

Vulvar Basal Cell Carcinoma with Clitoral Involvement

Husnu Celik¹, Bilgin Gurates¹, Adem Yavuz¹, Zeynep Dogan¹, Bengu Cobanoglu² and Yunus Saral³

Departments of ¹Obstetric and Gynecology, ²Pathology and ³Dermatology, Medical School, Firat University, TR-23119 Elazig, Turkey.

E-mail: drhusnuceлик@gmail.com

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Sir,

Basal cell carcinomas (BCC) are among the most common cancers seen in humans. The incidence of BCC increases with age. About 85% of cases are observed on areas that are exposed to sunlight, such as the head and neck, but BCC may also be seen, although rarely, in the vulva, axilla, perianal and genital areas, which are not exposed to sunlight (1). In a recent retrospective review of histological diagnoses of BCC, 1.7% (63/3604) were found in the vulva (1). We present here a case of BCC located on the left labium major with clitoral involvement.

CASE REPORT

A 72-year-old multiparous woman with a 5 × 2 cm tumoural mass that included the clitoral area on the left and extended towards the left labium major was referred to our clinic. The tumour had been punch biopsied and diagnosed as nodular BCC (Figs 1 and 2). It was learnt from her history that the vulvar lesion started as discoloration in the clitoral area, which was followed by itching and a burning sensation. She had not received any treatment. Her history did not include any previous sexually transmitted disease, radiation exposure, smoking, or skin cancer in the family. She had no history of cytological smear or gynaecological examination. She came to our clinic for increasing symptoms, and had not been examined previously for her lesion.

Pelvic examination showed a pigmented and ulcerated lesion and no inguinofemoral lymphadenopathy. There were no suspect BCC lesions on other parts of the body. Left hemivulvectomy and bilateral inguinofemoral lymph node dissection was performed under general anaesthesia with a 1-cm free margin, so as to include the entire tumour tissue. The diagnosis of nodular



Fig. 1. Basal cell carcinoma of the vulva.

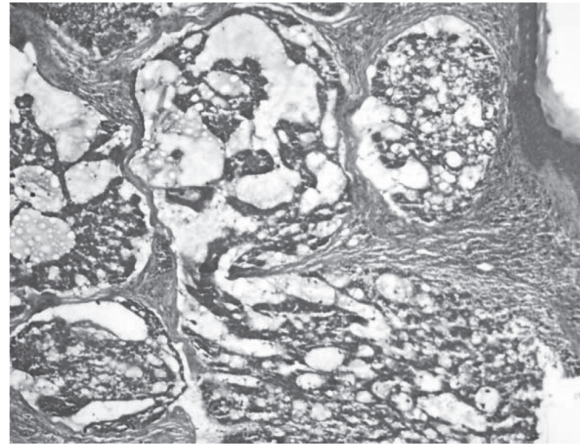


Fig. 2. Nodular basal cell carcinoma (H&E × 100).

BCC was confirmed in the final histopathological evaluation. Surgical margins and all lymph nodes were tumour negative.

The case was staged as Stage II (FIGO) and after 12 months' follow-up the patient is completely healthy in terms of both the previous lesion area and general health.

DISCUSSION

To the best of our knowledge this is the first published case of vulvar BCC with clitoral involvement. There are no data in the literature about the treatment and management of BCC with clitoral involvement. Although it is emphasized that local excision and hemivulvectomy is sufficient for the treatment of BCC located in other parts of vulva, inguinofemoral lymph node dissection is recommended in cases with extensive and deep lesions (2). In the case described here, inguinofemoral lymph node dissection was added to hemivulvectomy due to the size of the lesion and the involvement of clitoral and periclitoral areas together with left labium major, as well as the lymphatic network of the clitoral area.

In a review of 63 cases of vulvar BCC, the reported mean age of patients was 70 years and the mean lesion size was 2.1 cm. Twenty eight percent of the lesions presented as ulcerated and 3% as pigmented. Symptoms included itching (35%), perception of the lesion (30%), bleeding (25%) and pain (18%). Vulvar BCC could also be asymptomatic (1).

There is no consensus on the management of vulvar BCC, and the use of inguinofemoral lymph node dissection is controversial (3). Vulvar BCC lesion progresses slowly and has a low invasion capacity. Metastatic vulvar basal cell cancer exists, but is uncommon (4, 5). Vulvar

BCC is characterized by an indolent behaviour with a very low propensity for metastatic spread. The treatment of choice is wide local excision. Because of a substantial risk of local recurrence and high frequency of other primary cancers, close long-term follow-up is essential.

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