Asymptomatic Plaque and Nodule on the Nose

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An 80-year-old Asian woman presented to the hospital dermatology clinic for evaluation of 2 lesions on the nose of 2 years' duration. The patient reported that the lesions had initially manifested as an asymptomatic red rash, but within the past month, the affected area had grown in diameter with a rough surface and occasional bleeding. Additionally, a smaller new rash appeared around the original plaque. She had no personal or family history of skin cancer. Physical examination revealed a 1.5-cm reddish plaque on the tip of the nose with a central ulcer filled with viscous exudate. Another 0.5-cm reddish nodule with a smooth surface also was noted adjacent to the plaque. Dermoscopy and a skin biopsy of both lesions were performed.

WHAT'S YOUR **DIAGNOSIS?**

a. basal cell carcinoma
b. basosquamous carcinoma
c. coexisting squamous cell carcinoma and basal cell carcinoma
d. irritated seborrheic keratosis
e. squamous cell carcinoma

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THE **DIAGNOSIS:** Coexisting Squamous Cell Carcinoma and Basal Cell Carcinoma

Dermoscopy of the plaque showed central ulceration with blood spots surrounded by branched linear vessels, which was suggestive of squamous cell carcinoma (SCC)(Figure 1A). The nodule showed shiny, white-red, structureless areas with small gray spots, bright white crystalline streaks, and short fine telangiectasias suggestive of basal cell carcinoma (BCC) (Figure 1B). Histopathology showed that the plaque had irregular nests, cords, and sheets of neoplastic keratinocytes invading the dermis (Figure 2A) and the nodule had discrete nests of basaloid cells with peripheral palisading in the dermis (Figure 2B), which confirmed the diagnosis of coexisting SCC and BCC. The patient underwent surgical excision of the lesions, which achieved clear margins. At the 2-year follow-up, there was no sign of recurrence.

Squamous cell carcinoma is the second most frequent cancer in humans. Older patients are more susceptible due to chronic UV exposure.[1] Basal cell carcinoma is the most common human cancer worldwide.[2] These skin cancers have different clinical manifestations, pathologic features, treatment methods, and prognoses. The coexistence of 2 types of skin cancer presents a diagnostic challenge. Possible causes of this phenomenon are not clear. It may simply be a coincidence since the lesions typically occur in sun-exposed areas such as the nose, which may be affected by photodamage.[3] According to the field cancerization theory, chronically sun-exposed areas are at higher risk for development of coexisting skin cancers.[4] A more interesting explanation is the interaction theory, which suggests that one tumor produces epidermal or stromal changes that induce the formation of a second independent tumor via the paracrine effect (ie, growth mediators from nearby cells).[4]

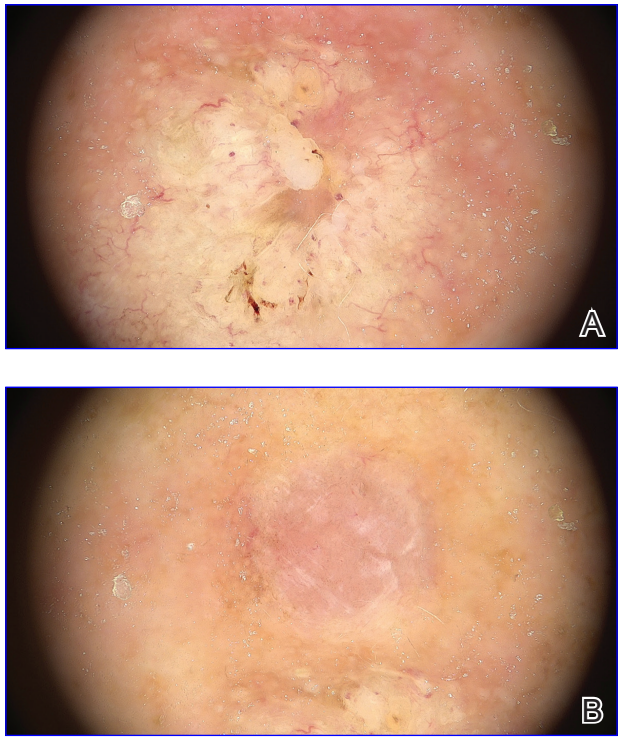

FIGURE 1. A, Dermoscopy of the plaque revealed central ulceration with blood spots surrounded by branched linear vessels, which indicated squamous cell carcinoma. B, Shiny white-red structureless areas with small gray spots, bright white crystalline streaks, and short fine telangiectasias indicated basal cell carcinoma.

