CASE REPORT

Rapidly enlarging skin lesion on the lip

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SUMMARY

Squamous cell carcinoma (SCC) is a malignant tumour arising from the keratinising cells of the epidermis. It is slow growing, locally invasive and has the potential to metastasise to other organs of the body. We report an unusual presentation of a rapidly enlarging, well-differentiated SCC on the upper lip of a 75-year-old woman. Rapidly enlarging skin lesions in specialised areas pose great challenges in its management. As the lesions increase in size, they eliminate first-line reconstructive options that can compromise functional and aesthetic outcomes. Accurate histological diagnosis prior to surgery is paramount, as it bears significance to the excision margins. Early, urgent referral to a specialist unit is essential and may avoid the need for more invasive procedures and associated morbidity.

BACKGROUND

Squamous cell carcinoma (SCC) is the second most common skin cancer and its incidence is rising. SCCs tend to be slow growing and typically present as an indurated nodular keratinising or crusted tumour that may ulcerate. Histologically well-differentiated SCCs typically enlarge at a slower rate compared with poorly differentiated SCCs.

Large lesions involving special areas, such as the lips, can pose reconstructive challenges following excision of the lesion. Rapidly enlarging lesions in these areas eliminate first-line reconstructive options and, in doing so, may cause great functional and aesthetic morbidity. Urgent referral is therefore exceedingly important in order to avoid more invasive procedures, and thereby limit functional and aesthetic morbidity.

CASE PRESENTATION

A 75-year-old woman presented to our unit with a 6-week history of a rapidly enlarging, painless lesion on her upper lip. She described the initial lesion as a 'spot' that did not itch or bleed and did not discharge. She had no history of cancer or radiotherapy and was a non-smoker. She admitted to excessive sun exposure in her youth. Her medical history included asthma, hypertension and osteoarthritis. There was no history of immunosuppressant or immunomodulator exposure.

Examination revealed a 2.5×2 cm well circumscribed, sessile, nodular lesion on her right upper lip. The lesion was cream in colour with overlying telangiectasia. It crossed the vermilion border and extended into the wet mucosa. It had no punctum and was not ulcerated (figure 1). The lesion was non-tender to touch and had a firm consistency. On further examination, she had no significant

Figure 1 Rapidly enlarging SCC involving the upper lip.

lymphadenopathy in the cervical and supraclavicular lymphatic drainage basins.

INVESTIGATIONS

We arranged an urgent incisional biopsy of the lesion.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis for a rapidly enlarging skin lesion can be subdivided into benign and malignant lesions. Benign lesions include keratoacanthoma, pyogenic granuloma, sebaceous adenoma, sebaceous cyst, lipoma and atypical fibroxyma. Malignant differential diagnoses include Merkel cell carcinoma, SCC, basal cell carcinoma, skin metastases and sarcoma.

TREATMENT

Following histological results from the biopsy urgent excision of the lesion was performed (figure 2).

OUTCOME AND FOLLOW-UP

Final histological examination confirmed it to be a well differentiated SCC with no perilymphatic, perivascular or perineural infiltration; pathologic TNM stage T2 as the tumour was greater than 2 cm in size. Margins were clear and the patient recovered well postoperatively (figure 3) At 1 year follow-up, there were no signs of recurrence and the patient had a good cosmetic outcome. She maintained oral competence without microstomia and her speech was not affected.

DISCUSSION

This case posed great challenges in its management as the lesion was enlarging at a very rapid rate; but,

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Figure 2 Intraoperative findings: (A) lesion postexcision and (B) closure of defect.

as it was enlarging, it was eliminating first-line reconstructive options. We needed to establish its histological nature prior to definitive excision as it would bear significance on the excision margins.

Current guidelines suggest that surgical excision should be regarded as the treatment of first choice for primary cutaneous SCC.¹ Undifferentiated tumours, those greater than 2 cm in diameter, tumours extending into the subcutaneous tissue and those on the ear, lip, scalp, eyelids or nose should be removed with a margin of 6 mm or more (or with Mohs' micrographic surgery) in order to ensure complete excision in 95% of cases.¹ For well-defined, low-risk tumours less than 2 cm in diameter, an excision margin of 4 mm will ensure the same degree of confidence of adequate excision.¹

Retrospectively, other possible differential diagnoses pertinent to this case would be keratoacanthoma and Merkel cell carcinoma.

Keratoacanthomas are usually solitary, dome-shaped, pink or flesh-coloured nodules developing on sun-exposed skin of the elderly.¹ The evolution of a keratoacanthoma can be divided into three phases: (1) a growth phase of 2–10 weeks, (2) a stationary period of similar duration and (3) a phase of involution which takes 8–50 weeks.^{2–4} Although curettage and electrodesiccation have been described, surgical excision remains the treatment of choice as the lesion can be removed in total which provides an adequate pathological specimen.

Merkel cell carcinoma is a rare and aggressive skin malignancy with unknown aetiology. It usually presents in the elderly and is linked to sun exposure. They commonly occur in the head/neck, buttocks and extremities of Caucasians and often metastasise to regional lymph nodes. Wide local excision with a recommended 2–3 cm margin is the mainstay of treatment.^{5–8} Radiotherapy is mostly used to control local recurrence and chemotherapy is usually reserved for advanced disease.⁹

Learning points

- Squamous cell carcinomas are slow-growing tumours and this is an unusual presentation.
- Even well-differentiated skin tumours can enlarge at a rapid rate.
- Rapidly enlarging lesions can threaten simple reconstructive options, especially if they involve specialised areas.
- Any rapidly enlarging lesion should be investigated with urgency to determine its histological diagnosis as this bears significance to the excision margins.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- 1 Motley R, Kersey P, Lawrence C. Multiprofessional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma. *Br J Dermatol* 2002;146:18–25.
- 2 Rowe DE, Carroll RJ, Day CL. Prognostic factors for local recurrence, metastasis and survival rates in squamous cell carcinoma of the skin, ear and lip. *J Am Acad Dermatol* 1992;26:976–90.
- 3 Weedon D. Keratoacanthoma: a personal perspective. *Curr Diagn Pathol* 2003;9:259–65.
- 4 Baer RL, Kopf AW. Keratoacanthoma. In: Rudolf L, Witten VH, eds. *Year Book of Dermatology*. Chicago: Year Book Medical Publishers, 1962/1963:7–41.
- 5 Schwartz RA. Keratoacanthoma. *J Am Acad Dermatol* 1994;30:1–19.
- 6 Blessing K, Al Nafussi A, Gordon PM. The regressing keratoacanthoma. *Histopathology* 1994;24:381–4.
- 7 Yiengpruksawan A, Coit DG, Thaler HT, et al. Merkel cell carcinoma. Prognosis and management. *Arch Surg* 1991;126:1514e9.
- 8 Hitchcock CL, Bland KI, Laney RG III, et al. Neuroendocrine (Merkel cell) carcinoma of the skin: its natural history, diagnosis and treatment. *Ann Surg* 1988;207:201e7.
- 9 Shaw JH, Rumball E. Merkel cell tumour: clinical behaviour and treatment. *Br J Surg* 1991;78:138e42.

Figure 3 Postoperative outcome.

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