



# Treatment of Basal Cell Carcinoma in the Elderly: What Nondermatologists Need to Know

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## ABSTRACT

As the population ages and incidence of basal cell carcinoma continues to increase, we will be faced more frequently with difficult treatment decisions for basal cell carcinoma in the elderly. Different treatment options, including surgical excision, electrodesiccation and curettage, cryosurgery, imiquimod, photodynamic therapy, 5-fluorouracil, radiation therapy, vismodegib, combination therapy, and observation, may be considered on the basis of tumor characteristics. Given the wide range of therapeutic options, treatments can be tailored to achieve patients' goals of care within their anticipated life expectancy.

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**KEYWORDS:** Basal cell carcinoma; Cryosurgery; Dermatologic surgery; Elderly; Electrodesiccation and curettage; Imiquimod; Life expectancy; Mohs surgery; Nonmelanoma skin cancer; Photodynamic therapy; Vismodegib

In the United States, basal cell carcinoma accounts for approximately 25% of all diagnosed cancers, with more than 2.8 million new cases diagnosed each year, and is the most common malignancy in Caucasians.<sup>1-5</sup> Although the US Preventive Services Task Force does not recommend routine screening for skin cancer and recently stated that the current evidence is insufficient to assess the balance of benefits and harms of visual skin cancer screening,<sup>6</sup> because these malignancies often occur in sun-exposed areas, they often will be detected by patients, their families or friends, or examining physicians.

In part because of a decline in fertility and a 20-year increase in average life span during the latter half of the 20th century, the median age of the world's population is increasing.<sup>7,8</sup> Given the recent increase in diagnosis of basal cell carcinoma without a change in death rate, some authors suggest that basal cell carcinoma is being overdiagnosed in the elderly and have proposed that practitioners differentiate

the treatment of symptomatic vs screening-detected basal cell carcinomas in the elderly.<sup>9</sup>

As the population ages and incidence of basal cell carcinoma continues to increase, we will be faced more frequently with difficult patient questions and treatment decisions: What is the appropriate treatment for basal cell carcinoma in the elderly? Should the basal cell carcinoma of a patient with a limited life expectancy be treated in the same way as that of a younger patient? Can nonagenarians safely undergo surgical excision or Mohs micrographic surgery? These questions and others are increasingly being addressed in the dermatologic and internal medicine literature, and nondermatologists should be able to discuss options with patients in clinical practice (**Table**).

In a study of treatment patterns for nonmelanoma skin cancer including basal and squamous cell carcinomas among patients with limited life expectancy, defined as age of 85 years or older or a Charlson Comorbidity Index of 3 or higher, 70.1% underwent surgery, of whom 33.9% underwent Mohs surgery and 36.2% underwent simple surgical excision, 25.2% were treated with destruction (a broad category that included cryotherapy, electrodesiccation and curettage, laser, and irradiation), and 3.3% received no treatment. There was no significant difference noted in rates of the various treatment types, including surgery, according to patient life expectancy. This study also reported

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complications in approximately 20% of patients with limited life expectancy, compared with 15% in other patients.<sup>10</sup>

## TREATMENT OPTIONS

Different treatment options may be considered on the basis of tumor characteristics. “High-risk” basal cell carcinomas have been defined as those of long duration, larger than 2 cm in diameter, with anatomic location in the mid-face or ear, with aggressive histologic subtype (infiltrative, sclerosing, morpheaform, or micronodular), with recurrence despite previous treatment, that are neglected, or occurring in patients with a history of radiation exposure.<sup>11,12</sup> Conversely, low-risk basal cell carcinomas are those on the trunk or limbs, less than 1 cm in size, and in patients without a history of radiation exposure and who are not organ transplant recipients. The incidence of metastatic basal cell carcinoma is low, reported between 0.0028% and 0.5%,<sup>13</sup> with more than 80% of these originating from head and neck primary basal cell carcinomas.<sup>14</sup> Histologic subtypes that are more aggressive, such as the aforementioned infiltrative, sclerosing, morpheaform, and micronodular, are at increased risk of subclinical tumor extension and metastasis.<sup>15</sup> Therefore, Mohs surgery, with its complete margin analysis, is typically preferred over standard excision followed by “bread loaf” processing of sections in these aggressive subtypes.<sup>16</sup>

