

# A squamous cell carcinoma of the nose presenting as an aggressive rhinophyma-like nodular lesion - A Case Report.

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## Abstract

An 80 year-old lady with tumoural lesion of the nasal dorsum which has no prior history of excessive, unprotected prolonged exposure to the sun's ultraviolet rays that progressively increased in size became ulcerated and bleeds in a very short duration. The biopsy was taken and histopathologic examination revealed it was keratinizing squamous cell carcinoma. Surgical interventions which consisted of total rhinectomy and reconstruction had been carried out by the ORL and Plastic reconstructive team.

## CASE REPORT

An 80 year old lady presented with a three months history of a rhinophyma-like nodular lesion of the dorsum of the nose associated with epistaxis and bilateral nasal blockage. No history of prolonged unprotective sun exposure, exposure to radiation, carcinogenic chemical agents nor smoking. Begins as a small, painless, firm and dull red nodule which rapidly increased in size and became ulcerative. It extent into the mucosal of nasal cavity occupying the right lateral wall, roof and septum. No regional lymph node was palpable. Histopathologically it shows a keratinizing squamous cell carcinoma. CT scan shows a soft tissue mass in both nasal area, minimal bony erosion of nasal bone and nasal septum. Paranasal sinuses, Nasopharynx and oropharynx were clear. The tumor was surgically removed via Total rhinectomy and reconstruction. She later underwent radiotherapy.

## Figure 1

Figure 1: The lady with tumoural lesion of the nasal dorsum



## DISCUSSION

Squamous cell carcinoma (SCC) remains the second most common skin malignancy worldwide (Goldman, 1998) and currently it is increasing in trend (Gallagher et al, 1990). It is more common in men than women (Miller and Weinstock, 1994). There is clinical evidence that most SCCs develop in areas that are exposed to the sunlight or ultraviolet light and about 75% of the tumor occurring in the head and neck region (Moore et al, 2006). This elderly lady presented with an aggressive infiltrated nodular lesion at the nasal pyramid which led us to put the diagnosis of basal cell carcinoma or rhinophyma initially.

**Figure 2**

Figure 2: In operation theatre, noted the tumour bled.



Other differential diagnosis: cutaneous tuberculosis, cutaneous sarcoidosis. SCC at the dorsum of the nose should be considered as carcinoma of skin rather than from sinonasal mucosal epithelium. SCC is a malignant tumor which arise from the more superficial layer of keratinocytes compared to the origin of basal cell carcinoma. Keratinocytes will be damage in response to repeated exposure to UV radiation therefore will change into precancerous lesions such as actinic keratoses especially in susceptible persons. These lesions can progress into carcinoma in situ and then into invasive cancer. The main feature that distinguishes invasive SCC from SCC in situ is the invasion of malignant keratocytes through the basement membrane and into the dermis.

**Figure 3**

Figure 3: The patient on day 20 post first stage operation.



Advanced squamous cell carcinomas of the skin of the head and neck especially over the midface are challenging lesions to be dealt by the head and neck surgeon due to significant morbidity and mortality. The majority of lesions are treated with wide surgical excision. With the advent of microvascular surgical techniques, the potential for more favourable surgical reconstruction of the nose is eminent therefore a combine approach by multi disciplinary team is important.

### References

1. Fornelli RA, Fedok FG, Wilson EP, Rodman SM (2000) Squamous cell carcinoma of the anterior nasal cavity: a dual institution review. *Otolaryngol Head Neck Surg* 123 : 207-210
2. Gallagher RP, Ma B, McLean DI, et al.(1990) Trends in basal cell carcinoma, squamous cell carcinoma, and melanoma of the skin from 1973 through 1987. *J Am Acad Dermatol*, 23:413-21.
3. Goldman GD (1998). Squamous cell cancer: a practical approach. *Semin Cutan Med Surg*, 17:80-95.
4. Teichgraeber JF, Goepfert H (1990). Rhinectomy: timing and reconstruction. *Otolaryngol Head Neck Surg*, 102(4):362-9.
5. Moore B, Weber RS, Prieto V, et al.(2006) Lymph node metastases from cutaneous squamous cell carcinoma of the head and neck. *Laryngoscope*, 115:1561.

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