Resposta / Reply

Irena Jankovic [1]

[1] Plastic and reconstructive surgeon, Master of Science, Assistant Surgeon. Plastic and Reconstructive Surgery Clinic, Clinical Center Nis, Serbia.

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 15mm (range: 2- 52 mm). They propose that a clinical excision margin of 2mm is adequate for treatment of simple, well demarcated BCCs arising in the head and neck.[1] Hsuan 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]

Bisson et al. are being asked do plastic surgeons resect BCC too widely. They excised lesions whose size was 8.9 mm (range: 1-30 mm) with clinical excision margin of 3 mm. They propose that these margins provide a satisfactory balance between maintaining a low rate of incomplete excision and minimizing the sacrifice of normal skin.[4] The surgical excision policy of Malik et al.[5] involves primary clinical margins of excision of 3 mm circumferentially for all facial lesions.

Hamada et al. define surgical excision as the "gold standard for treatment among oculoplastic surgeons," and they also note that a 4 mm safety margin allows for the most tissue conservation while also reducing the chance of recurrence.[6]

However, these varied recommendations emphasize the clinical difficulties in judging the margins of a proportion of BCC - by a wide range of experienced clinicians.

In our unit the excision margins was 3-4 mm from the tumor edge.[7] The margins of 3mm used in tumors diameter less than 2 cm, and the margins of 4 mm used in up to 2 cm tumor diameter.

The mean tumor size was 9.79 mm (range: 2-30 mm). Only primary tumors include in this study, of which just 3 (2.7 %) was morphealike form. Because morphealike form make up a small proportion of the total, making firm conclusions on their behavior was impossible.

More patients will be included in future research from multivariate analysis to define independent predictor(s) of recurrence, when except the tumor localization, incomplete excision, patients age and gender, be analyzed tumor size, various subtypes and the recurrent tumor.

Positive margins were diagnosed in 21 of 111 patients (18,92 %).[7] In the case of surgical removal of a lesion with positive margins of BCC, a treatment dilemma ensues. Should the lesion be watched or re-excised?

As adjuvant therapy, radiotherapy could be used in BCC with positive margins, but radiotherapy generally reserved for patients over 60 years because of concerns about long term sequellae.[8]

In addition, radiotherapy does have potential side effects: alopecia, cataract, conjunctivitis, corneal exposure, dermatitis, dry eye, lachrymal duct stenosis, ocular ischemia, optic neuropathy, pain, red eye, and retinopathy.[9] A drawback to radiation therapy is that it can usually only be given once to each location. Thus, if a tumor recurs after radiation therapy, further radiation therapy cannot be given. Also, radiation may complicate concurrent or future surgical reconstruction and healing.[10] Mendenhall et all. suggested that patients with BCCs on free skin that have been resected with a focally positive margin may be followed and treated only in the event of a subsequent recurrence.[11]

Moreover, in our country stand of Consilium of the skin and soft tissue is that adjuvant radiotherapy doesn't use in periorbital BCC with positive margins due to eye damage.

The likelihood of an irradiation-induced malignancy is likely less than 1% with a latency period of 7 to 10 years or more.[11]

Nevertheless, this is an additional reason to select postoperative monitoring rather than radiotherapy.

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Endereço para contato:
Irena Jankovic
Blv. Zorana Djindjica – 48
Nis. 18000. Serbia and Montenegro
jankovic@jotel.co.rs

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Dear Dr. Jankovic,

thanks for the explanations that could answer some questions about your paper. We are looking forward for the multivariate analysis and the further conclusions. In the opposite way, at our Hospital (Hospital A. C. Camargo, São Paulo, Brasil), the majority of the patients with positive margins of BCC are reoperated, most of them with frozen section margin control and reconstructive surgery. In our experience the recurrence rate is less than 3% (minimum 5 year follow up). We also hope you could buy as soon as possible a cryotome.

Kind regards,

Eduard René Brechtbühl.

Endereço p/ correspondência:
Eduard René Brechtbühl
R. Barata Ribeiro, 490, 5º andar
Bela Vista - São Paulo - SP
tel. 55-11-3255-7599
dr.erb@uol.com.br