

Comment on "Diagnosis and treatment of basal cell carcinoma: European consensus-based interdisciplinary guidelines"

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Editorial Comment

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



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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

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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.

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Conflict of interest statement

All authors declare that they have no conflict of interest.

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