

## Management Of Multi Stages Case Of Basal Cell Carcinoma By Hand Of Oral And Maxillofacial Surgeon

Case Report

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### Abstract

Basal cell carcinoma (BCC) is the most common skin cancer in the Caucasian population. This cancer arises in sun exposed area of skin.

The incidence of morbidity is high and it is still growing and the metastatic rate is low but the enlarging tumor may cause severe tissue disfigurement and poor cosmetic outcome.

The main problem in basal cell carcinoma management is the high recurrence rate.

**Keywords:** Basal Cell Carcinoma; Eyelid Reconstruction; Forehead Flap; Skin Malignancies.

### Introduction

Basal cell carcinoma (BCC) is one of the wide spectrums of neoplastic disorders that can emerge in the head and neck region [1, 2].

Greater proportion of face cancers is diagnosed and referred for treatment by maxillofacial surgeons [3]. Today an increasing number of oral and maxillofacial surgeons are additionally trained in the treatment of head and neck malignancies [4].

Surgery remains the primary treatment modality for head and neck cancers. Face cancers poses a signification challenge to OMFS specialty [5]. As the future unfolds advanced in molecular biology, cell signaling immunomodulation and angiogenesis will result is novel targeted therapies that will allow patients with cancer to live longer and healthier lives [5, 6].

Herein, we present un important case of BCC in azygomatic area.

### Case Report

A 72-year-old man consulted the department of oral and maxillofacial surgery because of “there is an ulcer increasing in size in the region between nose border and right eye”.

#### History of Present Illness

The patient complained of 6-months history of progressive non-painful ulcer of his skin distal nose and lower his right eye. The patient denied any history of pain, fever or purulence, he reports neurosensory changes in this area in the last month.

#### Clinical Examination

The patient has obvious ulcer in the referred area, the ulcer was soft in center and had hard borders, non-tender to palpation. eye movements were not affected. There were no facial or trigeminal nerve deficits except neurosensory changes in the ulcer area. Neck: there were no palpable mass and no cervical lymphadenopathy.

Incisional biopsy of the lesion was done for histopathology examination. The biopsy report case of nodular basal cell carcinoma

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with multiple mitosis surrounded by dense stroma.

**Radiographic examination**

A computed tomography (CT) scan of the head and neck is the commonly used imaging study of choice to delineated the lesion and assess the neck for cervical lymphadenopathy. In the current patient axial and coronal CT images of the head and neck revealed well-circumscribed lesion of the right lateral border of the nose and right zygoma. no evidence of cervical lymphadenopathy was noted.

**Surgical procedure**

The surgical procedures were done over five stages in different times.

The first stage: after the oral and endotracheal intubation, the border of incision was marked taking into consideration the margins of safety involving part of skin and cartilage of nose, skin of zygomatic area and underlying bone and part of lower eyelid, in this stage the whole mass of tumor was removed and sterilized dressing packed in the area. (Figure 1, 2)

The second stage: after oral and endotracheal intubation, we closed the entire defect by both right axial forehead flap and localized random flap from the cheek (this stage was done after 2 months of cancer removal). (Figure 3)

The third stage: under local anesthesia, the forehead flap was separated after about 20 days. (Figure 4)

**Figure 1. The first surgical stage.**



**Figure 2. The healing period between the first two stages.**



**Figure 3. The second surgical stage.**



**Figure 4. The third surgical stage.**



Figure 5. The fourth surgical stage: (A) after one day, (B) after one month.



Figure 6. The fifth surgical stage (immediately after the surgery).



Figure 7. One month after the surgery.



The fourth stage: after oral and endotracheal intubation, left forehead axial flap was used for reconstruction of the lower eyelid. (Figure 5)

The final stage: after 1 month and under local anesthesia, the left forehead flap was separated and new lower eyelid in its place, we checked the eye movement (open and close) in the normal range with normal appearance. (Figure 6, 7)

## Discussion

Basal cell carcinoma starts as small shiny bumps usually on nose or other parts of face, but can occur on any part of body including trunk, legs and arms [1, 2, 5].

BCC usually grows very slowly and often doesn't show up for many years after in ten or long-term exposure to the sun [7, 8]. Diagnosis is usually clinical and clinical features are dependent on the subtype of BCC [4, 9].

Skin biopsy is usually taken to identify a histological subtype of BCC for treatment planning. BCC may be part of Gorlin syndrome so, the diagnosis should be accurate [10, 11].

## Conclusion

The available data suggest that surgical methods remain the gold standard in BCC treatment. And the surgeon must have the ability to deal with complex cases anatomically, surgically and cosmeti-

cally.

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