

Squamous Cell Carcinoma of the Lower Lip Complicating a Recurrent Labial Herpes During HIV Infection: a Case Report

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Abstract

Introduction: Squamous cell carcinoma (SCC) is the main cancer of lips; it is increasingly diagnosed in HIV-positive patients. In most cases, there are factors that promote his occurrence. We report a case of an HIV-positive woman with SCC of the lower lip complicating recurrent labial herpes.

Medical observation: It was a case of a 40-year-old female received in consultation for a painful and ulcerous lesion of her lip lasting 5 months. She was a HIV-positive patient diagnose since 2007 and on Highly Active Antiretroviral Therapy since that time. She was taking alcohol, was exposed to sunlight regularly, and had presented many episodes of labial herpes in the past. On clinical examination she had a painful ulcero-crustal medallion measuring 2.5 centimeters in diameter; with a papular edge of pearlescent appearance of the lower lip. Given this clinical picture, the diagnosis of chronic decaying herpes labialis with in differential an epithelial tumor (in particular a squamous cell carcinoma of the lower lip) was mentioned. After surgical excision, an anatomopathological analysis of the part confirmed the diagnosis of squamous cell carcinoma. At the time of diagnosis, the patient had a respective CD4 and CD8 level of 939 and 964 cells / mm³. The evolution was marked 6 weeks later by the scarring with complete epithelialization of the site of the lesion.

Conclusion: SCC of the lips is a frequent cancer occurring during HIV infection; there are many risk factors which promote his occurrence. Earlier the treatment is instituted, better is the prognosis.

Keywords: Squamous cell carcinoma, lower lip, HIV, labial herpes.

Introduction

With the widespread use of highly active antiretroviral treatment (HAART), the life expectancy of people living with HIV had improved. However, the HIV infection can lead to the development of pathologies with a long latency period like cancers [1]. Squamous Cell Carcinoma (SCC) is the main cancer of lips (about 30% of cancers of oral cavity); it is increasingly diagnosed in HIV-positive patients [2,3]. The risk factors of SCC includes tobacco consumption, sun exposure, alcohol consumption, labial herpes, and immunodepression [3,4]. We report here a case of an HIV-positive woman with a SCC of the lower lip despite a controlled immunological status. For the best of our knowledge, this is the first case describes in Cameroon.

Medical observation

It was a 40-year-old patient who came to our department for a 5 months vesicular and ulcerative lesions on her lower lips in a context of weight loss (she lost 11.1% of her initial weight in 5 months). She had been HIV-positive since 2007, and on HAART containing Tenofovir, Lamivudine, Efavirenz since while. She was compliant with treatment and had no complications of HIV. Our patient consumed alcohol (26 grams / day) and do not consumed tobacco. She had repeated episodes of labial herpes in the past (2 episodes / year for about 10 years). In addition, she was regularly exposed to the sun due to her profession (trader). On dermatological examination, we noted an ulcero-crustal medallion from about 2.5 cm diameter, with a papular edge with a beaded appearance on the outer edge of the lower lip, painful and sometimes bleeding on contact (Figure 1). There were no locoregional or distant lymphadenopathies. The rest of the clinical examination was normal.



Figure 1: Squamous cell carcinoma of the lower lip

In front of this clinical picture, we have raised the diagnosis of a decaying chronic labial herpes with in differential epithelial tumors (a squamous cell carcinoma of the lower lip).

The anatomopathological examination of the cutaneous biopsy patch had revealed histopathological aspects in favour of a squamous cell carcinoma class II (T2N0M0) according to the TNM classification, well differentiated and keratinizing with ulceration of the epidermis, confirming our clinical diagnosis.

CD4 and CD8 levels were respectively 939 and 964 cells / mm³, with a CD4 / CD8 ratio of 0.97. The viral load was undetectable. Other biological tests including FBC and CRP, fasting blood glucose were normal. The tumoral extensions assessment including abdominal ultrasound, brain scan, could not be achieved because of the limited resources of our patient. Additionally, chest x-ray was normal. According to the size of the tumor and the absence of metastases a priori, we opted for surgical treatment, which consisted of the removal of the lesion. The favorable evolution after 6 weeks was marked by a scarring with complete epithelization without anomaly on site of the lesion (Figure 2).

