A 49-year-old male presented with a small 0.5x0.5 cm pigmented swelling on the scrotum, which was clinically diagnosed as a sebaceous cyst in view its common occurrence in the region. The lesion was excised and sent for histopathological examination. Multiple sections from the tumour showed cells arranged in nests composed of small cells with hyperchromatic nucleus and scanty cytoplasm resembling basal cells with prominent palisading at the periphery. (Figure 1). In focal areas intracellular melanin was seen. A diagnosis of pigmented basal carcinoma was made. The margins showed no evidence of tumour infiltration. However in view of the final diagnosis, the patient was recalled and a margin of 1 cms excised.

The scrotum is a rare site for basal cell carcinoma (BCC), which is predominantly known to occur in the sun-exposed areas in direct proportion to the pilosebaceous units present therein. Approximately only thirty-nine cases have been documented at this site.¹ These may present as persistent ulceration or plaques. Microscopic variants include superficial, nodulocytic, pigmented, morphei-like, micronodular, metatypical, clear cell etc. Among these, the morphei-like and the metatypical variants behave in a more aggressive fashion.² Metastasis is more often seen in the metatypical type, in the tumours with perineurial invasion and those located in the sun-protected skin.³

Treatment options include curettage and dessication, cryosurgery, surgical excision, radiotherapy and Moh’s Micrographic surgery. The treatment of Basal cell carcinoma must be tailored, depending on the size, location, and the subtype. In the more aggressive types with larger size, Moh’s Micrographic surgery is preferred. Though traditionally it is a tumour known to grow locally with minimal metastatic potential, the scrotal counterparts behave much more aggressively and the patient should be closely followed up.⁴

REFERENCES