Dear Dr. Jankovic,

your paper "Does incomplete excision of basal cell carcinoma of the eyelid mean tumor recurrence?" published last December was very interesting, but I have some questions about it.

1) Frozen sections were not used in any case/any topography. Why? According to literature, 4 mm around tumor would be enough to get free margins in basal cell carcinomas with low risk of recurrence, while tumors larger than 6 mm in the eyelid should have wider margins. This difference according tumor size was not mentioned in the paper: 1 mm basal cell treated with the same surgical margins as a 2.0 cm one.

2) there were only primary tumors or also recurrent ones?

3) I think the most important criticism is that the authors didn’t mention anything according tumor sub-types, i.e., how many/which were solid basal cell carcinomas, morphealike, micronodular, cystic, etc. The biological behavior of some sub-types of BCC is completely different and so might be the surgical margins. The same thing happens on primary versus recurrent BCCs.

4) as adjuvant therapy, radiotherapy could be used in BCC with positive margins. Wasn’t it a option to avoid wait and see?"

ENDEREÇO P/ CORRESPONDÊNCIA:

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Resposta / Reply

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We would like to thank Dr. Brechtbühl for his interest in our article and would like to attempt to address his questions.

Treatment of basal cell carcinoma (BCC) is a compromise between safe excision margins and obtaining a satisfactory cosmetic result.¹ In many patients the excision of BCCs results in the removal of significant amounts of normal tissue. To achieve the best functional and cosmetic results it is important to minimize the amount of normal tissue loss. On the other hand, surgical treatment should be made to ensure the best result from an oncological, functional, and aesthetic standpoint. Excision with frozen section margin control have the high cure rate with minimal loss of normal tissue, but in our study frozen sections where not used because we didn’t have cryotome.

For surgical excision many authors recommended minimum margins, especially for some particular areas as eyelid, for a better functional and aesthetic result.

Some authors recommended a surgical resection margin of 2 mm. Lallo et al. report the results of a prospective study of 63 patients who underwent excision of BCCs in the head and neck region. The mean tumor size was 15 mm (range: 2-52 mm). They propose that a clinical excision margin of 2 mm is adequate for treatment of simple, well demarcated BCCs arising in the head and neck.¹ Hsu et al. suggested that 2 mm excision margins of periocular basal cell carcinoma is a safe and efficient method.² Blasdale et al. excised BCCs with surgical margin of 2, 3 or 4 mm, where the mean tumor size was 12 mm (range: 5-30 mm).³