A RARE AND AGGRESSIVE TUMOR: ACANTHOLYTIC SQUAMOUS CELL CARCINOMA COEXISTING WITH BASAL CELL CARCINOMA – CASE REPORT

Funda Tamer1, Mehmet Eren Yuksel2, Haldun Umudum3
1Ufuk University School of Medicine Department of Dermatology, Ankara, Turkey
2Aksaray University School of Medicine Department of General Surgery, Aksaray, Turkey
3Ufuk University School of Medicine Department of Pathology, Ankara, Turkey

Corresponding author:
Dr. Funda Tamer
Ufuk Universitesi Tip Fakultesi Dr. Ridvan Ege Hastanesi, Mevlana Bulvari, No:86-88, Balgat/Ankara/Turkey
Tel: +905455611881
E-mail: fundatmr@yahoo.com

Case presentation
ACANTHOLYTIC SQUAMOUS CELL CARCINOMA COEXISTING WITH BASAL CELL CARCINOMA

Keywords:
basal cell carcinoma, neoplasms, squamous cell carcinoma.

Abstract
A 75-year-old Caucasian male presented with a two-year history of an erythematous mass on the forehead and an erythematous annular plaque with telangiectasias on the right upper arm. The histopathological evaluation of the specimens from the head and arm revealed acantholytic squamous cell carcinoma and basal cell carcinoma, respectively.

Introduction
Basal cell carcinoma (BCC) and cutaneous squamous cell carcinoma (SCC) show differences in biological behaviour, growth and tendency to metastasize. BCC has a low risk of local recurrence, local invasion, tissue destruction and metastasis. However, SCC is associated with a considerable risk for local recurrence and metastasis. Patients with BCC are more likely to develop subsequent BCC, SCC and malignant melanoma (1). However, acantholytic SCC is a rare and distinctive histologic subtype of SCC. It has been regarded as a high-risk variant of SCC (2). Hereby, we report a rare case of a patient presenting with both acantholytic SCC and BCC at the same time.

Case Report
A 75-year-old Caucasian male, phototype III, presented with a two-year history of an erythematous mass on the forehead. The patient stated that he had used diclofenac sodium 3% gel twice daily for four weeks. However, no clinical improvement was observed. The past medical history revealed glaucoma. The family history was unremarkable. Dermatological examination showed an erythematous plaque on the right frontal region (Fig. 1a), hyperpigmented macules on the vertex and erythematous annular plaque with telangiectasias on the right upper arm (Fig. 2a). Dermatoscopic examination of the lesion on the arm showed arborizing vessels, white structureless areas and scales (Fig. 2b). The lesion on the forehead showed follicular openings characterized by yellow globules and white circles (Fig. 1b). Both lesions were completely excised. The histopathological evaluation of the specimens from the head and arm revealed acantholytic squamous cell carcinoma and basal cell carcinoma, respectively (Figures 1c & 2c). Surgical margins were free of neoplasmy. Chronic sun exposure was the only risk factor of developing skin cancer. Therefore, the patient was recommended to wear broad spectrum sunscreen and regular follow-up.

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Basal cell carcinoma and SCC are known as nonmelanoma skin cancers (NMSC). The incidence rate of NMSC has been increasing worldwide, with 2-3 millions new cases occurring all over the world annually (3). Coexistence of nonmelanoma skin cancers indicates the common etiopathological factors. Immunosuppression, smoking, ultraviolet radiation (UVR) and arsenic exposure play a role in the development of SCC and BCC. Saini et al. reported multiple pigmented Bowen’s disease, giant BCC and SCC in the same patient (4). Radić et al. reported a patient who was on hydroxyurea therapy for polycythemia vera and developed both BCC and poorly differentiated sarcomatoid SCC (5).

Ramachandran et al. investigated patients who developed BCC only, and patients with both SCC and BCC. Patient characteristics such as age, gender and skin phototype were similar. However, they suggested that patients with BCC are more prone to develop a new BCC lesion during a five-year follow-up when compared to patients who had both BCC and SCC. The results were explained by major role of cumulative UVR and intense, intermittent UVR in the development of SCC and BCC, respectively (6).

Acantholytic SCC is a rare histopathologic variant of SCC. Only 2-4% of all SCC are acantholytic subtype. Etiological risk factors are similar to those of SCC. Acantholytic SCC usually presents as an ulcerated papula or a nodule on the head and neck region of elderly men. Moreover, the tumor has been reported in larynx, gingiva, breast, cecum, conjunctiva, penis, vulva and uterine cervix. It tends to have a more aggressive course when compared to non-acantholytic SCC (7).

The role of different UVR exposure patterns in the development of NMSC and non-cutaneous localization of acantholytic SCC make the etiology of acantholytic SCC is unclear. Hereby, we present a rare and an unusual coexistence of an acantholytic SCC and BCC. Early detection is the key to cure the cancer with aggressive clinical course effectively. Therefore, atypical variants of SCC should be kept in mind in the differential diagnosis of long-standing lesions in elderly patients.

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