A Brownish Elastic-firm Nodule on the Right Nipple in a 56-year-old Man

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CASE REPORT

This 56-year-old man visited our clinic presenting with a nodular lesion on the right nipple. The lesion was asymptomatic and evolved slowly in recent 3 years. Physical examination revealed a pea-sized, brownish, elastic-firm nodule occupying almost the entire right nipple, especially the outer part (Fig.1). There was no underlying mass or axillary lymphadenopathy. He was otherwise in good health and had neither a history of previous skin cancer, a family history of skin cancer, sunbathing, X-ray exposure, arsenic exposure, previous trauma, or pre-existing disease of the nipple. The initial differential diagnoses included skin appendage tumor, benign adenoma, leiomyoma, and basal cell carcinoma. An incision biopsy of the nodule permitted a histologic diagnosis of BCC, superficial pigmented type (Fig. 2, 3). Due to the involved section margin, another elliptical wide excision was performed, and obtaining adequate margins necessitated removal of the surrounding areola as well. There has been no recurrence after follow-up for seven months.

Fig. 1
A brownish, pea-sized, elastic-firm nodule on the right nipple.

Fig. 2
Photomicrograph shows superficial pigmented BCC consisted of basaloid cells with peripheral palisading of nuclei and clefts. (H&E × 20)

Fig. 3
Higher magnification shows basaloid tumors with a palisaded arrangement of the nuclei. Melanin pigment is present within the solid islands of BCC and the upper dermis. (H&E × 40)
**DIAGNOSIS: Basal Cell Carcinoma of the Nipple**

**DISCUSSION**

Basal cell carcinoma located on the areola-nipple complex is a very rare condition, and only 24 cases including ours have been reported in the literature.1 Sixteen cases arose in men. This male predominance may be related to the fact that men are more likely to received sun exposure to the nipple than are women.1,2 The most significant risk factors for development of BCCs are ultraviolet light and radiation exposure. Other risk factors may include a previous history of BCC, nevoid basal cell carcinoma syndrome, a tendency to sunburn, and arsenic exposure.3,4 Our patient had none of these risk factors.

The clinical presentation could be either an eczematous lesion, an eroded plaque, a nodular mass, or an enlarging firm nipple. Only two of these 24 cases were diagnosed clinically as a BCC, and six cases were diagnosed as Paget’s disease. We present the second case of BCC with the clinical manifestation of a skin appendage tumor.1-3

It has been clearly stated that some histologic features, such as poorly formed palisading, nuclear pleomorphism, morphea, superficial multicentric growth pattern, and distance to closest resection margin, have an increased potential for recurrence or metastasis.5 Only one previously reported case had a demonstrated metastatic axillary lymphadenopathy after 4 years follow-up. We agree with the statement that “there is no evidence that BCCs of the areola-nipple complex should be treated more aggressively than BCCs of other sites.”1,2 The majority of the reported cases were treated with simple excision. Besides, Mohs micrographic surgery (MMS) was used to treat three cases. We agree with Zhu and Ratner 3 that MMS should be strongly considered as a tissue-sparing measure to minimize deformity of this important anatomic area and to minimize the risk of recurrence. Series spiral advancement flap (SSAF) provided better cosmesis and smaller scars than would an ellipse, and created a surgical nipple on a reported case after MMS.6

BCCs in unusual sites at times present some diagnostic difficulty. If a nipple mass is noted like our presenting case, it is important to differentiated this lesion from other pathologic conditions since it may clinically resemble other skin appendage tumors, benign adenoma, fibroadenoma, leiomyoma, amelanotic melanoma, squamous cell carcinoma, primary lymphoma, and other carcinomas of the breast. All of them could be diagnosed correctly by histopathological examinations.

**REFERENCES**