Basal Cell Carcinoma of the Left Nasal Wall: A Case Report and Review of Clinical Management

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ABSTRACT

Among all the cutaneous malignancy basal cell carcinoma (BCC) is the most prevalent, mainly affecting sun-exposed regions of head and neck. Nasal involvement presents significant reconstructive and cosmetic challenges because of complex anatomical as well as aesthetic prominence. Hereby, we are reporting a his to pathologically confirmed case of fibroepitheliomatous variety of basal cell carcinoma involving left nasal wall in a 70year old male presenting with a slowly enlarging ulcero -proliferative lesion associated with intermittent bleeding. Wide local excision with adequate margins followed by local flap reconstruction achieved satisfactory oncologic and cosmetic outcomes. This case highlights the importance of early diagnosis, histopathological confirmation, and appropriate surgical management in preventing local tissue destruction and recurrence.

Keywords-Basal cell carcinoma; Nasal wall; Cutaneous malignancy; Wide local excision; Facial reconstruction, Local advancement flap

INTRODUCTION

BCC is the most prevalent (approximately 80%) non-melanoma skin cancer.[1] It arises from basal cells of epidermis and adnexal structures and is characterized by slow growth and low metastatic potential. Though indolent, BCC can land up in significant local destruction if neglected.[2]

Ultraviolet radiation exposure is considered the common etiological factor.[3] The factors are advanced age, male gender, immunosuppression, exposure to ionizing radiation, arsenic exposure, and certain genetic syndromes such as Gorlin-Goltz syndrome.[4]

Head and neck region constitutes the prevalent site for BCC, with the nose being particularly susceptible.[5] Nasal lesions offers unique reconstructive challenges owing to the intricate anatomy, limited tissue availability, and cosmetic significance. Early diagnosis and adequate surgical margins remain the cornerstone of treatment.[6]

This report describes a case of BCC involving left nasal wall managed successfully with surgical excision and reconstruction.

CASE REPORT

A 70year old male presented to the Department of ENT & Head and Neck Surgery with a non-healing lesion over the left lateral nasal wall of seven months' duration. The patient initially noticed a small papular lesion that gradually enlarged over time. It was associated with occasional crusting, itching, intermittent bleeding and mild discomfort. There was no history of pain, paraesthesia, nasal obstruction, or constitutional symptoms.

The patient is a daily wage worker by occupation reported prolonged occupational sun exposure as he had to work under sun for more than 35 years. There was no history of tobacco chewing, smoking, previous skin malignancy, radiation exposure, or immunosuppressive disorders.

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On clinical examination, a solitary ulceroproliferative lesion measuring approximately 1.2 × 1.5 cm was observed over the left nasal wall extending near medial canthus of left eye. The lesion had rolled pearly borders with central ulceration and surface telangiectasia. The margins were well defined, and no tenderness was found on palpation. No regional lymphadenopathy was detected.

Routine hematological investigations were within normal limits. Dermoscopic evaluation revealed arborizing vessels and blue-grey globules suggesting BCC. Incisional biopsy was performed. Histopathological examination demonstrated nests of basaloid cells with peripheral palisading and cords with reticulated pattern displaying monomorphic blue cells, showing hyperchromasia and pinpoint nucleoli. The surrounding showed dense lymphoplasma cell infiltration along with lymphoid follicle formation and focal myxoid areas, confirming epitheliomatous basal cell carcinoma.

Computed tomography of the nose and paranasal sinuses revealed a localized soft tissue lesion. Also, there was no evidence of bony erosion or adjacent structures involvement.

With proper consent from the patient surgery was planned. Wide local excision was performed with a 4-mm safety margin. The defect was reconstructed using local advancement flap (forehead advancement flap) with infra trochlear artery as the pedicle.

Gross examination of excised specimen revealed an ulcerated gray-white tissue mass. Histopathological analysis confirmed complete excision of BCC (Fibroepitheliomatous type-Fibroepithelioma of Pinkus) with clear margins. No perineural or lymphovascular invasion was identified.

Postoperative healing was uneventful. The patient is being followed up regularly. No evidence of recurrence or functional impairment was noted during follow-up. Overall, cosmetic outcome was satisfactory.

