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Rhinophyma-like BCC; A Cautionary Tale

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Abstract

A rhinophyma lesion can mimic cutaneous malignancies including basal cell carcinoma. Although coexistent malignant tumours have been diagnosed in patients with rhinophyma, no reports describe basal cell carcinoma clinically mimicking a rhinophymatous-like lesion. Herein we report a case of a 63-year old man with a basal cell carcinoma of the nose masquerading as rhinophyma. Extensive nasal resection and complex reconstructive surgery was required following a delay in diagnosis.

Keywords

Rhinophyma; Basal cell carcinoma; Nasal reconstruction

Introduction

Basal Cell Carcinoma (BCC) and Squamous Cell Carcinoma (SCC) have been described as occurring within rhinophyma. [1, 2] In these circumstances the neoplastic process can be hidden and therefore overlooked, resulting in large lesions requiring significant reconstruction following resection. In this case we report the rare finding of a rhinophymatous-like BCC occurring in the absence of rhinophyma or rosacea.

Case Report

A 63-year-old man presented with a three year history of an asymptomatic, asymmetrical, progressive swelling on the nasal tip. He had been reassured by his GP that the diagnosis was rhinophyma. There was no past history suggestive of rosacea. On examination, he had a 2.8 x 2.2 cm firm, yellowish, irregular nodule on the nasal tip extending to the right alar rim (Figure 1). A diagnostic biopsy revealed nodular basal cell carcinoma (BCC). Mohs micrographic surgery (MMS) was performed due to the large size, poorly defined clinical margin and critical anatomical site. Three stages were needed to achieve clearance with a resultant large, full-thickness defect (Figure 2a). Maxillofacial reconstruction involved a septal mucoperichondrial flap to reconstruct the mucosal defect and an ipsilateral paramedian forehead flap to reconstruct the soft tissue defect. No cartilage graft was required. Division of the forehead flap was performed four weeks after inset. The patient was satisfied with the aesthetic outcome and declined any further cosmetic contouring of the reconstructed nose (Figure 2b).

Discussion

Rhinophyma is considered to be the end stage of rosacea but patients may not have a prior history of other subtypes e.g. papulopustular or erythematotelangiectatic. Sebaceous hyperplasia of the nose is

common and may mimic rhinophyma. BCC arising in pre-existing rhinophymas is recognised. [1, 2] Clinical diagnosis may be difficult due to the background of a rhinophymatous change which causesanatomical distortion, erythema and fibrosis and can lead to a delay in diagnosis. Therefore,a high index of suspicion is required for such lesions. As telangiectasia is found in both rhinophyma and BCC, dermoscopy may not be helpful in differentiating the two. The gold standard for early, proper diagnosis is therefore adiagnostic biopsy for histological confirmation.

Incidental histological diagnosis of BCC arising within rhinophyma may be found after rhinophymaplasty. [1 - 2] However, to our knowledge, there are no previous reports of BCC misdiagnosed as rhinophyma *per se*. Our patient had localised progressive swelling on the nose without convincing evidence of background rhinophyma and so an early diagnostic biopsy was desirable. The delay in diagnosis led to a large, deeply invasive tumour with an extensive surgical defect required to achieve clearance before initiation of complex, multi-stage reconstruction.

The diagnosis of skin tumours can be difficult in patients with nasal sebaceous hyperplasia and rhinophyma. [1-3] An early diagnostic biopsy should be considered in such patients, especially when there is a history of lesion evolution. MMS is the desirable technique for the treatment of BCC in such cases for margin control, to maximise clearance and to preserve unaffected tissue. A multidisciplinary approach involving a reconstructive facial surgeon is desirable for complex, full-thickness defects.

The morphology of BCCs arising on the nose is variable. Lack of bleeding, ulceration or crusting and slow growth may contribute to a delay in presentation. BCC should be considered in the differential diagnosis of rhinophyma, particularly in the absence of background rosacea. Several other skin tumours and localised inflammatory dermatoses have also been reported to mimic rhinophyma (Table 1). [4-6]

Learning Points

- Nodular basal cell carcinoma of the nasal tip may mimic rhinophyma
- Alternative diagnoses to rhinophyma should be considered in absence of background rosacea
- A skin biopsy should be considered early in evolving localised lesions on the nose when clinical diagnostic uncertainty exists

Figures

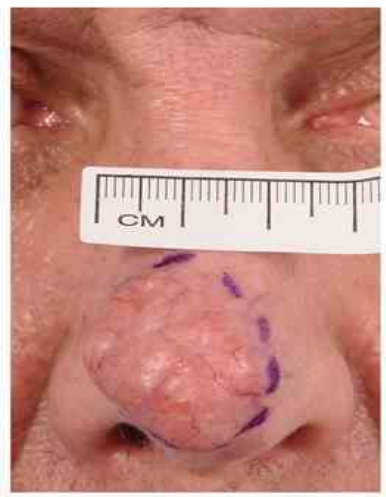

Fig 1: Rhinophymatous-like basal cell carcinoma

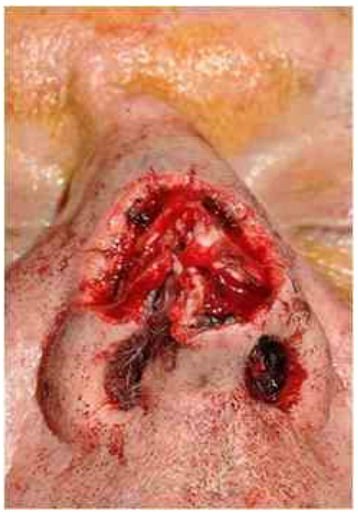

Fig 2a: Nasal defect following 3 stages of Mohsmicrographic surgery
Fig 2b: Satisfactory functional and aesthetic outcome 4-months post-reconstruction

Table

1	Tumours[1-5]	BCC,SCC, angiosarcoma, lymphoma
2	Inflammatory dermatoses[4, 6]	Sarcoid, pyoderma faciale, granuloma faciale
3	Vascularmalformations[5]	

Table 1: Reported Rhinophyma-Like skin disorders [1-6]

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