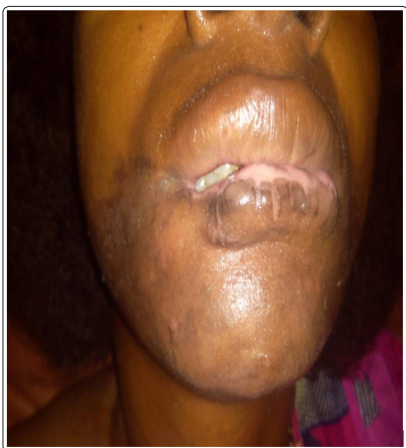


Figure 2: Complete scarring with epithelization

Discussion

At the beginning of HIV infection, the most common head and neck cancers were Kaposi Sarcoma and non-Hodgkin's Lymphoma.

Today, SCC is frequently diagnosed in these patients [1]. HIV-associated cancers are increasingly diagnosed in younger patients, at an advanced stage, and in more aggressive forms [3-5]. The literature does not provide sufficient data on SCC in HIV patients; nevertheless, it is described a younger average age of onset of the disease between 40 - 45 year, as is the case with our patient aged 40 years. HIV-related SCC is becoming more prevalent in women, unlike SCC in HIV-negative patients where older men are most concerned with a sex ratio of up to 13: 1 [4-7].

The risk factors found in this patient were sun exposure, alcohol consumption, immunodepression and a history of repeated labial herpes. These results corroborate those found in the literature [1-3,7]. The role of herpes simplex virus 1 in the occurrence of SCC is not yet clearly elucidated in literature. However, hypotheses suggest that Herpes Simplex Virus (HSV) infection would promote a state of chronic inflammation responsible for the malignant degeneration of cells, and also that the transient acquisition of a complete or incomplete viral genome can be sufficient to induce malignant transformation of host cells in vivo, resulting in the development of neoplastic cells [8]. The vesicular and ulcerative aspect of the lesion is the most commonly form found in literature and thus represents the most severe aspect found in HIV-positive patients [2,9]. The confirmation of SCC is made through the histological analysis of the tumor. Thus, in our patient, the histological analysis shows a well-differentiated squamous cell carcinoma, which is a less aggressive form and is consistent with the literature [10]. Among all SCC, labial SCC is the one with high metastatic power; so, an extension assessment is necessary to find out locoregional invasion and distant metastases [9]. The extension of Lips's SCC can be mucous, cutaneous, osseous and ganglionic [4]. In our patient, because of her lower socio-economic level, para-clinical exams could not be performed except for a chest X-ray which was normal. Nevertheless, the physical examination for local and distant invasion did not reveals any abnormality. It should be known that the absence of lymphadenopathy does not exclude a microscopic histological invasion, especially since the risk of lymph node metastases increases when the tumor size is ≥ 2 cm, with neurovascular invasion [4,9].

Concerning the treatment, there is no consensus so far. The treatment mainly depends on the clinical stage, the presence or absence of metastases but also on the aesthetic aspect. Surgery is recognized as the standard treatment of SCC because it allows in addition to the healing of patients, to provide a piece of excision for the histological confirmation of the diagnosis and verification of the quality of the excision [9]. Surgical management is often delicate in the lips because of the aesthetic damage. Radiotherapy can be performed in case of lymph node involvement [11]. In our patient, because of the size of the tumor and the absence of metastases a priori, surgical treatment was preferred. The evolution was marked by good healing and good preservation of the aesthetic appearance.

Conclusion

We have reported here, an original case of Squamous Cell Carcinoma complicating recurrent labial herpes in a 40-year-old HIV-positive woman, with a satisfactory immunological status (CD4 = 939 cells / mm³ and undetectable viral load). This observation may allow us to emphasize the surveillance of the risk factors of SCC in HIV-positive patients.

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