Basal Cell Carcinoma

Guidelines for Management in the Primary Care Setting

Basal cell carcinoma (BCC) is the most common cancer in Australia. As it is a slow-growing, locally invasive tumour, morbidity results from local tissue destruction but metastasis is extremely rare. There are several treatment options, depending on the presence of high risk features and other patient-related factors. Adequate primary treatment is essential as recurrent tumours are more difficult to cure than primary disease.

HIGH RISK FEATURES

- Tumours >10mm on head and neck or >20mm on trunk and extremities (except for superficial BCC that can be managed non-surgically)
- Facial tumours (around eyes, nose, ears)
- Poorly defined margins or induration
- Aggressive histologic subtypes (micronodular, infiltrating, morphoeic, basosquamous/metatypical)
- Symptoms that may indicate perineural invasion (tingling, pain, paraesthesia, formication, dysaesthesia, impaired motor function)
- Fixation to underlying structures or location over important structures
- Recurrent or incompletely excised tumours
- Genetic predisposition (e.g. Gorlin Syndrome, Xeroderma Pigmentosum)
- Immunosuppression

Depending on the circumstances and expertise, the presence of high risk features should prompt consideration of referral for specialist review.

PRIMARY THERAPEUTIC OPTIONS

In addition to the presence of high risk features, the choice of treatment is influenced by patient factors including age, general health and co-morbidities.

Surgical excision

Most low-risk cases can be excised with a 2-3mm margin. Aggressive subtypes require a wider surgical margin of at least 3-4mm; however, some cases may require much wider margins and referral for frozen section or Mohs micrographic surgery may be appropriate.

Other techniques

These methods are generally not suitable for cases with high risk features, but may be appropriate for patients who will not tolerate surgery. They can be used in combination.

- Cryotherapy
- Curettage and cautery

Specialist referral is required for other treatment options such as Imiquimod, photodynamic therapy and radiation therapy.

HISTOPATHOLOGY REPORT

This should include

- Greatest diameter
- Subtype
- Clark level of invasion (not required for superficial BCC)
- Perineural invasion including location and diameter of nerves involved, as well as margin clearance
- Lymphovascular invasion (only for basosquamous carcinoma)
- Margin clearance including growth pattern at involved margin and extent of involvement

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Histological margins

For low risk tumours, a histological margin of 0.5mm is adequate. In high risk tumours a minimum histological clearance of 1mm is desirable.

In incompletely excised primary tumours, the risk of recurrence is higher when:

- Both deep and peripheral margins are involved
- The deep margin is involved (33% versus 17% for lateral margin involvement)

Incompletely excised tumours in high risk sites, particularly if an aggressive subtype, should be referred for specialist opinion.

Perineural invasion (PNI)

This is a rare occurrence and requires no further treatment if present in a low risk pattern.

- Incidentally detected (i.e. no clinical symptoms)
- Focal and close to advancing edge of tumour
- Involves nerves no larger than 0.1mm diameter
- At least 1mm from margin

Extensive PNI is usually seen in infiltrative BCCs of the face and these cases require specialist referral.

FOLLOW UP

No specific follow up scheme is required for low risk tumours that have been completely excised.

Patients with any high risk features should be followed up at 3 months then every 6 months, including nodal examination.

Patients who have been treated with ablative techniques should be followed up at 3 months, then every 6 months for 3 years. This should be followed by at least annual professional examinations, supplemented by 3-monthly self-examinations.

Annual skin examination is recommended for all patients who have had skin cancer.

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