

Non-Melanoma Skin Cancer Differential Diagnosis: Spinocellular Skin Cancer Vs. Basocellular Skin Cancer

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1. Medical Query

97-year-old woman, who lives in rural area, consults her primary care doctor because of a neck injury of approximately 2 months of evolution, which began as a pimple and has a rapid evolution, bleeding and painless.

Personal data: Allergy to sulfa drugs. Right hip surgery. Waterfalls.

Treatment: oral iron Tablets. Vitamin supplement.

2. Physical Examination and Additional Tests

Reddish lesion on the right lateral and anterior region of the neck, 2 cm × 1.5 cm in size, well defined, not adherent to deep planes, and hard consistency. At the same time of the examination, no bleeding. In the upper area of this region, another nodular lesion, pearly, 0.5 cm diameter, shiny, smooth surface, with telangiectasias, and a small central ulcer.

Exeresis of both lesions was performed and the pieces were sent to pathological anatomy.

Biopsy: completely excised spinous skin carcinoma, free margins. Basal cell skin carcinoma of the neck.

2.1 Suspected diagnosis

Squamous cell carcinoma and basal cell carcinoma.

2.2 Differential diagnosis

- Non-melanocitic carcinoma.
- Melanoma.

3. Final Comment

The basal cell carcinoma is the most common skin cancer (75% of malignant skin tumors). It is originated from the pluripotent cells of the basal layer of the epidermis.

The main risk responsible factor is the chronic exposure to solar radiation. People with fair skin, blond or reddish hair and light eyes have the higher risk.

When they are treated in time, the prognosis is excellent. In contrast, persistent tumors have higher recurrence rates with any type of treatment.

Squamous cell is a malignant keratinocyte of the stratum spinosum cancer. Less common than basal cell carcinoma 1:10, it is the second most common skin cancer after basal cell carcinoma (20%-25% of all skin cancers). It is a malignant proliferation of a type of cells called keratinocytes.

Overall survival at 5 years after resection of squamous cell carcinoma is greater than 90% and the mortality rate is 1%.

In the patient of the case, the two tumors were removed under local anesthesia, leaving a margin of safety. Follow-up was carried out at first month, sixth month and then, one year until after five years.

It is essential to insist on skin self-examination and the use of sunscreen as a fundamental pillar of follow-up (TABLE 1).

TABLE 1.

	BASOCELLULAR SKIN CARCINOMA	SPINOCELLULAR SKIN CARCINOMA
LOCATION	Most common malignant tumor. On healthy skin. Face.	In areas of sun exposure. Above actinic keratoses
CLÍNIC	Pearl plaque or nodule and telangiectasias. No lymphatic or hematic metastases on the surface. It does not affect mucous membranes.	Friable plaque or ulcer with superficial serocrust that bleeds episodically. Lymphatic and hematic metastases. It affects mucous membranes.
TREATMENT	Surgery: the first choice. Recurrent eyelids and face: Mohs surgery. Vismodegib. In very elderly patients (with poor quality of life and anticoagulated): Radiotherapy.	Surgery: the first choice. On the face and eyelids: Mohs surgery. On the lip of the old man: Radiotherapy. In very elderly patients (with poor quality of life and anticoagulated): Radiotherapy.
DERMATOSCOPY	Focused arboriform telangiectasias, pigmentation, pigment globules that when put together = nests, cartwheels, maple leaves.	Central mass of keratin and ulceration surrounded by hairpin vessels, and “targetoid” hair follicles (white circles) over an unstructured white area.

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