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CASE REPORT

Misdiagnosis of Basal Cell Carcinoma and Discoid Lupus Erythematosus on Face

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ABSTRACT

This case study comprises of two patients with lesion on face. First case was having asymptomatic, slightly pigmented, shallow ulcerative lesion on right cheek since three years. Patient was treated with steroid ointments without any results. Lastly she came at us &Superficial Spreading Basal Cell Carcinoma (BCC) was diagnosed after biopsy. Second case was having pigmented plaques with follicular plugging on face since last three years with application of some ointment without resolution. At last patient attended to us &Discoid Lupus Erythematosus (DLE) was confirmed after biopsy. BCC & DLE should not be overlooked on sun exposed sites like face when lesions are indolent & asymptomatic. Such cases should be referred to dermatologists for biopsy so as to avoid further complications of BCC & DLE.

KEY WORDS : BCC, DLE, Face, Misdiagnosis, Biopsy.

Introduction

Basal cell carcinoma (BCC) & Discoid Lupus Erythematosus (DLE) are common after middle age & triggered by sunlight. The slow growing (indolent) & non pruritic nature of these lesions is ignored by patients. Here the two cases are discussed, which were misdiagnosed & were wrongly treated for more than 3 years, before they approached to the dermatologists.

Case Report

First case, is a 45 years female having non-pruritic, ulcerative oval shaped of size approximately 2 x 1½ cm on right cheek. Lesion is "shallow" (i.e. minimal deep) ulcer with firm borders. Margins are pigmented, with signs of healing. Biopsy from the edge revealed diagnostic findings of BCC i.e. cuboidal to round small cells of darkly stained scanty cytoplasm with hyper chromatic nuclei. "Superficial Spreading Variety of BCC" was diagnosed after biopsy. Skin grafting was done after surgical removal of cancerous skin.

Second case, 55 years man was having non-pruritic, pigmented lesion on chin, below left side of lower lip, as well as small healed pigmented lesions below lower lip at junction of the chin since last three years. Borders are firm, pigmented with de-pigmentation at center along with adherent scales. "Follicular plugging" on under surface was present after plucking out them. i.e. positive "carpet-tack sign," which is a diagnostic sign of DLE. Biopsy revealed hyperkeratosis, hydropic

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degeneration at basal level, lymphocytic infiltration at dermo-epidermal junction, hyalinization, edema & fibrinoid changes in dermis. So DLE was confirmed.

Systemic Lupus Erythematosus (SLE) in this case was ruled on the grounds of A) normal laboratory values of C.B.C., E.S.R, antinuclear antibody (ANA) titer & B) by clinical examination. We continued treatment with a) Mild steroid i.e. Clobetasone Butyrate o.1% ointment b) Sunscreen locally c) Tablet Hydroxychloroqine 250 mg daily d) Photo protection. Lesions started fading after 6 months & treatment is still continued.

Discussion

Superficial Spreading Variety of BCC& DLE was diagnosed respectively on clinical & histological grounds.

The possible differential diagnoses (DD) in case -1 are 1) Lupus vulgaris 2) Non-malignant ulcer of any variety.

The possible differential diagnoses (DD) in case -2 are1) Post inflammatory pigmentation 2) Vitiligo 3) Psoriasis with healing abrasions.

Eczema i.e. contact dermatitis- in chronic stage, are the common DD in both cases. All DD as above were ruled out clinically. The diagnostic histopathology of above two cases also rules out respective possibilities.

'Superficial spreading' (multicentric) is a sub type (variety) of BCC. This poorly pigmented lesion can be confused with Eczema or Psoriasis[1]. Psoriasiform DLE, with few scales nearby borders as in this case may be wrongly treated as Psoriasis[2].

Diagnosis of DLE usually made by clinical examination, biopsy can be done for confirmation, as we done[3].

DLE may transform in to SLE (case-2), is ruled out by 1) normal laboratory values as above & 2) Clinically by absence of at least 4 out of 11 A.R.A. criteria.

Lesions of the DLE started disintegrating within 6 months of treatment as shown in photograph & thus scaring was prevented.

Prompt diagnosis by dermatologists can prevent complications like scaring or squamous cell carcinoma, for which skin biopsy is warranted in DLE[4 & 5].

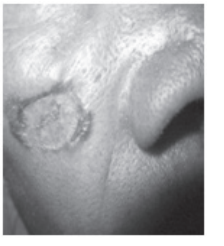
Donzis & co-workers reported an average delay of two years before the correct diagnosis of DLE[6]. This maybe because of either the patient do not approaches to doctor for indolent nature of lesion or attempt by a non-dermatologist.

In Indians, DLE can present simply as asymptomatic hyper pigmented macules, hence one has to have a high index of suspicion so as not to miss the diagnosis [7].

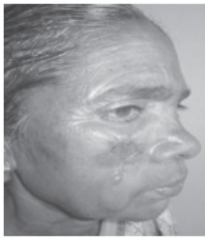
Conclusion

On the sun exposed sites of face shallow ulcerated or adherent-scaly, pigmented lesions should not be neglected in older ages. The BCC & DLE should be kept in mind for chronic, indolent, slightly pigmented asymptomatic lesions. Such cases should be referred to dermatologists for prompt diagnosis, biopsy if needed, so as to avoid further complications of BCC & DLE. In such cases biopsy must not be forgotten.

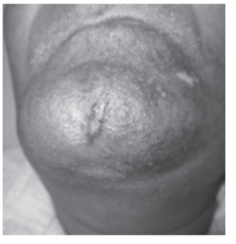
Case-1 (BCC): A shallow ulcer on right cheek.



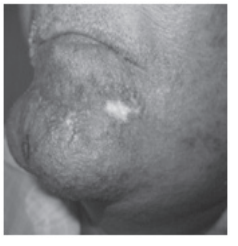
Case-1 (BCC): After skin grafting.



Case 2(DLE): De-pigmented lesions with pigmented borders.



Case 2(DLE): Lesions under healing after 6 months of treatment.



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