A Case of Superficial Basal Cell Epithelioma of the Labium Majus

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A 40-year-old woman presented with a pruritic erythematous eroded patch on the right labium majus which had been for 3 years. Histopathological findings were consistent with superficial basal cell epithelioma.

Basal cell epithelioma of the labium majus is a rare neoplasm and its clinical appearance is usually nodular. In contrast to the other types of basal cell epithelioma, the superficial type occurs mainly on the trunk.

We report a case of superficial basal cell epithelioma arising from the labium majus.
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Key Words : Labium majus, Patch, Superficial basal cell epithelioma

Basal cell epithelioma (BCE) of the vulva is a rare neoplasm, 2% to 3% of all vulvar malignancies[1]. Its four clinical types are nodular; superficial or erythematous; morpheaform or fibrosing; and basal-squamous or transitional[4, 5]. This lesion appears predominantly as an ulceronodular mass, and mainly shows histopathological patterns of the solid type.

We, herein, report a case of superficial BCE of the labium majus which presented as a patch.

CASE REPORT

A 40-year-old woman presented on acount of a pruritic patch on the labium majus. She had experienced vulval irritation for 3 years but did not seek medical advice. There was a well-defined 3 × 4 cm sized erythematous eroded patch with multiple tiny black dots on the right labium majus (Fig. 1). The vulvar skin surrounding this lesion was normal. There was no lymph node enlargement.

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On histopathological examination, the epidermis showed mild atrophy. The tumor was seen to arise from the basal aspect of the overlying epidermis. Peripheral palisading of the tumor cells and peritumoral lacunae were distinct features (Fig. 2). The cells were characterized by round to oval nuclei with infrequent mitosis, a high nuclear-cytoplasmic ratio, indistinct cell borders and a varying quantity of melanin pigments. There was a moderate lymphocytic infiltrate in the upper dermis. Immunohistochemical stainings of S-100 protein and CEA were negative.

After irradiation, the patient was well with no evidence of recurrence.

DISCUSSION

Five clinical types of BCE occur: (1) nodulo-ulcerative BCE; (2) pigmented BCE; (3) morphea-like or fibrosing BCE; (4) superficial BCE; and (5) fibroepithelioma. Of these types, the nodulo-ulcerative type is by far the most common type[2]. The lesions are most frequently found on the face, especially on the nose, and multiple lesions may occur on the upper trunk simultaneously with arsenic ingestion. However, they may also occur on the unusual locations such as external genitalia or nipple without concomitant evidence of radiodermatitis, chronic ul-

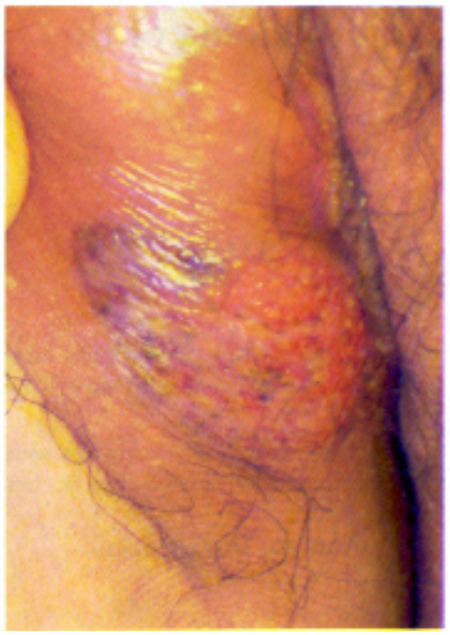

Fig. 1. A well-circumscribed 3×4 cm sized erythematous eroded patch on the right labium majus.

