Dermatoscopy in vulvar basal cell carcinoma

Editor
Basal cell carcinoma (BCC) is frequently seen in Caucasians on sun-exposed sites but it can also arise on non-sun-exposed sites such as the perianal and genital regions.1–6 The prevalence of vulvar BCC, of all BCCs, is reported to be 0.92% in China3 and 2–4.9% in Europe1,2 with incidence of 3.2% of all vulvar cancers in Caucasians4 up to 8% in China.5 It occurs most commonly in post-menopausal women.1–3 Vulvar BCC may be presented as any other type of BCC with nodule or ulcer, but sometimes, it can be presented with slightly visible, indolent lesion that may be present for years.5 In Caucasians, only 3% of vulvar BCC were pigmented2 and in China, in contrast, 81% BCC were pigmented.3 So far, only one vulvar BCC case has been published with dermatoscopy image provided.7 The aim of this report is to present rare, pigmented vulvar type of BCC preoperatively examined with dermatoscopy in order to make distinction to melanoma.

A 63-year-old multiparous Caucasian woman presented with tumour on her right labium majus. The lesion lasted 2 years with constant growth. No pruritus was reported. The blue-grey pigmented tumour on her right labium majorum sized 1.5 × 1 cm with elevation of 3 mm. The surface of the tumour was rough and cracked (Fig. 1 inset).

Contact digital dermatoscopy using oil with polarized light (Dermlite-3 Gen, San Juan Capistrano, CA, USA; Nikon Coolpix 4500 camera, Nikon Corporation, Tokyo, Japan) and polyvinylchloride film (for hygienic purposes) was used. The present structures7–9 (Fig. 1) allowed one of us (D.D.V.) to formulate the diagnosis of BCC. The margins of the lesion were clearly visible at dermatoscopy examination. The lesion was surgically removed with 1 cm margin. The histopathology revealed BCC (Fig. 2).

The patient is clinically free of disease 1 year after surgery. Basal cell carcinoma of vulvar area affects post-menopausal woman with average age 70.35 years (range 34–96 years).2 The youngest reported case was 20-year-old nulligravid African-American woman.6 The most frequent clinical presentation was on the labium majus and labium minus.4,5 The main clinical misdiagnosis is usually eczema and psoriasis, especially if being non-pigmented and accompanied with the most frequent symptom in BCC’s – itching.2,5 BCC can also mimic Bowen disease, Paget disease, squamous cell carcinoma, leukoplakia, lichen planus, lichen sclerosus, melanocytic nevus, melanoma, seborrhoeic keratosis, angioma and various pigmented and non-pigmented tumours.3 The diagnosis is delayed, leading to average clinical size of vulvar BCC of 2.1 cm, with infiltrative growth with neoplastic involvement of the excision margins in 25% of cases that required second operation.2

Tumours on the vulva are less likely to be monitored by both patients and clinicians, so there is potential for delay in

Figure 1 Pigmented tumour present on the right labium majus in a 63-year-old woman (inset). Dermatoscopy picture: complete absence of any criteria for melanocytic lesion. Leaf-like areas, ulcers and fine telangiectasia are present. White shiny structures (chrysalis) are scattered throughout the whole lesion. A few black fibres present in the largest ulcer – sticky fibre sign indicating long-standing ulcer.

Figure 2 Histology: Dermal tumour made up of confluent nodules composed of basophilic cells with palisaded arrangement at the periphery. The basaloid cell islands contained melanin pigment. The pigment was present in macrophages in the tumour stroma. Retraction zones in the tumour stroma formed rare micro-pseudo-cysts (haematoxylin and eosin, 20×).
A network meta-analysis of the relative efficacy of treatments for actinic keratosis of the face or scalp in Europe: response to comments from Prof Dirschka

Editor

I read with great interest the response letter by Prof. Dirschka related to the comment on the recently published meta-analysis of treatments of actinic keratosis. On this basis I thought it would be important to clarify a few points he raised.