Dermoscopy is an important noninvasive diagnostic tool for the evaluation of skin cancer, particularly early detection. Dermoscopic findings of blood vessels, ulcers, the fiber sign, blood spots, white structureless areas, keratin, and centered vessels indicate a diagnosis of SCC.[5] In contrast, common dermoscopic findings for BCC include arborizing vessels, ulceration, shiny white structures, and blue-gray ovoid nests or globules.[6]

Irritated seborrheic keratosis is an inflammatory variant of seborrheic keratosis, which often is challenging to identify clinically due to its similar features with SCC; however, SCC is more likely to demonstrate dotted or branched vessels, white structureless areas, white circles around follicles, irregular or peripheral vessel patterns, and central scales on dermoscopy. In contrast, irritated seborrheic keratosis is more likely to have hairpin vessels, regular vessel patterns, and white halos around vessels, which may aid in the differentiation between the two entities.[7]

Due to the higher sensitivity of dermoscopy for detecting pigmented BCC compared to nonpigmented BCC, it holds substantial diagnostic value in Asian populations, in whom pigmented BCC is the most common subtype.[6,8] However, the lack of pigmentation in the nodule in our case posed a diagnostic challenge, as the diagnosis of BCC had to rely on subtle vascular and shiny white structures rather than more obvious pigment clues. This absence of pigment, however, also helped rule out pigmented BCC as a diagnosis for the nodule. Short fine telangiectasias is the second most common vascular pattern in BCC, and bright white structures are highly suggestive of nonpigmented BCC.[6] Therefore, dermoscopic findings of bright-white structures with fine telangiectasias should be alerted to the possibility of nonpigmented BCC.

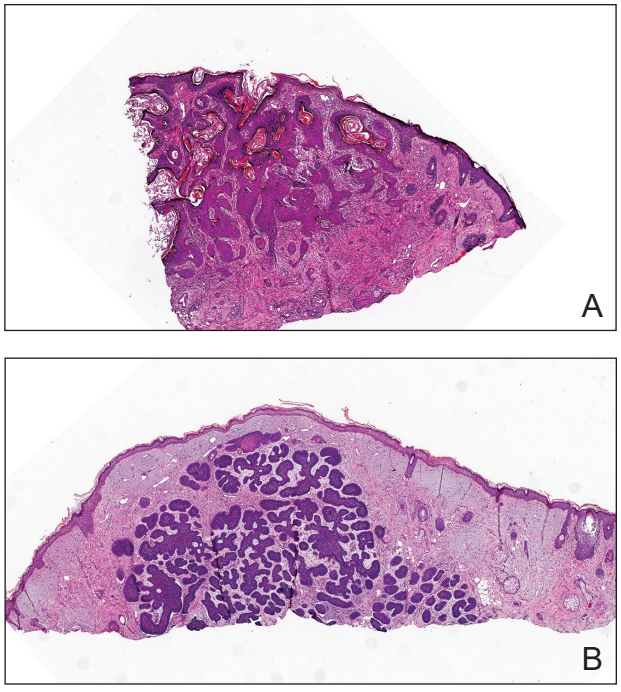

FIGURE 2. A, Histopathology of the plaque showed irregular nests, cords, and sheets of neoplastic keratinocytes invading the dermis, which indicated squamous cell carcinoma (H&E, original magnification ×40). B, Histopathology of the nodule showed discrete nests of basaloid cells with peripheral palisading in the dermis, which indicated basal cell carcinoma (H&E, original magnification ×40).

Basosquamous carcinoma has clinical and dermoscopic features between SCC and BCC, and the presence of dermatoscopic features from both BCC and SCC should raise suspicion, but the diagnosis is particularly challenging because its presentation is nonspecific.[9] We need to be vigilant about the possibility of coexistence of 2 types of skin cancer, and that regular physical examination and dermatoscopy are very important for early detection and diagnosis.

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