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Local recurrence of clinically observed basal cell carcinomas following complete saucerization or punch removal with negative margins: Retrospective case series from 2010 to 2020

To the Editor: Clinically well-defined, smaller (<1 cm) basal cell carcinomas (BCCs) are often amenable to saucerization shave or punch biopsy with the intent of complete removal at diagnosis. Few studies have assessed whether narrow-margin complete biopsy with negative histopathologic margins may be sufficient treatment for lower-risk BCCs; limited data of mainly superficial BCCs tangentially shave biopsied with negative margins showed low (0.5%) recurrence.[1] Our retrospective analysis aimed to determine (1) local recurrence of completely biopsied BCCs with negative histopathologic margins on standard vertical breadloaf sectioning that were then clinically observed and (2) whether prebiopsy size, biopsy type, anatomic location, subtype, and histologic deep and peripheral margin measurement differed in recurrent versus nonrecurrent cases.

The cohort consisted of consecutive dermatology patients with clinically/dermoscopically characteristic BCCs who underwent attempted complete saucerization (to the mid-reticular dermis) or full-thickness punch removal with estimated 1- to 2-mm margins at the Veterans Affairs Palo Alto Health Care System from May 24, 2010, through December 31, 2017, and were followed for at least 1 year thereafter, with clinical follow-up through February 18, 2020. Biopsy intent (excisional versus partial) was documented for all lesions, as was recurrence/nonrecurrence of each biopsy site at the last clinic follow-up visit. The study was approved by the institutional review boards at Stanford University Medical Center and Veterans Affairs Palo Alto Health Care System. Standard breadloaf sectioning was performed, along with additional processing of tip specimens for complete saucerizations, for more thorough margin assessment. A subset of specimens was reviewed by a dermatopathologist (EB) and dermatologist (SMS) to measure the narrowest deep and mean peripheral margins (to the right and left of the tumor), with the closest peripheral margin used for analysis. BCCs with stroma at the margins were considered narrowly excised and were coded as less than 0.1-mm margins. Partial/incomplete biopsies were excluded, as were cases treated with electrodesiccation and curettage, cryotherapy, topical 5-fluorouracil, or imiquimod cream after biopsy (n = 36) and those with less than 12 months of follow-up (n = 97). Differences between recurrent and nonrecurrent tumors were evaluated by chi-square test for categorical features, Student *t* test for age, and Wilcoxon's rank sum test for prebiopsy size and histologic margins. All tests were 2 sided; statistical significance was defined as *P* less than .05. Statistical analyses were performed with SAS, version 9.4 (SAS Institute Inc, Cary, NC).

Of 2739 BCCs identified in 327 patients (98% male; mean age, 72 years), 413 were intentionally completely biopsied (92% via saucerization) and had clear histologic margins; 14 BCCs (3.4%) recurred at a mean (standard deviation [SD]) follow-up of 51.4 (27) months, with a mean (SD) time to recurrence of 17 (9) months. Most tumors were nodular (68%) or superficial/early nodular (23%) subtype, with a median size of 6 mm (range, 1-27 mm). Recurrences were less common on the trunk/extremities (5/268; 1.9%) compared with the head/neck (9/145; 6.2%; $P = .02$) (Table I). Recurrent BCCs were treated as described in Table II. In 10 recurrent and 76 randomly selected nonrecurrent cases, histologic measurement of the mean (SD) closest peripheral margin was similar (1.7 [1.1] vs 1.2 [1.3] mm; $P = .10$); the same was true for the narrowest deep margins (0.5 [0.6] vs 0.6 [0.8] mm; $P = .98$).

Narrow-margin saucerization or punch removal of smaller (<1 cm) nodular BCCs on the trunk and extremities with clear histopathologic margins showed low recurrence, although this study is limited by follow-up time (mean, 51.4 months) and imprecise prebiopsy margin measurement. Likewise, our practice of documenting biopsy intent (incomplete vs complete removal), pathology sectioning for excisional saucerizations to include

Table I. Baseline characteristics of study population

Characteristics	Total (N = 413)	Nonrecurrent (n = 399)	Recurrent (n = 14)	*P* value
Sex, n (%)				
M	406 (98)	395 (99)	14 (100)	>.99
F	4 (1)	4 (1)	0	
Age, y, mean (SD)	71.6 (11.3)	71.7 (11.4)	68.9 (9.3)	.35
Follow-up time, mo, mean (SD) (at least 1 year for all patients)	51.4 (27.2)	51.2 (26.9)	57.9 (32.9)	.42
BCC subtype of initial tumor, n (%)				
Nodular	279 (68)	268 (67)	11 (79)	
Superficial/early nodular	93 (23)	90 (23)	3 (21)	
Superficial	37 (9)	37 (9)	0	
Infiltrative	4 (1)	4 (1)	0	.72
Biopsy type, n (%)				
Shave	381 (92)	369 (92)	12 (86)	.30
Punch	32 (8)	30 (8)	2 (14)	
Location, n (%)				
Head and neck	145 (35)	136 (34)	9 (64)	
Extremities	72 (17)	69 (17)	3 (21)	.02
Trunk	196 (47)	194 (49)	2 (14)	
Prebiopsy size, mm, greatest dimension, median (range)	6 (1-27)	6 (1.5-27)	7 (1-15)	.56
Histologic closest peripheral margin, mm, mean (SD)	1.7 (1.1)	1.7 (1.1)	1.2 (1.3)	.10
Histologic deep margin, mm, mean (SD)	0.5 (0.6)	0.5 (0.6)	0.6 (0.8)	.98

