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ORIGINAL ARTICLE

Dermoscopic Features of Basal Cell Carcinomas According to Tumor Size, Anatomical Location, and Histopathological Subtype

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OBJECTIVE

Basal cell carcinoma (BCC) is the most common skin cancer, and dermoscopy significantly enhances its diagnostic accuracy by enabling early, noninvasive recognition. However, dermoscopic patterns may differ according to histologic subtype, tumor size, and anatomical location. This study aimed to compare the dermoscopic features of BCC according to tumor size and anatomical location (H-zone vs. non–H-zone), and to evaluate the association of histologic subtype on these variations.

METHODS

Dermoscopic images of histopathologically confirmed BCCs from 70 patients were retrospectively analyzed. Dermoscopic features of BCC were evaluated according to tumor size (≤5 mm vs. >5 mm), anatomical location (H-zone vs. non–H-zone), and histopathologic subtype, and comparisons were performed between these predefined groups.

RESULTS

Blue-gray ovoid nests were significantly more frequent in smaller tumors (≤5 mm) ($p<0.05$). Within the H-zone, blue-gray ovoid nests were observed more frequently in small tumors (≤5 mm) ($p=0.017$). Similarly, in nodular BCCs, blue-gray ovoid nests were significantly more common in smaller lesions ($p=0.048$). In contrast, ulceration was significantly more frequent in larger tumors (>5 mm) ($p<0.05$). No significant dermoscopic differences were identified between H-zone and non–H-zone lesions, and no correlations were found when tumor size was analyzed as a continuous variable.

CONCLUSION

Our results show that ulceration was more frequent in larger tumors, whereas blue-gray ovoid nests predominated in smaller lesions, particularly in the nodular subtype. Recognition of these size- and subtype-related variations may aid earlier diagnosis and assist clinical evaluation of BCC.

Keywords: Basal cell carcinoma; dermoscopy; histologic subtype; H-zone; tumor size.

INTRODUCTION

Basal cell carcinoma (BCC) is the most common form of skin cancer worldwide, with a steadily increasing incidence over the past decade. Despite its indolent growth and low metastatic potential, BCC represents a major public health concern due to its locally invasive nature and potential for significant tissue destruction.[1,2] Clinically, the diagnostic accuracy of BCC is approximately 60%; however, dermoscopy, a readily accessible

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and noninvasive diagnostic technique, can increase the diagnostic accuracy of BCC to over 90%.[3]

The clinicopathologic spectrum of BCC includes nodular, superficial, morpheaform, and pigmented variants. Nevertheless, BCC may present with a wide range of clinical and dermoscopic features, reflecting diverse combinations of its underlying histopathological structures.[4] Accordingly, the dermoscopic appearance of BCC varies according to patient-related factors (age, sex, ethnicity) and tumor-related characteristics such as histologic subtype, anatomical site, and degree of pigmentation.[5] Understanding these variations is crucial for accurate diagnosis and optimal management. Superficial and nodular BCCs are considered low-risk subtypes, whereas micronodular, infiltrative, basosquamous, and morpheaform variants are classified as high-risk due to their invasive growth patterns, increased surgical complexity, and higher recurrence rates.[6,7]

Dermoscopy of BCC typically reveals characteristic vascular and pigmented structures including arborizing vessels, blue-gray ovoid nests, globules, and ulceration that mirror the underlying histopathological architecture.[3,8] The expression of these features may differ according to histologic subtype, pigmentation, and tumor location.[3,6,8–10] The facial H-zone, encompassing the nose, periocular area, and ears, corresponds to embryonic fusion lines between mesodermal and ectodermal tissues. This region is considered a high-risk area for the development of BCC, and tumors arising within it have been reported to display a more aggressive clinical course.[3] Given the aggressive behavior of BCCs arising in the H-zone, early diagnosis is critical, as even minimal increases in tumor size may significantly influence treatment planning and prognosis.[11]

Dermoscopy enables reliable detection of small BCCs, which often exhibit characteristic dermoscopic patterns even at early stages.[12,13] Previous studies have suggested that dermoscopic features of BCC may vary with tumor size, with blue-gray structures being more common in smaller lesions and ulceration more frequent in larger ones.[12–14] To date, few studies have systematically compared dermoscopic features of BCC according to both tumor size and anatomical location within the same patient cohort, limiting the applicability of existing data to real-world clinical decision-making.