First, Prof. Dirschka is correct that the initial letter included a misstatement as the imbalance between treatment arms in the Dirschka et al. (2012) trial related to grade II lesions and not to grade II patients as initially stated. Indeed the 246 patients randomized to methyl-5-aminolaevulinate (MAL) had 991 grade II lesions compared to 880 in the 248 patients randomized to 5-aminolaevulinic acid, which corresponds to a 13% in the number of lesions difference between treatment arms.

The chi-square test was used to assess whether the distribution of lesions by level of severity differed significantly between treatment arms and concluded in a significant difference. The comparison could not be made based on the number of grade II lesions per patients as these were not reported in the initial publication.

On this basis, although the mean number of lesions per patient did not differ significantly between arms, the proportion of moderate lesions was significantly higher in the MAL arm, which may have impacted the results in terms of complete patient clearance.

Complete patient clearance is a highly stringent endpoint which is very sensitive to a number of factors including the number as well as the severity of lesions at baseline: using the definition of the endpoint, if a patient clears 9/10 lesions he or she is counted as a failure.

Results from clinical trials have shown that grade II lesions are more difficult to treat than grade I lesions and are associated with lower total clearance rates as reported in Table 1.

Within this context, a difference of 111 lesions between the two treatment groups spread across all patients could be expected to have an impact on the complete patient clearance results.

I felt it was important to reflect on the above limitations of the study as they had not been discussed by the authors of the study.

D. Dobrosavljevic Vukojevic, I. Djurisic, S. Lukic, B. Kastratovic-Kotlica, J. Vukicevic

1 Clinic of Dermatovenerology, Clinical Center of Serbia, School of Medicine, Belgrade, Serbia, 2 Surgical Oncology Clinic, Institute of Oncology and Radiology of Serbia, Belgrade, Serbia, 3 Department of Pathology, Institute of Oncology and Radiology of Serbia, Belgrade, Serbia, 4 Clinic of Gynecology and Obstetrics, Clinical Center of Serbia, School of Medicine, Belgrade, Serbia

*Correspondence: D. Dobrosavljevic Vukojevic. E-mail: danijela_dobrosavljevic@yahoo.co.uk

Table 1 Difference in lesion clearance rate between grade I and grade II lesions

| Treatment | Szeimies et al.² | Freeman et al.³ | Tarstedt et al.⁴ | Pariser et al.⁵ | Szeimies et al.⁶ |
|-----------|----------------|----------------|-----------------|----------------|----------------|
|           | MAL PDT        | MAL PDT        | MAL PDT once    | MAL PDT once   | MAL PDT twice  |
| Grade I   | 107/143 (74.8%)| 161/167 (96%)  | 92/99 (93%)     | 96/99 (97%)    | 76/85 (89%)    |
| Grade II  | 133/201 (66.2%)| 106/128 (83%)  | 69/99 (70%)     | 87/99 (88%)    | 95/113 (84%)   |

MAL, methyl-5-aminolaevulinate; PDT, photodynamic therapy.

References

1 Feakins RM, Lowe DG. Basal cell carcinoma of the vulva: a clinicopathologic study of 45 cases. Int J Gynaecol Obstet 1997; 16: 319–324.
2 De Giorgi V, Salvini C, Massi D, Rosaria Raspollini M, Carli P. Vulvar basal cell carcinoma: retrospective study and review of literature. Gynecol Oncol 2005; 97: 192–194.
3 Lui PCW, Shan Fan Y, Lau PL. Two treatment groups spread across all patients could be expected to have an impact on the complete patient clearance results.

Within this context, a difference of 111 lesions between the two treatment groups spread across all patients could be expected to have an impact on the complete patient clearance results.

I felt it was important to reflect on the above limitations of the study as they had not been discussed by the authors of the study.

