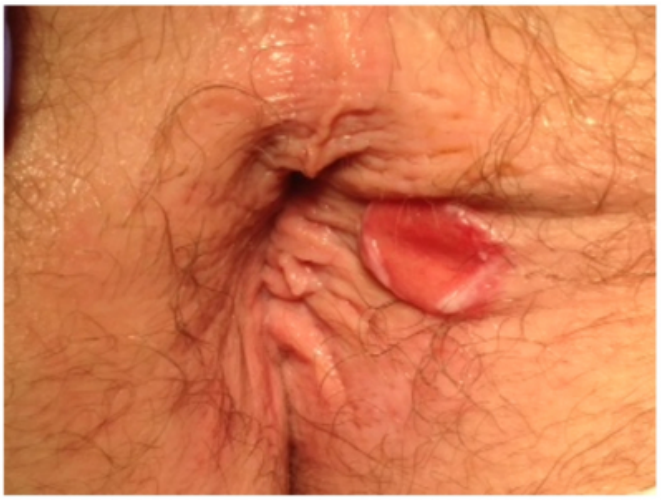
CASE TWO

A 67-year-old man complained of a perianal skin lesion for several years. It was not painful but burned when in a swimming pool. He had no other skin lesions but had a hernia repair a year earlier. His physical exam revealed an

ulcerated 1.5X2 cm non-pigmented skin lesion several cm below the dentate line. Digital rectal exam and anoscopy were normal. Incisional biopsy demonstrated a basal cell carcinoma. The lesion was completely excised with clear margins.

Figure 2

Ulcerated basal cell carcinoma.

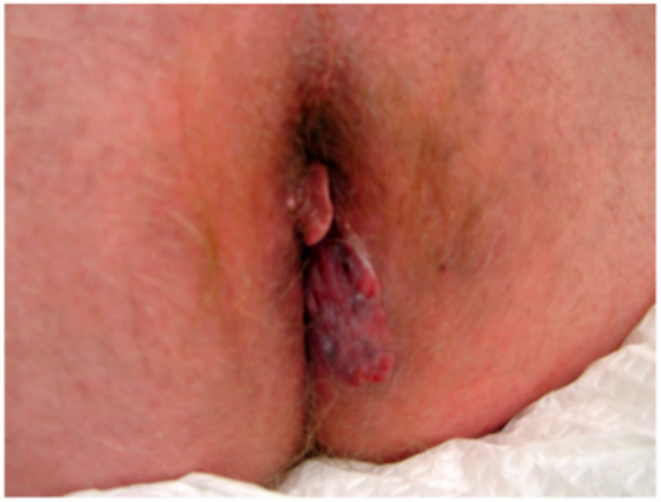


CASE THREE

A sixty-three year old man complained of perianal itching and a raised skin lesion. Those symptoms were present for more than two years. Physical exam demonstrated an irregular, raised two by three cm perianal skin lesion. Incisional biopsy proved the lesion was a basal cell skin cancer and the lesion was completely excised. There was no recurrence after a two year follow-up.

Figure 3

Perianal basal cell carcinoma. Patient also had unrelated anal tag on the right side.



DISCUSSION

Surgeons are frequently asked to evaluate and treat patients with perianal skin lesions. Some skin lesions in the perianal region are caused by fistula-in-ano. Others are caused by viral outbreaks, by granulomatous disease such as tuberculosis or Crohn's disease. Still others are caused by malignant skin disease. Melanoma, squamous cell cancer and cloacogenic or basaloid cancers can all be seen in perianal skin. In this article we illustrate the clinical appearance of three patients with basal cell carcinoma arising in perianal skin. The fact that basal cell carcinoma can be pigmented means that they can be mistaken for melanoma.

Diagnostic procedures should be driven by clinical suspicion. Bacterial or viral culture should be done if there is suspicion of Herpetic, Tuberculous or another infectious condition. Punch biopsy, incisional or excisional biopsy are options for neoplastic processes. In each of our patients, diagnosis was established with incisional biopsy allowing for definitive complete excision with narrow but clear margin.

Paterson1 reviewed perianal basal cell carcinomas treated at the Mayo Clinic over a twenty year period. Nineteen patients were reviewed. Most were men and mean age was 67. Most of their patients were treated with complete excision and there were no recurrences. Nagendra2 recommended treating this lesion with a wide local resection. Our experience suggests that narrower clear margin may suffice.

References

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