Therefore, this study aimed to provide a comprehensive comparative analysis of the dermoscopic features of BCC according to tumor size, anatomical location, and histopathologic subtype, to improve early diagnosis, facilitate risk stratification, and support clinical decision-making in daily dermatologic practice.

MATERIALS AND METHODS

Study Design and Patients

In this retrospective cross-sectional study, 70 patients with histopathologically confirmed BCC who attended the dermatology outpatient clinic between January 2023 and December 2023 were included. All patients underwent a comprehensive clinical and dermoscopic evaluation prior to surgical excision. Inclusion criteria comprised a definitive histopathological diagnosis of BCC following surgical excision, availability of histopathological subtype information, and high-quality dermoscopic images obtained before excision. Patients with genetic syndromes associated with an increased risk of BCC were excluded from the study.

Histopathological Classification and Clinical Variables

Based on histopathological findings, lesions were classified into three groups: Superficial BCC, nodular BCC, and infiltrative BCC. Tumor size was measured clinically and lesions were categorized as ≤5 mm or >5 mm in diameter.

The anatomical location of each lesion was recorded and classified as either within the facial H-zone (nose, periocular area, and ears) or non-H-zone (forehead, cheek, chin, and the remaining facial and cervical regions).[3]

Dermoscopic Evaluation

Dermoscopic images were obtained using a polarized contact dermatoscope (DermLite DL5; 3Gen, USA). Classical dermoscopic features of BCC were evaluated, including ulceration; arborizing vessels; short fine telangiectasias; blue-gray ovoid nests; blue-gray non-aggregated globules; brown dots; brown clods; brown nests; crust; white and pink structureless areas; fiber sign; erosion; shiny white lines; spoke-wheel-like structures; leaf-like areas; blue-gray veil; and milia-like cysts.

All dermoscopic images were independently evaluated by a dermatologist experienced in dermoscopy. Each dermoscopic feature was recorded as either present or absent, and analyses were performed according to histopathologic subtype, tumor size, and anatomical location (H-zone vs non-H-zone).

Ethical Considerations

Ethical approval for the study was obtained from the ethics committee on March 28, 2024 (File No. 44). The study is conducted according to the Declaration of Helsinki.

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Table 1 Demographic, clinical and histopathological characteristics of patients

Variable	Value	
	n	%
Age, year, median (IQR)	70 (62–77.5)	
Lesion duration, month, median (IQR)	24 (12–36)	
Tumor size (longest diameter), mm, median (IQR)	10 (6–14)	
Sex		
Female	30	42.9
Male	40	57.1
Location		
H-zone	42	60.0
Non–H-zone	28	40.0
Histological subtype		
Superficial	10	14.3
Nodular	50	71.4
Infiltrative	10	14.3
Size		
≤5mm	14	20
>5mm	56	80

Table 2 Dermoscopic characteristics of patients

Dermoscopy Findings	n	%
Ulceration	43	61.4
Blue-gray ovoid nests	17	24.3
Short fine telangiectasia	21	30.0
Arborizing vessels	42	60.0
Brown dots	22	31.4
Brown clods	18	25.7
Brown nests	5	7.1
Crust	12	17.1
White structureless areas	9	12.9
Pink structureless areas	33	47.1
Spoke-wheel-like structures	9	12.9
Shiny white lines	20	28.6
Blue-gray non-aggregated globules	8	11.4
Concentric structures	4	5.7
Leaf-like areas	10	14.3
Blue-gray veil	3	4.3
Milia-like cysts	1	1.4
Erosion	1	1.4

Statistical Analysis

Statistical analyses were performed using IBM SPSS Statistics version 22.0 (IBM Corp., Armonk, NY, USA). Continuous variables were summarized as median and interquartile range (IQR), while categorical variables were presented as frequencies and percentages.

