Recurrent, multifocal basal cell carcinoma of upper lid and forehead

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Abstract
Recurrent, multifocal basal cell carcinoma is a rare tumour of eyelid and forehead. We present a case of a 76 year old male patient with a multifocal, nodular ulcerative and recurrent tumour of the left upper lid and left side of fore-head. History of previous surgical excision of the mass twice was there. Wide surgical excision with forehead advancing flap, nasolabial advancing flap and free skin graft was done. Histopathology confirmed basal cell carcinoma with tumour free surgical margins.

Keywords: Basal cell carcinoma, Nodular, Recurrent, Graft, Flap.

Introduction
Basal cell carcinoma [BCC] is the most common malignant skin tumour.[1] Approximately 5-10% of skin cancer occur in the eye lid.[2] BCC is the most frequent malignant tumour affecting eye lid (90% all lid malignancy) followed by Squamous cell carcinoma, Sebaceous gland carcinoma, Malignant melanoma.[3] BCC affect lower lid in 59%, inner canthus 22%, upper lid 14%, outer canthus 5%. BCC can present with various clinical manifestations.[4] It usually appears as painless, non healing ulcer or nodular lesion over exposed body parts. The basal cells typically grow slowly and it is rare for them to metastases or spread to regional lymph node.[2] We present a case of recurrent, multifocal nodular basal cell carcinoma over left upper lid and fore head with its surgical management and reconstruction.

A 76 year old male presented to ophthalmic department with history of progressive multiple swelling over left upper eyelid & forehead since 6 months. Swellings were painless & slowly increasing in size. There was history of surgical excision of swelling 15 years back & 2 years back.

O/E there was multiple ulcerated nodular lesions over left upper lid involving medial canthus, superior orbital margin & forehead. The lesions were blackish in color with prominent vessels, non tender free from underline bone and tarsal plate. (Fig. 1) There was no involvement of regional lymph node or distant metastases present. A provisional diagnosis of BCC was made. Patient was diabetic for 10 years with good metabolic control rest general examination was within normal limit.

Radical surgical excision of tumour was done under general anesthesia. Wide excision of forehead, whole of upper lid skin and medial canthus was done with 4 mm of tumour free tissue. Reconstruction with local forehead advancement flap was done over upperlid, nasolabial advancing flap made for medial canthus and raw area was covered with split skin graft. Postoperative period was uneventful. (Fig. 2-7)

Histopathological analysis confirmed Basal cell carcinoma with dermis infiltration, surgical margins were free of any tumour cells. No recurrence of BCC 2 yrs following surgery. Good esthetic result was obtained.

