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Case Report

Axillary basal cell carcinoma: New case report

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54-year-old patient, phototype III, without any notion of chronic inflammatory skin pathology, or application of irritant product, or exposure to ionizing radiation, or sunburn in the axillae.

He was not taking any immune suppressive medication and had no history of malignancy other, and had not suffered any traumatism in the axilla

Operated 15 years ago for a left axillary lesion without an anatomopathological study

Who presents in dermatology consultation for management of a skin lesion evolving for 5 years, gradually increasing in size at the site of excision of the old lesion

The dermatological examination objectified a linear erythematous tumor and pigmented in place of 5 cm long, left axillary, with slightly infiltrated base, sitting next to a linear scar from the old excision (Figure 1)

Figure 1 : Image showing linear erythematous tumor and pigmented in place of 5 cm long, left axillary, sitting next to a linear

The dermoscopy objectified the presence of telangiectatic vessels, some arborizing vessels, ovoid nests, horny plugs, and crisalids, appearance evoking a basal cell carcinoma (Figure 2 A, B)

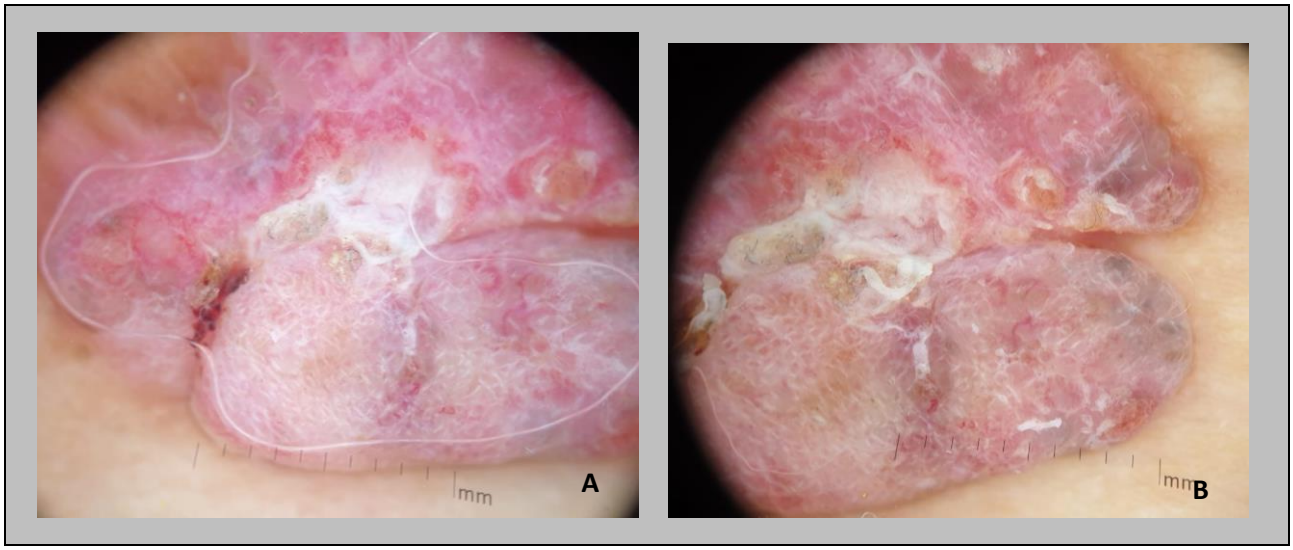

Figure 2 (A, B) : dermoscopic images showing : telangiectatic vessels, some arborizing vessels, ovoid nests, horny plugs, and crisalids

The rest of the skin examination was unremarkable and the lymph node examination was normal

A biopsy of the tumor was performed confirming the diagnosis of a nodular basal cell carcinoma, then the patient was operated by thoracic surgeons with a skin graft.

The patient did not present any sign of relapse, in a follow-up period of one year after the intervention.

Basal cell carcinoma (BCC) is the most common skin cancer, but significant differences exist in its incidence in the various anatomical locations (1) Unusual sites include the axillae, breasts, perianal area, genitalia, palms, and soles (2) the axilla is one of the most sun-protected body sites and represents a rare location at which BCC develops (3), up to 2014, 70 cases of axillary BCC were reported in 69 patients (4) then in 2017, 6 new cases were reported in a Japanese study out of a total of 333 CBC (5), probably the real incidence is underestimated because no systematic study of axillary BCC has generally been conducted (3)

Because the axilla is not a sun-exposed area, risk factors other than ultraviolet may be relevant, and it is still unclear whether race is a determining factor in the incidence of BCC (5).

Different hypotheses have been proposed to explain the origin of BCC Heckman et al. (6) proposed that a disturbed cell-matrix interaction found at particular sites characterized by concave shape, reduced skin tension or marked skin folds may be a cofactor for developing BCCs ..

Moreover, Depressed immune surveillance caused by ultraviolet radiation at distant sites has also been proposed as a mechanism in the pathogenesis of BCCs at sunprotected sites (7), and the development of axillary BCC did not appear to be related to the occurrence of noncutaneous malignancies or the use of immune suppressive medications (8)

Most of the patients with axillary BCC are Caucasian, with an average age of 65 (4), the sex ratio differs from one study to another.

Conventionally the dermosocpie of the BCC finds: arborizing, blue / gray ovoid nests, ulceration, multiple blue / gray globules, leaflike areas, and spoke-wheel areas (9)

The BCC of the axillary air is classified as a type of low risk, but in our patient, the recurring character as well as the size of more than 2 cm, classify it as a BCC of high risk, requiring then margins higher than 4 mm.

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