Comparisons of categorical variables between groups were conducted using the Chi-square test when expected cell counts were adequate. When expected frequencies were less than 5 in more than 20% of cells, the Fisher's exact test was applied.

Tumor size was analyzed both as a categorical variable (≤5 mm vs. >5 mm) and as a continuous variable. The association between continuous tumor size and dermoscopic features was evaluated using binary logistic regression analysis, with results expressed as odds ratios (ORs) and 95% confidence intervals (CIs).

All statistical tests were two-sided, and a p-value <0.05 was considered statistically significant.

RESULTS

The Demographic and Clinical Features of the Study Population

A total of 70 patients with histopathologically confirmed BCC were included in the study. The median age of the patients was 70 years (IQR: 62–77.5 years), with a male predominance (57.1%). The median lesion duration was 24 months (IQR: 12–36 months), and the median tumor size measured by the longest diameter was 10 mm (IQR: 6–14 mm). According to lesion location, 60% of tumors were located in the H-zone, while 40.0% were located in non–H-zone areas. Histopathological examination revealed nodular BCC as the most frequent subtype (71.4%), followed by infiltrative and superficial subtypes, each accounting for 14.3% of cases. The clinical, demographic and histopathological, characteristics of the lesions are summarized in Table 1.

The most frequent dermoscopic features were ulceration (61.4%) and arborizing vessels (60.0%). The dermoscopic characteristics of the lesions are summarized in Table 2.

Comparison of Dermoscopic Findings According to Tumor Size and Tumor Location

When analyzed according to tumor size, ulceration was significantly more frequent in lesions >5 mm (67.9% vs. 35.7%, p=0.027), whereas blue-gray ovoid nests were more commonly observed in lesions ≤5 mm (50.0% vs. 17.9%, p=0.031). No statistically significant differences were identified for the remaining dermoscopic features.

When dermoscopic findings were compared between H-zone and non–H-zone lesions, no statistically significant differences were observed. Although blue-gray ovoid structures tended to be more frequent in non–H-zone lesions, this difference did not reach statistical significance (p=0.06). All other dermoscopic parameters were similarly distributed between the two groups. The detailed distribution of dermoscopic findings according to tumor size and anatomical location is presented in Table 3.

Table 3 Comparison of dermoscopic findings by tumor size and location

Dermoscopic Feature	≤5 mm		>5 mm		p	H-zone		Non–H-zone		p
	n	%	n	%		n	%	n	%	
Ulceration*	5	35.7	38	67.9	0.027	28	65.1	15	34.9	0.27
Blue-gray ovoid nests*	7	50.0	10	17.9	0.031	7	41.2	10	58.8	0.06
Telangiectasia	6	42.9	15	26.8	0.329	10	47.6	11	52.4	0.16
Arborizing vessels	7	50.0	35	62.5	0.393	26	61.9	16	38.1	0.69
Brown dots	4	28.6	18	32.1	1.000	11	50.0	11	50.0	0.24
Brown clods	5	35.7	13	23.2	0.331	10	55.6	8	44.4	0.65
Brown nests	2	14.3	3	5.4	0.260	3	60.0	2	40.0	1.00
Crust	0	0	12	21.4	0.107	9	75.0	3	25.0	0.33
White structureless areas	2	14.3	7	12.5	1.000	5	55.6	4	44.4	1.00
Pink structureless areas	4	28.6	29	51.8	0.120	21	63.6	12	36.4	0.55
Shiny white lines	0	0	9	16.1	0.188	13	65.0	7	35.0	0.58
Erosion	0	0	1	1.8	1.000	1	100	0	0	1.00
Fiber sign	3	21.4	17	30.4	0.742	5	55.6	4	44.4	1.00
Blue-gray non-aggregated globules	1	7.1	7	12.5	1.000	7	87.5	1	12.5	0.13
Spoke-wheel-like structures	3	21.4	6	10.7	0.370	6	66.7	3	33.3	0.73
Concentric structures	0	0	4	7.1	0.577	2	50.0	2	50.0	1.00
Leaf-like areas	3	21.4	7	12.5	0.407	7	70.0	3	30.0	0.72
Blue-gray veil	1	7.1	2	3.6	0.494	1	33.3	2	66.7	0.56
Milia-like cysts	0	0	1	1.8	1.000	0	0	1	100	0.40

