Asal cell carcinoma (BCC), the most common form of skin cancer in Caucasians, will affect about two million Americans this year. According to one estimate, a 16-year-old Caucasian living in the US today has a 28 to 33 percent lifetime risk for developing BCC. Although with less frequency, BCC occurs in African-American and other dark-skinned individuals. BCC is associated with excessive UV-exposure and occurs most frequently on sun-exposed body sites, such as the face and arms, however, it can occur anywhere on the body, including areas rarely exposed to light, such as the axilla, buttocks, inguinal crease (Fig. 1), and thighs. Clinicians must be prepared to recognize unusual variants and able to identify BCCs that occur in unusual anatomic locations.

**BCC Overview**
The most common forms of BCC are superficial and nodular. According to one analysis, nodular BCCs are most common, accounting for 57.6 percent of all BCCs in a clinical cohort of 1,711 subjects with 2,990 histologically confirmed BCCs. Superficial BCCs accounted for 16.2 percent of all BCCs in the same cohort. Nodular BCCs were found to occur more frequently in males and in older patients (those age 60 to 79 had the highest proportion of nodular tumors), while superficial BCCs occurred more frequently in women and men (approximately 57 percent each).

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**Fig. 1.** BCC of the inguinal crease.

**Photos courtesy of Joseph Bikowski, MD/DermEdOnline.com**

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**Take-Home Tips.** Basal cell carcinoma (BCC), is the most common form of skin cancer in Caucasians. It occurs with less frequency in African-American and other dark-skinned individuals. BCC is associated with excessive UV-exposure and occurs most frequently on sun-exposed body sites, such as the face and arms, however, it can occur anywhere on the body, including areas rarely exposed to light, such as the axilla, buttocks, inguinal crease, and thighs. The most common forms of BCC are superficial and nodular. Clinicians must be prepared to recognize unusual variants and able to identify BCCs that occur in unusual anatomic locations.
younger patients. The mean age at diagnosis of superficial BCC was 57.5 years, compared to 65.5 years for nodular BCC.

Compared to individuals over age 90, those patients aged 40 and younger who were diagnosed with BCC had a higher prevalence of the cancers on the trunk (59.3 percent versus 31.5 percent). Older patients had a higher prevalence of BCCs on the head and neck (57.3 percent versus 36.0 percent) and of superficial BCCs (43 percent versus 31.5 percent). Superficial BCCs were mostly on the trunk, morpheic BCCs were mostly on the head and neck, and nodular BCCs were mostly on the head and neck, in this cohort.

A recent analysis suggests that the incidence of BCC in women may be on the rise. Overall, the age-adjusted incidence of basal cell carcinoma per 100,000 persons was 25.9 for women and 20.9 for men, and the incidence of BCC increased significantly during the study period among women only. Among all patients, nodular BCC was the most common histologic subtype (43 percent), while an additional 11 percent of patients had a mixed composition that included the nodular subtype.

**BCC Clinical Subtypes and Characteristics**

**Nodular or Nodulo-ulcerative BCC**
- Skin-colored, pink, gelatinous, translucent, pearly, grey nodules form.
- A central depression is commonly seen, and telangiectatic vessels may be noted.
- Gradual enlargement leads to central ulceration and peripheral, “rolled” border.
- Erosion with crust may be seen.
- As noted, this is the most common clinical presentation.

**Cystic BCC**
- A fluid-filled, smooth, round, pink-red, telangiectatic nodule/mass is noted.
- Incision and drainage will exude a clear mucinous fluid.

**Morpheiform/Sclerosing BCC**
- Classic presentation is a whitish, waxy, sclerotic plaque with ill-defined borders that resembles localized scleroderma.
- Most commonly affected sites are the nasolabial fold or forehead.
- Lesions may be depressed and firm, resembling a scar.
- This is the least common but most aggressive form of BCC.
Superficial Spreading Multicentric BCC
• Erythematous, scaly, plaques with slightly elevated “rolled” edges are extrafacial, occurring on the limbs or trunk.
• Lesions demonstrate slow centrifugal growth.
• Erosions, crusts, and nodules are commonly seen.
• This is the least aggressive BCC subtype.

Pigmented BCC
• Marked by a brownish to blue-black pigmentation and a pearly surface, this subtype is seen in more darkly pigmented individuals.
• Due to this phenotypic distribution, as a general rule of thumb, pigmented BCC is more likely in individuals with brown eyes, whereas similar appearing lesions in those with blue or green eyes are more likely to be melanoma.

Fibroepithelioma of Pinkus BCC
• Extremely rare, with a predisposition to women, this form of BCC usually appears on the lower anterior abdominal wall.
• Sessile, firm, flesh-to-pink-to-red or reddish-brown colored nodules or plaques on the abdomen or thigh are commonly seen.
• The appearance of these lesions can be similar to that of seborrheic keratosis.

Depressed BCC
• As its name suggests, this form of BCC appears like a depressed scar, however, an important clinical clue is an absence of history of local trauma.
• Lesions often have a sharp drop-off and crater-form edges.
• Males are more frequently affected, with the central third of the face being the most common site of involvement.
Recurrent BCC
Recurrence rates for BCC range as high as 32 percent.\(^1\) Incomplete excision or destruction are often cited as primary reasons for recurrence, although these do not appear to account for all recurrences. There are six primary features that may characterize recurrent BCCs:

1. Superficial in the scar tissue
2. On the border of the scar tissue (Fig. 2)
3. Deep in the dermis or subcutaneous tissue
4. Deep recurrences show a normal or brownish erythematous surface
5. Erosions in or on the border of the scar
6. Mimic epidermal cysts.

Index of Suspicion
The clinical diagnosis of basal cell carcinoma presents challenges. Multiple subtypes exist, each with varying presentations. Furthermore, while tumors most frequently occur on body sites commonly exposed to UV radiation, such as the face, chest, and arms, tumors may develop on virtually any body site. Unusual sites of involvement may complicate the diagnosis.

While tools such as dermatoscopes improve the clinician’s ability to confidently diagnose skin cancers (melanoma), and modalities such as Mohs micrographic surgery offer improved therapeutic outcomes, the initial identification of suspicious tumors depends on keen-eyed clinicians. The development of a visual memory store of unusual lesion types and locations is an essential tool for the dermatologist. To see more examples of BCCs on unusual body sites, log onto PracticalDermatology.com or DermEdOnline.com.

Dr. Bikowki has no relevant disclosures.