## SURGICAL EXCISION

Surgical treatment options for basal cell carcinomas include conventional surgical excision and Mohs micrographic surgery. Mohs surgery is considered the gold standard of therapy for a variety of nonmelanoma skin cancers in large part because of its complete margin analysis that can delineate subclinical tumor spread.<sup>17</sup>

The appropriate use criteria for Mohs surgery, which were developed in 2012 by the American Academy of Dermatology in collaboration with the American College of Mohs Surgery, the American Society for Dermatologic Surgery Association, and the American Society for Mohs Surgery, did not specifically address age in their recommendations of appropriateness of Mohs surgery for specific tumor types and anatomic locations.<sup>18</sup> These criteria ascertained that Mohs surgery was appropriate for the majority of basal cell carcinomas, although it was designated inappropriate in certain forms and subtypes of patients (eg, for low-risk subtypes including recurrent superficial and primary

nodular basal cell carcinoma when located on the trunk and extremities, excluding pretibial surface, hands, feet, nail units, and ankles).

Mohs surgery has been reported to take 3 times as long as conventional excision, with mean procedure length of the former reported as 3 hours vs 1 hour for the latter.<sup>19</sup> This

increase in procedure length has been suggested to be more problematic for frail patients,<sup>10</sup> although Mohs surgery has been shown to be a safe procedure in the elderly. A retrospective study of 115 nonagenarians (average age of 92.4 years) who underwent Mohs surgery for skin cancer (including nonmelanoma skin cancer and melanoma) reported just 1 postsurgical complication and concluded that Mohs surgery is a safe and effective therapy for this population.<sup>20</sup> A different study in nonagenarians having undergone Mohs for non-melanoma skin cancer reported a median survival of 36.9 months, with no complications.<sup>21</sup> This

study also found that tumor type, size, location, number of stages, and defect size did not affect survival. Specifically, there was no survival difference between patients who underwent 1 to 2 stages and those who had  $\geq 3$ . The only significant risk factor the study identified was gender, with women experiencing a survival advantage over men ( $P < .02$ ), as is consistent with average life expectancy and earlier studies.<sup>22</sup>

The role of comorbid conditions on survival after Mohs micrographic surgery also has been studied. A retrospective study of 99 nonagenarians who underwent Mohs micrographic surgery for nonmelanoma skin cancer found that patients without comorbidities (as quantified by the Charlson index) had a significantly longer survival than those with multiple comorbidities ( $\geq 3$ ). The same study also found that women survived longer than men at both 1 and 5 years follow-up.<sup>22</sup> These findings suggest a role for considering comorbid conditions when evaluating life expectancy and treatment approach in basal cell carcinomas.

## ELECTRODESSICATION AND CURETTAGE

Dermatologists frequently use electrodesiccation with curettage to treat basal cell carcinomas, and cure rates as high as 97% to 98.8% have been reported.<sup>23,24</sup> This treatment is not considered appropriate for lesions with extension into the deep dermis. Lesional and perilesional skin are anesthetized, with curettage and electrodesiccation following in 2 to 3 cycles. The highest cure rates have been reported with a 2- to 8-mm peripheral margin from the initial curettage. One study reported an inverse relationship

### CLINICAL SIGNIFICANCE

- As the population ages and incidence of basal cell carcinoma continues to increase, we will be faced more frequently with difficult treatment decisions for basal cell carcinoma in the elderly.
- Different treatment options may be considered on the basis of tumor characteristics.
- Given the wide range of treatment options for basal cell carcinoma, treatments can be tailored to achieve patients' goals of care within their anticipated life expectancy.

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