Perianal Basal Cell Carcinoma Presenting as a Papilloma

Faiqa Binte Aamir[1], Shanila Ahmed[2], Qurratulain Chundriger[3] and Imran Ahmad[2]

[1]*Medical College, The Aga Khan University Hospital, Karachi, Pakistan*
[2]*Department of Oncology, Section of Medical Oncology, The Aga Khan University Hospital, Karachi, Pakistan*
[3]*Department of Pathology, The Aga Khan University Hospital, Karachi, Pakistan*

ABSTRACT

Basal cell carcinoma (BCC) develops commonly in body areas that are exposed to sunlight, such as the face and neck. It is uncommon in the closed areas of the body and quite rare in the perianal and genital regions. We are reporting an extremely rare case of a middle-aged man with BCC of the perianal area that was treated adequately with local excision. He presented with an exophytic nodular lesion with surface ulceration in the right-lateral perianal region. He underwent examination under anaesthesia and excision of the anal lesion. Histopathological findings were consistent with BCC and the tissue was positive for P63, Cytokeratin 7, and Ber EP4. BCCs of the perianal area were adequately treated by local excision. There was no evidence of either local recurrence or distant metastasis. Early identification and prompt treatment can give better outcomes.

Key Words: *Basal cell carcinoma*, *Perianal area*, *Excision*.

How to cite this article: Aamir FB, Ahmed S, Chundriger Q, Ahmad I. Perianal Basal Cell Carcinoma Presenting as a Papilloma. *JCPSP Case Rep* 2025; **3**:18-20.

INTRODUCTION

Around 8 out of 10 diagnosed skin cancers are of basal cell in origin and commonly present in areas with high exposure to ultraviolet (UV) rays.[1,2] The basal cell carcinoma (BCC) presenting in the anogenital region is very rare, contributing only 0.48% of all BCCs despite BCC being the most common type of skin cancer.[3]

We hereby report an extremely rare case of a middle-aged man with BCC of the perianal area who was treated adequately with local excision.

CASE REPORT

A 55-year male, a known diabetic and hypertensive for 13 years, presented at a tertiary care hospital with a tender swelling in the perianal region with two episodes of suppuration in the past six months.

Upon examination, a pus-filled exophytic growth of 3 × 4 cm was identified in the perianal region. A diagnosis of anal papilloma was made, and the patient was advised for excision of the same under local anaesthesia.

Correspondence to: Dr. Shanila Ahmed, Department of Oncology, Section of Medical Oncology, The Aga Khan University, Karachi, Pakistan
E-mail: shanilaahmed90@yahoo.com

Received: March 21, 2024; Revised: July 21, 2024; Accepted: December 23, 2024
DOI: https://doi.org/10.29271/jcpspcr.2025.18

Following the surgery, the excised tissue was sent for histopathological analysis which showed light brown skin-covered papillomatous tissue measuring 1.9 × 1.4 × 0.8 cm which exhibited a cavity measuring 1.5 × 1.5 × 1 cm as shown in Figure 1 (A and B).

A diagnosis of BCC of nodular and nodulocystic subtype at Clarke level V of invasion was made. It extended into the dermis and was less than 0.1 cm from the closest resected margin with the depth of invasion being 1.4 cm. The cells stained positive for BerEp4 (Figure 2) and P63, patchy positive for cytokeratin 7 but were negative for EMB and HMB-45.

The tumour was staged as pT_1 (invaded submucosa but not muscle) and N_x (undetermined nodal invasion). The patient was informed about the diagnosis and was advised to undergo re-excision of the tumour margins which was performed under general anaesthesia 19 days after the first excision. The patient was discharged when he was haemodynamically stable and remained stable in the follow-up visits.

DISCUSSION

BCC is the most common cancer accounting for 90% of all skin cancers. It arises from basal cell layers of the lower epidermis or from the outer root sheath of the hair follicles. It is prevalent in areas of skin frequently exposed to sunlight most commonly presenting in the head and neck region; however, a few cases have been reported of it being located in the groin, nipple, and axillae.[4] Furthermore, BCC in genital and perianal regions remains very rare, accounting for only 0.27% of all

cases as reported in a review by Gibson and Ahmed, which is so far the largest review carried out on perianal and genital BCC.[5] Although UV exposure remains the most important risk factor for developing BCC, factors such as male gender, old age, immunosuppressive state, exposure to toxic substances such as polycyclic aromatic amines and arsenic, use of tanning beds, family history of skin cancer, and presence of specific phenotypic characteristics such as freckles or blonde hair seem to play a role in the development of BCC.[5] Despite the identification of all these factors which increase the risk of the development of BCC, the cause of perianal BCC still remains unknown. The clinical presentation of perianal BCC is very diverse and often depends upon its variant based on histopathological analysis, aggressiveness, and clinical appearance. The variants of BCC include nodular, ulcerated, pigmented, sclerosing, cystic, superficial, fibroepithelioma--like, metatypical, and basal cell nevus syndrome.

