Giant Basal Cell Carcinoma of the Face: Role of Radiotherapy

Dear Editor,

An 83-year-old woman presented with an asymptomatic large cutaneous tumoral lesion on the right temple. She referred it appeared 12 years ago and grew progressively, invading the orbital tissue. Since her husband died 25 years ago, she had been living alone with no social life. As the lesion was asymptomatic, she never visited a medical clinic. Physical examination revealed a partially ulcerated vegetating mass (Fig. 1) with small necrotic areas, measuring 15 cm by 12 cm, which easily dripped serum and blood. The mass was warm to the touch and non-tender. Perilesional skin showed no alterations. There was no evidence of lymph node involvement. Magnetic resonance imaging (MRI) showed neoplastic infiltration of orbital tissue with bone invasion. A total body computed tomography (CT)and a positron emission tomography (PET) were performed and no metastases were observed.

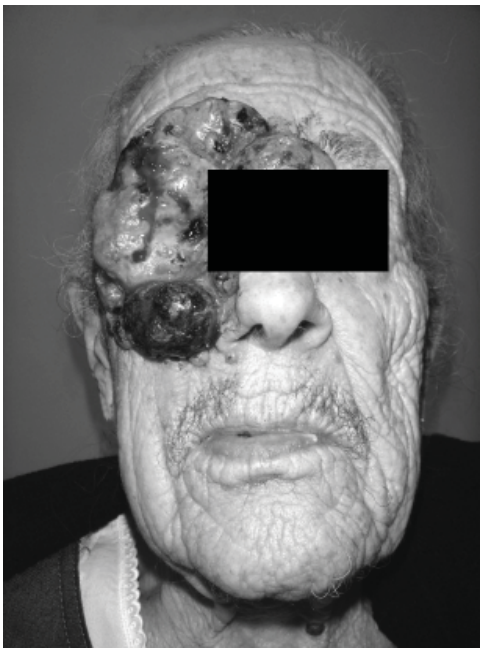

Fig. 1. Giant basal cell carcinoma involving the eye orbit tissue, measured 15cm by 12cm and was refractory to radiotherapy.

Basal cell carcinoma (BCC) is the most common carcinoma in humans and it occurs on sun-exposed areas. Reclusive patients, such as our case, or patients who neglect the lesions for long periods of time are more likely to have giant, invasive BBC.[1] Giant BBC mainly occurs on the back, followed by the face. These carcinomas are usually slow growing, locally aggresive tumours that rarely metastasise.[2,3] The presence of metastasis at the time of presentation represents the most significant adverse prognotic factor. Tumours greater than 3 cm in diameter have a 2% incidence of metastasis. This increases to 25% in those lesions more than 5 cm in diameter and to 50% in lesions more than 10 cm in diameter.[4] In our case, no metastasis was observed, but local invasion of orbit bone had iniciated. Despite discussion of the risk of cerebral invasion and destruction of the left eye, our patient declined surgical reduction of the tumour. She was treated with palliative radiotherapy to improve her quality of life. The dose fractionation regimen used was 8 Gy per fraction delivered on days 0, 7 and 21. This regimen has showed impressive outcomes in patients with malignant melanoma[5] and BCC.[6] No reduction of tumour size was observed at the follow-up 4 months after treatment, and the patient died 8 months later.

Surgery remains as the gold standard in the treatment of BCC. Obviously radiotherapy has its role, particularly in large facial lesions and patients with poor general choice, but response to this kind of therapy is heterogene and hard to predict. It seems that there is no correlation between site and local control,[6] while histologic subtype is a risk factor for unsatisfactory response with sclerosing subtype showing high recurrence rate after radiotherapy.[7] Our case presented a predominant nodular BBC, which is known to respond well to radiotherapy.[7] However, this therapy did not have result in our patient. A possible better prognostic outcome would have reached with a combination of partial debulking plus radiotherapy, but our patient declined any surgical intervention. There are still many issues unsolved concerning the role of radiotherapy in BCC such as if the size of the lesion may influence the response to radiotherapy. With this case, we want to highlight that it is difficult to gauge radiotherapy treatment decisions appropriately for every patient until we have better tools for predicting survival.

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