BCC Algorithm Praised

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A M S T E R D A M — There has been “very little good quality research” overall on treatments for basal cell carcinoma, according to the latest Cochrane Systematic Review on the topic.

This is particularly hard to fathom since basal cell carcinoma (BCC) is the most common form of cancer in humans and an enormous volume of physician work is devoted to its treatment, Fiona J. Bath-Hextall, Ph.D., the review’s lead author, noted at the 11th World Congress on Cancers of the Skin.

The review encompassed 27 published and unpublished randomized controlled trials involving surgical excision, radiotherapy, cryotherapy, photodynamic therapy (PDT), intralesional interferon, the plant-derived mixture of salsodine glycosides known as BCC-5 cream, topical 5-fluorouracil, and imiquimod.

The clear winners in terms of efficacy as reflected in the primary end point adopted for the review—BCC recurrence rates at 1-3 years—were surgery and radiotherapy. And in the sole head-to-head comparative trial of these two therapies, surgery had had fewer residual tumors. Only one of the most widely used form of treatment compared directly with surgery, which is the recently completed 32 randomized study involving 505 primary superficial BCCs at the Skin Cancer Foundation and Erasmus University, Rotterdam.

Few of the other therapies have been compared directly with surgery, which is the most widely used form of treatment as well as the one supported by the strongest evidence of efficacy.

Most of the clinical trials involved only BCCs in low-risk locations. Only one focused on high-risk facial BCCs. Moreover, many of the studies didn’t make it clear what type of BCC was included. Not most trials consider recurrent or morpheaform BCCs separately, as is warranted given their lower treatment success rates.

Although the seven PDT trials included in the review collectively indicate that it is a promising modality with cosmetic outcomes significantly better than surgery, PDT has also a relatively high failure rate and is expensive. Longer-term efficacy data are needed before it is appropriate for PDT to enter routine clinical practice, according to the Cochrane reviewers.

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DR. BATH-HEXTALL

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BCC. Histologically aggressive subtypes such as morpheaform or infiltrative BCC are also at increased risk for recurrence. For this reason, Dr. Smeets recommends always obtaining a biopsy before treating a BCC.

For a primary lesion on the face that is at least 1 cm and located in the H zone, or of an aggressive subtype, Mohs surgery is clearly the best option, she said. It is not as widely available in Europe as in the United States, though, and when it is unavailable surgical excision is next best. Other options are best reserved for patients who are poor surgical candidates.

For primary superficial BCCs less than 2 cm located in areas other than the face, the strongest supporting evidence is for surgical excision, but PDT with fractionated illumination has recently joined it as a legitimate first-line therapy in Dr. Smeets’ view. She cited a Dutch randomized study involving 165 primary superficial BCCs in which “the group receiving the treatment following 5-aminoavulinic acid PDT with illumination using two light fractions 2 hours apart was a very acceptable 97%, compared with 89% with a single illumination (J Invest. Dermatol. 2006;126:1679-86).”

For nodular BCC outside the face, however, excision remains the sole first-line therapy. The recently completed 3-year follow-up of a previously published British trial (Arch. Dermatol. 2004;140:17-23) showed a 14% recurrence rate for PDT, compared with just 4% for excision in 93 randomized patients, she noted.

Dr. Perry Robins, honorary president of the congress, praised Dr. Smeets’ algorithm, with its major role for Mohs surgery, as “a beautiful presentation.”

“Mohs surgery is a misnomer,” asserted Dr. Robins, chief of the Mohs micrographic surgery unit at New York University, New York. “What is Mohs surgery? Is it something complicated, something expensive, something difficult? Non-sense! Mohs surgery is surgical excision with instant pathology.”

“I’ve done 47,000 Mohs cases, 10% in the periorbital area. More than half were on one layer. So what would you like to do: Excise something and have instant pathology, or excise something, send it to the laboratory, and tell the patient, ‘I hope we got it all’?”

Mohs surgeons are required to read their own slides, so the cost is not all that great,” he added. “You don’t have the cost for the pathologist, it’s done in an office setting, and the patient goes home with a big smile. And because we have the luxury of going back a second time we don’t have to do a guessmate.”

Dr. Smeets’ trial was sponsored by the Dutch Foundation for Investigative Medicine, a governmental agency.