SD, Standard deviation.

Table II. Features of recurrent cases

Case	Initial BCC subtype	Age at diagnosis, y	Recurrence BCC subtype	Location	Largest dimension of initial tumor, mm	Time to recurrence, mo	Treatment of recurrence
1	sup/early nod	67	nod	extremity	15	22	MMS
2	nod	63	nod	head + neck	5	26	MMS
3	nod	61	nod	head + neck	not specified	9	MMS
4	sup/early nod	69	sup/early nod	trunk	10	17	excision
5	nod	85	nod	head + neck	7	36	MMS
6	nod	64	nod	head + neck	1	11	MMS
7	sup/early nod	66	nod	head + neck	10	27	MMS
8	nod	92	nod	head + neck	2	4	MMS
9	nod	60	sup/early nod	head + neck	8	11	excision and imiquimod
10	nod	76	nod	head + neck	7	7	excision
11	sup/early nod	69	nod	extremity	not specified	71	excision
12	nod	68	nod	extremity	4	17	n/a, excised on repeat biopsy
13	sup/early nod	64	sup/early nod	trunk	10	9	n/a, excised on repeat biopsy
14	nod	65	nodular	head + neck	7	26	MMS

MMS, Mohs micrographic surgery; *n/a*, not applicable; *nod*, nodular; *sup*, superficial.

tips, and joint review of pathology specimens by the clinician and pathologist may not apply to other clinical settings. Current clinical practice guidelines for BCC do not address biopsy intent, recommending excision of low-risk BCCs with 4-mm surgical margins, or electrodesiccation and curettage, based on expert opinion and a few small studies.[2-4] Our findings suggest that biopsy with excisional intent is curative in the majority of cases; however, any decision to forego further treatment should consider

BCC subtype and size, cosmetic outcome, and patient functional status or desire to pursue surgery. Prospective analyses with longer follow-up are needed to confirm similar favorable outcomes and assess whether clinical observation after complete biopsy of lower-risk BCCs reduces treatment-related morbidity and cost.[5]

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Dermoscopy predicts outcome in hemoporfin-mediated photodynamic therapy of port-wine stains: A prospective observational study

To the Editor: Port-wine stain (PWS) is defined as ectasia of the vessels in the dermis, affecting the dermal papillae capillary loops, the horizontal plexus at the dermal-subcutaneous junction, or a combination of these.[1] Recent studies have identified 2 main dermoscopic patterns of PWS. Type 1 is a superficial pattern composed of red globules and dots that correspond to dilated capillary loops in the papillary dermis. Type 2 is a deep pattern that features red ring structures corresponding to dilated ectatic vessels located deep in the horizontal vascular plexus.[2] Histopathologic examination is the standard approach to determine the depth of the vascular lesion, but it is invasive.

Dermoscopy can preoperatively predict the outcome of treatment and the minimal effective fluence in pulsed dye laser treatment.[3,4] PWS in areas that typically respond well to laser treatment were more likely to have a superficial type 1 but those that have a poorer response were more likely to have a deeper type 2. The immediate vessel disappearance after pulsed dye laser treatment observed by dermoscopy can predict the minimal effective fluence and prevent adverse effects.

Table I. Profile of the patients in the study

Patient No.	Age, y	Sex	PWS location	Response*
Group A				
1	10	Female	Right cheek	CR
2	31	Male	Mandible and neck	GI
3	4	Female	Mandible	CR
4	8	Male	Right chin	GI
5	6	Male	Left cheek	GI
6	11	Male	Left cheek	GI
7	4	Female	Left cheek and orbit	CR
8	4	Female	Left temporal	CR
Group B				
1	8	Male	Right cheek	NI
2	40	Female	Mandible and neck	SI
3	6	Female	Right cheek	NI
4	7	Male	Right cheek	NI
5	18	Male	Left cheek	NI
6	9	Male	Left cheek	NI
7	8	Male	Right cheek	NI
8	19	Male	Right cheek	NI

PWS, Port wine stain.
*No improvement (*NI*): <20%; some improvement (*SI*): 20%-59%; great improvement (*GI*): 60%-89%; nearly completely resolved (*CR*): 90%.