Comment on "Guidelines of care for the management of basal cell carcinoma"

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To the Editor: With interest we read the new guidelines for the management of basal cell carcinoma (BCC) by the American Academy of Dermatology.[1] The objective was to provide an updated review (based on studies published up to August 2016) of the evidence and recommendations for diagnostic, therapeutic, and preventative modalities for US dermatologists. The authors did a great job judging the extensive amount of available evidence used in creating these guidelines. We agree with encouraging a patient-specific approach. Surgical excision remains superior to other treatments in terms of efficacy, though practical considerations and cosmetic outcome could counterbalance this choice.[2] As an addition, we have some suggestions with regard to the treatment of low-risk BCC with imiquimod, and we wish to address the position of radiation therapy (RT) in treatment of BCC.

The US guidelines advise initiating additional trials to compare the efficacy of noninvasive therapies for BCC. Fortunately, after the search on which the updated guidelines are based was completed, 2 large, well-executed randomized controlled trials (RCTs) were published.[3,4] Williams et al. report the 5-year results of an RCT comparing imiquimod to surgery in superficial and nodular BCC.[4] They conclude that surgery remains the criterion standard on the basis of its efficacy in 97.7% (relative risk of imiquimod compared with that of surgery, 0.84 98% confidence interval [CI], 0.77-0.91). However, with an 82.5% clearance rate, imiquimod was deemed an important treatment modality for low-risk superficial and nodular BCC.

Our group recently described the 5-year results of an RCT comparing imiquimod, 5-fluorouracil, and methyl-aminolevulinate photodynamic therapy (MAL-PDT).[3] Imiquimod was superior to MAL-PDT and 5-fluorouracil in terms of efficacy. The rates of tumor-free survival were 62.7% (95% CI, 55.3-69.2%) for MAL-PDT, 70.0% (95% CI, 62.9-76.0%) for 5-fluorouracil, and 80.5% (95% CI, 74.0-85.6%) for imiquimod. Imiquimod is therefore considered the first-choice noninvasive treatment for superficial BCC.

In our opinion, both trials provide good-quality evidence to conclude that imiquimod is a reliable treatment for patients with low-risk superficial BCC as an alternative to surgery, with excellent cosmetic outcome and the possibility of at-home treatment.

With regard to the position of RT in treatment of BCC, both the US guidelines and the European Dermatology Forum guideline[2] conclude that RT should be reserved for cases in which surgery is not feasible; however, the US guidelines align RT with noninvasive therapies for low-risk BCCs whereas the European Dermatology Forum guidelines reserve RT for high-risk BCCs.[2]

Until now, only 2 RCTs on RT for BCC have been published; both are dated, and RT techniques have changed extensively.[5] Thus, the current conclusion on the position of RT in treatment of BCC depends mostly on expert opinion.

There are many (noninvasive) alternatives for treatment of low-risk BCCs; therefore, in our opinion RT should be reserved for elderly patients with high-risk (facial) BCC, for whom surgery is unsuitable.[2]

Patients and physicians can make an educated treatment choice only after deliberation on all options and the advantages and disadvantages for their situation. We would like to add that there is appropriate evidence for the efficacy and safety of imiquimod for low-risk superficial BCC. Further evidence is needed to establish the position of RT in treatment of BCC.

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