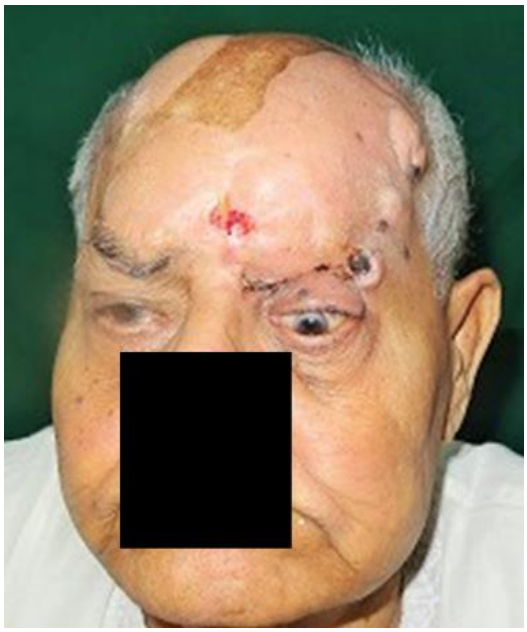

Fig. 1

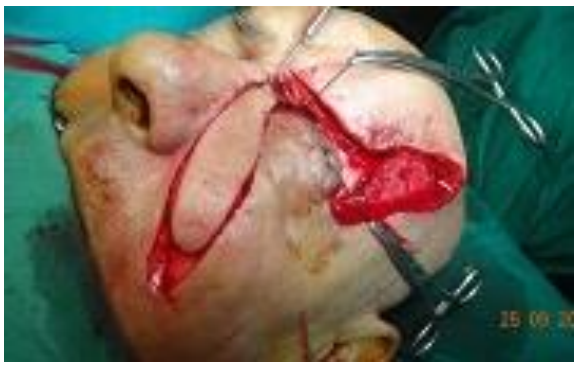

Fig. 2

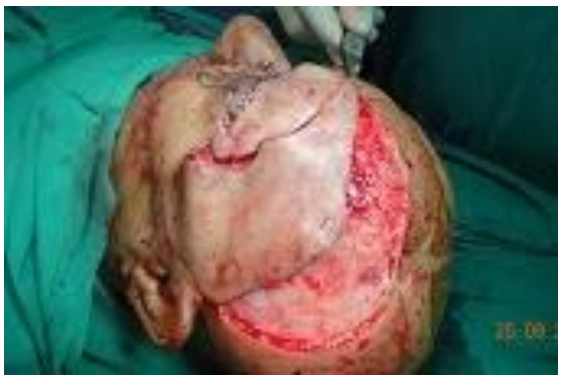

Fig. 3

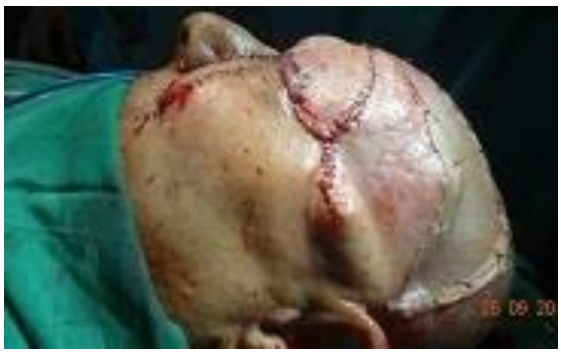

Fig. 4

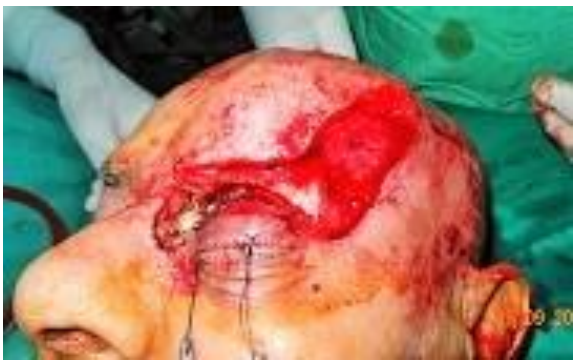

Fig. 5

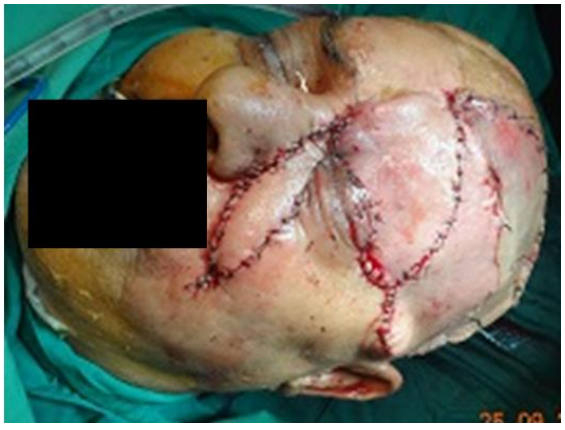

Fig. 6

Fig. 7

Discussion

Multi focal recurrent basal cell carcinomas are rare tumours in periocular region. Risk factor for recurrence is incomplete surgical resection with positive margins. Recurrence after surgical resection is mulifocal nodular basal cell carcinoma is very rare may be due to mulifocal nodular histological type or genetic predisposition. Our case presents with multiple nodular lesions over his left upper lid, medial canthus, fore head and scalp. There were 7 nodules in total. The nodules were painless and slowly progressive in size since 6 month. Size range from 2 cm to 5 cm. The lesions was blackish in colour, non-tender and free from underline bone and tarsal plate. There was history of surgical excision of solitary mass at fore head 2 years back and 15 years back, no surgical records or histopathological records were available with the patient. There was no regional lymphnode involvement or any sign of metaststis. Wide excision of forehead, whole of upper lid skin and medial canthus involving all nodular lesions was done under general anesthesia. Reconstruction with local forehead advancement flap was done over upperlid, nasolabial advancing flap made for medial canthus and raw area was covered with split skin grafting. Surgery was uneventful. Histopathology confirms basal cell carcinoma and surgical margins were free of tumour. No recurrence after follow-up for 1 year. Patient advised regular follow-up. It is difficult to determine a patient risk of development of recurrent BCC. Recurrence can manifest in form of erythema, induration, ulceration or bleeding at prior excised site for a known primary lesion.[5] The most important demographic clinical and histopathological predictors are tumour location, status of excised surgical margins and histological type. Other risk factors for recurrences are age of presentation, tumour size, number of lesions, pathological stage, gender, skin type, previous treatment and postoperative management.[6,7] Incomplete surgical excision rather their anatomical location or histopathological features is the main cause for

recurrence. Incidence of recurrence varies.[8] Multiple Basal cell carcinoma can occur as feature of various hereditary conditions such as naevoid BCC syndrome (Gorlins Syndrome), Xeroderma pigmentosa, and keratoacanthoma, Rombo syndrome and unilateral basal cell naevus syndrome.[9-11]

Conclusion

Mulifocal basal cell carcinoma are rare tumour in periocular region, recurrence usually occurs due to incomplete surgical excision with positive margins. Complete surgical resection with negative surgical margins with appropriate reconstruction is best treatment option. Regular follow up is essential for early detection of any recurrence. Prognosis is better if no underlying bony involvement occur.

Conflict of Interest: None.

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