p values were calculated using the chi-square test or Fisher's exact test, as appropriate. Statistically significant p values ($p<0.05$) are shown in bold.

Dermoscopic Findings According to Tumor Size in H-zone and Non–H-zone Lesions

When dermoscopic features were analyzed by tumor size within H-zone and non–H-zone lesions, a significant association was identified only in the H-zone group. Blue-gray ovoid nests were more frequently observed in H-zone tumors measuring ≤5 mm compared with those >5 mm ($p=0.017$). No other dermoscopic parameters demonstrated statistically significant differences according to tumor size in either group.

Influence of Tumor Size on Dermoscopic Features by Histologic Subtype

When dermoscopic findings were evaluated according to tumor size within histologic subtypes, a significant difference was detected only in nodular BCC. In this subgroup, blue-gray ovoid nests were more common in tumors ≤5 mm than in those >5 mm ($p=0.048$). No significant associations were observed in superficial or infiltrative subtypes.

Distribution of Histologic Subtypes in H-zone and Non–H-zone Lesions

Comparison of histologic subtypes between H-zone and non–H-zone lesions revealed no statistically significant association ($p=0.338$). Although nodular and infiltrative BCCs tended to occur more frequently in the H-zone, this distribution did not reach statistical significance.

Correlation Between Continuous Tumor Size and Dermoscopic Findings

When tumor size was analyzed as a continuous variable, none of the dermoscopic parameters showed a significant association with increasing tumor diameter. A positive trend was noted for ulceration, with a 9% increase in odds for each 1-mm increase in tumor size; however, this did not reach statistical significance ($p=0.062$).

DISCUSSION

The dermoscopic criteria of BCC include arborizing vessels, large blue-gray ovoid nests, multiple blue-gray globules, short fine telangiectasias, leaf-like areas, blue-gray dots, and ulceration, as initially described by Menzies et al.[15] These features reflect the underlying histopathological architecture and may vary according to tumor subtype, size, and anatomical site.[16] Of particular clinical relevance, BCCs arising in the facial H-zone are associated with a higher-risk profile related to their histologic subtype distribution.[17] Therefore, dermoscopic recognition of early changes in this region is crucial for timely diagnosis and appropriate management.[11–13]

Previous studies have similarly highlighted that the dermoscopic features of BCC vary according to tumor size. Longo et al.[12] and Arias-Rodriguez et al.[1] reported that ulceration and erosions are more

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frequent in larger tumors, while blue-gray ovoid nests and dots predominate in smaller lesions. Takahashi et al.[14] noted that in BCCs measuring ≤3 mm, multiple blue-gray globules and large blue-gray ovoid nests were particularly evident, whereas lesions measuring 4–6 mm showed additional shiny white areas alongside these pigmented structures.[14] Similarly, Foltz et al.[18] observed that very small BCC (≤2 mm) may already exhibit various dermoscopic features, including blue-gray dots, blue-gray ovoid nests, spoke-wheel–like, and leaf-like areas. In line with these observations, our study demonstrated that ulceration was significantly more frequent in larger tumors (>5 mm), whereas blue-gray ovoid nests predominated in smaller lesions (≤5 mm). Although not statistically significant, our findings revealed a positive trend between increasing tumor size and ulceration likelihood, supporting the hypothesis that ulceration develops progressively during tumor enlargement. Taken together, these findings suggest that dermoscopic changes in BCC may follow a size-dependent pattern that reflects tumor progression. The absence of significant associations in continuous analyses may be attributed to the limited sample size and reduced statistical power, particularly in subgroup analyses. Therefore, the results should be interpreted with caution. Recognizing these size-dependent dermoscopic variations both in smaller and larger lesions may facilitate earlier detection and provide useful insights into the morphological evolution of BCC during tumor growth.

