

Comment on "Diagnosis and treatment of basal cell carcinoma

Citation for published version (APA):

van Delft, L. C. J., van Loo, E., Mosterd, K., & Kelleners-Smeets, N. W. J. (2020). Comment on "Diagnosis and treatment of basal cell carcinoma: European consensus-based interdisciplinary guidelines". *European Journal of Cancer*, 131, 98-99. <https://doi.org/10.1016/j.ejca.2019.12.002>

Document status and date:

Published: 01/05/2020

DOI:

[10.1016/j.ejca.2019.12.002](https://doi.org/10.1016/j.ejca.2019.12.002)

Document Version:

Publisher's PDF, also known as Version of record

Document license:

Taverne

Please check the document version of this publication:

- A submitted manuscript is the version of the article upon submission and before peer-review. There can be important differences between the submitted version and the official published version of record. People interested in the research are advised to contact the author for the final version of the publication, or visit the DOI to the publisher's website.
- The final author version and the galley proof are versions of the publication after peer review.
- The final published version features the final layout of the paper including the volume, issue and page numbers.

[Link to publication](#)

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal.

If the publication is distributed under the terms of Article 25fa of the Dutch Copyright Act, indicated by the "Taverne" license above, please follow below link for the End User Agreement:

www.umlib.nl/taverne-license

Take down policy

If you believe that this document breaches copyright please contact us at:

repository@maastrichtuniversity.nl

providing details and we will investigate your claim.



Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.ejcancer.com



Editorial Comment

Comment on “Diagnosis and treatment of basal cell carcinoma: European consensus–based interdisciplinary guidelines”



Lieke C.J. van Delft ^{a,b,*}, Eva van Loo ^{a,b}, Klara Mosterd ^{a,b},
Nicole W.J. Kelleners-Smeets ^{a,b}

^a Department of Dermatology, Maastricht University Medical Centre+, Maastricht, the Netherlands

^b GROW-School for Oncology and Developmental Biology Maastricht University Medical Centre+

Received 29 November 2019; accepted 4 December 2019

Available online 11 January 2020

KEYWORDS

Basal cell carcinoma;
Follow-up;
Mohs micrographic
surgery;
Safety margins;
Surgical safety margins

To the Editor

The European interdisciplinary guidelines on the diagnosis and treatment of basal cell carcinoma (BCC) are a thorough updated and expanded review of the literature [1]. The guidelines provide guidance for

physicians to optimise BCC care. We strongly agree with emphasising personalised care and an individualised approach for each patient and tumour. In addition, we would like to comment on the extensive safety margins advised for conventional (2D) surgical excision of high-risk BCCs and the proposed frequent follow-up of patients with a history of BCC.

Conventional surgery for BCC should always involve a safety margin of clinically uninvolved skin because BCC growth often reaches beyond the clinical tumour border. The tumour margins should be determined before surgery with the use of dermoscopy, especially when ill-defined [2]. Last year's American guidelines

DOI of original article: <https://doi.org/10.1016/j.ejca.2019.06.003>.

* Corresponding author: Maastricht University Medical Centre+, PO Box 5800, 6229 HX Maastricht, the Netherlands.

E-mail address: lieke.van.delft@mumc.nl (L.C.J. van Delft).

advise a 4-mm margin for low-risk BCC and do not give recommendations for safety margins for high-risk BCCs [3]. Peris *et al.*, more or less, agree with the American guidelines by advising a 3- to 4-mm margin for low-risk BCC, but recommend a margin of 5–15 mm for high-risk BCC [1]. Extensive margins such as these were previously described in 1989 by Breuninger *et al.* [4] based on margins needed for complete removal of high-risk primary and recurrent BCC in 3D histology. Peris *et al.* refer to guidelines and review articles that go back to 1987 because there is little to no prospective evidence available [1,5,6]. If physicians deem it necessary to use extensive margins up to 15 mm for high-risk primary and recurrent BCCs (in high-risk locations), micrographic surgery (3D histology or Mohs micrographic surgery) should be the standard of care to avoid unnecessary morbidity. We are well aware of the fact that there is limited access to micrographic surgery in several countries in Europe, but when expensive targeted therapies become more available in many countries in Europe, implementing a simple surgical/histopathological technique should not be too difficult. This would improve BCC care enormously.

