

Perianal Basal Cell Carcinoma Treated With Mohs Micrographic Surgery

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PRACTICE POINTS

- Basal cell carcinoma is less common in non-sun-exposed areas of the body and is exceptionally rare in the perineal and perianal regions.
- Thorough total-body skin examinations may lead to early detection of asymptomatic skin lesions, allowing for earlier and less invasive treatment.
- Appointment attendance and patient compliance are common challenges that dermatologists face. Patient reminders via their preferred method of communication may help reduce missed dermatology appointments.

Perianal basal cell carcinoma (BCC) is a rare lesion that accounts for less than 0.08% of all BCCs. It is challenging to diagnose, as it can be overlooked or mistaken for an inflammatory dermatosis. When discovered early and treated properly, BCC is associated with low mortality and a good prognosis. Thorough total-body skin examinations and biopsy of suspected lesions found in the perianal region is recommended. We present a case of a superficial nodular perianal BCC that was discovered following a routine total-body skin examination and was treated with Mohs micrographic surgery (MMS). Patient nonattendance is also discussed.

Cutis. 2018;101:362, 365-366.

Basal cell carcinoma (BCC) is the most common skin cancer in the United States¹ and most commonly occurs in sun-exposed areas. Although BCCs can and do develop on other non-sun-exposed areas of the body, BCCs of the perianal or genital regions are very rare (0.27% of cases). It is estimated that perianal BCCs account for less than 0.08% of all BCCs.²

We present a case of a superficial nodular perianal BCC that was discovered following an annual total-body

skin examination and was treated with Mohs micrographic surgery (MMS).

Case Report

A 76-year-old man presented to the dermatology clinic for an annual total-body skin examination as well as evaluation of a new submental skin lesion. The patient's medical history included successfully treated malignant melanoma in situ, multiple actinic keratoses, and an eccrine carcinoma. His family history was noncontributory. Inspection of the submental lesion revealed a pearly, 1.8-cm, telangiectatic, nodular plaque that was highly suspected to be a BCC. During the examination, a 1-cm pinkish-red plaque was found on the skin in the left perianal region (Figure 1). The patient was unaware of the lesion and did not report any symptoms upon questioning.

A shave biopsy of the submental lesion confirmed a diagnosis of micronodular BCC, and the patient was referred for MMS. It was decided to reevaluate the perianal lesion clinically at a follow-up appointment 2 months later and biopsy if it had not resolved. However, the patient did not attend the 2-month follow-up visit as scheduled, and it was not until the following year at his next annual total-body skin examination that the perianal lesion was rechecked. The lesion was unchanged at the time and was similar to the previous findings in both appearance and size. A punch biopsy was performed, and the pathology showed a superficial nodular perianal BCC (Figure 2). The perianal BCC was excised during a 2-stage MMS procedure with no recurrence at 6-month follow-up (Figure 3).

Comment

At the time of the patient's initial visit, the differential diagnosis for this perianal lesion included an inflammatory or infectious dermatosis. Its asymptomatic nature made it difficult to determine how long it had been present.

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The authors report no conflict of interest.

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The lack of resolution on reevaluation of the lesion 1 year later raised the possibilities of amelanotic melanoma, squamous cell carcinoma, and lichen planus. Basal cell carcinoma was much lower in the differential diagnosis, as BCCs rarely are found in this area of the body; in fact, BCCs account for 0.2% of all anorectal neoplasms,³ and less than 0.08% of BCCs will occur in the perianal region.²

This challenging presentation is common for BCCs found in the perianal and perineal regions, as they are difficult to diagnose and often are overlooked as inflammatory dermatoses.^{4,5} The infrequency of perianal BCC reported in the literature as well as the predominance of BCC in



FIGURE 1. A 1-cm, pinkish-red plaque in the left perianal region prior to excision with Mohs micrographic surgery that was later confirmed on histology as a perianal basal cell carcinoma.

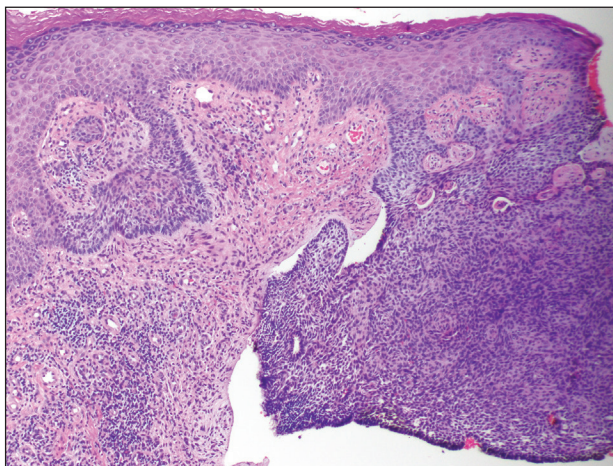


FIGURE 2. Superficial nodular perianal basal cell carcinoma demonstrating classic features of basaloid epithelial proliferation budding off of the epidermis with peripheral palisading and clefting of tumor cells from the surrounding myxoid stroma (original magnification $\times 10$).

sun-exposed areas makes it difficult for dermatologists to diagnose perianal BCC without biopsy. Another feature indicative of this diagnostic difficulty is that the average size of perianal and perineal BCCs has been found to be 1.95 cm.² Without thorough and routine total-body skin examinations, there is no reliable way to catch asymptomatic BCCs in the perianal region until they have progressed far enough to become symptomatic. When possible, we recommend that dermatologists check the genital and anal regions during skin examinations and biopsy any suspicious lesions.

This case also highlights the challenge of missed appointments, which dermatologists also consistently face. Nonattendance rates in US dermatology clinics have been estimated at 17%,⁶ 18.6%,⁷ 19.4%,⁸ and 23.9%⁹ and present a challenge for even the best-run practices. Among patients with missed appointments, the most frequently stated reason in one survey was forgetting, and 24% of those contacted reported that they had not been reminded of their appointment.⁸ Many of the patients surveyed also expressed that they had preferred methods of receiving reminders such as e-mail or text message, which fell outside of traditional contact methods (eg, phone calls, voicemails). Confirming appointments ahead of time can reduce the number of missed appointments due to patient forgetfulness, and incorporating multiple communication modalities may lead to more effective appointment reminders.

Conclusion

Perianal BCC is challenging to diagnose and easy to overlook. Basal cell carcinoma is rarely found in the perianal regions and accounts for a fraction of all anorectal neoplasms. We recommend thorough total-body skin examinations that include the genital region and gluteal



FIGURE 3. Site of primary closure of an excised perianal basal cell carcinoma following a 2-stage Mohs micrographic surgery procedure.

cleft when possible and encourage physicians to biopsy suspicious lesions in these regions. Routine, thorough total-body skin examinations can reveal neoplasms when they are smaller and asymptomatic. When surgical excision is indicated, MMS is an effective way to preserve as much tissue as possible and minimize recurrence.

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