

Case 15 Two men with facial ulceration

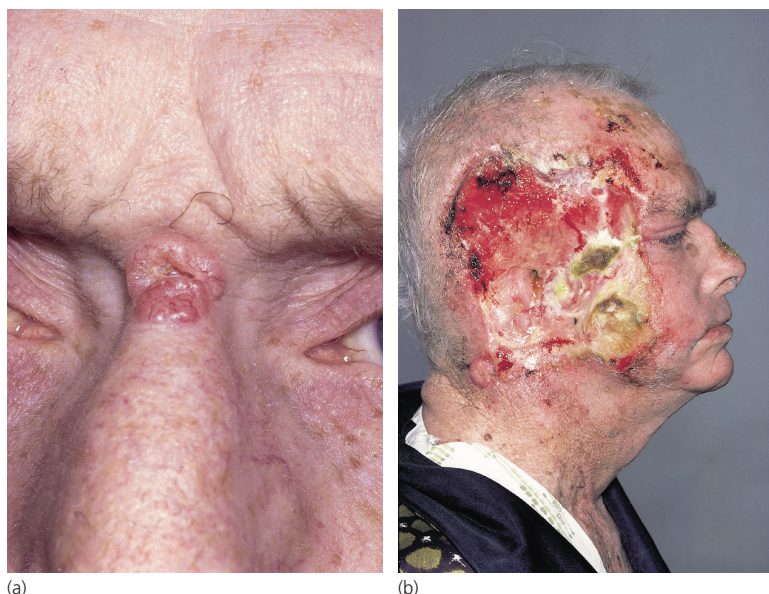


Figure 15.1

These two patients presented in consecutive weeks in surgical outpatients. Figure 15.1a shows the nose of a 78-year-old retired merchant-seaman, now living in London. He had noticed a little lump on the bridge of his nose about 3 years before, which had slowly grown to its present size. It was painless and had never bled.

On examination, it was firm to touch, not tender, and showed some classical features – pearly nodules, with small blood vessels coursing over its surface and with rolled, rather than everted, edges. These are shown in the sketch made in the patient's clinic notes (Fig. 15.2).

Figure 15.1b shows the extraordinary appearance of the second patient, a retired building worker aged 83. At first he would not tell us how long this lesion had been there, but then admitted that it had started as a 'little pimple' just above the pinna of his right ear 'about 10 or so years ago'. Slowly the lump got bigger, his ear disappeared and the lesion bled from time to time; it also became very smelly but only gave him mild discomfort. He lived by himself and hid the lesion from the neighbours under a scarf.

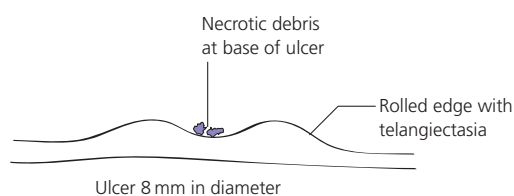


Figure 15.2 Diagram illustrating a rodent ulcer.

Examination revealed not only the ulcer, which exposed the skull and the cartilage of the external auditory meatus, but also numerous maggots. These were killed with surgical spirit before this photograph was taken, but not before a (male) medical student in the clinic had fainted. The regional lymph nodes were impalpable.

What are the scientific and 'popular' names for this lesion?

Basal cell carcinoma and rodent ulcer, respectively.

What is the typical cutaneous distribution of this tumour?

Over 90% are found on the face above a line that joins the angle of the mouth to the external auditory meatus. It is particularly common around the eye, in the nasolabial fold and along the hairline of the scalp.

What is its typical appearance under the microscope?

It is characterized by solid sheets of uniform, darkly staining cells, which arise from the basal layer of the epidermis (basal cell tumour). Prickle cells and epithelial pearls, typical of squamous cell carcinoma of the skin, are absent. Note the central ulceration and islands of basaloid cells in the deep dermis (Fig. 15.3).

How does this tumour spread?

Spread is by slow but steady infiltration of the surrounding tissues, which may include the underlying skull and meninges, face, nose and eye (hence the term 'rodent'). Lymphatic spread and blood-borne metastases are extremely rare.

How are these lesions treated?

A small basal cell tumour can be treated by surgical excision, where this can be done with an adequate margin and without cosmetic deformity. Surgery may also be

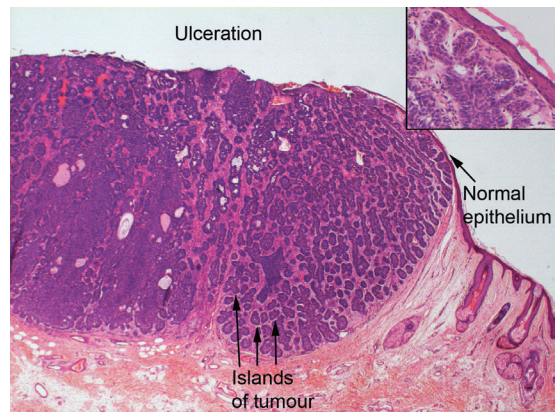


Figure 15.3 Histology of a rodent ulcer (magnification $\times 2$ (inset $\times 10$), haematoxylin and eosin stain).

indicated in late cases, where the tumour has recurred after radiotherapy or where it has invaded underlying bone or cartilage. In these cases, major plastic surgery reconstruction is usually necessary. In most cases, such as in the first patient, the lesion is treated by radiotherapy after biopsy confirmation of the diagnosis.