Considering that time and resources are limited everywhere in Europe, we were surprised by the proposed follow-up scheme. The authors distinguish two groups of patients that are eligible for ‘rigorous and long-term follow-up’. [1]. The first group consists of patients at high risk for recurrence, for instance, patients that already had a recurrence after treatment of any kind of BCC. The second group includes patients with an history of many BCCs. Contrarily to the statements in the text, where the authors suggest 6- to 12-month follow-up; in the conclusion, the authors recommend a more frequent follow-up with 3-, 6- or 12-monthly intervals. Locally advanced or ‘difficult to treat’ BCC can cause functional and/or cosmetic morbidity and as stated, these tumours indeed need surveillance by a multidisciplinary team including radiologic follow-up in some cases every 6–12 months for 5–10 years. However, most other BCCs will not cause problems when detected a few months or even a few years later because BCCs are slow growing and have a non-aggressive nature [7].

Research has shown that patients with a first BCC often develop multiple BCCs and are at higher risk for developing other skin cancers [8,9]. Recurrences of high-risk BCCs can occur after 5–10 years of follow-up [10]. Moreover, recurrences of low-risk BCCs often present within the first three years of follow-up and can, at that time, be effectively treated surgically [11,12]. Thus, we would like to propose a more nuanced follow-up schedule with yearly follow-up, if follow-up is deemed necessary. In addition, a single check for residual BCC after destructive or non-invasive therapies for low-risk BCC, because there is no histological confirmation of

clear margins, is most of the time sufficient. For patients with completely excised low-risk BCCs, instructions for self-screening and follow-up might also be sufficient.

In conclusion, knowing that there is an average lifetime risk for fair-skinned individuals to develop BCC of approximately 30%, we have to be chary with resources [13]. If we put our efforts in optimal treatment, for instance, making micrographic surgery more available in Europe, extensive follow-up schemes might become redundant.

Funding

None.

Conflict of interest statement

All authors declare that they have no conflict of interest.

References

- [1] Peris K, et al. Diagnosis and treatment of basal cell carcinoma: European consensus-based interdisciplinary guidelines. *Eur J Cancer* 2019;118:10–34.
- [2] Reiter O, et al. The diagnostic accuracy of dermoscopy for basal cell carcinoma: a systematic review and meta-analysis. *J Am Acad Dermatol* 2019;80(5):1380–8.
- [3] Baum C, et al. Guidelines of care for the management of basal cell carcinoma. *J Am Acad Dermatol* 2018;78(3):540–59.
- [4] Breuninger H, et al. The margin of safety and depth of excision in surgical treatment of basalioma. Use of 3-dimensional histologic study of 2,016 tumors. *Hautarzt* 1989;40(11):693–700.
- [5] Nahhas AF, Scarbrough CA, Trotter S. A review of the global guidelines on surgical margins for nonmelanoma skin cancers. *J Clin Aesthet Dermatol* 2017;10(4):37–46.
- [6] Wolf DJ, Zitelli JA. Surgical margins for basal cell carcinoma. *Arch Dermatol* 1987;123(3):340–4.
- [7] Cameron MC, Lee E, Hibler BP, Giordano CN, Barker CA, Mori S, et al. Basal cell carcinoma: contemporary approaches to diagnosis, treatment, and prevention. *J Am Acad Dermatol* 2018; 80(2):321–39.
- [8] Wheless L, Black J, Alberg AJ. Nonmelanoma skin cancer and the risk of second primary cancers: a systematic review. *Cancer Epidemiol Biomarkers Prev* 2010;19(7):1686–95.
- [9] Verkouteren JAC, et al. Predicting the risk of a second basal cell carcinoma. *J Invest Dermatol* 2015;135(11):2649–56.
- [10] van Loo E, et al. Surgical excision versus Mohs’ micrographic surgery for basal cell carcinoma of the face: a randomised clinical trial with 10 year follow-up. *Eur J Cancer* 2014;50(17):3011–20.
- [11] Roozeboom MH, et al. Overall treatment success after treatment of primary superficial basal cell carcinoma: a systematic review and meta-analysis of randomized and nonrandomized trials. *Br J Dermatol* 2012;167(4):733–56.
- [12] Williams HC, et al. Surgery versus 5% imiquimod for nodular and superficial basal cell carcinoma: 5-year results of the SINS randomized controlled trial. *J Invest Dermatol* 2017;137(3):614–9.
- [13] Flohil SC, et al. Trends in Basal cell carcinoma incidence rates: a 37-year Dutch observational study. *J Invest Dermatol* 2013; 133(4):913–8.