A Rare Case of Neglected Basal Cell Carcinoma:

Metastatic Cancer that Changed the Course of a Patient's Life

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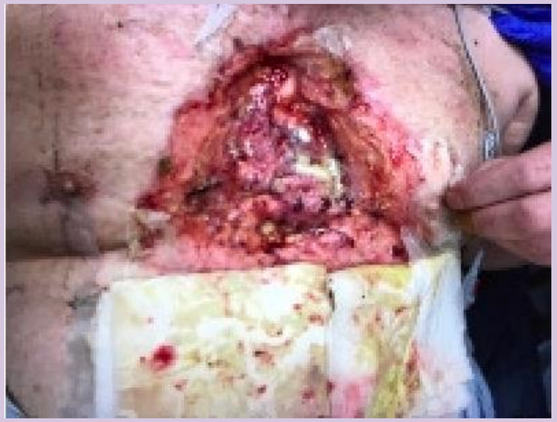
Introduction

Basal cell carcinoma (BCC) is typically an indolent, locally invasive malignancy, also considered the most diagnosed skin cancer. Metastatic BCC (mBCC) is extremely rare, with only 400 total cases documented over the last two centuries. Its most frequent routes of transmission are the lymphatic and hematogenous systems, the latter often involving bone. The average survival in mBCC patients with hematogenous spread has been reported to be 8-14 months. We present a rare case of metastatic chest wall BCC presenting as a large non-healing wound in a patient who surpassed his predicted life expectancy.

Image 1 – 25 cm x 25 cm sternal wound in our patient



Case Report

A 59-year-old-male presented to the emergency department complaining of severe progressive shortness of breath for five days. He denied orthopnea, fevers, chills, productive cough, or pleuritic chest pain. He was noted to have a large open sternal wound measuring 25 cm x 25 cm, concerning for malignancy (Image 1). It was painless, not associated with bleeding, and grew slowly. It first appeared 18 years ago and was treated as a non-healing wound with fungal infection. Chest x-ray revealed a new right lung base density, found to be an empyema requiring video-assisted thoracoscopic surgery. Plastic surgeons performed sternal wound debridement with excision of bilateral rib margins, followed by radical surgical resection of the anterior chest wall tumor. Biopsies of several tissues chest wall tissues were obtained. Since the massive sternal defect could not be closed with primary repair, it was covered with pectoral and myocutaneous flaps. A rib plate was placed for chest wall closure, and the postoperative course was uneventful.

Histopathological analysis revealed basal cell carcinoma eroding through the sternum. The patient underwent radiation therapy, however, a full body scan showed clear metastases to the bones. Given the diagnosis of stage IV BCC, he was started on Vismodegib and Zometa for palliative therapy. 15 months after his initial diagnosis, repeat imaging showed diffuse bony metastasis unchanged compared to the previous exam. The patient is currently stable, continues to receive palliative chemotherapy, and follows up with his oncologist every 3 months.

Discussion

The primary source of our patient’s BCC was a massive anterior chest wall tumor. Impressively, he had been living with it for almost two decades. This is a rarity, and it is remarkable that he far outlived the reported 14-month life span for mBCC survivors. The standard of care for patients with mBCC is a Sonic hedgehog pathway inhibitor, namely Vismodegib or Sonidegib. Unfortunately, our patient’s diagnosis was severely delayed due to his own neglect. It is crucial for patients with skin abnormalities to obtain prompt and proper medical care to improve long term survival. Although mBCC is an uncommon diagnosis, physicians should keep it on their differential diagnosis when evaluating for aggressive cutaneous malignancies.