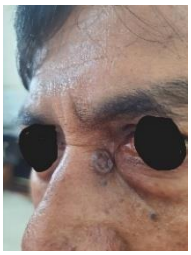

Fig: Preoperative photograph showing BCC lesion over left lateral wall of nose

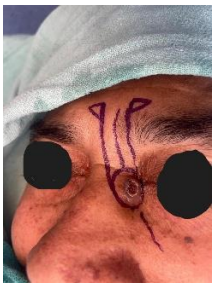

Fig: Showing skin markings before incision

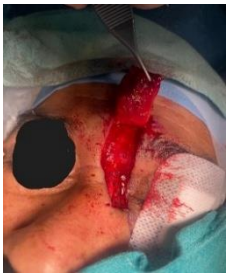

Fig: Depicts elevation of local flap

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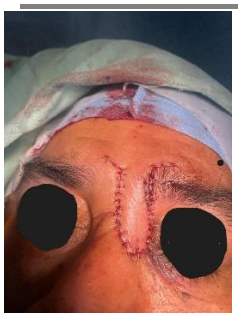

Fig: Skin closure with local flap after excision of lesion

DISCUSSION

BCC is an epithelial malignancy which is locally invasive with a favourable prognosis when diagnosed and managed early.[7] Although metastasis is very rare, neglected lesions may invade deep structures including cartilage, muscle and bone especially in facial regions.[8]

The nose is among the most frequent sites of facial BCC because of its maximal exposure to ultraviolet radiation. The embryological fusion planes of the nose may facilitate tumor spread along tissue planes.[9] Lesions involving the nasal wall require meticulous surgical planning to acquire complete oncological clearance while preserving the function and aesthetics.

Histopathology report remains the gold standard for definitive diagnosis. The histological findings which is specific for BCC are nests of basaloid cells, peripheral palisading, hyperchromatic nuclei and stromal separation .[10] Radiological imaging is best for evaluation for deeper structure involvement and in anatomically complex regions such as the nose and orbit.

Surgical management remains the treatment of choice for most BCCs because it offers high cure rates and histological margin assessment.[6] Recommended surgical margins vary depending on lesion size, histological subtype and risk category. Low-risk lesions generally require 3–4 mm margins, whereas high-risk lesions may necessitate wider excision or Mohs micrographic surgery.[5]

Mohs micrographic surgery is advantageous in cosmetically sensitive areas because it permits maximum tissue conservation with complete margin control.[7] However, limited availability and cost effectiveness may restrict its use in many institutes. In the present case, conventional surgical excision with adequate margin assessment achieved successful disease clearance.

Reconstruction of nasal defects following tumour excision requires careful consideration of defect size, depth, skin texture and contour. Local flaps such as nasolabial, bilobed and forehead flaps provide excellent cosmetic outcomes because of their superior colour and tissue match.[9] The forehead advancement flap used in this patient produced satisfactory aesthetic and functional results.

Alternative treatment modalities for BCC include curettage, cryotherapy, radiotherapy, photodynamic therapy, topical imiquimod, and hedgehog pathway inhibitors such as vismodegib.[4] These therapies are generally reserved for superficial lesions, recurrent tumours, medically unfit patients, or advanced unresectable disease.

Long-term follow-up is essential because recurrence rates vary according to histological subtype, lesion location, and adequacy of excision. Patients with BCC are also at increased risk of developing subsequent skin cancers.[8] Patient education regarding photoprotection, regular dermatological examination, and early reporting of suspicious lesion is therefore important for management of the patient.

This case highlights the significance of prompt recognition and multidisciplinary approach of nasal BCC. Early surgical intervention enabled complete tumour resection while minimizing facial deformity and preserving nasal function.

CONCLUSION

BCC involving the lateral nasal wall is a common yet destructive cutaneous malignancy hence requires early diagnosis and definitive surgical treatment. For proper management and successful outcome histopathological confirmation and complete surgical excision with adequate margin is of outmost importance. Reconstruction with local flaps can provide excellent cosmetic and functional outcome in nasal defects. Regular and long term follow-up is very necessary. Patient awareness regarding sun protection is essential to reduce recurrence and to prevent future skin malignancies.

Declaration of Patient Consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Conflict of Interest-There are no conflict of interest

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