D. Dobrosavljevic Vukojevic, I. Djurisic, S. Lukic, B. Kastratovic-Kotlica, J. Vukicevic

1 Clinic of Dermatovenerology, Clinical Center of Serbia, School of Medicine, Belgrade, Serbia, 2 Surgical Oncology Clinic, Institute of Oncology and Radiology of Serbia, Belgrade, Serbia, 3 Department of Pathology, Institute of Oncology and Radiology of Serbia, Belgrade, Serbia, 4 Clinic of Gynecology and Obstetrics, Clinical Center of Serbia, School of Medicine, Belgrade, Serbia

*Correspondence: D. Dobrosavljevic Vukojevic. E-mail: danijela_dobrosavljevic@yahoo.co.uk

Table 1 Difference in lesion clearance rate between grade I and grade II lesions

| Treatment | Szeimies et al.² | Freeman et al.³ | Tarstedt et al.⁴ | Pariser et al.⁵ | Szeimies et al.⁶ |
|-----------|----------------|----------------|-----------------|----------------|----------------|
|           | MAL PDT        | MAL PDT        | MAL PDT once    | MAL PDT once   | MAL PDT twice  |
| Grade I   | 107/143 (74.8%)| 161/167 (96%)  | 92/99 (93%)     | 96/99 (97%)    | 76/85 (89%)    |
| Grade II  | 133/201 (66.2%)| 106/128 (83%)  | 69/99 (70%)     | 87/99 (88%)    | 95/113 (84%)   |

MAL, methyl-5-aminolaevulinate; PDT, photodynamic therapy.

References

1 Feakins RM, Lowe DG. Basal cell carcinoma of the vulva: a clinicopathologic study of 45 cases. Int J Gynaecol Obstet 1997; 16: 319–324.
2 De Giorgi V, Salvini C, Massi D, Rosaria Raspollini M, Carli P. Vulvar basal cell carcinoma: retrospective study and review of literature. Gynecol Oncol 2005; 97: 192–194.
3 Lui PCW, Shan Fan Y, Lau PL. Two treatment groups spread across all patients could be expected to have an impact on the complete patient clearance results.

Within this context, a difference of 111 lesions between the two treatment groups spread across all patients could be expected to have an impact on the complete patient clearance results.

I felt it was important to reflect on the above limitations of the study as they had not been discussed by the authors of the study.

D. Dobrosavljevic Vukojevic, I. Djurisic, S. Lukic, B. Kastratovic-Kotlica, J. Vukicevic

1 Clinic of Dermatovenerology, Clinical Center of Serbia, School of Medicine, Belgrade, Serbia, 2 Surgical Oncology Clinic, Institute of Oncology and Radiology of Serbia, Belgrade, Serbia, 3 Department of Pathology, Institute of Oncology and Radiology of Serbia, Belgrade, Serbia, 4 Clinic of Gynecology and Obstetrics, Clinical Center of Serbia, School of Medicine, Belgrade, Serbia

*Correspondence: D. Dobrosavljevic Vukojevic. E-mail: danijela_dobrosavljevic@yahoo.co.uk

Table 1 Difference in lesion clearance rate between grade I and grade II lesions

| Treatment | Szeimies et al.² | Freeman et al.³ | Tarstedt et al.⁴ | Pariser et al.⁵ | Szeimies et al.⁶ |
|-----------|----------------|----------------|-----------------|----------------|----------------|
|           | MAL PDT        | MAL PDT        | MAL PDT once    | MAL PDT once   | MAL PDT twice  |
| Grade I   | 107/143 (74.8%)| 161/167 (96%)  | 92/99 (93%)     | 96/99 (97%)    | 76/85 (89%)    |
| Grade II  | 133/201 (66.2%)| 106/128 (83%)  | 69/99 (70%)     | 87/99 (88%)    | 95/113 (84%)   |

MAL, methyl-5-aminolaevulinate; PDT, photodynamic therapy.