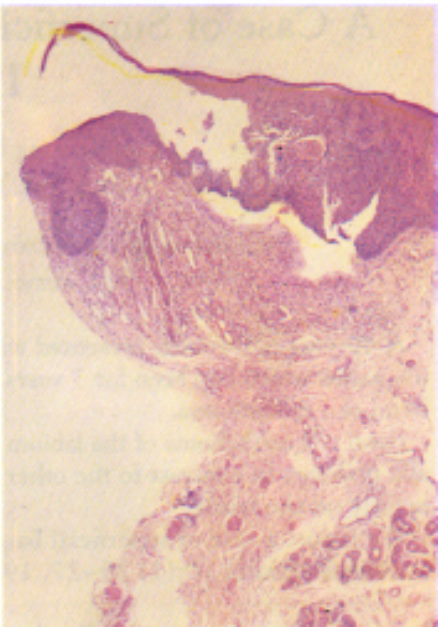

Fig. 2. Histopathological section from the lesion showed irregular proliferations of tumor tissue attached to the undersurface of the epidermis and peritumoral lacunae. (H & E, ×40).

ceration, etc[3]. Superficial BCE has been described as intraepidermal carcinoma, intraepidermal BCE of Borst-Jadassohn, and "multicentric" BCE[3]. This consists of one or several erythematous, scaling, only slightly infiltrated patches that slowly increase in size by peripheral extension[2]. The lesions may grow to be about 10 to 15 cm in diameter without ulceration[3]. In contrast to the first three types of BCE that are commonly situated on the face, superficial BCE occurs predominantly on the trunk[2]. It is frequently mistaken not only for plaques of psoriasis but also for Bowen's disease and extramammary Paget's disease[3].

Although BCE is the most common tumor of the skin, it is rare in the vulva. The incidence of BCE of the vulva is only 2% to 3% of all vulvar malignancies. It occurs most commonly in patients over 60 years old and is more prevalent in Caucasian women than in Negro women.[4, 5, 6, 7]. The clinical types that occur on the vulva are similar to those elsewhere: (1) nodular; (2) superficial or erythematous; (3) morpheaform or fibrosing; and (4) basal-squamous or transitional[4, 5]. There is no mention about the most common type of basal cell epithelioma of the vulva, but the nodular type with/without ulceration may be the most frequent clinical appearance with patches or plaques being rare[5, 8].

Most frequent symptoms are intermittent episodes of pruritus, the presence of a mass, burning with urination, pain, and bleeding. However, there may be no symptoms[4]. This patient had experienced only extremely severe pruritus. There is no predisposing factor of evidence except old age, but syphilis, arsenic, radiation, hyperkeratosis, chronic vulvovaginitis, endogenous hormones or their absence, and chronic irritation have been mentioned as predisposing factors[5, 8, 9]. Our patient was younger than those reported with BCE of the vulva, and had no significant past history. Most of the vulval BCE are located on the labium majora and less commonly on the labium minora, urethral meatus and clitoris[9, 10]. Differential diagnosis includes squamous cell carcinoma, pigmented nevus, melanoma, fibroma, granular cell myoblastoma, Bowen's disease, Paget's disease, tuberculosis, senile keratosis, psoriasis, hydradenoma, lymphogranuloma venereum and granuloma inguinale.

In choosing the proper method of treatment, age, the size, cosmetic effect, type of lesion and previous treatment history are important. As with BCE in other locations, a variety of treatments

have been used, including electrocautery, carbon dioxide freezing, liquid nitrogen, podophyllin and acid nitrate of mercury[9]. Regarding surgical therapy, wide local excision is preffered to radical procedures in that the majority of patients with vulvar BCE are elderly[5]. Although irradiation in the form of radium applications or external radiotherapy have been suggested, it is presently reserved for lesions so advanced that surgery is not feasible because BCE is relatively radioresistant[5].

In many vulvar lesions, there is a significant delay in seeking treatement or in receiving definitive treatement. In this patient, the interval from the patient's awareness to definitive treatement was about 3 years. Although this delay may be partially attributed to patient's neglect, it must be noted that it is common for physicians to dismiss the symptoms of pruritus vulvae, placing the patient on a wide variety of topical antibiotics and steroid preparations. It is necessary for physicians to be carefully concerned about any vulvar lesions.

We report a rare case of superficial basal cell epithelioma of the labium majus.

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