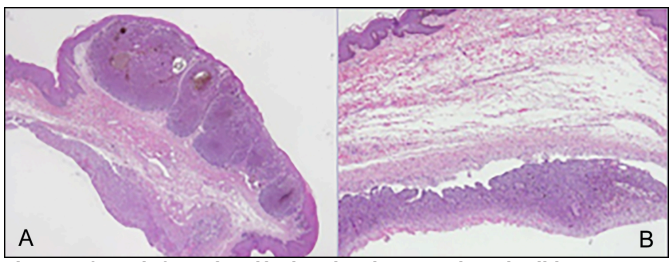

Figure 1 (A and B): Perianal lesion showing a cystic and solid component of the basaloid lesion.

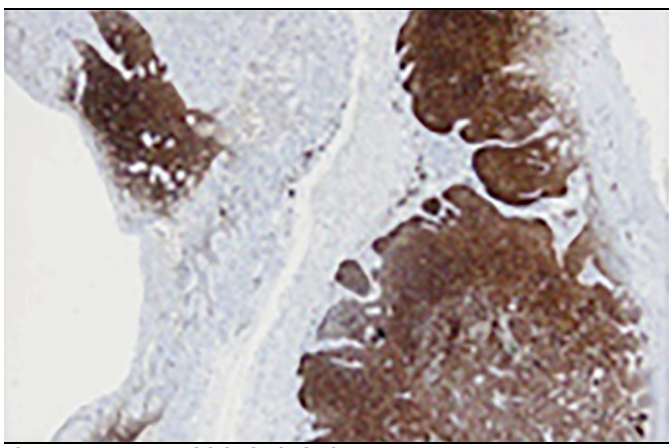

Figure 2: BerEp4 positivity in the lesion.

Nodular BCC, being the most common subtype, is a slow-growing tumour, presenting as a painless, translucent, flesh-coloured, irregular, well-defined papule or nodule with a very variable size ranging from a few millimetres to a few centimetres in diameter and is accompanied by telangiectasia. The most common presentation includes bleeding or exfoliative lesions that recur and heal between the episodes. Nodular BCC is predominantly reported on areas of skin with high UV exposure and has a good prognosis. Superficial BCC is the least aggressive subtype while sclerosing or desmoplastic BCC being the most aggressive is the least common subtype. BCC remains restricted on the hair-bearing skin of the perianal region and spreads to the anal canal in advanced stages. Immunohistochemical stain, BerEp4, is helpful in confirming the diagnosis of BCC as well as in excluding basaloid anal carcinoma from the differential, which usually presents within the anal canal.[6] The most common treatment for perianal BCC remains the local excision of the tumour. Local recurrence is typical for perianal BCC and has not been reported yet.

In conclusion, BCC is the most common non-melanoma skin cancer, and treatment modalities include wide local excision, electrodesiccation and curettage, and Mohs micrographic surgery. BCCs of the perianal area are adequately treated by local excision. There is no evidence of either local recurrence or distant metastasis. However, despite having low chances of metastasis, it still leads to local disfigurement, local tissue destruction, and can be fatal if untreated.

PATIENT'S CONSENT:
Informed consent was obtained from the patient.

COMPETING INTEREST:
The authors declared no conflict of interest.

AUTHORS' CONTRIBUTION:
FBA: Writing of the first draft.
SA: Conception, reviewing, and drafting of work.
QC: Provision of figures with illustrations and reviewing the pathology part.
IA: Reviewing and approval of final case report.
All authors approved the final version of the manuscript to be published.

REFERENCES

1. Basal and squamous cell skin cancer statistics. Cited 2023 Oct 31. Available from: https://www.cancer.org/cancer/basal-and-squamous-cell-skin-cancer/about/key-statistics.html.
2. Basal cell carcinoma - Symptoms and causes. Mayo clinic. Cited 2021 Oct 1. Available from: https://www.mayoclinic.org/diseases-conditions/basal-cell-carcinoma/ symptoms-causes/syc-20354187.
3. Rahbari H, Mehregan AH. Basal cell epitheliomas in usual and unusual sites. *J Cutan Pathol* 1979; **6(5)**: 425- 31. doi: 10.1111/j.1600-0560.1979.tb01165.x.
4. Basal cell and squamous cell carcinoma. ucsf health.org. Available from: https://www.ucsfhealth.org/Conditions/ Basal CellandSquamousCellCarcinoma.

5. Gibson GE, Ahmed I. Perianal and genital basal cell carcinoma: A clinicopathologic review of 51 cases. *J Am Acad Dermatol* 2001; **45(1)**:68-71. doi: 10.1067/mjd.2001.114588.

6. Kreuter A, Bechara FG, Stucker M, Brockmeyer NH, Altmeyer P, Wieland U. Perianal basal cell carcinoma - unusual localisation of a frequent tumour. *J Dtsch Dermatol Ges* 2012; **10(1)**:59-61. doi: 10.1111/j.1610-0387.2011.07801.x.