In addition to tumor size, anatomical location has also been reported to influence the dermoscopic presentation of BCC. Tumors located in the H-zone more frequently exhibit ulceration, micro-ulceration, and bleeding.[19] Similarly, another study comparing the dermoscopic features of lesions located in and outside the H-zone found that ulceration was more common in H-zone lesions, whereas brown globules were observed more frequently in non–H-zone lesions.[3] In contrast to these findings, our study did not reveal any significant differences in dermoscopic features between H-zone and non–H-zone lesions. However, blue-gray ovoid nests were significantly more frequent in small tumors (≤5 mm) located within the H-zone, suggesting that this feature may represent an early dermoscopic marker of tumor development in this anatomically high-risk area. Given the higher risk profile and anatomically challenging nature of tumors arising in the H-zone, recognition of characteristic dermoscopic features in early, small lesions may be particularly important for facilitating prompt diagnosis and reducing the likelihood of delayed detection, which in this region may complicate subsequent clinical management.

Basal cell carcinoma subtypes are known to exhibit distinct dermoscopic characteristics that reflect their underlying histopathological architecture.[4] Among these, nodular BCCs display a wide range of dermoscopic features, including arborizing vessels, shiny white structures, and pigmented areas such as blue-gray globules and leaf-like structures. Blue-gray ovoid nests, in particular, are frequently observed and, in the study by Popadić et al.,[20] were found to have the highest diagnostic accuracy for nodular BCCs.[16] However, in our study, blue-gray ovoid nests were significantly more frequent in smaller nodular lesions (≤5 mm), suggesting that this feature may serve as an early dermoscopic marker of nodular BCC before ulceration and vascular structures become more prominent.

Our findings indicate that tumor size and histologic subtype interact to shape the dermoscopic appearance of BCC. Blue-gray ovoid nests were predominantly observed in smaller lesions, particularly in early nodular BCCs, whereas ulceration became more frequent in larger tumors, indicating progressive tumor growth and surface breakdown. These observations support the notion that discrete size thresholds, rather than gradual increases in tumor diameter, together with subtype-specific growth patterns and anatomical site-related factors, play a pivotal role in determining dermoscopic morphology. The identified dermoscopic variations likely mirror underlying histopathological progression, with blue-gray ovoid nests corresponding to early dermal tumor aggregates and ulceration reflecting more advanced stages of tissue invasion.

Limitations of the Study

Several limitations should be acknowledged. First, the retrospective, single-center design may limit the generalizability of the findings. Second, the sample size was relatively small particularly for superficial and infiltrative subtypes and the distribution of tumors across histologic categories, size groups, and anatomical sites was heterogeneous. No formal statistical power analysis was conducted; therefore, the results should be interpreted as exploratory and hypothesis-generating. Third, all dermoscopic assessments were performed by a single experienced dermatologist, which eliminated interobserver variability but may have introduced observer bias. Interobserver agreement was not assessed and should be addressed in future studies. In addition, lesions were not separately classified according to pigmentation status (pigmented vs. non-pigmented), which precluded subgroup-based analyses according to this variable. Finally, the cross-sectional design precluded evaluation of longitudinal dermoscopic changes, limiting insights into the temporal evolution of BCC morphology.

CONCLUSION

Given these findings, recognizing size- and subtype-dependent dermoscopic variations may aid earlier detection of BCC and particularly in small nodular lesions located in cosmetically and surgically challenging H-zone areas, and provide supportive information for clinical assessment.

Ethics Committee Approval: The study was approved by the Kayseri City Hospital Ethics Committee (no: 44, date: 28/03/2024).

Informed Consent: Informed consent was obtained from all participants.

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