the patient who had good functional and cosmetic outcomes at 7-week review (Figure 4).

We also presented data from a literature review highlighting 6 cases that explicitly described buccal mucosa BCC. All 6 of these had been managed surgically with one also managed with a combination of Vismodegib and radiotherapy before the residual tumour was excised. Recurrence was reported in 1 of these 6 cases and this was treated with a combination reexcision and radiotherapy. We share our experience to enhance awareness of this phenomenon and to increase vigilance for intraoral extension when reviewing patients with large skin cancers of the face, especially perioral BCC.

References

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Diagnosis of Periocular Basal Cell Carcinoma With Optical Coherence Tomography

Basal cell carcinoma is the most common cancer in the periocular region, representing 84% to 96% of all skin cancers in this region. It can cause significant morbidity due to the close proximity to functional (peri)ocular structures such as the eyelid, lacrimal duct, or intraorbital structures. In addition, periocular basal cell carcinomas (BCCs) may grow more rapidly compared with BCCs occurring at other locations. Mohs micrographic surgery is the preferred treatment for periocular BCCs because it preserves healthy skin and has higher long-term clearance compared with standard excision. Optical coherence tomography (OCT) and reflectance confocal microscopy (RCM) are noninvasive imaging techniques that have been used to diagnose BCC (Figure 1). With OCT, vertical slides are obtained with a penetration depth of 1.0 to 1.5 mm, whereas RCM provides horizontal slides with a higher resolution, at the cost of the imaging depth of 250 μm.

Optical coherence tomography can be used to diagnose BCC with a sensitivity of approximately 95% and significantly increases specificity in diagnosis and subtyping of BCC compared with clinical observation alone. In a study including 10 patients, the ability to define BCC margins with OCT prior to Mohs micrographic surgery (MMS) seems promising. It might also be a valuable technique for diagnosing periocular BCC without the use of a diagnostic biopsy. However, there is no information regarding the use of OCT in this region in the studies performed to date. In this article, we demonstrate the use of OCT in the periocular region and show that it can be helpful to select a representative area for biopsy.

A 52-year-old patient with a history of multiple (>50) BCCs, visited the dermatology outpatient clinic of the Maastricht University Medical Center+. Three BCCs on the upper left eyelid had been treated in 2005, 2008, and 2012 with cryotherapy and MMS. A skin-colored nodule of 2 mm was visible on her upper left eyelid, without any
clinical or dermoscopic signs of BCC (Figure 2). Optical coherence tomography showed a localized protrusion into the upper dermis with a dark border, corresponding to a superficial BCC nest. In the dermis, an ovoid gray structure with a dark border was seen, corresponding to a nodular BCC nest (Figure 3). Based on previously defined criteria by Hussain and colleagues,3 the diagnosis of a superficial/nodular BCC was established. The patient was planned for MMS. On the day of the procedure, a punch biopsy with frozen section analysis confirmed our diagnosis of a superficial/nodular BCC and we subsequently performed MMS.

Diagnosis and treatment of periocular BCCs can be challenging. In small tumors, a diagnostic punch biopsy partially removes the clinically visible BCC. This can make it difficult to find the exact location of the BCC before surgery or even leads to a larger surgical defect because of scar tissue formation around the biopsy site. By using OCT in patients with a periocular skin lesion suspicious for BCC, these problems can be avoided. To minimize the risk of overtreatment of benign lesions even further, a frozen section biopsy just before the first Mohs stage can be considered.

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References


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Bilateral Posterior Ear Squamous Cell Carcinoma In Situ Lesions Along the Path of Mask Strap Friction

Although the greatest risk factor for development of cutaneous squamous cell carcinoma is exposure to ultraviolet (UV) radiation, other known factors that influence carcinogenesis include immunosuppression, infection with human papilloma virus, and trauma.1 Squamous neoplasms, such as keratoacanthomas and Marjolin ulcers, have been associated with trauma, scars, chronic wounds, cutaneous grafts, and laser resurfacing.2 With the coronavirus pandemic, masks have become commonplace, and prolonged use has resulted in irritation along the posterior ears. In this study, we report a novel case of simultaneously appearing bilateral squamous cell carcinoma in situ lesions on the posterior ears along the path of mask strap friction.

An 80-year-old man presented with irritated papules on the posterior upper sulci of the ears bilaterally. The patient described pruritus and scaling without significant pain or hemorrhage. He reported that these areas were frequently